LGBT Aging at the Golden Gate:

San Francisco Policy Issues & Recommendations

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FORWARD

The San Francisco Lesbian, Gay, Bisexual, and Transgender (LGBT) Aging Policy Task Force and this final Report are products of a community effort to raise the profile of issues affecting LGBT seniors in San Francisco. The Task Force was established at the urging of LGBT community members following a community-led process that started in the San Francisco's Human Rights Commission's LGBT Advisory Committee.

While a few special programs and services have been created in San Francisco to help LGBT seniors age in place here, there is still not even close to an adequate level to meet the significant unmet needs of this special population within the larger community of seniors. The reasons that San Francisco lacks these specialized services for LGBT seniors in 2014 are twofold.

First, city leaders and department heads are just now beginning to grapple with a senior service industry that includes seniors who choose to identify openly as LGBT and other LGBT seniors who may choose to stay in the closet but nevertheless want and expect to be treated with dignity – and free from harassment and discrimination - as an LGBT person. To a large extent, this is a case of first impression for city programs and services that cater to seniors and aging adults. There may be few if any analogous programs or services in other parts of the country for the city to emulate in building an adequate infrastructure here for LGBT seniors.

Second, and just as significant, the LGBT community in San Francisco has not advocated for senior services as any kind of community priority in the past, and certainly not in a sustained way. While some of the reasons are fairly clear why this was not a community priority – including ageism within the LGBT community as well as other political issues that dominated the community's agenda – the fact remains that the LGBT community in San Francisco has not effectively advocated for senior services.

It is the sincere goal of the Task Force that every LGBT senior and aging adult in San Francisco can pick up this Report and see themselves reflected here. We hope that our research and recommendations not only benefit a large number of LGBT seniors, but we also hope that our work touches the lives of those who are typically left out of the discussion: lesbians, bisexuals, transgender men and women, seniors of color and homeless seniors. Our recommendations are not only for low-income seniors, but seniors in all socio-economic groups. Our work is not just about the mainstream in the LGBT community but encompasses the breadth and beautiful diversity that makes our community so unique and wonderful. Any lesser effort would not be worthy of our great city.

While assessing, researching and analyzing the needs of San Francisco's vulnerable LGBT seniors, we did so with doors open wide for collaboration. We understand the wisdom in the adage that says "what we desire for ourselves we should also desire for others" - a safe place to live, affordable housing, a supportive community, adequate food, health care and the basic necessities of life. We also value the principles of justice and equity, and understand that along with the tangible measurements of policy adoption and regulatory implementation, the principles of justice and equity will also be a measure of our success.

So now the Task Force is present at this moment in our history – at a time and a place that gives us an opportunity to create a safe and respectful environment for the pioneering LGBT men and women who built the community we all call home. We must stand for the principle that LGBT men and women who built their homes here should be able to stay here as they age. And we must be part of the generation that not only tells young LGBTs that "it gets better" but tells older LGBTs, "it keeps getting better."

We stand at the intersection of social justice and public policy for vulnerable LGBT seniors in San Francisco, and proudly recommend these essential public policies that we believe will enhance the living LGBT seniors in San Francisco. Our recommendations are mostly aimed at the city government and what it can do to improve the lives of LGBT seniors. At the same time, the Task Force has issued recommendations and challenges to the LGBT community and beyond, individuals and organizations alike, to embrace seniors in a new way. To build a model community that honors and cares for LGBT men and women of all ages, and in turn builds a senior service infrastructure that better serves all San Franciscans.

San Francisco LGBT Aging Policy Task Force
March 2014

TASK FORCE MEMBERS AND STAFF

Marcy Adelman, Ph.D. is a clinical psychologist in private practice and a writer, researcher and lecturer on LGBT aging. Adelman, co-founder of Openhouse, a non-profit LGBT senior housing and service organization, serves on the Board and chairs the Research and Policy Committee. She is a member of the Advisory Council of the Department of Aging and Adult Services. In 2011 she received the Advocate Innovator of the Year Award and the Purpose Prize in 2009. Member, Health/Social Services Work Group

Michelle Alcedo (Health/Social Services Work Group Vice-Chair), is Director of Programs at Openhouse, a San Francisco-based non-profit organization serving LGBT older adults 55+ in the San Francisco Bay Area. Since 2007 as a diversity trainer on LGBT aging issues for Openhouse, Michelle has trained over 2,500 from 200+ agencies to foster safe and welcoming services and programs meeting the needs of LGBT older adults. Michelle is Vice-Chair of the San Francisco Coalition of Agencies Serving the Elderly (CASE) Board of Directors. Member, Health/Social Services Word Group.

Bill Ambrunn (Task Force Chair) is a native San Franciscan and an attorney, currently serving as Donor Relations Officer for the ACLU of Northern California. In the 1990s, he served as chief of staff to former Supervisor Susan Leal, the first LGBT person of color elected in San Francisco and he has worked in the LGBT community for more than 25 years. Ambrunn is a former member of the S.F. Human Rights Commission's LGBT Advisory Committee. Member, Legal Issues Work Group

L. Michael Costa, M.P.P., is a health policy professional who has developed and implemented innovative healthcare coverage products and programs increasing access to affordable healthcare and new therapies. He successfully lobbied for changes in state law minimizing discriminatory underwriting in the health insurance market, helped develop patient assistance programs providing free therapy to underinsured individuals, and advised the Washington State Legislature, NYS Health Department, Congressional Budget Office, NYC Council, and the SF Board of Supervisors. Member, Health/Social Services Work Group

Scott J. Haitsuka is currently an associate clinical social worker and the Program Coordinator with Openhouse. His commitment to the health and wellbeing of San Francisco's LGBTQQI community spans over 25 years. He began as an emotional support volunteer with Shanti Project, has worked professionally with the LGBT Community Center, and New Leaf Services for Our Community. As an advocate for peer-based recovery, he recently served on SF MHSA Older Adult Peer Services Planning Committee. Member, Health/Social Services Work Group

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Tommi Avicolli Mecca (Housing Work Group Chair) is a longtime queer activist who was part of the Gay Liberation Front at Temple University in Philadelphia in the early 1970s. Since moving to San Francisco in 1991, he helped set up four LGBT shelters, a food program and a shower project. He currently works at the Housing Rights Committee doing tenants' rights and affordable housing advocacy. In his spare time, he is a writer, playwright and singer/songwriter.

Joyce Pierson, M.A., M.F.T., is an activist and elder law advocate since 1975. Joyce served LGBT seniors in San Francisco's early outreach services through Operation Concern, Gay & Lesbian Outreach and New Leaf from 1991-1999. An experienced elder law paralegal/educator in the California Aging Network, she served as consultant /organizer for NCLR's LGBT Elder Law Project, the nation's first LGBT elder law services. Now semi-retired, Joyce is a long term and elder care consultant for Bay Area seniors. Member, Health/Social Services Work Group

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Jorge Rodriguez is a retired case manager for HIV Clínica Esperanza. A former hotel general manager, Jorge made a change in careers after losing his partner to AIDS. Besides the Task Force, Jorge helps new Latino HIV+ immigrants seeking political asylum and volunteers for the AIDS Legal Referral Panel and the SF Lawyers Committee. He is bilingual (Spanish) and works as an interpreter and translator. Member, Health/Social Services Work Group

Kaushik Roy serves as Executive Director of The Shanti Project, one of San Francisco's oldest nonprofits supporting people with HIV/AIDS and cancer. He holds a B.A. from UC Berkeley, is a graduate of the Metta Institute's End-of-Life Care Practitioner Program, and recently completed the LeaderSpring 2-year Fellowship Program for leading change in strengthening underserved communities. Kaushik was recognized as the 2013 Bay Area Young Nonprofit Executive Director of the Year by the Young Nonprofit Professionals Network. Member, Health/Social Services Work Group

Larry Saxxon is a member of the state AARP Executive Council and the Human Rights Commission's LGBT Advisory Committee. He served in the AIDS field in the early 1980s and has served the LGBT, African American, and the African immigrant communities in philanthropy, government and the nonprofit sector for the past 30 years. Larry and his husband are fathers and have been together for over 33 years. Member, Health/Social Services Work Group

Moli Steinert is Executive Director of SteppingStone Adult Day Health Care. She previously was Executive Director of Openhouse where she led efforts to build better access to LGBT aging services and housing in San Francisco. Her career has spanned over 30 years as a leader in the nonprofit community. Moli is currently a member of San Francisco's Long Term Care Coordinating Council and a Board member of the California Association of Adult Day Services. Member, Health/Social Services Work Group

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Tom Nolan is Special Projects Manager for the Department of Aging and Adult Service. Tom served as Executive Director of Project Open Hand for 17 years. Before that he was a Member of the San Mateo County Board of Supervisors and its President twice. Nolan was actively involved in LGBT issues locally and nationally as an out gay elected official. He and his partner of 36 years, Larry Friesen, live in the Western Addition.

Sneh Rao is a Policy Coordinator at the Human Rights Commission and oversees violence prevention initiatives. Before joining HRC, he was a director at an international human rights organization and worked on education and advocacy around human rights issues in Latin America. He also served as a fellow with the Thomas J. Watson Foundation. Sneh holds an M.P.P. from Harvard University’s John F. Kennedy School of Government.

DEDICATION

The Task Force respectfully dedicates its work and this Report to the memories of two members who passed away before the final report was completed – Jazzie Collins and Stu Smith. Each contributed immensely to the process and the Report is a reflection of their vision, their participation, their passion, their concern and their ideas.

Jazzie Colllins served as Vice-Chair of the Task Force until her untimely death on July 11, 2013. Jazzie was an HIV-positive transgender female of color. She was born in 1958 to a teen mother in Memphis, Tennessee and moved to San Francisco in 1988. She started her transition from male to female in her late 40s. Jazzie was a force in San Francisco community organizing and LGBT politics, especially with regard to affordable housing and tenants' rights work as a part of the LGBT shelter effort. Her heart and soul were in the work she did as a community organizer, and she was a dedicated transgender rights and economic equality activist. Before her death, Jazzie was honored in Sacramento during LGBT History Month by the California Assembly. She was active with Senior Action Network and on the Board of Trans March, among many, many activities.

Stu Smith was a member of the Housing Work Group. He was a fourth generation San Franciscan and a gay senior. He left San Jose State University to become CEO of a Silicon Valley start-up where he found business success. Stu operated numerous other businesses in San Francisco including half a dozen successful bars and restaurants. He became disabled in 1989 and had to stop working in 1994 which allowed Stu to get involved in a number of nonprofits including St. Anthony's, the SF Fire Department Toy Program, The UCSF AIDS Research Center, Castro County Club, The Richmond/Ermet AIDS Foundation and Shanti where he was a long-time board member and board President. Stu also served as an adjudicator for the District Attorney's community court and was a vocal advocate for the LGBT recovery community. Stu passed away on February 3, 2014.

ACKNOWLEDGEMENTS

The Task Force wishes to acknowledge the many individuals and organizations that assisted the Task Force in its work over the past year and a half. Without the active participation of every element of the diverse San Francisco LGBT community, the Task Force's work and the results of this Report would not have been possible.

Although there are far too many individuals who helped the Task Force along the way, the Task Force would like to thank the following organizations that stepped forward to provide resources and guidance for the Task Force's ground-breaking work including the survey of LGBT seniors, the focus groups, outreach, data collection and analysis, language services and other logistical needs: The Task Force is deeply grateful.

Our thanks go out to:

The San Francisco Foundation

The Horizons Foundation

The Estate of Thomas Dross

The Bob Ross Foundation

Alvin H. Baum

Deb Kinney, Esq.

San Francisco LGBT Pride Committee

San Francisco Department of Aging and Adult Services, especially Tom Nolan

San Francisco Human Services Agency Planning Unit, especially Diana Jensen

San Francisco Human Rights Commission, especially its LGBT Advisory Committee, Sneh Rao and Taraneh Moayed

S.F. District Attorney George Gascon

Karen Fredriksen-Goldsen and Jayn Goldsen of the University of Washington

Brian de Vries of San Francisco State University

Glide Memorial Church

St. John's Episcopal Church

LIST OF ACRONYMS

AAAs - Area Agencies on Aging

ADRCs - Aging and Disability Resource Centers

AoA - Administration on Aging

BMR - Below Market Rate

CASE - Coalition of Agencies Serving the Elderly

CCRC - Continuing Care Retirement Communities

CHIS - California Health Interview Survey

CHTF - Cultural Humility Task Force

DAAS – San Francisco Department of Aging and Adult Services

DBI – San Francisco Department of Building Inspections

DOMA - Defense of Marriage Act

DPH – San Francisco Department of Public Health

EDC - Eviction Defense Collaborative

HIV/AIDS – Human immunodeficiency virus infection / acquired immunodeficiency syndrome

HRC – San Francisco Human Rights Commission

HSA – San Francisco Human Services Agency

HOPE - Housing Opportunities Partnerships and Engagement

HUD – Housing and Urban Development Agency

IDAs - Individual Development Accounts

LGBT – Lesbian, Gay, Bisexual, Transgender

LGBTQQI – Lesbian, Gay, Bisexual, Transgender ,Queer, Questioning, Intersex

MHSA - Mental Health Services Act

MOHCD – San Francisco Mayor's Office of Housing and Community Development

MOWSF - Meals On Wheels of San Francisco

N4a - National Association of Area Agencies on Aging

NSCLC - National Senior Citizens Law Center

PEI - Prevention and Early Intervention

SF EMA - San Francisco Eligible Metropolitan Area

SRO – Single Room Occupancy Hotel

TLC - Transgender Law Center

UCSF – University of California, San Francisco

USDA - US Department of Agriculture

EXECUTIVE SUMMARY

The San Francisco Board of Supervisors passed legislation creating an LGBT Aging Policy Task Force to meet for eighteen months to study issues affecting LGBT seniors and issue a report with recommendations. The Task Force's first meeting was in October 2012 and its last meeting was in March 2014. This report represents the findings of the many months of research conducted by that group, including the administration of a ground-breaking survey of a diverse sample of LGBT older adults in our community. The Task Force identified the following key areas of concern and associated solutions for the consideration of the Board of Supervisors.

Data collection

Problem 1: Lack of data on gender identity and sexual orientation among city agencies prevents understanding of service needs and utilization in the LGBT population.

Solution 1:

- Collect data on gender identity and sexual orientation whenever other voluntary demographic data is collected.

Cultural competency

Problem 2: Senior service providers do not have adequate cultural competence to appropriately serve LGBT seniors.

Solution 2: Require training to improve cultural competency of service providers in working effectively with LGBT older adults.

Health and Social Services

Problem 3: LGBT seniors lack information and enrollment support for social services, financial support, benefits counseling, legal advocacy, and health insurance access.

Solution 3: Develop and implement an information, referral, enrollment assistance, and case management referral program that provides a single place for LGBT seniors to receive information, referral, and enrollment assistance for a wide range of available social services and health care.

Problem 4: There are limited supportive services available to aid in the provision, coordination, and planning of care to address unique challenges facing LGBT older adults.

Solution 4: Develop and implement an LGBT senior case management and peer specialist program.

Problem 5: There are limited supportive services available to address the emotional, behavioral health, and social isolation challenges of LGBT seniors.

Solution 5: Develop and implement an LGBT senior peer counseling program and an LGBT peer support volunteer program.

Problem 6: LGBT older adults have unique barriers to accessing information about and services for Alzheimer's and dementia care.

Solution 6: Create an LGBT-targeted education and awareness campaign and increase availability of related support groups.

Problem 7: Some LGBT older adults struggle with low incomes and poor financial literacy.

Solution 7: Develop and implement financial literacy training services targeting LGBT older adults.

Housing

Problem 8: LGBT older adults are especially vulnerable to losing their residential housing as a result of evictions and physical barriers to aging in place, and the consequences of losing housing late in life is severe for most LGBT seniors.

Solution 8: Improve eviction prevention protections for LGBT seniors through rental and homeowner assistance, legal services, and increased restriction on evictions and increase resources for LGBT senior homeowners.

Problem 9: LGBT seniors need more access to affordable housing.

Solution 9: Increase availability of and access to affordable housing by including LGBT older adults in planning processes, prioritizing developments that target them, and providing LGBT-focused housing counseling and rental assistance.

Problem 10: Conditions in apartments and SROs where many LGBT seniors live are often unacceptable.

Solution 10: Improve conditions in apartments and SROs through improved DBI policies and enhanced work on habitability.

Problem 11: Many LGBT seniors feel unsafe and unwelcome in city shelters.

Solution 11: The city should address unsafe and unwelcoming treatment of LGBT senior in city shelters by providing targeted shelter services and implementing training at existing shelters.

Legal Services

Problem 12: LGBT seniors in long-term care facilities face systemic discrimination and abuse.

Solution 12: Improve legal protections and resources for LGBT seniors in long-term care facilities.

Problem 13: LGBT seniors face obstacles to and lack resources for drafting appropriate life-planning documents.

Solution 13: Promote LGBT life-planning legal clinics, referral protocols, and sample documents, and develop resources to aid LGBT seniors who wish to complete the planning process.

TASK FORCE BACKGROUND AND RESEARCH

HISTORY

The first organized effort to examine issues affecting LGBT seniors in San Francisco was the San Francisco Human Rights Commission's report in 2003. Before that time, the community's focus was primarily upon the HIV/AIDS pandemic as it took its horrific toll on members of the community in the early 1980s. New HIV medications arrived in 1996 and in the ensuing years proved efficacious for many persons living with HIV/AIDS.

The LGBT community's attention then began to focus on a variety of social issues such as marriage equality, ending the Defense of Marriage Act (DOMA), gays in the military, hate crimes, employment non-discrimination and others. As the Stonewall generation began greying, advocacy attention started to focus on the lives of LGBT seniors in San Francisco and around the country. Several national surveys were conducted and academic institutions began researching issues of importance to older LGBT people. As part of this examination of issues affecting LGBT seniors, the San Francisco Human Rights Commission (HRC) issued a report in 2003 on the situation of LGBT seniors in the city including over eighty recommendations for improvements in areas like health care, social services, legal reforms, education, housing and more. While the HRC's focus on LGBT seniors, which not only included the 2003 report but also a very successful period of study and a well-attended hearing at City Hall, raised the profile of these issues for a time, there unfortunately failed to be a sustained interest in following up on the issues after 2003.

Issues affecting LGBT seniors were taken up again seven years later when, in 2010, the HRC's LGBT Advisory Committee voted to form a Senior Issues Work Group. In 2011, the Advisory Committee voted to continue the Senior Issues Work Group for a second year reflecting a growing interest in the LGBT community to create a sustained focus on issues affecting seniors. During 2011, the Senior Issues Work Group developed a proposal to have the Board of Supervisors create an advisory body to study the issues impacting LGBT seniors in San Francisco and to issue recommendations for improving programs and services.

In 2012, members of the HRC LGBT Advisory Committee approached Supervisors David Campos, Christina Olague and Scott Wiener and asked them to introduce legislation creating an LGBT seniors advisory body. The Supervisors, along with Supervisor Malia Cohen, then called for a hearing to consider issues affecting LGBT seniors and the creation of an advisory body. The Board of Supervisors' Neighborhood Services Committee held a hearing in January 2012 with an overflow crowd of members of the LGBT community and senior advocates concerned

about aging in San Francisco. The overwhelming community response solidified the Supervisors' resolve to raise the profile of issues affecting LGBT seniors in San Francisco and they introduced legislation to establish the San Francisco LGBT Seniors Task Force. (Note: the Task Force voted to change its name to the LGBT Aging Policy Task Force to clarify the mission of the Task Force and that the Task Force's membership was not limited to senior members.) The legislation was approved unanimously by the Board of Supervisors on June 5, 2012.

Members of the Task Force were appointed by the Board of Supervisors' Rules Committee following a rigorous outreach effort to attract a diverse representation of the LGBT community. The Board received over 40 applications for 15 Task Force slots. The members appointed represented a relatively diverse cross-section of San Franciscans although the overall membership was always under-represented in terms of women.

The legislation creating the Task Force provided for an eighteen month period for the Task Force to study issues affecting LGBT seniors and issue a report with recommendations to the Board of Supervisors. The Task Force's first meeting was in October 2012 and its last meeting was in March 2014, at which point the Task Force ceased operation.

The first order of business for the Task Force was to commission a study of LGBT seniors in San Francisco so that its recommendations could be based on actual data and not estimates and anecdotal accounts. As the Task Force began asking for data from city departments on LGBT seniors being served by the city, city officials explained that data on sexual orientation and gender identity was largely not collected and therefore there was very little actual information available on LGBT seniors.

Faced with this absence of data, the Task Force voted to commission data collection and analysis with the University of Washington. The SF Department of Aging and Adult Services (DAAS) provided an initial $30,000 grant to help the Task Force conduct the necessary research. This amount was matched by foundation grants and individual contributions from members of the community. In all more than $80,000 was raised in a combination of funds from the city and private sources to pay for the research and support the Task Force's work. The city also supported the Task Force by creating a part-time policy advisor position within DAAS to assist the Task Force (Tom Nolan, Special Projects Manager), and the Human Rights Commission committed significant administrative staffing to assist with the conduct of public meetings and other logistical matters. In addition, the SF Human Services Agency (HSA) provided staffing to the Task Force to complete a study of existing LGBT data held by the city, to advise the Task Force on development of the research projects and to provide ongoing technical advice and

support. This staff support was vital to the Task Force's ability to function and greatly enhanced the quantity and quality of work taken on by the Task Force.

The Task Force organized itself into three work groups: housing, legal matters, and health and social services. The Task Force also decided to act as a committee of the whole to consider "community within communities" which would deal with issues raised by the great racial, ethnic and socio economic diversity within the larger LGBT community. Each work group met in public session to discuss ideas and develop recommendations. The housing work group also held a very well-attended public meeting to take community testimony on housing issues.

FACT FINDING PROCESS

The Task Force committed to a rigorous investigation of the needs of San Francisco's LGBT older adults. The fact-finding process included:

- Analysis of the limited existing data on LGBT seniors being served by a handful of DAAS and SF Department of Public Health (DPH) programs, along with analysis of LGBT older adult demographics available in population-based data sets such as the San Francisco City Survey, the US Census, and the California Health Interview Survey (CHIS);
- Commissioning a two-part study of LGBT seniors to assess demographic trends, needs, unmet needs, service utilization, experience with LGBT harassment and discrimination, housing, resiliencies, and more;
- Compilation of the comments and recommendations from the 2003 and 2012 public hearing processes;
- Rigoruous outreach to traditionally overlooked communities of seniors within the LGBT community: women; lesbians; bisexuals; LGBTs of color; non-English speaking LGBTs; and, homeless and marginally housed LGBTs;
- Literature review, including local, state, and national research;
- Focus groups of LGBT seniors conducted by HSA personnel;
- New public hearings, in particular a widely publicized hearing on housing issues;
- Interviews of leaders in the LGBT older adult service community, as well as city department heads;
- Meetings with interested community groups, including the Coalition of Agencies Serving the Elderly, the LGBT Senior Community Partnership, the San Francisco Organizing Project;
- Meetings with city officials;
- Review of national best practices and educational presentations during public meetings of the Task Force including the following subjects concerning LGBT seniors, among others: lessons learned from the Transgender Task Force; life as a member of the intersex community; homelessness; mental health; cultural competency; and development of public policy.

The Task Force commissioned the following four research projects in order to flesh out its understanding of the LGBT older adult population and its needs and strengths. The LGBT Aging Policy Task Force collaborated with the Institute for Multigenerational Health at the University of Washington and with the HSA Planning Unit. The two reports completed in collaboration with the University of Washington were funded by a combination of funding from DAAS, private foundations and individual donors and were guided by a research team comprised of Task Force members and an HSA Planning Unit analyst.

Project	Purpose	Method	Finding Types & Limitations
Lesbian, Gay, Bisexual, and Transgender (LGBT) Seniors in San Francisco: Current Estimates of Population Size, Service Needs, and Service Utilization Conducted by the HSA Planning Unit (Jensen, 2012)	In preparation for the work of the Task Force, community members wanted an analysis of existing local data available on LGBT seniors.	The HSA Planning Unit analyst identified existing local, state, and national sources of quantitative and qualitative data related to LGBT older adults, conducted new analysis where appropriate, and synthesized findings to describe San Francisco's LGBT older adult population. Sources included: • California Health Interview Survey; • SF City Survey 1996-2011; • 2006 DAAS Phone Survey; • American Community Survey (2010, IPUMS); • SF Seniors enrolled in Office on the Aging database FY11/12; • 2005 Survey of residents of 8 SF Senior/Disabled SFHA Buildings; • SF DPH 2011 estimates of men who have sex with men; • SF DPH HIV Health Services Clients 2009-2011 • Notes from focus groups with LGBT senior consumers and service providers from 2006 & 2011; • 2010 Report on HIV and Aging in San Francisco; • National reports related to prevalence of LGBT status, HIV surveillance, service needs of LGBT older adults, and health disparities.	The report provides estimates of the following characteristics of San Francisco's LGBT older adults: • The size of the population; • Demographics and geographic distribution • Service utilization; • Reported needs for social, medical, and community supports. Limitations include: • Many public programs do not collect sexual orientation or gender identity data; • Age ranges were limited for some data sources; • Census data only includes information about couples; • Most data sources appeared to over-represent white gay men.

Project	Purpose	Method	Finding Types & Limitations
LGBT Older Adults in San Francisco: Health, Risks, and Resilience (Fredriksen-Goldsen et al., January 2013)	The report provided new analysis of existing data to inform the task force about the health, risks, and resiliency of the community. The goal of the report was to provide information that would aid in the development of a community-based survey of the aging needs of culturally diverse LGBT older adults in San Francisco.	The report provided an initial snapshot of the 295 participants of the 2010 *Caring and Aging with Pride* national survey of LGBT older adults residing in San Francisco. The national survey was distributed through mailing lists of 11 community-based agencies, two of which were in San Francisco (Openhouse and New Leaf).	The findings were considered preliminary given the limited sample size, especially for transgender and bisexual older adults and older adults from specific racial and ethnic communities. This report was organized into the following sections: • Background characteristics; • Physical health; • Mental health; • Resilience; • Risks; • Healthcare access; • Services and programs. Limitations include: • Outreach was limited to mailing lists of existing organizations; • Representation of minority groups, as well as bisexuals and transgender respondents did not allow for comparisons between groups.

Project	Purpose	Method	Finding Types & Limitations
Addressing the Needs of LGBT Older Adults in San Francisco: Recommendations for the Future (Fredriksen-Goldsen et al., July 2013)	The study was designed to identify key experiences, needs, and barriers to services and programs among LGBT older adults in San Francisco. An important goal of the study was to address some of the limitations from the previous project - obtaining a diverse sample in order to better understand the needs of subpopulations.	It is based on 616 surveys completed by LGBT San Francisco residents aged 60 and older. The LGBT Aging Policy Task Force conducted targeted recruitment to improve sample sizes for statistical comparisons of lesbian, gay, bisexual, and transgender respondents, as well as targeting diverse representation of racial and ethnic groups. It was not intended to produce a representative sample. Both electronic and hard-copy versions of the survey were distributed in English, Spanish, Russian, Chinese, and Tagalog.	Report findings include: • Background characteristics • Use, need, and barriers to services and programs • Housing • Resources & Risks • Health Analyses include responses for all participants, as well as summaries of statistically significant differences between groups. The report also provides recommendations for next steps, related programs and policy issues. Limitations include: • Participants were not identified at random, so findings cannot be easily generalized to the entire population; • Despite outreach efforts, representation from some sub-populations was still low.
Focus groups with LGBT older adults (2013)	Two focus groups were conducted to provide a qualitative supplement to the more data-driven projects listed above.	The focus groups were conducted at Glide Memorial and St. John the Evangelist Episcopal Church. The groups had six and ten participants, respectively. The groups included representation from gay, lesbian, bisexual, and transgender communities, as well as White, African American, and Latino participants.	Topics of discussion included: • Experiences with LGBT friendly and unfriendly local services; • Public safety, including decisions to report incidents to local authorities; • Recommendations for outreach to diverse LGBT communities. Limitations include: • Only two focus groups were conducted, both were located at religious organizations.

See below for highlights from each study. Additional findings are incorporated throughout the rest of this report as appropriate.

Project	Highlights of Findings
Lesbian, Gay, Bisexual, and Transgender (LGBT) Seniors in San Francisco: Current Estimates of Population Size, Service Needs, and Service Utilization	Population estimate findings: • As much as 12.4% of San Francisco's seniors age 60 and older identify as LGBT in state and local surveys. This is equivalent to 19,200 people; • San Francisco's LGBT seniors in available datasets are: disproportionally male; fairly young (most are under age 70); mostly English-speaking; disproportionately White; living all over the city but with higher rates in North of Market, South of Market, Castro, and Mission districts; often living alone; likely to have incomes at the extremes; mostly renters; and are often veterans. Utilization of local services findings: • City departments and contractors do not consistently collect data on sexual orientation and gender identity; • Despite efforts to provide LGBT cultural relevancy training to mainstream senior service providers, enrollment rates for LGBT seniors remain low for most programs; • HIV Health Services are dominated by LGBT clients, including among the senior clientele. The most common services used by seniors in the HIV Health Services system were: Outpatient/Ambulatory Medical Care (34%); Oral Health Care (28%); Case Management (non-medical) (26%); Medical Case Management (including treatment adherence) (24%); and Food bank/Home-delivered meals (20%);and, • Prevalence of older adults in the HIV Health Services is projected to increase in the coming years. Common needs expressed by LGBT older adults: • Discrimination and/or lack of sensitivity to LGBT issues among mainstream service providers, including; • Need for information about social services, including financial supports, benefits counseling, legal advocacy, and health insurance access; • Need for supports to alleviate the extreme social isolation that some LGBT seniors experience; • Need for additional behavioral health services; • Public safety concerns; and, • Medical and health care concerns specific to older people living with HIV/AIDS.
LGBT Older Adults in San Francisco: Health, Risks, and Resilience	Of the 295 participants: • One-half live alone • 20% have HIV/AIDS • Most have college degrees but 40% live below national poverty levels • 1 in 3 report being clinically depressed • 1 in 3 report losing a life partner • 1 in 3 do not have a will or durable power of attorney • Services most needed - housing, transportation, delivered meals, social events, in-home health services, support groups and assisted living options • Many have experienced victimization and discrimination, mostly in the form of verbal assaults but some report having objects thrown at them. • Transgender and bisexual seniors report higher levels of discrimination and abuse.
Addressing the Needs of	Of the 616 participants:

LGBT Older Adults in San Francisco: Recommendations for the Future	• 60% live alone; 63% are neither partnered nor married; • 40% do not have minimum income necessary to meet basic needs based on California Elder Economic Security Index; • 15% have children, and of those who do have children, they report that 60% would not be available to help them; • Of those not accessing services, 50% did not feel comfortable as LGBT senior at alcohol/drug programs, and 1 in 6 do not feel comfortable in congregate meal and grocery programs; • Two thirds say they may not be able to stay in their homes & may need to relocate due to financial concerns and health issues; • Nearly 24% need housing assistance, but 42% were not comfortable using housing assistance services as an LGBT person; • LGBTs in legally recognized partnerships report better health and less need for services; • 9% say they have no one to turn to for social support, and gay men are at a higher risk for lacking social support than lesbians; • Nearly 44% have experienced discrimination in last 12 months due to their sexual orientation or gender identity; nearly 50% experienced another type of discrimination; • 5% have been abused by someone in a trusting relationship; 25% reported abuse to authorities; 9% didn't report because they didn't trust authorities • One-third report poor general health, and 40% have one or more physical disabilities; • 33% of males are living with HIV/AIDS; • 15% report having seriously considered suicide in last 12 months; • Transgender, those living in poverty and those not married or partnered are more likely to have poor health.
Focus groups with LGBT older adults	Participants at two focus groups discussed: • A variety of indicators that demonstrate LGBT friendliness of an organization: openly LGBT staff; hosting of LGBT targeted services/groups; explicit marketing as such or in targeted media; staff and participant behavior; leadership requesting input from LGBT consumers; recognition on intake forms; etc.; • Having a primary trusted service agency to which they were most likely to turn to help; • Experiences with LGBT-focused discrimination and lack of staff response to discrimination – on transit, at city agencies, in retail settings, at work, and more; some providers were simply ignorant of LGBT issues; • Heightened discrimination against transgender older adults, and lack of acceptance of bisexual identity; • Within community concerns: exclusion of older adults by the younger LGBT community, and discrimination against transgender people; • The need for LGBT-targeted housing options; • Public safety concerns for LGBT older adults: on transit, on the street, with contractors working in the home; • Generally, participants' recent experiences with the SFPD were positive; • Concern regarding social isolation and lack of caregiver support, especially for LGBT older adults who are single and/or estranged from family.

FACT FINDING PROCESS – HIGH RISK SUB-POPULATIONS

At the outset of its deliberations, the Task Force set a goal of rigorous and wide-spread outreach to traditionally overlooked segments of the LGBT community. The Task Force's recommendations take into account sub-populations who in many areas have heightened needs requiring specialized attention. The majority of participants in past national and local surveys of LGBT seniors have been white gay men. Many surveys of LGBT seniors have included insignificant numbers of bisexuals, transgender men and women, lesbians, homeless seniors and seniors of color. In addition, the Task Force found that no survey of LGBT seniors had ever been offered in any language other than English. The Task Force was determined to not repeat this pattern.

In order to reach significant numbers of LGBT seniors in the targeted groups, the Task Force hired a research assistant who committed hours and hours of time to highly targeted community outreach and education about the Task Force survey. In addition, Task Force members and city staff met with dozens of community representatives from all across the city in preparation for the release of the survey. The Task Force also incurred substantial additional cost to have the study and the outreach materials translated into the top four non-English languages spoken in San Francisco: Chinese, Spanish, Russian and Tagalog.

The study was released in May 2013 and data was collected for eight weeks primarily via online participation although hard copy surveys were also widely distributed. All five languages were offered both online and in hard copy form. See Appendix K for outreach materials, list of community contacts, etc.

Thanks to this rigorous outreach process, the survey was completed by a large number of LGBT seniors who represented an unprecedented cross-section of San Franciscans including significant numbers of LGBT seniors in the targeted groups. The number of respondents in almost every targeted category allowed the researchers to produce a highly detailed analysis examining differences between groups within the LGBT community for the first time.

One example of successful outreach was in the Latino community, respondents from which comprised 7% of the survey's total participants. Through the personal efforts of Task Force members, volunteers visited agencies that served LGBT Latinos/as, both men and women. Task Force members also gave presentations, distributed material and helped respondents who did not have or were not familiar with a computer. Other contacts were made through emails. This effort would not have been possible without the cooperation of those colleagues that work directly with these persons, many of them longtime HIV survivors.

Through the personal efforts of other Task Force members, the outreach effort proved successful in collecting a minimum of 30 seniors in quite a few target groups including African American LGBT seniors, Latino/a seniors as mentioned above, and lesbians, and to a slightly lesser extent, API LGBT seniors, bisexual men and women, and transgender men and women. In the case of Latino, African-American, API LGBT seniors and lesbians, much of the outreach success is no doubt related to the personal efforts of Task Force members who engaged their own personal contacts as well as activating personal, face-to-face dissemination of information about participating in the survey to LGBT seniors who are not usually included in such survey efforts. And, while the Task Force was committed to offering the survey in five languages, translation alone was clearly not enough to penetrate certain hard to reach sub-populations. The bottom line is that, despite achieving an historic level of diverse participation in its study, the Task Force was not able to perfect the outreach process to LGBT seniors in the limited time it had to disseminate the survey.

In addition, the Task Force had a particularly difficult time finding an effective way to reach LGBT seniors in the Russian émigré community even given outreach to numerous Jewish community agencies that serve members of the Russian community in San Francisco. The Task Force was told that the stigma associated with LGBT issues in this community was so strong that agencies were reluctant or simply unwilling to even announce the survey to the seniors they served or help distribute it because of their apparent fear of how some seniors would react. The Task Force was left with the very strong impression that much work needs to be done to address homophobia and transphobia in this and other communities especially where it impacts LGBT seniors who are forced to live with this seemingly overwhelming stigma.

Overall, the Task Force was most successful at reaching gay white men and with much effort, also reasonably successful with some exceptions at reaching the targeted communities who are traditionally overlooked. The response confirmed that it is much easier to communicate with gay white men in San Francisco than other groups of LGBTs. The city's LGBT press, which reaches over 75,000 readers every week, is largely read by an audience that is male and white. Women, bisexuals, transgender men and women and non-white LGBTs also read the mainstream gay press but do not necessarily rely on this media as modes of communication within these sub-groups. Lesbians, bisexuals and transgender men and women, and LGBTs of color have much less formal ways of communicating than print/online LGBT media outlets and those communities tend to rely on numerous smaller, interconnected groups. Therefore the LGBT press was a valuable partner in getting the word out to large numbers of gay white men, but it was much more difficult and time-consuming for the Task Force to reach other targeted groups of seniors.

The Task Force found that there are very few established ways of communicating with LGBT seniors in these other communities. The connections don't currently exist, either through DAAS or other city programs or through the LGBT community either which is not used to communicating with older people or about aging issues to begin with. One of the major lessons learned in the outreach process is that both the city and the LGBT community have important work to do to establish ways of communicating regularly with seniors of color, non-English speaking seniors, bisexual and transgender seniors, and homeless seniors among others.

Through the survey and other research efforts, the Task Force identified several high risk sub-populations of LGBT older adults that received additional consideration with respect to the implementation of the group's recommendations and should continue to receive additional attention moving forward:

Transgender older adults nearly always reported higher risks, including lower incomes, higher service needs, lower housing stability, victimization, and discrimination. They also more frequently reported poor general health and mental health, and much higher rates of suicidal ideation. In category after category, the situation facing transgender older adults is worse than their lesbian and gay counterparts and far worse than their heterosexual counterparts (Fredriksen-Goldsen et al., July 2013). It is not extreme or alarmist to call the current situation facing older transgender adults as a crisis.

Bisexual older adults also reported higher risks in the Task Force's local research. The difficulty in recruiting bisexual participants in the Task Force survey and low participation in focus groups may suggest increased isolation from LGBT older adult service systems for this group. Those who did participate reported lower incomes, higher service needs, lower housing stability (including a higher rate of living in SROs or on the street), lower rate of identity disclosure, less legal planning for the future, as well as more discrimination and victimization (Fredriksen-Goldsen et al., July 2013).

LGBT older adults of color often experience the compounding effects of discrimination based on sexual orientation, gender identity, race, and age. Again, while the Task Force conducted significant outreach, the isolation of LGBT older adults of color, especially among Asian/Pacific Islanders and in the Russian community was evident in the low turnout for the survey and focus groups. Those who did participate reported higher service needs in certain categories, lower rates of identity disclosure, less legal planning for the future, higher rates of discrimination and abuse, and higher rates of HIV/AIDS (Fredriksen-Goldsen et al., July 2013).

Low income LGBT older adults face heightened challenges in this increasingly expensive city. Not surprisingly, LGBT older adults with incomes below 200% of the federal poverty level reported increased risks in many areas addressed by the Task Force survey. For example, those

participants had higher unmet service needs, higher rates of homelessness or SRO residence, less social support, less legal planning for the future, and higher rates of discrimination and victimization. They were also more likely to report poor general health including physical disability, poor mental health, and higher rates of suicidal ideation (Fredriksen-Goldsen et al., July 2013).

LGBT older adults living with HIV/AIDS report unique concerns as well, and the size of that population is growing. Medical and health care needs identified for that community include issues such as: missed HIV/AIDS diagnosis when HIV/AIDS symptoms mimic those of normal aging; unknown long-term effects of antiretroviral therapies; reduced production of T-cell exacerbated by aging; chronic inflammation; need for Complementary Alternative Therapies; lack of geriatrics expertise among HIV care providers; and increased presence of co-morbidities (especially depression, arthritis, hepatitis, and neuropathy). Older persons living with HIV/AIDS commonly experience increased prevalence of substance abuse and the need for mental health services. In terms of social services, housing and homelessness resources are a common need, as well as socialization and support group opportunities targeted to older PLWHA. As long term disability policies stop paying benefits when the beneficiary reaches retirement age (usually 65), the need for financial supports, benefits counseling, and legal advocacy is critical. Finally, older adults with HIV/AIDS need stronger HIV/AIDS cultural competency among mainstream senior service providers (Allgaier, 2010).

LGBT older adults with dementia face the dual stigma of living with dementia and being LGBT. They also struggle with less family support and informal caregiver support compared to other seniors, both of which are critical in allowing people with cognitive impairment to continue living in the community as long as possible. Lack of information about services for people with dementia, the sometimes poor LGBT cultural competency of service providers, as well as poor legal planning can leave LGBT older adults with dementia at risk.

The Task Force has identified six key areas needing improvement in order to improve city services for San Francisco's LGBT older adults:

1. Data collection
2. Cultural competency
3. Health and social services
4. Housing
5. Legal Services
6. Community within community

This report provides background on a variety of issues within each of these areas, followed by concrete programmatic and policy recommendations. The final section of the report provides recommendations on implementation.

1. IMPROVING DATA COLLECTION

PROBLEM 1: LACK OF DATA ON GENDER IDENTITY AND SEXUAL ORIENTATION AMONG CITY AGENCIES PREVENTS UNDERSTANDING OF SERVICE NEEDS AND UTILIZATION IN THE LGBT POPULATION.

SOLUTION 1: COLLECT DATA ON GENDER IDENTITY AND SEXUAL ORIENTATION WHENEVER OTHER VOLUNTARY DEMOGRAPHIC DATA IS COLLECTED.

Background

Many city agencies and their contractors do not collect information on client sexual orientation or gender identity on intake forms or during the course of providing services. As a result, it is difficult to quantify the needs of the LGBT population, to identify services in which they are underrepresented, or to track improvement in access to services over time. Policymakers are left to assess the needs in the LGBT community based on anecdotal evidence including stories that receive significant press coverage.

At an early meeting of the Task Force, members discussed this lack of data available from city departments and contractors. The Task Force voted to recommend that the city begin collecting gender identity and sexual orientation data at the same time that other voluntary demographic data is collected. The Task Force recommended this policy be adopted throughout all city departments and programs regardless of whether the programs serve seniors, adults or students.

Upon adoption of this recommendation to collect LGBT data, the Task Force met with Supervisor Scott Wiener, Supervisor David Campos and representatives of Mayor Ed Lee's office. All of the city leaders agreed that San Francisco should begin collecting voluntary data on sexual orientation and gender identity. The Mayor's Office made a commitment to begin working with relevant city departments to begin the process of including these questions and requiring contractors to include these questions on future intake and other forms. Thereafter, DPH began formulating language to achieve this goal.

In embracing this Task Force's recommendation to begin collecting LGBT data, the city acknowledged the following public policy considerations: 1) the health care and social services industries are increasingly moving toward data collection as a driving force behind setting strategy and creating efficiencies in modern systems; 2) the state and federal governments have begun collecting LGBT data on health surveys and other state and federal forms and so this kind of data collection is inevitable; 3) DPH and DAAS are already moving in this direction and are entirely supportive of this policy change; 4) the LGBT community is advocating this

change in policy due to the lack of data currently available and the way in which that lack of data inhibits further research and other scholarly inquiry and makes it more difficult to create public and private funding streams for LGBT specific programs for seniors and LGBTs of all ages.

District Attorney George Gascon has already embraced the Task Force's recommendation on this issue and recently announced that his office had begun collecting gender identity and sexual orientation information in domestic violence cases. The District Attorney noted that his office can better direct resources to LGBT victims of domestic violence now that he has hard data to guide his efforts. An initial analysis of domestic violence data showed that approximately 9% of cases involved LGBT victims, a number the D.A. believes to be under-reported, and he has vowed to focus additional attention and make resources available to LGBT victims. This is just one example of how data on gender identity and sexual orientation can drive public policy and create positive change.

One important example is housing -- very few agencies working on housing issues keep any data on sexual orientation and gender identity. Therefore, it is impossible to know how many LGBT seniors need affordable housing, how many are already on waiting lists, how many utilize rental assistance programs, how many are victims of no-fault evictions, and so on. Most housing services providers do track other consumer demographics, but do not include sexual orientation or gender identity.

The Task Force recommends that the city look to those programs that do collect sexual orientation and gender identity data for insight into the most successful ways to incorporate those questions into intake forms. The AIDS Housing Alliance, the AIDS Emergency Fund, and Mission Neighborhood Health Center all collect this information. The Department of Public Health has recently conducted extensive discussions to identify the best way to ask for this data consistently across all of their programs. Another powerful example is Meals on Wheels San Francisco which voluntarily instituted LGBT data collection several years ago. MOWSF learned important lessons implementing the data collection that are instructive regarding the importance of when, how and why questions on sexual orientation and gender identity are asked and the likelihood of getting answers in response to the questions. After all, the goal is not merely to ask the question but rather to collect as much information as possible. It does no good to ask the questions in ways that make LGBT seniors feel uncomfortable about sharing that information – that will simply lead to the same situation we have now – a dearth of data.

Recommendation 1.1
The Board of Supervisors should mandate that all City agencies and their contractors include questions about sexual orientation and gender identity on all client intake or information forms or at another appropriate time while delivering services or performing an important city function when other demographic data is also being requested.

2. IMPROVING CULTURAL COMPETENCY

PROBLEM 2: SENIOR SERVICE PROVIDERS DO NOT HAVE ADEQUATE CULTURAL COMPETENCE TO APPROPRIATELY SERVE LGBT SENIORS.

SOLUTION 2: REQUIRE TRAINING TO IMPROVE CULTURAL COMPETENCY OF SERVICE PROVIDERS IN WORKING EFFECTIVELY WITH LGBT OLDER ADULTS.

Background

Due to a history of discrimination and victimization based on sexual orientation and gender identity/presentation over the course of their lifetimes, many LGBT older adults fear discrimination, mistreatment, disrespect, or compromised care in housing, healthcare and social service settings. In fact, LGBT older adults are five times less likely than their heterosexual peers to access health and social services available to them through the Older Americans Act (OAA)[1] (Meyer, 2011; Orel, 2006a; Hartzell et al., 2009).

Most caregiving (83%) in the United States is provided by family caregivers—unpaid persons such as family members, friends, and neighbors of all ages who are providing care for a relative (FCA & AARP, 2005). In contrast, the vast majority of LGBT seniors do not have children and are more likely to be distant from their biological family members, and therefore do not have access to this critically-needed, often no-cost, network of support and advocacy (MAP & SAGE, 2010). This disparity creates more reliance on formal, traditional institutions of care that have been historically unresponsive or ill-equipped to meet their needs. Research shows that older adults with diminished social and caregiving supports may experience greater social isolation, which can lead to premature institutionalization and even early death (Mohan, 2013). With the population of LGBT older adults across the country growing from approximately 3 million in 2006 to 7 million by 2030, aging network providers must proactively educate themselves about the unique challenges and barriers facing LGBT older adults and learn best practices for serving this vulnerable population.

Research has underscored the challenges facing LGBT older adults at senior centers and other agencies whose mission is to serve seniors: they may be denied services for fear of harassment from service providers or straight-identified senior participants or feel their needs are invisible due to a lack of affirming services, programs and outreach to LGBT older community (Fairchild et al., 1996; Hicks, 2003; Meyer, 2011). Despite the need for services such as mental health

[1] OAA funds critical services that keep older adults healthy and independent, including meals, senior centers, in-home support, socialization activities, caregiver support, transportation, health promotion, benefits enrollment, and more.

support, housing assistance, case management, and information and assistance, the Task Force's July 2013 study of LGBT older adults (Fredriksen-Goldsen et al.) revealed:

- Half of participants who used alcohol/substance abuse programs and housing assistance indicated that they did not feel comfortable utilizing these services as an LGBT older adult;
- About one in six participants did not use meal site/free grocery programs and telephone/online referrals because they felt these services were not LGBT friendly;
- Nearly half of participants experienced discrimination in the prior 12 months because of their sexual orientation or gender identity;
- One in five LGBT participants had been victimized during the prior 12 months because of their sexual orientation or gender identity;
- Transgender participants, those living in poverty, and those not married or partnered were more likely to have poor health.

Other studies have revealed the following additional data:

- LGBT older adults were much more likely to be childless, single and living alone than their heterosexual counterparts (Adelman, Gurevitch, deVries, & Blando, 2006) and therefore often lacked the informal caregiver support typically provided by adult children, spouses, or other family members (MAP & SAGE, 2010);
- 30% of LGBT seniors in a 2010 San Francisco survey reported having served in the military (Fredriksen-Goldsen et al., January 2013). Nationally, 14% of LGBT households have at least one veteran, compared to 11% in heterosexual households (National Resource Center on LGBT Aging, 2013). The Task Force's 2013 study (Fredriksen-Goldsen et al., July 2013) found veterans services to have low ratings in terms of LGBT friendliness.

When it comes to creating LGBT welcoming services, training matters. Senior service providers make assumptions that unintentionally exclude and further isolate LGBT older adults. These assumptions can create barriers to services as seen in the San Francisco study above. Recently, the California Reducing Disparities Project, a project funded through the Prevention and Early Intervention (PEI) component of the Mental Health Services Act (MHSA), conducted a statewide survey of mental health providers (N=1,247, N=350 self-identified as LGBT). The Provider Survey (PS) presented questions specifically intended to assess barriers *providers* may face in providing culturally appropriate, sensitive and competent care to LGBTQ people. Among the top barriers to providing culturally competent mental health services reported by PS respondents are:

- Not enough access to training on:
    - the concerns and needs of transgender clients/patients/students;
    - the concerns and needs of LGBTQ parents;
    - the coming out process;
    - the concerns and needs of lesbian, gay or bisexual clients/patients/students;
- No access to supervision/consultation with providers who have expertise in LGBTQ concerns and needs;
- Not able to provide services in the native language of the clients/patients;
- Personal religious beliefs (Mikalson, Pardo, & Green, 2012).

As stated above, PS respondents indicated "not enough access to training" in their top four barriers to providing culturally competent LGBTQ services. Including questions about sexual orientation and gender identity on all city and contractor forms is a positive first step. However, this alone does not directly translate into welcoming and affirming services for LGBT older adults.

Trainings increase the comfort level and confidence of providers in asking the sexual orientation and gender identity of clients. According to the PS, "There is a positive correlation between the number of trainings a provider had in the past 5 years and how often they reported asking clients/patients about their sexual orientation or gender identity. That is, the more trainings a provider participated in, the more often that provider asked clients/patients about their sexual orientation or gender identity. This was true for all providers" (Mikalsonet al., 2012). That is, more trainings yield more affirming providers over all.

Josh Martin, Client Services Manager with In-Home Support Services Consortium, commented on the results of training: "I was startled by how immediately the training proved effective." He continued, "Right afterwards, a case manager asked a client if he wanted us to know about his sexual orientation. The client was delighted and said, 'I'm really glad you asked me that. I identify as a gay man.' The client also indicated that not enough professionals ask that question and that a lot of LGBT people like him are isolated and invisible."

When data collection is integrated with LGBT aging cultural competency training, the effectiveness of the data collection is increased and the positive impact on LGBT clients and patients is much greater. Momentum is growing at the national and federal levels of the need to address disparities faced by LGBT older adults. Training was a key predictor of agencies' understanding of the need to address issues unique to LGBT populations and in their provision of LGBT-specific services and outreach (Mikalson et al., 2012). In 2011, the National Association of Area Agencies on Aging (n4a) published, "Ready to Serve?: The Aging Network and LGB and T

Older Adults." The study provides the first snapshot of Area Agencies on Aging[2] (AAAs) experience with and readiness to serve aging LGBT populations. Fifty percent of eligible agencies from across all regions of the country participated in the online study. The study revealed:

- Only one-third of agencies had offered or funded some type of LGBT aging training to staff although four out of five agencies were willing to offer training;
- Very few agencies were providing LGBT-specific outreach;
- Trained agencies were more likely to offer targeted services and outreach;
- Agencies with trained staff were three times more likely to have received a request to assist a transgender senior and twice as likely to have received a request for help from a lesbian, gay, or bisexual older adult;
- Nearly four out of five agencies serving older adults in urban areas across the country feel there is a need to address LGBT-specific issues (Knochel, Croghan, Moone, & Quam, 2011).

In 2010, the Administration on Aging (AoA) recognized that LGBT older adults experience unique needs and concerns. In the same year, AoA provided funding to create the country's first national technical assistance resource center focused on the health and social disparities faced by LGBT elders. In 2011, the National Resource Center on LGBT Aging developed partnerships with ten lead organizations (including two local organizations) to provide LGBT aging cultural competency training and technical assistance to providers across the country. This federally-funded training and technical assistance program works to: educate mainstream aging services organizations about the existence and special needs of LGBT elders; sensitize LGBT organizations to the existence and special needs of older adults; and educate LGBT individuals about the importance of planning ahead for future long-term care needs. In California, two laws (SB-1441 and AB-2920) promote services that address needs of LGBT older adults and prohibit discrimination based on sexual orientation and gender identity in state operated or funded services, activities and programs.[3]

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[2] Area Agencies on Aging are offices established through the Older Americans Act (OAA) that serve to facilitate and support the development of programs to address the needs of older adults in a defined geographic region.

[3] **SB1441:** The Nondiscrimination in State Programs and Activities Act, signed into law in 2006, prohibits discrimination based on sexual orientation and gender identity in state operated or funded services, activities and programs. Since the courts had not, yet, held that discrimination based on sexual orientation violated any Constitutional provisions, this law was necessary to make certain that no one was turned away from taxpayer funded programs or activities because of their sexual orientation or gender identity. **AB2920**: This legislation amends the Welfare and Institutions Code to require the California Department of Aging and Area Agencies on Aging to ensure that programs and services for elders account for the needs of aging lesbian, gay, bisexual and transgender (LGBT) Californians. AB 2920 requires the California Department of Aging to: 1) Include the needs of lesbian, gay, bisexual and transgender (LGBT) seniors in their needs assessments and area plans; 2) Provide technical assistance to local agencies for the training of staff, contractors and volunteers regarding the unique

At the local level, San Francisco's General Hospital Department of Psychiatry has formed a Cultural Humility Task Force (CHTF) with treatment teams focusing on specific groups including ethnic, linguistic, gender, and LGBT diversity. The purpose of the CTHF is "to provide leadership to the department in maintaining a focus on the importance of culture in clinical work; and to advance the importance of cultural humility through organizing trainings, workshops and culturally focused seminars." Since the development of the cultural humility[4] model in 1998 (Turvalon & Murray-Garcia), educational institutions of social work and social welfare across the country have been moving towards this model to prepare social workers for the dynamic and culturally diverse communities they will be serving. Cultural humility recognizes an ongoing, proactive approach to becoming inclusive and responsive to the needs of diverse populations, including LGBT older adults. The cultural humility model recognizes the need and benefits of annual or other regular training for the same provider or employee rather than a "one and done" model of training.

San Francisco, as a world leader for LGBT rights, needs to ensure that its city departments and contractors are trained to work effectively with LGBT older adults.

Recommendation 2.1
Require annual LGBT aging cultural competency training for San Francisco County employees and contract agencies prioritizing contracts within the Department of Aging and Adult Services. The preferred method is an in-person, facilitator-led initial training for *front-facing* staff within 90 days of employment as a part of orientation for new hires. For staff with *limited* contact with older adults, required participation in a one-hour webinar or alternative modes listed in Recommendation 2.3. *(See Appendix A for best practices for LGBT inclusion.)*

needs of LGBT seniors; and 3) Ensure that programs and services provided through the Older Americans Act and Older Californians Act in each planning and service area are available to all older adults regardless of sexual orientation, gender identity or any other basis set forth in the Fair Employment and Housing Act, California's most comprehensive nondiscrimination law.

[4] Cultural humility is best defined as "a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves; a process that requires humility in how we bring into check the power imbalances that exist in the dynamics of communication."

Recommendation 2.2
Include specific language in city contracts (especially at HSA and DPH) and monitoring documents requiring annual LGBT aging issues training to ensure compliance and accountability. Language should specify the minimum number of hours of in-service training on LGBT aging issues for all *front-facing*, direct service staff working with older adults (e.g., social workers, case managers, program aides, in-home workers, directors, and peer volunteers).

Recommendation 2.3
Require LGBT aging issues training for internal-facing staff (those with limited contact with the public) of HSA, DPH, and their contractors. For example, training could include one-hour training on LGBT aging cultural competency available annually, such as: internally-led discussion; online (webinar) training; LGBT aging-themed film screening with facilitated discussion; LGBT-diversity panel presentation by older adult consumers; etc. These modalities may increase accessibility for providers who are non-native English speakers, and those with limited familiarity with computers, or limited computer training.

Recommendation 2.4
Incorporate program-specific tailored curriculum on effectively serving LGBT older adults and LGBT adults with disabilities into training programs for the following programs: case management programs, to be incorporated into existing city-funded case management training institutes; In-Home Supportive Services staff, including social service staff, service coordinators, case management, and direct caregivers; County Veterans Service Offices (CVSO).

Recommendation 2.5
Ensure that the cultural competency training model made available to San Francisco employees and contractors utilizes a cultural humility framework.

These recommendations should be implemented starting in FY 2014/2015. Potential funding sources include the General Fund, and the Mental Health Services Act Oversight and Accountability Commission.

3. IMPROVING HEALTH AND SOCIAL SERVICES FOR LGBT OLDER ADULTS

PROBLEM 3: LGBT SENIORS LACK INFORMATION AND ENROLLMENT SUPPORT FOR SOCIAL SERVICES, FINANCIAL SUPPORT, BENEFITS COUNSELING, LEGAL ADVOCACY, AND HEALTH INSURANCE ACCESS.

SOLUTION 3: DEVELOP AND IMPLEMENT AN INFORMATION , REFERRAL, ENROLLMENT ASSISTANCE, AND CASE MANAGEMENT REFERRAL PROGRAM THAT PROVIDES A SINGLE PLACE FOR LGBT SENIORS TO RECEIVE INFORMATION, REFERRAL, AND ENROLLMENT ASSISTANCE FOR A WIDE RANGE OF AVAILABLE SOCIAL SERVICES AND HEALTH CARE.

A common theme emerging from surveys, focus groups, and other research involving LGBT seniors is the need for more information about social service availability, financial support, benefits counseling, legal advocacy, and health insurance access. In addition, LGBT senior participation in a range of DAAS programs is significantly lower than expected, and one of the most common reasons given by LGBT seniors for not using services is difficulty in accessing them (Jensen, 2012; Fredriksen-Goldsen et al., July 2013).

The Task Force believes that a geographic based system such as the city's Aging and Disability Resource Centers (ADRCs) does not adequately address the needs of the senior LGBT population in San Francisco. More than 12% of San Franciscans over 60 are estimated to be LGBT, one of the highest LGBT percentages in the country. Yet they underutilize public programs compared to their non-LGBT counterparts in a wide range of services (Jensen, 2012). Moreover, the absolute numbers of LGBT seniors will grow as boomers age into retirement, creating increased demand over time. A basic role of government is to provide equal access to services to all residents, and to remove barriers to that access wherever possible – in this instance to minimize the discrepancy between LGBT and non-LGBT residents in terms of access to services.

The Task Force's 2013 study showed that more than 20% of respondents reported needing but not using each of the following services: health services; health promotion; mental health; housing assistance; case managers; telephone/online referrals; and, meals programs/free groceries (Fredriksen-Goldsen et al., July 2013). In addition, an analysis of the 2011 San Francisco City Survey data indicated that over 30% of LGBT seniors needed assistance in getting benefits such as Medicare as compared to 20% of non-LGBTs (Jensen, 2012). The extent to which LGBT seniors themselves recognize that they are not accessing, yet need, assistance is

another reason for the city to address the perceived needs of its residents, by taking a series of steps to provide a one stop shop aimed at increasing access to a wide range of services.[5]

Recommendation 3.1

DAAS should develop and implement an Information, Referral, Enrollment Assistance, and Case Management referral program that provides a single place for LGBT Seniors to receive information, referral, and enrollment assistance for a wide range of available social services and health care. The program should leverage and build on DAAS' existing related internal and contracted programs to achieve efficiencies. *(See Appendix B for more detailed recommendations for program design.)*

PROBLEM 4: THERE ARE LIMITED SUPPORTIVE SERVICES AVAILABLE TO AID IN THE PROVISION, COORDINATION, AND PLANNING OF CARE TO ADDRESS UNIQUE CHALLENGES FACING LGBT OLDER ADULTS.

SOLUTION 4: DEVELOP AND IMPLEMENT AN LGBT SENIOR CASE MANAGEMENT AND PEER SPECIALIST PROGRAM.

Background

Research indicates that LGBT older adults live with higher rates of physical disabilities, are more likely to live alone, lack companionship, and have lower levels of social support (Adelmen et al., 2006; Fredriksen-Goldsen et al., 2011, 2013). These factors are likely contributors to the demonstrated higher percentages of social isolation, depression, anxiety and thoughts of suicide. Currently, there are few supportive services available that aid in the **provision, coordination, and planning of care**, and address the unique physical, social, emotional and behavioral health challenges facing LGBT older adults in San Francisco.

The Task Force's 2013 study identified case manager/social worker services as one of the most frequently needed programs and services among survey participants (Fredriksen-Goldsen et al., July 2013). There is a need for wrap-around services with integrated social services including case management for underserved LGBT older adults. Felton et al. (1995) found that "case management services plus a peer specialist were associated with an enhanced quality of life,

[5] Expanded Access program recommendations reflect San Francisco focused research results as well as conversations and correspondence with Jason Adamek (DAAS), Diana Jensen (HSA), Brett Andrews (Positive Resource Center) Erin Loubier and Daniel Bruner (Whitman-Walker Health, Washington, DC), Steve Grattick (LA LGBT Center Senior Services), Heshie Zinman (LGBT Elder Initiative, Philadelphia) and Catherine Thurston (SAGE, New York, NY).

fewer major life problems, and greater gains in social support for those receiving such services without a peer" (as cited in Salzer et al., 2002, p. 362).

Estimating the number of LGBT older adults needing case management services is somewhat difficult. Using estimates of unmet needs from the 2012 DAAS Needs Assessment, and combining those with estimates of the proportion of those older adults who are likely to be LGBT (Jensen, 2012) at least 500 LGBT older adults would appear to benefit from an LGBT senior case management program.

Recommendation 4.1
The city should develop and implement an LGBT senior case management and peer specialist program targeting LGBT older adults in San Francisco living with bio-psychosocial health challenges. *(See Appendix C for more detailed recommendations for program design.)*

PROBLEM 5: THERE ARE LIMITED SUPPORTIVE SERVICES AVAILABLE TO ADDRESS THE EMOTIONAL, BEHAVIORAL HEALTH, AND SOCIAL ISOLATION CHALLENGES OF LGBT SENIORS.

SOLUTION 5: DEVELOP AND IMPLEMENT AN LGBT SENIOR PEER COUNSELING PROGRAM AND AN LGBT PEER SUPPORT VOLUNTEER PROGRAM.

Background

The Task Force finds that currently there are very limited individual supportive services that address the emotional and behavioral health challenges of isolated LGBT older adults in San Francisco. Research indicates that LGBT older adults live with higher rates of physical disabilities, are more likely to live alone, lack companionship, and have lower levels of social support leading to significantly higher rates of social isolation, depression, anxiety and thoughts of suicide (Fredriksen-Goldsen et al., July 2013).

There is considerable evidence that San Francisco's LGBT older adults struggle with emotional and behavioral health challenges. The Task Force's 2013 study found that participants had higher rates of mental distress, suicidal ideation, depression, and anxiety when compared to estimates for San Francisco seniors as a whole and in comparison to LGBT older adult respondents nationwide. Loneliness and social isolation were also of particular concern for participants. Bisexual and transgender respondents had especially high rates of many mental health indicators, as did non-white participants (Fredriksen-Goldsen et al., January 2013).

The Task Force study also identified these additional emotional health concerns:

- 15% of participants report having contemplated suicide *in the prior year*. Rates were statistically significantly higher for bisexual women and men (16%), and transgender men and women (32%);
- 10% of participants experience frequent limited activities due to poor mental health; and
- Nearly 60% of the participants live alone -- LGBT participants who live alone have lower levels of social support than those who live with others, and are also more likely to have no one to turn to for emotional and social support (Fredriksen-Goldsen et al., July 2013).

A recent study of local adults age 50 and older living with HIV/AIDS, many of whom are LGBT, found:

- 48% of participants experience anxiety;
- 43% of participants experience depression; and
- Most participants are long term HIV/AIDS survivors (93% have had HIV 10 years or longer) living with the emotional effects of being long-term survivors of a pandemic that killed approximately two-thirds of those contracting advanced HIV disease since 1981 (i.e. lost friends, partners, post-traumatic stress) (Meissner & deVries, 2013).

As previously discussed, LGBT aging adults are more often living by themselves and are, therefore, at risk for isolation and less likely to access available services and supports. Multiple factors contribute to heightened social isolation among LGBT older adults. Regardless of income, they are more likely to live alone. The Task Force's 2013 survey found that only 15% of participants have children, and 60% indicate that their children are not available to help them if needed. Nearly two-thirds are neither partnered nor married. While 72% reported turning to a close friend for social support and 35% reported turning to a partner or spouse, as people age, this social support network diminishes (Fredriksen-Goldsen et al., July). These barriers result in an acute disparity in care as LGBT older adults age and need it most.

Social isolation makes older adults vulnerable to depression and deteriorating mental health including suicide (D'Augelli & Grossman, 2001). Minority LGBT individuals, especially transgender people, are even more isolated and unconnected to resources. Many are not able to navigate the health care system (including substance and alcohol abuse counseling) and, as a result, are not in systems of care (Singh & Mistra, 2009; Fredriksen-Goldsen et al., advanced 2013).

The Task Force finds that, despite the evidence for the need for emotional support services for LGBT older adults, few such services target that population in San Francisco. In 2010, San Francisco's primary LGBT community based mental health organization, New Leaf, closed its doors. One consumer described to a Task Force member in May 2013, "I was seeing a counselor at [a local organization], and I was limited in the number of sessions. Now that it is over, finding

a counselor who is gay and understands my life experience as an older gay man is challenging -- I've tried all of the community based organizations."

The following services for LGBT seniors are currently being provided by community nonprofit organizations in San Francisco:

1. Alliance Health Project offers a 14-week support group for gay and bisexual men age 50 years and older. Individual counseling is limited to 20 sessions;
2. Queer LifeSpace offers individual and group support (on a sliding scale) to LGBTQ persons of all ages, but no support groups specifically for LGBT older adults;
3. Openhouse offers individual emotional and behavioral support (2013 pilot program) in response to lack of available emotional and/or behavioral support to live successfully in the community;
4. Openhouse also offers a women's support group, a men's HIV support group, and a men's drop-in group, and a peer-facilitated transgender women's support group, grief group and, in partnership with the Alzheimer's Association, an Alzheimer's/dementia care provider support group;
5. Access Institute, in partnership with Openhouse, provides a grief and loss support group, and a caregiving and self-care support group for LGBT older adults.

The Task Force recommends the expansion of peer support based counseling, emotional and practical support services to reduce the impact of social isolation and to address emotional and behavioral health needs of LGBT older adults.

Peer support services are a well-established model for providing the help that is needed by LGBT older adults. Peer support is grounded in the belief that people who faced, endured and overcame adversity can offer support, encouragement, hope and mentorship to others facing similar situations (Davidson, Chinman, Sells, & Rowe, 2006). Social support can be generally defined as the support which is provided by others and "arises within the context of interpersonal relationships" (Crooke, Rossman, McCubbin, & Patterson, 1998). Within this definition Salzer et al. (2002) further delineate five primary types of support. *Emotional support* is providing empathy, caring, reassurance, intimacy, and concern. *Instrumental support* is aid in the form of goods or services. *Informational support* is advice, suggestions, guidance, and problem-solving. *Companionship* involves socializing, and a sense of belonging, including stronger social ties; and Validation through feedback and social comparison provides affirmation.

In practice, the Peninsula Family Service Senior Peer Counseling Program (2013) has found that more than half of participants were more likely to speak with their peer counselors than their friends and family members about important decision they had to make. It also found that 62%

asked questions about where to get help for their needs, 75% discussed difficulties, worries and concerns, 79% talked about the good things that have happened, and 80% discussed their health and how they feel. Moreover, 89% felt that their conversations with their peer counselor had “helped them a lot”.

Peer support services align with our natural tendency to seek company, and they have special impact for those living with mental health conditions. Festinger’s 1954 theory of social comparison puts forth that people intrinsically seek out the company of others who share similar experiences or commonalities, which may inherently provide a sense of normalcy (as cited in Solomon, 2004). For persons living with mental health conditions, the interaction they have with others they perceive better than them increases the development of emotional and behavioral skills towards self-improvement and further provides an increased sense of hope and optimism (Salzer et al., 2002). In contrast, when persons living with mental health conditions compare themselves with others who are doing worse it maintains a “positive effect by providing examples of how bad things could really be” (Salzer et al., 2002). Social learning theory puts forth that people’s behaviors are learned from others through observation and modeling. When a person living with a mental health condition observes a peer who is successfully coping with their condition, they may view this person as a role model, and it is more likely to result in a positive behavior change by modeling coping and health-enhancing behaviors (Bandura, 1977, as cited in Solomon, 2004). This can instill a sense of self-empowerment and hope that one can successfully make a change in behavior (Salzer et al., 2002).

Existing literature suggests that peer support makes people better off. It is beneficial for persons living with mental health difficulties and is “associated with reduced symptoms, increased functioning, and an enhanced sense of empowerment, recovery, hope and quality of life”(Salzer & Liptzin Shear, 2002, p. 281). A study conducted in 1998 by Klien, Cnaan, & Whitecraft of a one-to-one peer support program for persons with co-occurring substance abuse and mental health issues found that “program participants had fewer crisis events and hospitalizations, improved social functioning, greater reduction of substance use, and improvements in quality of life compared to a non-matched comparison group” (Salzer et al., 2002). Research conducted on self-help groups for individuals living with mental health conditions found the following benefits, especially among long-term attendees: decreased symptoms, increased coping skills, and life satisfaction (Davidson et al., 1999 as cited in Salzer et al., 2002), increased perceptions of self-esteem, and better decision-making skills and improved social functioning (Davidson et al., 2006). Additionally:

- Kurtz (1988) conducted a study with members of the National Depressive and Manic Depressive Association and their group members reported “significantly lower rates of

hospitalizations after members joined the respective groups compared to before they joined." Galanter (1988) reported the same results for members of Recovery, Inc. Furthermore, members of Recovery, Inc. also reported an "increased utilization of outpatient services during this period" (as cited in Davidson et al., 2006).

- Felton et al. (1995) found that "case management services plus a peer specialist counselor were associated with an enhanced quality of life, fewer major life problems, and greater gains in social support for those receiving such services without a peer" (as cited in Salzeret al., 2002). Studies have shown that "consumer-delivered case management services as effective as non-consumer, and crisis teams involving consumers are as effective as those with non-consumers" (Salzer et al., 2002).

Peer support may also have some benefits over other models. Experiential knowledge (Borkman, 1999) is specialized knowledge obtained through a lived experience. In other words, for an individual living with a mental health condition, this means that the person's "understanding and knowledge base is different from that acquired through research and observation" (as cited in Salzer et al., 2002). In that same work, the authors further emphasize that it is the sharing of personal experience that is at the foundation of CDS and what makes them beneficial as it is widely understood that many mental health practitioners may have personal experiences with mental illnesses but choose not to identify them and share their personal experience. More importantly, a person living successfully with a mental health condition may be viewed as more "credible" in their role, and their experiential knowledge may lead to "different intervention approaches" (Salzer et al., 2002). The peer support group allows members to learn from each other's wisdom – the ability to teach recovery from processing losses, building love, trust, and friendship (Reno, 2013).

Peer support also has demonstrated impact in reducing isolation: "Developing a peer support network can be of special importance for people who experience mental health problems and have become socially isolated due to the attendant stigma and discrimination" (Loumpa, 2012). The peer support group allows members to "widen their social circle – bonding with emotional satisfaction and a sense of being connected, thus building trust and intimacy, well-being and feeling known" (Reno, 2013). Furthermore, Davidson et al. (2005) state that "sharing similar life experiences with others can increase a person's understanding of his or her situation and reduce social isolation."

One model for reducing social isolation and its consequences is a volunteer peer support model focused on culturally competent emotional and practical support. A similar program has been a staple in the array of services for people with HIV/AIDS provided through the federal Ryan White Care Act for the San Francisco Eligible Metropolitan Area (SF EMA). Not only has the program for people with HIV exceeded all goals, it is also the second most cost-effective

contract per unit of service for the SF EMA (second only to distribution of food). Basing the Task Force's recommendation for older LGBT adults on this long-standing, cost-effective model is designed to affirm and strengthen the older LGBT adults' ability to make empowering, life and health-enhancing personal choices and is aimed at easing the burden of losing physical and mental capacity while improving their well-being at a time they find themselves without family and/or friends who can assist with caregiving.

Care navigation teams that include peer support volunteers reap benefits for the consumers as well as for the volunteers themselves who enjoy making purposeful connections to their community, as well as to learn about caregiving and the aging process. Peer support is also beneficial to the peer-provider as defined by the Helper-Therapy Principle (Risman, 1965; Skovholt, 1974). Helping others is beneficial by increasing a sense of interpersonal competence as a result of making an impact on another person's life and developing a sense of equality in so far as the helper feels that he/she has gained as much as he/she has given. Furthermore, the helper acquires "personal and relevant knowledge" during the process, and receives social approval through feedback, which results in an increased sense of self-enhancement (as cited in Salzeret al., 2002). A qualitative study examining the benefits of peer-providers was conducted in a peer-support program for persons with re-occurring mental health and substance use conditions, and it indicated that peer-providers benefit from their roles as helpers, a finding consistent with the helper-therapy principle (Salzer & Liptzin Shear, 2002).

Consumers who are matched with middle and younger-aged LGBT adult volunteers increase intergenerational connectivity in a community where biological family is not often available. The program is life affirming and builds a caring community across age, gender, sexual orientation and culture.

Given the findings of this research, the Task Force recommends three initiatives. The first is an LGBT Senior Peer Counseling Program to complement and/or *bridge* the gap between intensive case management and formal mental health services. This program will empower LGBT older adults living with emotional and behavioral health issues to live at an optimal capacity in the community. The second is an LGBT Peer Support Volunteer Program to provide isolated LGBT older adults with emotional and practical support through care navigation and peer support.

Recommendation 5.1
DAAS or DPH should develop and implement an LGBT senior peer counseling program targeting LGBT older adults in San Francisco living with emotional and behavioral health challenges. *(See Appendix D for more detailed recommendations for program design.)*

Recommendation 5.2
DAAS or DPH should develop and implement an LGBT older adult targeted program that

includes individual emotional support, peer support groups, outreach and early intervention and suicide prevention. *(See Appendix E for more detailed recommendations for program design.)*

Recommendation 5.3

DAAS should develop and implement an LGBT Peer Support Volunteer Program to provide isolated LGBT older adults with emotional and practical support through care navigation and peer support, effective in FY 2014/2015. *(See Appendix F for more detailed recommendations for program design.)*

PROBLEM 6: LGBT OLDER ADULTS HAVE UNIQUE BARRIERS TO ACCESSING INFORMATION ABOUT AND SERVICES FOR ALZHEIMER’S AND DEMENTIA CARE.

SOLUTION 6: CREATE AN LGBT-TARGETED EDUCATION AND AWARENESS CAMPAIGN AND INCREASE AVAILABILITY OF RELATED SUPPORT GROUPS.

In its 2009 report, *San Francisco Strategy for Excellence in Dementia Care,* an Alzheimer’s/Dementia expert panel, projected that the total population of older adults in San Francisco living with Alzheimer’s disease will be 26,774 older adults by 2020. Using the city’s 12% estimate of the LGBT senior population (Jensen, 2012), it can be extrapolated that, by 2020, approximately 3,213 LGBT seniors will be living with Alzheimer’s disease.[6]

Major dementia-related issues confronting LGBT seniors:

- **Isolation:** Discrimination, fear of discrimination and living alone increases the risk of isolation in LGBT seniors. These factors are compounded when a person is challenged by a chronic illness. This is especially true for persons with Alzheimer/dementia. According to Janice Wallace, an elder coach and small business owner: “Unlike other illnesses, the person with dementia cannot be the individual asking for help. If you don't have a plan in place, you can easily be in trouble and become isolated.”
- **History of discrimination, discrimination, and fear of discrimination:** According to the Alzheimer’s Association of Northern California, “LGBT seniors with dementia as well as

[6] This estimate is specifically related to Alzheimer’s. The Alzheimer’s Association estimates that Alzheimer accounts for approximately 60% of all dementias. Accordingly this estimate is low in regard to the total number of LGBT older adults in San Francisco with all forms of dementia.

their caregivers are reluctant to access support services in San Francisco. Fear of discrimination keeps these seniors from coming out in our support groups. The older the LGBT person is, between 65 to 90, the less likely they are to be out in the Alzheimer's Association support groups. There are 2,200 to 2,700 participants in our groups, approximately 700 to 800 people a month. Approximately 2 to 5% of support group participants may be LGBT at any one time but the percent "out" is smaller than that. Level of outness, who they are comfortable being out with is what makes the difference" (Adelman et al., 2013). Erika Erney, a Volunteer Facilitator of an LGBT Caregiver Support Group elaborates on this: "There is a level of mistrust of service and service providers. LGBT seniors and their caregivers are often fearful of people coming into their world." Many LGBT seniors became adults in the pre-liberation era when disclosure invariably meant rejection, loss and possibly incarceration. Consequently, LGBT seniors often fear for their safety if they invite service providers into their lives and their homes. LGBT seniors often go back into the closet to access needed services or, at the risk of jeopardizing their health and well-being, do not access these services at all.

- **Dual Stigma - LGBT & dementia:** Alzheimer's disease and other forms of dementia are still little understood by many people, and there is much stigma associated with dementia. "LGBT seniors are vulnerable to the dual stigma associated with dementia and being LGBT"(Adelman et al., 2013).

- **Lack of family support:** Mainstream seniors rely on the assistance of a spouse, adult children, and other family members to research disease information and to access long term services and supports. But studies have found that San Francisco LGBT seniors are more likely than heterosexual seniors to be childless, single, and live alone (Fredriksen-Goldsen et al., July 2013; Jensen, 2012; Adelman et al, 2006). These factors have important implications for care and support for LGBT seniors since having children and/or a partner reduces the likelihood of poverty, and increases access to information and to services and care in old age.

- **Lack of informal caregiver support:** LGBT seniors rely on their family of choice for support and assistance. But families of choice are more often than not people of similar age and so are aging at the same time. Friends may well need services themselves when a senior is in need of assistance. Further, families of choice exist outside of legal support and are challenged by legal obstacles when providing care. Clearly LGBT seniors are in need of more formal support systems to assist them in accessing information and needed care.

- **Lack of information about dementia:** According to Edie Yau, Director of Diversity & Inclusion, Alzheimer's Association, Northern California and Northern Nevada Chapter,

although discrimination is a very real problem, there is an even larger problem of not knowing where to go for dementia services. The LGBT community remains largely uninformed about the disease and the resources and supports available to help people manage daily tasks as the disease progresses.

- **Complications from HIV/AIDS:** The complex management medication demands and the requirement to maintain medical appointments can be especially challenging for those living with both HIV/AIDS and dementia.
- **Lack of advanced care planning:** Future planning, correct information about Alzheimer's and where to go for LGBT sensitive dementia services are all critically important issues that will assist LGBT older adults and seniors with Alzheimer/dementia to live as long as possible and as well as possible in their own homes and in their own communities.

Every effort needs to be made to integrate LGBT seniors into the existing network of dementia care services. Any delay in the transition from less costly, community-based in-home care, to more expensive institutional settings would significantly reduce costs to the City and County of San Francisco. The proposed recommendations would facilitate integration of services and provide the LGBT community with the information and resources to live in community for as long as possible.

It is recommended that mainstream dementia and senior services providers expand services to LGBT seniors by mandating cultural competency LGBT dementia care training for senior and health service providers (primary care doctors, nurses, senior service providers, mental health workers, senior serving institutions, nursing homes, senior housing, etc.), and first responders (fire, police and EMTs). Cultural competency training will increase and broaden expertise in working with LGBT seniors with dementia and facilitate LGBT senior integration into the dementia care network.

Unlike the AIDS epidemic, the coming dementia epidemic is well documented and the disease is well understood. Consequently, a coalition of LGBT organizations and allies that could provide direct services to LGBT older adults would reduce the risk of service duplication, increase cost-effectiveness, and allow funding to be channeled in the most expeditious way.

It is recommended that educational programs, resource tools and a community awareness campaign be funded by the city to increase outreach to the LGBT community about Alzheimer/dementia and dementia resources. Educational programs are needed to increase knowledge about dementia and to assist the LGBT community, individuals and couples to better plan for the future. Presently there are few tools available for service providers, first responders or the LGBT community. One of the few tools available is the Alzheimer's

Association brochure for LGBT Caregiver Concerns. This is a good start. But a full range of tools is needed for people living with dementia, their caregivers and service providers.

Recommendation 6.1
Coordinate an LGBT targeted education and awareness campaign with the Alzheimer's Association about dementia and the issues it presents to LGBT persons. *(See Appendix G for more detailed recommendations for program design for Recommendations 6.1 through 6.4.)*

Recommendation 6.2
Create an informational campaign about the importance of advanced care planning.

Recommendation 6.3
Work to create new and strengthen existing LGBT-specific dementia caregiver support services.

Recommendation 6.4
Create cultural competency training that is both LGBT sensitive and dementia care capable.

All of the above recommendations should be explored and implemented, whenever possible, in collaboration with the Alzheimer's Association of Northern California and Northern Nevada and DAAS or another appropriate city department.

PROBLEM 7: SOME LGBT OLDER ADULTS STRUGGLE WITH LOW INCOMES AND POOR FINANCIAL LITERACY.

SOLUTION 7: DEVELOP AND IMPLEMENT FINANCIAL LITERACY TRAINING SERVICES THAT TARGET LGBT OLDER ADULTS.

Background

While there is very little literature and research that focuses on the explicit needs of the low income LGBT communities, certain reasonable extrapolations can be made from analysis of the financial position of mainstream Americans at large. Of particular interest are the recent findings that reveal approximately 40% of American households live off of 110% of their income (Bell & Lerman, 2005). In spite of having a generally higher educational level than many mainstream individuals, gay men in San Francisco have a history of commanding considerably

less pay (Fredriksen-Goldsen et al., July 2013). This may be a direct result of sexual orientation-related discrimination both in access to higher rungs of organizational earnings in the workforce and as a result of fewer merit-based salaries based on potential job-related bias. In spite of the general assumptions that associate the LGBT community, particularly gay men, as being top income earners, the Task Force's findings contained in the aforementioned research project, and other studies, paint a more dire financial picture of financial realities experienced by the aging LBGT populations in San Francisco (Fredriksen-Goldsen et al., 2011 pg, 18).

Institutional/Environmental Barriers

San Francisco presents a remarkably unique challenge that, associated with the fact that many LGBT seniors are low income, exacerbates their aging in place desires without appropriate public policy intervention. The most recent comparative analyses by the Brookings Institution of nation-wide cost of living standards, reveals that San Francisco is now the most expensive city in America in which to live (Berube, 2014). Compound this development with excessively high rents, inflated food costs, the costs of medical services, etc., make for a challenging financial situation for the vast majority of aging LGBT community members who wish to continue living in the City. Even with the recent changes heralded by the repeal of DOMA and the judicial over-turning of Proposition 8 in California, same-sexed couples who are social security recipients have historically lost millions of dollars because of laws that prevented them from enjoying the same financial benefits that their heterosexual counterparts benefit from as social security retirees (Maril & Estes, 2013).

All of the aforementioned demand a heightened capacity for prudent spending habits in order to survive, let alone thrive, within the context of the high costs of living in San Francisco. Financial literacy has been and continues to be, a proven tool that all Americans, particularly seniors subsisting on limited incomes, require in order to endure in the tumultuous current financial times that we are experiencing. Heightened financial literacy can greatly assist limited income LGBT seniors from accidently taking on excessive debt, assist in discerning habits relative to shopping and purchasing goods and services at reasonable market rates, and can contribute to asset building that can hold the potential of lifting low-income seniors out of poverty altogether (Bell & Lerman, 2005 pg.8).

Acute Psychosocial Neighborhood/Geographic Example:

There are deeply entrenched environmental issues and policies that tend to both maintain low-income seniors' limited spending power and prevent their accessing an overall higher quality of life. For example, there is a known critical mass of LGBT seniors, particularly transgender community members, who, out of both necessity and choice, choose to live in SROs in the Tenderloin neighborhood. Asset mapping reveals that there are few if any high quality,

reasonably priced grocery stores in this neighborhood. As a consequence, they typically rely on corner liquor stores and markets to purchase needed goods and supplies including food and personal hygiene staples. Unfortunately, the average prices of these neighborhood stores tend to be significantly higher than those of the larger traditional supermarkets and food stores. Here, we have an environmental impediment to both cost savings and healthy nutrition (Conway, 2011).

Educating LGBT seniors about minimizing food costs, for example, would empower San Francisco LGBT seniors to take action to address a major concern: food insecurity. The Williams Institute's recent findings have revealed that there is pervasive "food insecurity" within the LGBT communities. Referencing the US Department of Agriculture (USDA), they posit the following:

> According to the US Department of Agriculture (USDA), approximately 49 million Americans (nearly 16%) were food insecure in 2012. Food insecurity is generally defined as having limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways. US Department of Agriculture surveys measure food insecurity through a variety of questions including worries about food running out, not having enough food, not being able to afford a balanced meal, reducing or skipping meals, eating less than one should, feeling hungry but not eating, losing weight, and not eating over extended time periods. Despite evidence that lesbian, gay, bisexual, and transgender (LGBT) communities may be at increased risk of poverty when compared to the heterosexual population, little is known about the degree to which LGBT communities experience food insecurity. USDA surveys do not include sexual orientation or gender identity measures that would allow for direct measures of food insecurity in the LGBT population (Gates, 2014).

Additionally, the above-referenced research report reveals that 34% of LGBT-identified women did not have money for food in the last year compared to 20% of non-LGBT women and that 17% of same-sex female couples received food stamps, compared to 10% of male same-sex couples and just 9% of different sex couples. The picture that emerges is in stark contrast to the stereotypical assumptions of LGBT financial well-being that is often portrayed by the mainstream media but has been debunked by researchers as a myth for many years (Badgett, Durso, & Schneebaum, 2013).

Financial literacy training can also address issues like transportation, continued employment, and preventing victimization and loss through fraud. A lack of adequate and affordable transportation in order to access larger variety rich food and supplies stores is an additional barrier for low-income LGBT seniors that can be addressed by policy changes on a local level. Moreover, it is worth mentioning that the traditional definition of retirement no longer holds

sway within the context of our current economic realities. Older individuals, particularly the Baby Boomers, are finding that they not only do not wish to retire at traditionally historical age benchmarks; many are discovering, as a result of the financial losses incurred because of the recent recession, that they cannot afford to retire and must remain in or reenter the job force at later ages than expected or planned (Rix, Baer, Figueiredo, McKenzie, & Shvedo, 2012).

Finally, statistical indicators point to an increase in the occurrence of financial abuse and fraud being perpetrated on seniors (Wootsen, Schindler, & Tran, 2010). This phenomenon is exacerbated by the tendency of many LGBT to not report or under-report crimes and other kinds of victimization. Because of past negative experiences with the aforementioned agencies, LGBT seniors tend to report victimization crimes at a considerably lower rate in spite of the facts that show that they are often victimized. Financial literacy is one of many empowering strategies, along with more user-friendly public policy initiatives, that will assist this and other at-risk populations within the aging LGBT communities.

Best Practices

Public assistance agencies hold promising potential for imparting financial literacy to their recipients in part because agency clients are a captive audience. Moreover, there has been success in these types of arrangements with human services agencies in other states (Rand, 2004). The Housing and Urban Development Agency (HUD) currently offers financial education programs for their clients i.e., Individual Development Accounts, (IDAs), financial literacy classes, budgeting training, etc. Capital One Credit Card Services, Visa, and a host of other private/corporate and nonprofit entities offer financial literacy training, all of which are free. However, there is a chronic lack of coordination in and among the few agencies that offer financial literacy services, nor is there a readily known central LGBT-friendly agency or place where a low-income LGBT senior might access all these options for ease of choice. The development and coordination of a centralized, easy access resource point of this nature should hypothetically be a low-cost and high-yield commodity for a city like San Francisco.

Recommendation 7.1.
The city should enhance the availability of centralized, LGBT-friendly, financial literacy services. These services should be coordinated with the case management, information, referral, and assistance services proposed in Recommendations 3.1. and 4.1. of this report.

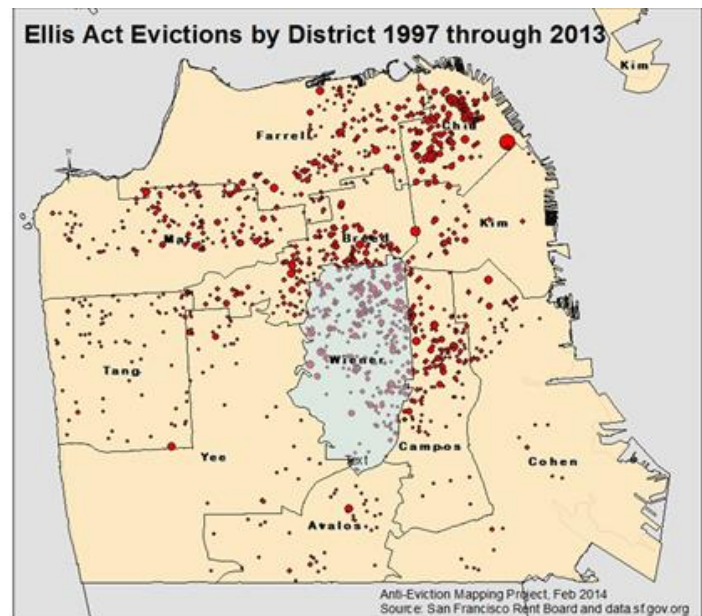
PROBLEM 8: LGBT OLDER ADULTS ARE ESPECIALLY VULNERABLE TO LOSING THEIR RESIDENTIAL HOUSING AS A RESULT OF EVICTIONS AND PHYSICAL BARRIERS TO AGING IN PLACE, AND THE CONSEQUENCES OF LOSING HOUSING LATE IN LIFE IS SEVERE FOR MOST LGBT SENIORS.

SOLUTION 8: IMPROVE EVICTION PREVENTION PROTECTIONS FOR LGBT SENIORS THROUGH RENTAL AND HOMEOWNER ASSISTANCE, LEGAL SERVICES, AND INCREASED RESTRICTIONS ON EVICTION, AND INCREASE RESOURCES FOR LGBT SENIOR HOMEOWNERS.

Background

A number of factors place LGBT older adults at heightened risk for eviction:

1. **Geographic location of evictions:** The Anti-Eviction Mapping Project, a San Francisco group that has created maps of evictions in the city since the first dot-com boom of the late 1990s, has a map of Ellis Act evictions from 1997-2013 by supervisorial districts, demonstrating that the area with the most Ellis evictions is District 8, which the San Francisco City Survey shows is also home to the largest number of LGBT older adults.[7]



2. **LGBT residents face eviction at high rates.** According to the latest eviction report by the city's Eviction Defense Collaborative (EDC), the leading agency doing eviction defense for tenants in the city, 15% of "households were home to at least one person who identified as LGBTQ," a higher rate than would be expected based on projections that LGBT residents make up 12% of the city's population (Jensen, 2012). While statistics are unavailable specifically for LGBT older adults, older adults living in rent controlled apartments are thought to be attractive targets for eviction.

[7] See map here: http://antievictionmappingproject.files.wordpress.com/2013/04/screen-shot-2013-06-17-at-12-54-50-am.png. Data from the mapping project revealed that The Castro has been the hardest hit area of the city since 1997, with 294 buildings (837 units) Ellis Act evicted, and 917 units lost to Owner Move-In (OMI) evictions.

3. **Lack of legal services with expertise in both discrimination and eviction prevention, despite evidence that eviction is an important issue in the LGBT community.** Legal services within the LGBT community for LGBT seniors facing eviction are nearly nonexistent. Groups that do legal advocacy on other fronts (discrimination, for example) do not offer legal help when an LGBT senior is fighting or threatened with eviction (an unlawful detainer).
4. **Low incomes make moving to new apartments nearly impossible.** With median rent for apartments in San Francisco at over $3,300, a tenant would need approximately $10,000 upfront for first month, last month and security deposit in order to get a new apartment, not counting moving costs (Said, 2013). Without rental assistance, these moving costs are prohibitive: Nearly half of EDC's clients facing eviction "live at or below the poverty line -- less than $11,490 per year." Low-income seniors cannot exceed liquid assets of $2,000 without endangering Medi-Cal benefits. Both the 2013-2018 Analysis of Impediments to Fair Housing report and the most recent Homeless Count report (Applied Survey Research, 2013) points to rental assistance as a major barrier to housing of senior and disabled persons in San Francisco. Not only do LGBT seniors need rental assistance, but they also need help to meet the minimum income requirement qualifications for affordable housing.[8]

Once a senior is out of his/her apartment, it is very difficult to find affordable housing. Consider the case of Tim Oviatt, 64, who once ran All American Boy in the Castro. After his eviction (documented on a KQED radio segment called "Wave of SF Evictions Displaces Gay Men with AIDS" by Bryan Goebel, October 4, 2013), he ended up sleeping in his car in the parking lot next to the store he lost. Another gay disabled senior, Jeremy Mykaels (who runs a website called ellishurtsseniors.org and who has been featured in many stories in the straight and queer press in the past year, including the *Chronicle, SF Bay Guardian* and *BAR*), has temporarily won his battle against the Ellis Act of his unit by three investors from out of town. They could still appeal the court's decision to toss out his eviction and refile the Ellis. Should he be evicted, he has nowhere to go.

Following eviction, San Francisco's LGBT seniors face considerable challenges:

1. **Inability to afford market rate housing.** Seniors, who often live on fixed incomes, are particularly vulnerable when evicted from long-term rent-controlled apartments, especially now that the rental market currently has the highest rents the city has ever recorded, and

[8] Some low-income seniors do not qualify for certain "affordable" housing units because they do not have enough income. This is especially true in tax credit and below-market-rate units where the qualifying income level can be higher than what many seniors get from SSI or disability payments.

rents are still rising.

2. **Lack of availability of affordable housing.** Affordable senior housing is limited. Only one LGBT senior development, 55 Laguna, is in the works. Construction is scheduled to begin in late 2014 and be completed in phases over three years. Even when it is built, it will not be sufficient to fill the need.

The consequences of homelessness are more acute for seniors. Studies have found that elderly homeless persons often find difficulty getting around on the street, have difficulty standing in long lines to get a bed at shelters, and struggle with shelters that may not be physically accessible. They are more likely to sleep on the street due to distrust of crowds at shelters and clinics. Elderly homeless persons are more prone to victimization and more likely to be ignored by law enforcement (National Coalition on Homelessness, 2009). Finally, a comparison study of homeless mortality rates in seven cities throughout North America and Europe shows that the average life expectancy for a person without permanent housing is between 42 and 52 years, far below the country's average expectancy of 80 years. Premature death most often results from acute and chronic medical conditions aggravated by homeless life rather than either mental illness or substance abuse (O'Connell, 2005).

Even those not facing eviction may face unstable housing circumstances. Only about one-third of respondents to the Task Force's 2013 survey of LGBT older adults indicated that they were very confident that they would be able to stay in their current housing for as long as they wished; the most common reason for uncertainty was "economic reasons," including foreclosure (Fredriksen-Goldsen et al., July 2013).

Given these considerations, the best way to lessen the need and the cost for affordable housing for seniors is to keep LGBT seniors in their existing homes. It is extremely expensive to re-house LGBT seniors in an affordable unit. Replacement affordable housing costs hundreds of thousands of dollars, anywhere from $250,000 to $500,000, and waiting lists abound at existing affordable buildings including public housing and Section 8 properties.

While the Task Force might like to have the city enact a blanket prohibition on evicting seniors in San Francisco, the Task Force understands that this may not be legally possible. Instead, the city must provide adequate rental assistance programs and other services for renters aimed at curbing senior evictions that are within the limits of the law, albeit pushing those limits to the greatest extent possible.

Even when the senior is at fault, such as nonpayment of rent or a nuisance, eviction may or may not be the best solution. In the case of nonpayment, having programs in place to help the senior pay the rent or, if needed, get their finances in order including education in economic

empowerment and economic literacy. There is also considerable value in working with a senior in the event that they become a nuisance to try and change the behavior or perhaps arrange another living situation. Sometimes when a tenant receives help with paying the rent, a landlord refuses to sign off on the paperwork the rental assistance agency requires. A fix is needed for this in the law especially for seniors, to make sure no one ends up evicted even when offered rental assistance.

LGBT seniors face the additional threat of displacement from San Francisco or the Bay Area to another community in which discrimination against LGBT individuals may be the norm. The consequences of further social marginalization in the wake of a loss of housing are myriad. For those with AIDS, San Francisco offers the best care possible. Relocating to another place could put a person with AIDS' life in danger.

The only way to prevent the consequences of eviction and foreclosures for LGBT older adults is to make eviction defense and assistance of LGBT seniors a crucial part of both City and LGBT community efforts. The Task Force recommends the following eviction protection and other measures to keep LGBT seniors in their homes, many of which can be implemented within six months of this Report:

Recommendation 8.1
The City should establish a rental assistance fund that aids LGBT seniors when they cannot pay or get behind in monthly rental payments.

Recommendation 8.2
The City should contract with LGBT community organizations doing legal work so that they can begin to offer eviction defense for LGBT seniors, including but not limited to, representation in unlawful detainer actions.

Recommendation 8.3
The Board of Supervisors should explore additional legal protections for senior renters, including: 1) an exploration of the legality of restricting seniors from evictions and, 2) a requirement that landlords accept rental assistance that a senior receives.

Recommendation 8.4
A fund should be established by HSA and/or the MOHCD to help LGBT seniors with first month's rent, security deposit and to meet minimum income requirements for affordable housing.

Recommendation 8.5

The MOHCD should offer a grant to provide help for LGBT senior homeowners who are in danger of losing their homes and for tenants' rights education and advocacy for LGBT seniors.

Recommendation 8.6

Local officials should work with state elected officials to repeal the Ellis Act or exempt San Francisco.

PROBLEM 9: LGBT SENIORS NEED MORE ACCESS TO AFFORDABLE HOUSING.

SOLUTION 9: INCREASE AVAILABILITY OF AND ACCESS TO AFFORDABLE HOUSING FOR LGBT OLDER ADULTS BY INCLUDING LGBT SENIORS IN PLANNING PROCESSES, PRIORITIZING DEVELOPMENTS THAT TARGET THEM, AND PROVIDING LGBT-FOCUSED HOUSING COUNSELING AND RENTAL ASSISTANCE.

Background

Current data on the number of homeless LGBT individuals and the prevalence of LGBT populations in affordable housing suggests that the LGBT community has not been as successful at accessing available affordable housing when it becomes available. The 2013 Homeless Count report estimated that 29% of homeless individuals were lesbian, gay, or bisexual, and 3% were transgender (Applied Survey Research). These rates are far higher than would be expected based on the size of the LGBT population. About 10% of those individuals are seniors.[9] The combination of high rates of existing homelessness and the threat of eviction described in the previous section requires interventions that increase availability of and access to affordable housing for LGBT older adults.

Three issues are at the center of this policy concern:

1. **Lack of representation of LGBT older adults in the planning processes that direct affordable housing development.** Historically, LGBT seniors have not had a formal voice in the planning process for the Mayor's Office of Housing and Community Development's (MOHCD) Consolidated Plan, a report for HUD that determines the City's priorities in the development of affordable housing. Inclusion of an LGBT older adult in

[9] Analysis of age breakdown of LGB respondents provided by the HSA Planning Unit.

this planning body would ensure that the Consolidated Plan takes into account the unique needs of this population.

2. **Lack of low income housing development that is truly affordable and targeted to LGBT older adults.** While the Castro and Upper Market areas are currently seeing a lot of development, none of it, even the below market rate (BMR) units, is affordable to LGBT seniors on fixed incomes (pension, SSI, etc.). The only truly low-income housing option targeted to LGBT seniors is 55 Laguna..
3. **Lack of affordable housing counseling services for LGBT older adults.** There is only one San Francisco organization that offers counseling for LGBT seniors on how to apply for affordable housing (where to look, how to know if you qualify, how to fill out applications, etc.), and only one other San Francisco organization assists people with HIV/AIDS who are in need of housing.

Recommendation 9.1
The MOHCD should include an LGBT senior in the community-based work group that drafts the Consolidated Plan for HUD.

Recommendation 9.2
The City should work with the SF Land Trust to set up at least one LGBT senior housing coop or land trust.

Recommendation 9.3
Affordable housing advocates, members of the Board of Supervisors, and the MOHCD should meet to develop a plan for 200 very low-income (0-30% of AMI) LGBT senior housing units in the Castro/Upper Market area to be constructed within the next 10 years.

Recommendation 9.4
The city should provide funding for housing search counseling (MOHCD) and rental assistance specifically for LGBT seniors (DPH).

Recommendation 9.5
The City's Housing Opportunities Partnerships and Engagement (HOPE) office should commit to a plan for reducing LGBT senior homelessness and need for affordable housing by 50% within the next five years.

PROBLEM 10: CONDITIONS IN APARTMENTS AND SROS WHERE MANY LGBT SENIORS LIVE ARE OFTEN UNACCEPTABLE.

SOLUTION 10: IMPROVE CONDITIONS IN APARTMENTS AND SROS THROUGH IMPROVED DBI POLICIES AND ENHANCED WORK ON HABITABILITY.

Background

San Francisco has about 500 residential hotels that have a total of about 19,000 units that are home to over 8,000 seniors and persons with disabilities (Mayor's Office on Housing et al., n.d.). Though there is no official count of how many of these folks are LGBT, one can safely assume that about 12% or roughly 1,000 SRO residents are senior and/or disabled LGBT individuals. Among the many issues that respondents to a study of SRO tenants listed as primary concerns were infestations (roaches, rats, mice, bedbugs, etc.), cleanliness, elevator problems, and maintenance and repairs (Bilick, Lam, Lehman, & Vining, 2012).

Other LGBT seniors live in apartments that are old and in need of rehabilitation, especially in rent-controlled housing stock when long tenancy and low rents give landlords an excuse not to address repair and infestation problems. Both the San Francisco Housing Code and California Civil Code Section 1941.1 mandate that apartments and SROs must be kept in good repair and free of infestations and vermin. The responsibility for any repairs is with the landlord, not the tenant, and California Civil Code Section 1942.5 provides that a landlord cannot retaliate and evict a tenant for filing a complaint against him/her for not making repairs or eliminating an infestation. However, seniors who fear losing their housing may not complain or report problems to their landlords for fear that they will be retaliated against and evicted. Those who do pursue a complaint with the Department of Building Inspections (DBI) can face a long waiting period for a Director's Hearing and eventual referral to the City Attorney's Office if the landlord does not abate the problems within the designated time period. DBI does not currently prioritize complaints from seniors.

Preventative measures can also help address habitability issues. Federal law requires that an inspector from the San Francisco Housing Authority sign off on an apartment before a Section 8 tenant is placed in it. A similar policy on the part of the city in regards to persons being placed in hotel rooms by city agencies or nonprofits funded by the city would force hotel owners that master lease with the city to do repairs and bring their rooms up to code so that they pass inspections, thus preventing seniors from being placed in substandard hotel rooms.

According to the survey done by this task force, 21% of LGBT senior respondents had unmet needs in housing assistance. Forty-two percent of those using housing assistance services indicated that they were "not comfortable" using those services as an LGBT individual. It is

therefore important the city assure that groups doing housing assistance work with city funds be qualified to provide services to LGBT seniors.

Recommendation 10.1
The DBI should make housing complaints from seniors, especially those who live in SROs, a priority.

Recommendation 10.2
LGBT groups serving seniors and people with AIDS should conduct outreach to groups that do housing assistance and habitability work throughout the city, especially to those living in the Tenderloin, South of Market, Castro, Haight, Chinatown and Mission neighborhoods where many LGBT seniors live, to make them aware of and sensitive towards LGBT seniors and their unique needs.

Recommendation 10.3
The city should make it policy that any organization that receives city funds to place people in SRO hotel rooms and apartments be required to have DBI inspect and sign off at the time the unit becomes city-funded and at the time of each new tenant move-in.

PROBLEM 11: MANY LGBT SENIORS FEEL UNSAFE AND UNWELCOME IN CITY SHELTERS.

SOLUTION 11: THE CITY SHOULD ADDRESS UNSAFE AND UNWELCOMING TREATMENT OF LGBT SENIORS IN SHELTERS BY PROVIDING TARGETED SHELTER SERVICES AND IMPLEMENTING TRAINING AT EXISTING SHELTERS.

Background

According to the latest biennial report by the city, 29% of the homeless in San Francisco are lesbian, gay, or bisexual and 3% transgender. Seventeen percent of the homeless are age 51 or older (Applied Survey Research, 2013). The city needs at least 150 beds for LGBT seniors, assuming 12% of the city’s homeless seniors are LGBT. Even if only 12% of the 17% who are seniors would be LGBT seniors who could potentially need a space in shelters, at least 150 individuals. The capacity of the LGBT shelter in the Mission District that will open in 2014 is 24 beds. Considering that the shelter will be serving all ages, 18 and above, it will not be sufficient for the homeless LGBT senior population needing shelter housing.

Ample evidence indicates that LGBT homeless people do not feel and, in fact, are not safe in the shelter system. A report conducted in 2007 found that 70% of transgender respondents reported having experienced violence or harassment at the city's shelters (Albertson, 2007). At a March 2010 hearing convened at the request of queer housing activists by Supervisor David Campos, about 35 homeless or formerly homeless LGBT folks testified of harassment and anti-gay/transgender violence at the shelters. At the time, Supervisor Campos asked Human Services Agency officials to address this problem. To date, it has not been adequately addressed in the opinion of the Task Force.

Many LGBT homeless seniors prefer not to go into shelters as a result of the discrimination and violence, and many sleep in parks and other public spaces that put them at risk of arrest and/or citation under the city's sit/lie law and ordinances against sleeping in public spaces. Any arrest or citation can prevent a person from receiving housing that is federally funded, thus possibly making them permanently homeless.

Recommendation 11.1
The City should develop a plan to implement training for safe and welcoming LGBT senior accommodations for those who are homeless and must seek a shelter.

Recommendation 11.2
The City should mandate cultural sensitivity training for the staff including a component for the residents of all shelters in order to make them more LGBT senior friendly, including a timeline for starting and completing training, as well as consequences for lack of effective implementation including discontinuation of the city funded contract.

Recommendation 11.3
The city should expand the current LGBT friendly shelter opening in 2014, with emphasis on additional LGBT friendly beds for seniors.

5. IMPROVING LEGAL SERVICES FOR LGBT OLDER ADULTS

Introduction

There have been significant legal advances for the LGBT community in just the last few years. With the end of "Don't Ask, Don't Tell" and the partial demise of the Defense of Marriage Act, we are clearly in a new era. Comparing the current legal climate to the mass terror LGBT people faced in the 1950s and 1960s, the pace of change appears extraordinary.

In California, LGBT people enjoy one of the most protective legal regimes in the nation, and San Francisco has a strong tradition dating back to Harvey Milk of providing even more legal protections. The Legal Issues Work Group aimed to draw on these traditions, focusing on two areas: better protecting LGBT seniors in long-term care facilities and expanding access to life-planning documents.

Long-term care facilities house some of the most vulnerable LGBT seniors, and while there are state laws mandating nondiscrimination, there has not been clear guidance to facilities on how to implement those laws—especially for transgender seniors. With new guidelines in place to enforce specific standards for nondiscriminatory care, the Task Force believes that San Francisco can lead and innovate in finding new ways to protect LGBT seniors.

Life-planning documents are a crucial way for seniors to protect and articulate their wishes for their care, disposition of their property, and for designating who should make decisions upon incapacity. These documents are particularly important for LGBT seniors because their families of choice are frequently more complicated and less recognized, even with the advent of marriage equality in California. With expanded access, more seniors in the community will be able to make their wishes known and respected.

PROBLEM 12: LGBT SENIORS IN LONG-TERM CARE FACILITIES FACE SYSTEMIC DISCRIMINATION AND ABUSE.

SOLUTION 12: IMPROVE LEGAL PROTECTIONS AND RESOURCES FOR LGBT SENIORS IN LONG-TERM CARE FACILITIES.

Background

LGBT seniors face discrimination and mistreatment in long-term care facilities. In "*Stories from the Field: LGBT Older Adults in Long-Term Care Facilities*," published in 2011 by the National Senior Citizens Law Center (NSCLC), nearly half of respondents—which included LGBT seniors, their families, their friends, and service providers—reported that they themselves or someone

they knew had experienced discrimination in a care facility. That study reported on the results of a survey of nearly 800 LGBT seniors, family members and friends of LGBT seniors, or service providers. The results paint a devastating picture. Among respondents to that survey (NSCLC, 2011):

- 78% felt it would be unsafe for an LGBT senior to be "out" in a care facility;
- 89% believed that staff would discriminate against an LGBT elder who was out of the closet;
- 81% believed that other residents would discriminate against an LGBT elder;
- 53% believed that staff would abuse or neglect an LGBT elder; and,
- 43% reported personally witnessing or knowing individuals who experienced instances of mistreatment, including: verbal or physical harassment from other residents; refused admission or re-admission or being abruptly discharged; verbal or physical harassment from staff; staff refusal to accept medical power of attorney from resident's spouse or partner; restrictions on visitation; and, staff refusal to respect or properly care for transgender seniors.

The report included several California and San Francisco-based examples of mistreatment. A respondent named "John D.," age 83 from San Francisco, reported that staff members at his partner's skilled nursing facility refused to bathe his partner for sixteen days because they weren't "comfortable helping a gay man bathe." An anonymous staff member of a California ombudsman office reported that a transgender resident was prevented from eating with other residents, talking with them, or getting involved in social activities. Another San Francisco respondent reported that her friend, a lesbian in her 80s, was transferred without reason from place to place and faced isolation by staff and other residents. In addition, staff members refused to call her "Rusty" (her chosen name) and insisted on calling her by her given (more feminine) name, "Hazel." A California ombudsman reported: "I have been told that some facilities would choose to not have the problem by denying admission to an LGBT resident" (NSCLC, 2011, pp. 8-16).

Transgender residents are particularly vulnerable to mistreatment. There is widespread fear of disrespect and discrimination. According to Judge Phyllis Frye, a prominent transgender activist, "A secret fear of all transgender people…is to grow old and be psychologically abused, day after day, by the staff of a nursing home" (Redman, 2011). Loree Cook-Daniels of the Transgender Aging Network stated that some transgender people,"Would rather kill themselves than enter a nursing home and be at the mercy of staff." Cook-Daniels emphasized, "That's how afraid some people are at the thought of being unable to defend themselves from transphobic healthcare providers" (Redman, 2011).

In *Injustice at Every Turn,* a 2011 report issued by the National Gay & Lesbian Task Force and the National Center for Transgender Equality, the authors report that nearly a fifth of transgender people responding to their survey stated that medical providers had refused to provide care for them. According to *Improving the Lives of LGBT Older Adults*, a 2010 report by Movement Advancement Project and SAGE, 39% of transgender people face harassment or discrimination when seeking medical care.

LGBT seniors are more likely to require facility-based care than straight seniors because they are less likely to have informal caregivers available to help them remain in their homes. According to a 2010 study published by the Movement Advancement Project (MAP), *Improving the Lives of LGBT Older Adults*, 80% of long-term care in the United States is provided by biological family members. Though many LGBT people rely on families of choice for care, these families also face challenges because often members are of the same age, and facing health challenges at the same time (MAP & SAGE, 2010). The 2013 Task Force study of San Francisco LGBT seniors supports these findings. Survey participants reported living alone at twice the rate as San Francisco seniors overall – 60% of participants live alone. Only 15% of respondents had children, but 60% indicated that these children would not be available to assist them. 63% were neither partnered nor married. Survey results also point to a heightened need for services: nearly one-third of the participants reported poor general health; more than 40% reported one or more physical disabilities; and—among male participants—33% were living with HIV/AIDS (Fredriksen-Goldsen et al., July 2013).

The state regulatory systems governing long-term care in California are widely acknowledged to be broken and in need of repair. While many long-term care facilities provide excellent care, a recent report from the Center for Investigative Reporting found that regulators at the state level,"Have conducted only cursory investigations into hundreds of cases of suspected violence and misconduct allegedly committed by nursing assistants and in-home health aides over the past decade" (Gabrielson, 2013). Another report from the San Diego Union Tribune found: "Among 12,000 complaints lodged with [the Department of] Social Services every year — claims including beatings, theft and deaths due to neglect —…[only] 82 [have been reported] to state prosecutors as criminal cases since 2002" (McDonald, 2013). So, while LGBT seniors face discrimination based on sexual orientation, gender identity, and gender expression, it is important to remember that this mistreatment is occurring in a broader context of neglect that affects many seniors in long-term care.

There are several types of care facilities, and each category is governed by different laws. **"**Health Facilities" provide intensive medical care to residents, and this category includes skilled

nursing facilities, intermediate care facilities, and hospice facilities.[10] "Residential Care Facilities for the Elderly" include both small board and care homes and large assisted living facilities (California Residential Care Facilities for the Elderly Act).[11] These institutions provide personal care and assistance to residents but not medical care. "Continuing Care Retirement Communities" frequently include a range of options on-site, from independent living apartments for seniors who do not require assistance, to assisted living and memory care units for seniors with dementia, to skilled nursing. Each area of a CCRC is governed by the laws that correspond to the type of care being provided.[12]

State laws broadly prohibit discrimination on the basis of sexual orientation, gender identity, and gender expression in care facilities. Under California's Unruh Civil Rights Act, "All persons within the jurisdiction of this state are free and equal, and no matter what their sex…or sexual orientation are entitled to the full and equal accommodations, advantages, facilities, privileges, or services in all business establishments of every kind whatsoever."[13] Gender identity and expression are included under the definition of "sex."[14] In addition, California law bars discrimination based on a person's perceived sexual orientation, gender identity, or gender expression.[15] The regulations governing Skilled Nursing Facilities, Intermediate Care Facilities, and Residential Care Facilities for the Elderly also bar discrimination on the basis of sexual orientation (though not explicitly gender identity).[16]

LGBT seniors, however, could benefit from clearer and more comprehensive nondiscrimination laws to prevent mistreatment and address violations. The NSCLC Report and other sources demonstrate that more more specific guidelines are needed to protect LGBT seniors who face discrimination in: admissions, transfer, and eviction; housing and room assignment; access to restrooms; confidentiality and privacy; gender expression; bullying by residents and staff; medical care and treatment; visitation; and access to and respect for advance health care directives. One solution is for San Francisco to pass laws providing guidance as to what constitutes nondiscriminatory care for each of these areas.

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[10] *See* Cal. Health & Safety Code §§1250-1339.70 (licensing of health facilities); Cal. Health & Safety Code §§1417-1439.8 ("Long-Term Care, Health, Safety, and Security Act of 1973"); and 22 California Code of Regulations §§72001-72713.
[11] *See* Cal. Health & Safety Code §§1569-1569.87 ("California Residential Care Facilities for the Elderly Act"); and 22 California Code of Regulations §§87100-87793.
[12] *See* Cal. Health & Safety Code §§1770-1793.91.
[13] Cal. Civil Code §51(b).
[14] Cal. Civil Code §51(e)(5).
[15] Cal. Civil Code §51(e)(6).
[16] *See* 22 California Code of Regulations §87118 (in RCFEs), §72521 (for admission to SNFs), §72527 (regarding patient's rights in SNFs), §73519 (regarding administration of ICFs), and §73523 (regarding patient's rights in ICFs).

There is a long tradition at both the state and local levels of passing laws to give additional clarification to existing nondiscrimination provisions to aid in enforcement. At the state level, "Seth's Law" (AB 9, signed in 2011), gave greater force to LGBT nondiscrimination laws in the bullying context, even though state law already prohibited discrimination against LGBT students. Similarly, even though the Unruh Civil Rights Act prohibits discrimination against transgender people, the "School Success and Opportunity Act" (AB 1266, signed in 2013) sought to better protect transgender students by laying out specific guidelines for equal treatment. San Francisco has previously passed more stringent nondiscrimination laws than existed at the state level for sexual orientation, gender identity, and HIV status.[17] San Francisco has the power under California law to do the same for LGBT seniors in care facilities.[18]

The San Francisco Human Rights Commission and the Long-Term Care Ombudsman office are well-positioned to administer a comprehensive law enforcing nondiscriminatory care for LGBT seniors in long-term care facilities. The HRC is empowered by local law to, "Investigate, mediate between parties, and enforce laws prohibiting discrimination on the basis of sexual orientation, gender identity, gender expression, and HIV/AIDS status in the City and County of San Francisco."[19] The Long-Term Care Ombudsman Office is empowered by state and federal law to investigate mistreatment in care facilities (Older Americans Act, Older Californians Act). While the Ombudsman reports to the state Department of Public Health regarding violations by facilities, the Ombudsman is not barred from bringing discrimination concerns to the San Francisco Human Rights Commission. In addition, the San Francisco Human Rights Commission may take complaints directly from LGBT seniors and their advocates through its intake line. Whether through the fostering of voluntary compliance with city-established best practices or through legal enforcement of more stringent nondiscrimination provisions, the city has a significant opportunity to innovate and lead in demonstrating how LGBT seniors should be cared for in long-term care facilities.

This Task Force, thus, proposes that San Francisco adopt policies to ensure proper treatment of LGBT seniors in long-term care facilities including the possible adoption of an ordinance setting forth comprehensive guidelines for non-discrimination regarding the treatment of LGBT seniors in long-term care facilities.

Recommendation 12.1

[17] San Francisco Police Code, Article 38, sec. 3811.
[18] "A county or city may make and enforce within its limits all local, police, sanitary, and other ordinances and regulations not in conflict with general laws;" and charter cities like San Francisco have authority to "make and enforce all ordinances and regulations in respect to municipal affairs." Cal. Const. art. XI, §§5, 7. And "insofar as State law is applicable [and preempts local law], voluntary compliance therewith should be fostered by" the San Francisco Human Rights Commission. San Francisco Administrative Code §12A.1.
[19] See San Francisco Administrative Code Chapter 12A, San Francisco Police Code, Article 38, sec. 3811.

Within six months of this report, the Board of Supervisors should act to reduce discrimination at long term care facilities including possible adoption of an ordinance, to be administered by the San Francisco Human Rights Commission, the Long-Term Care Ombudsman Office,[21] or other appropriate agencies, to ensure appropriate care and treatment of lesbian, gay, bisexual, and transgender seniors in long-term care facilities. The Board should seek to ensure protections against discrimination in: admission, transfers and eviction; bathrooms, housing, and room assignment; access to restrooms; confidentiality and privacy; gender expression; bullying; medical care and treatment; visitation; and advanced health care directives. Insofar as State law is applicable and preempts this law, voluntary compliance could still be fostered by the San Francisco Human Rights Commission as a voluntary matter.[22] *(See Appendix H for detailed policy recommendations.)*

Structured enforcement and implementation of these improvements requires the following additional elements:

Recommendation 12.2

The HRC or another appropriate city agency should be required or encouraged to draft a Layperson Guide to Enforcement and Implementation for the ordinance described in Recommendation 12.1.

Recommendation 12.3

San Francisco's licensed care facilities should be required to select a staff member or administrator to serve as an LGBT liaison.

Recommendation 12.4

DAAS should require that San Francisco's Long Term Care Ombudsman office create implementation guidelines in its policy manual including new guidelines adopted pursuant to Recommendation 12.1 above.

[21] See San Francisco Administrative Code Chapter 12A, San Francisco Police Code, Article 38, sec. 3811.
[22] San Francisco Administrative Code §12A.1.

PROBLEM 13: LGBT SENIORS FACE OBSTACLES TO AND LACK RESOURCES FOR DRAFTING APPROPRIATE LIFE-PLANNING DOCUMENTS.

SOLUTION 13: PROMOTE LGBT LIFE-PLANNING LEGAL CLINICS, REFERRAL PROTOCOLS, AND SAMPLE DOCUMENTS, AND DEVELOP RESOURCES TO AID LGBT SENIORS WHO WISH TO COMPLETE THE PLANNING PROCESS.

Background

Life-planning documents enable individuals to state their wishes and decisions. They cover the disposition of assets upon incapacity or death (wills and trusts, power of attorney for financial decision-making); who shall make medical decisions and what the scope of those decisions shall be (advance health care directive, HIPAA release, power of attorney for medical decision-making, hospital visitation authorization); and instructions for the disposition of a decedent's remains. If an individual does not have documents in place, then state law default options will give these powers to biological family members if there is no spouse or Registered Domestic Partner. Given that many LGBT seniors have created families of choice and are estranged from biological family members, California's default laws for people without documents put LGBT seniors in a poor position for successfully aging in place in San Francisco.

The Task Force's 2013 study revealed that many LGBT seniors lack basic life-planning documents (Fredriksen-Goldsen et al., July 2013). Only 61% of survey participants stated that they had a power of attorney for healthcare; only 53% had executed a will; only 30% had executed a power of attorney for finances; only 29% had executed a trust; and only 23% had made funeral plans.

Many LGBT seniors rely on a family of choice instead of a legally-recognized partner or biological family members for support. This makes life-planning documents even more important. While 80% of caregiving in the United States is provided by biological family members, LGBT seniors are far more likely to rely on a family of choice for care and support (MAP & SAGE, 2010).[23] This creates challenges for medical decision-making, visitation, and health records access. State default rules can give powers to estranged biological family members at a moment of vulnerability instead of chosen family members whom the senior would want to make decisions. Life-planning documents, however, can help ensure that an LGBT senior's wishes are articulated and followed.

LGBT people have specific life-planning document needs. While marriage rights have extended many new rights and protections to same-sex couples, for LGBT people with families of choice

[23] Movement Advancement Project, "Improving the Lives of LGBT Older Adults," at p. 6.

and/or non-traditional parentage arrangements, more creative options are needed. For transgender seniors in particular, ensuring respect for gender identity and expression once an individual lacks capacity, or a respectful funeral ceremony after death, is very important. In addition, if there are individuals an LGBT senior does or does not wish to visit in a hospital or care facility, a visitation authorization form is vital to enforce those wishes.

A local policy response to this problem should include two components: increased access to life-planning documents and estate planning services for low-income LGBT seniors and better sample documents that are readily available and that particularly address the needs and situations faced by LGBT seniors.

Models for Increasing Access to Life-Planning Documents and Estate Planning

The Mazzoni Center in Philadelphia and the Los Angeles Gay & Lesbian Center provide examples of law clinics that increase access to life-planning documents and estate planning services.

Philadelphia's Mazzoni Center offers direct legal services to LGBT people in addition to health and wellness services. Elder law is a component of the Center's direct services programming, focusing on the needs of low-income LGBT seniors. Each month, the Center holds a legal clinic specifically targeted to the LGBT elder community. The Center finds the majority of their clients by contacting LGBT centers and senior centers, and the turnout is often very high. A top priority for many LGBT seniors who come to the clinic is obtaining assistance to set up life-planning documents for medical decision-making. The Mazzoni Center is largely funded by the City of Philadelphia, in addition to funding from foundations. The Center's legal department draws on the support of area law professors, attorneys, and a referral network of culturally competent counsel.

The L.A. Gay & Lesbian Center provides a similar service, assisting 3,300 LGBT seniors every year. Their clients are referred by word of mouth, city agencies, and the Center's newsletter. The direct services they provide to low-income LGBT seniors include drafting the full range of life-planning documents. The clinic is staffed by volunteers, legal aid, and L.A.-based legal services provider Bet Tzedek.

In San Francisco, such an LGBT elder law clinic model does not currently exist, although there are a number of LGBT organizations or educational institutions that could partner to implement something similar(e.g., the LGBT Community Center, area law schools, the City's legal assistance contractors, the local bar, etc.). There are many opportunities to provide referrals to such a clinic with appropriate training of staff and contractors at DAAS and DPH to incorporate such referrals into the business practices of programs that regularly serve isolated seniors. Every senior who has capacity should be alerted to the existence and necessity of life-planning documents, and sample documents or referrals to legal assistance should be provided by DAAS

staff or contractors. Wellness programs funded by the City should incorporate a know-your-rights component, so that seniors have the opportunity to learn about life-planning documents and the protections they afford. When done properly, the life planning/estate planning process is also life affirming and empowering. It creates peace of mind, and therefore can promote wellness.

Models for Sample Documents

The Transgender Law Center (TLC) provides one pioneering example of a sample planning document. In 2013, TLC released a sample trans-focused advanced health care directive to ensure respect of a transgender person's gender identity and expression in the event of incapacity or death (see Appendix I). Worksheets that get seniors started in the process of identifying their last wishes are also valuable sample resources – see an example of one such worksheet in Appendix J.

The following recommendations will create a structure for LGBT olders adults to access life-planning services and documents.

Recommendation 13.1
DAAS should partner with local community-based nonprofit organizations to expand or establish legal clinics to provide low-cost or pro bono life planning/estate planning assistance for low- and moderate-income LGBT seniors.

Recommendation 13.2
DAAS and DPH should implement referral protocols for connecting low- and moderate-income LGBT seniors who access existing social services and wellness programs to free and low-cost life planning services and resources. This effort should include training for direct-service city staff and contractors on the value of life planning/estate planning services.

Recommendation 13.3
The city should work with local community-based advocacy organizations and private attorneys to ensure that strong sample documents are collected and/or developed and made readily available to LGBT seniors. The city should help ensure that these materials are incorporated into a web-based resource and that LGBT seniors receive education about available self-help and low-cost resources.

6. IMPROVING "COMMUNITY WITHIN COMMUNITY" FOR LGBT OLDER ADULTS

Background

In 2003, an HRC report on LGBT seniors examined ways in which the LGBT community could help be more accepting of LGBT seniors; the 2003 report referred to this inquiry as "community within community." The legislation establishing the Task Force directed a follow up inquiry into the community within community recommendations contained in the 2003 report.

Ageism in American culture is a well-documented phenomenon. Ageism in the LGBT community, while less documented by formal studies, is an obvious and powerful force. There has been very little emphasis in the LGBT press and in LGBT culture in general on the aging process and how it impacts LGBT men and women. That trends is beginning to change with more media attention being focused on LGBT seniors since 2012, but the fact remains that the LGBT community is quite youth-focused in most ways and in some ways even more so than in the heterosexual community. The Task Force frequently heard comments from senior gay men, for example, who said they felt invisible walking down the street in the Castro. Ads in San Francisco's LGBT weekly papers focus almost entirely on young men. Examples of inter-generational programs bringing together LGBT seniors and youth are almost non-existent in San Francisco.

Rather than establishing a working group to examine community within community issues, the Task Force voted to have each work group (Health/Social Service, Legal and Housing) discuss community within community ideas in each subject matter area. Specific recommendations addressing how the LGBT community can provide more support for LGBT seniors can be found throughout the recommendation section of this report. For example, there are numerous specific references to particular areas where LGBT seniors would benefit from the investment of private philanthropic dollars from community foundations and individual LGBT donors. The following are additional recommendations supported by the Task Force.

1. The Task Force is issuing a public challenge to the entire San Francisco LGBT community to do at least one significant act within the next six months to improve the lives of LGBT seniors in San Francisco. For nonprofit organizations that serve LGBT seniors, we challenge you to do at least one significant act to increase or improve those services. For organizations that don't serve LGBT seniors, the Task Force challenges you to find at least one significant way to make LGBT seniors feel more welcome – add a senior to your Board of Directors; include a senior in an ad campaign; provide senior tickets to your annual event so more seniors can attend. For major LGBT institutions like the Pride

Committee, the Task Force challenges you to find ways to honor seniors from our community on an ongoing basis such as creating an annual Elder Statesman/Stateswoman Grand Marshall category or something of similar stature to highlight the role of seniors. For LGBT foundations and donors, the Task Force challenges you to allocate a larger portion of philanthropic dollars for programs and services helping LGBT seniors in San Francisco. In this Report, the Task Force is recommending government funding that in some cases will rely on private matching funds. The community must help come through with these private dollars.

2. More community organizations need to get involved in the business of providing programs and services to LGBT seniors. The current level of services for LGBT seniors in San Francisco is inadequate compared to the unmet needs revealed in the Task Force's survey. Moreover, the number of LGBT seniors in San Francisco is estimated to double in the next twenty years as the Baby Boomer generation ages. Therefore the city must grow the infrastructure that is currently delivering services to LGBT seniors. In growing the infrastructure, the Task Force recommends that the city encourage more nonprofit organizations to begin providing services for this population. In the long-run, the community will be best served by having a robust infrastructure of nonprofit community organizations that have deep roots in the community and are capable of not only providing excellent services now but also able to reform and innovate in the development of new services that meet the unique unmet needs of LGBT seniors across many disciplines.

3. The Task Force recommends that LGBT community organizations examine ways to develop innovative new programs and services that address the specific, unique unmet needs of LGBT seniors. For example, there are very few programs in San Francisco addressing inter-generational connections. San Francisco needs an innovative new program that links LGBT seniors with LGBT youth, such as a foster-grandparent program. During the HIV/AIDS pandemic, San Francisco nonprofits were responsible for helping the city develop a model of care that addressed unique needs, and eventually many of these HIV/AIDS programs and services became the standard for excellent care all across the nation. San Francisco needs to help lead the way now in developing a new model of care for LGBT seniors and in part, that begins with innovation on the part of the nonprofit community.

7. IMPLEMENTATION PLAN

The key to the Task Force's efforts is the set of recommendations and the key to the recommendations is their implementation. The Task Force is aware that numerous well-meaning and hard-working advisory bodies in San Francisco have issued numerous reports on various subjects in the past. Unfortunately, some reports end up collecting proverbial dust on the shelf. The Task Force was determined to present a set of recommendations that are feasible, practical and very likely to be implemented in relatively short order. At the same time, the Task Force understands that it will take months and years to develop and fully fund all the programs and services this Report calls for. As the Task Force sunsets in March 2014, the members gave serious thought to an implementation plan. The Task Force recommends that the following steps be taken to help ensure full and timely implementation.

1. Review by Board of Supervisors – The Task Force recommends that the Board of Supervisors hold a hearing to review the Report and its recommendations, hear responses from city departments, and collect public testimony. The Task Force also recommends that the Human Rights Commission and its LGBT Advisory Committee review the Report and issue a resolution of support.

2. Public Education – The Task Force members have committed to help disseminate the Report as widely as possible in the community through media opportunities, public speaking engagements, meetings with stakeholders and opinion leaders and other activities aimed at educating the LGBT community about seniors and educating straight seniors and the mainstream senior service community about LGBTs. Public education and outreach should include an effort to disseminate the Report to a national audience. The Task Force will use its remaining funds to widely disseminate the report, not only through LGBT channels, but also through mainstream media.

3. Ongoing Advisory Body – The Task Force strongly recommends the creation of an ongoing advisory body to help oversee the city's implementation of the recommendations and provide ongoing advice and guidance. The advisory body might take one of a few different forms, including an advisory group that exists outside of the formal city government such as the Coalition of Agencies Serving the Elderly (CASE) or an advisory body that is attached to one or more city departments such as the HRC's LGBT Advisory Committee. The Task Force recommends that DAAS and HRC determine the best structure for the advisory body and the membership that will be most helpful to the city moving forward including the appropriate level of city staffing to support the advisory body's activities. While this new advisory body is being formed, the Task Force recommends that the HRC's LGBT Advisory Committee and its' Chair

attempt to monitor progress and lend technical support and encouragement so that the Task Force's recommendations move forward as quickly, efficiently and seamlessly as possible.

4. Sustained Community Focus - The Task Force recommends that political clubs, community organizations and interested individuals in the San Francisco LGBT community organize around the issue of LGBT seniors and proactively lobby the city government for full implementation of these recommendations. This should be seen as a long-term effort requiring sustained focus and not a quick fix.

5. Report Cards - Members of the Task Force have made a commitment to informally reconvene at periodic intervals to review the progress of implementation and to issue an objective report card summarizing progress to date. Report cards will be issued at the minimum intervals of one year, two years and five years.

6. State-wide Advisory Body - The Task Force recommends that city staff, elected officials and community leaders work with Assemblyman Tom Ammiano and Senator Mark Leno to establish an advisory body at the state level to address issues affecting LGBT seniors throughout California. Improving programs and services beyond San Francisco is outside the scope of the Task Force's mission. At the same time, it is clear that in San Francisco the Task Force has been successful at raising the public profile of issues affecting LGBT seniors and focusing the government's attention on the problems. Therefore the Task Force believes that establishing an advisory body on the state level could also raise the profile of the issues on an even larger scale. There is much work to be done throughout California to ensure that LGBT seniors all over the state can age well and with dignity.

BIBLIOGRAPHY

Adelman, M., Gurevitch, J., DeVries, B. & Blando, J. (2006). "openhouse: Community Building and Research in the LGBT Aging Population." In D. Kimmel, T. Rose, and S. David, (Eds.), *Research and Clinical Perspectives on Lesbian, Gay, Bisexual and Transgender Aging*. New York: Columbia University Press.

Adelman, M., Nolan, T., Haskell, B. (2013, October 1) *LGBT Seniors and Dementia Care – Case Statement.*

Albertson, Jason et al. (2007). *Shelter Shock: Abuse, Cruelty, and Neglect in San Francisco's Shelter System.* Coalition on Homelessness.

Allgaier, R. (2010) *An Emerging Issue: HIV/AIDS and Aging in the San Francisco Eligible Metropolitan Area (EMA) San Francisco, San Mateo and Marin Counties.* Retrieved from http://www.aids-ct.org/pdf/publications/hiv_and_aging.pdf

Alzheimer's/Dementia Expert Panel for Department of Aging and Adult Services (2009). San Francisco's Strategy for Excellence in Dementia Care. Retrieved from http://www.sfhsa.org/asset/ReportsDataResources/DementiaStrategyPartONEofTWO.pdf

Applied Survey Research (2013). *2013 San Francisco Homeless Point-in-Time Count and Survey Comprehensive Report.* Retrieved from http://www.sfgov3.org/modules/showdocument.aspx?documentid=4819

Badgett, M. V. L., Durso, L. E., & Schneebaum, A. (2013). *New Patterns of Poverty in the Lesbian,Gay, and Bisexual Community* Los Angeles: The Williams Institute, UCLA School of Law.

Bell, E. & Lerman, R. I. (2005). *Can Financial Literacy Enhance Asset Building?* Washington, D.C.: The Urban Institute.

Berube, A. (2014). All Cities Are Not Created Unequal. The Brookings Institution. Retreived from http://www.brookings.edu

Bilick, S., Lam, J., Lehman, J., Vining, J. (2012). *Seniors and Adults with Disabilities in SROs: Survey and Recommendations.* Retrieved from http://www.sfhsa.org/asset/ReportsDataResources/SeniorsAdultsDisabilitiesSROsJune2012.pdf

City and County of San Francisco (n.d.). *2013-2018 Analysis of Impediments* to Fair Housing Choice. Retrieved from http://sf-moh.org/modules/showdocument.aspx?documentid=6333

Conway, Jake (2011). A Trip to the Corner Store. *The New Journal*.

Crooke, B., Martin Rossmann, M., McCubbin, & Patterson, J. (1988). Examining the Definition and Assessment of Social Support: A Resource for Individuals and Families. Family Relations, 37(2), 211-216.

D'Augelli, A. and Grossman, A. (2001). "Disclosure of Sexual Orientation, Victimization and Mental Health Among Lesbian, Gay and Bisexual Older Adults." *Journal of Interpersonal Violence.* 16 (10): 1009 - 1027.

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer Support Among Adults With Serious Mental Illness: A Report From the Field. Schizophrenia Bulletin, 32(3), 443-450.

Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D., & Kraemer-Tebes, J. (2005). Peer Support Among Individuals with Severe Mental Illness: A Review of the Evidence. Clinical Psychology: Science and Practice, 412-450.

Dean-Coffrey, J. and Jackson, S. N. (2011). *Informing the Field: People of Color Creating Equality (POCCE) Evaluation Report.* jdcPartnerships. Retrieved from http://jdcpartnerships.com/Publications/POCCE_Evaluation_Report-Final1.pdf

Eviction Defense Collaborative (2012). *2012 Eviction Report.* Retreived from http://www.evictiondefense.org/EDC_report_6_smaller.pdf

Fairchild, S. K., Carrino, G. E., and Ramirez, M. (1996). "Social Workers' Perceptions of Staff Attitudes Toward Resident Sexuality in Random Sample of New York State Nursing Homes: A Pilot Study." *Journal of Gerontological Social Work* 26(1): 153- 169.

Fredriksen-Goldsen, K., Kim, H-J., Emlet, C. A., Muraco, A., Erosheva, E.A., Hoy-Ellis, C.P., Goldsen, J., Petry, H. (2011). *The Aging and Health Report: Disparities and Resilience among Lesbian, Gay, Bisexual, and Transgender Older Adults.* Institute for Multigenerational Health University of Washington.

Fredriksen-Goldsen, K., Kim, H., Goldsen, J., Hoy-Ellis, C., Emlet, C., Erosheva, E., Muraco, A. (2013, January) *LGBT Older Adults in San Francisco: Health, Risks, and Resilience*, *Findings from Caring and Aging with Pride*. Institute for Multigenerational Health University of Washington.

Fredriksen-Goldsen, K.,Kim, H., Hoy-Ellis, C.P., Goldsen, J., Jensen, D., Adelman, M., Costa, M., De Vries, B. (2013, July). *Addressing the Needs of LGBT Older Adults in San Francisco: Recommendations for the Future.* Institute for Multigenerational Health University of Washington.

Fredriksen-Goldsen K. I., Kim, H., Barkan, S. E., Muraco, A., & Hoy-Ellis, C. P. (2013). "Health Disparities Among Lesbian, Gay, and Bisexual Older Adults – Results from a Population-Based Study." *American Journal of Public Health.* Advance online publication DOI: 10.2105/AJPH.2012.301110

Gabrielson, R. (2013, September 9). Probes lax into suspected violence by caregivers. *San Francisco Chronicle.* Retreived from http://www.sfgate.com/crime/article/Probes-lax-into-suspected-violence-by-caregivers-4800530.php

Gates, G. J. (2014). *Food Insecurity and SNAP (Food Stamps) Participation in LGBT Communities* Los Angeles: The Williams Institute,UCLA School of Law.

Grant, J., Mottet, L., Tannis, J. (2011). *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey.* National Center for Transgender Equality, 72. Retrieved from http://www.thetaskforce.org/reports_and_research/ntds

Hartzell, E., Frazer, S., Wertz, K. and David, M. (2009). *The State of Transgender California: Results from the 2008 California Transgender Economic Health Survey.* San Francisco, CA: Transgender Law

Hicks, D. (2003). *Are long term care providers inclusive of lesbian, gay, bisexual and transgender elders?* Unpublished master's thesis. San Francisco: San Francisco State University.

Jensen, D. (2012). *Lesbian, Gay, Bisexual, Transgender Seniors in San Francisco: Current Estimates of Population Size, Service Needs and Service Utilization.* Retrieved from http://www.sfhsa.org/asset/ReportsDataResources/LGBTSeniorsReport.pdf

Knochel, K., Croghan, C., Moone, R., Quam, J. (2011). *Ready to Serve?: The Aging Network and LGB and T Older Adults.* Retreived from http://www.n4a.org/pdf/ReadyToServe1.pdf

Ledbetter, L. (1978, March 22). Bill on Homosexual Rights Advances in San Francisco. *The New York Times,* p. A21.

Loumpa, V. (2012). Promoting Recovery Through Peer Support: Possibilities for Social Work Practice. *Social Work in Health Care*, 51, 53-65.

Maril, R. & Estes, C. (2013). Living Outside the Safety Net: LGBT Families & Social Security. In *LGBT Symposium: Living Outside the Safety Net - LGBT Families & Social Security* The Foundation of the National Committee to Preserve Social Security and Medicare & The Human Rights Campaign.

Mayor's Office on Housing, Office of Economic and Workforce Development, and the San Francisco Redevelopment Agency (n.d.). *2010-2014 Five-Year Consolidated Plan.* Retreived from http://sf-moh.org/Modules/ShowDocument.aspx?documentid=4605

McDonald, J. (2013, September 9). Crimes go uninvestigated at care homes. *San Diego Union Tribune.* Retreived from: http://www.utsandiego.com/news/2013/Sep/09/assisted-living-crimes-police-force-state-dss/

Meissner, L., De Vries, B. (2013). *HIV and Aging – A Survey in Three San Francisco Area Counties – San Francisco City and County, San Mateo County, Marin County*. Retreived from http://sf-hrc.org/sites/sf-hrc.org/files/migrated/FileCenter/Documents/Advisory_Committees/LGBTAPTF/Resources_Reports_and_Presentations/H.I.V._and_Aging_A_Survey_in_Three_San_Francisco_Area_Counties_San_Francisco_City_and_County_San_Mateo_County_Marin_County_Report_2013.pdf

Mental Health Services Act (2004). Retreived from http://www.sfdph.org/dph/comupg/oservices/mentalHlth/MHSA/

Meyer, H. (2011, July) Good training, Good care: Center Kickstarts Curricula in LGBT Aging. *Aging Today Online*, American Society on Aging. Retreived from https://www.lgbtagingcenter.org/resources/resource.cfm?r=295

Mikalson, P., Pardo, S., Green, J. (2012). *First, Do No Harm: Reducing Disparities for Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Populations in California.* Retrieved from http://mhanca.org/news_script/userfiles/First_Do_No_Harm-LGBTQ_Report.pdf

Mohan, Geoffrey (2013, March 26) "Social Isolation Increases Risk of Early Death, Study Finds" *Los Angeles Times*. Retrieved from http://articles.latimes.com/2013/mar/26/science/la-sci-social-isolation-health-20130326

Movement Advancement Project (MAP) & Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (SAGE) (2010). *Improving the Lives of LGBT Older Adults.* Retrieved from http://www.lgbtmap.org/file/improving-the-lives-of-lgbt-older-adults.pdf

National Alliance for Caregiving, American Association of Retired Persons (AARP) (2009). *Caregiving in the U.S., 2009*. Retrieved from http://www.caregiving.org/data/Caregiving_in_the_US_2009_full_report.pdf.

National Coalition for the Homeless (2009). *Homelessness Among Elderly Persons.* Retrieved on March 12, 2014 from http://www.nationalhomeless.org/factsheets/Elderly.pdf

National Resource Center On LGBT Aging (2013). *Improving the Quality of Services and Supports Offered to LGBT Older Adults By Aging Providers*

National Senior Citizens Law Center (2011). *Stories from the Field: LGBT Older Adults in Long-Term Care Facilities.* Retrieved from http://www.nsclc.org/wp-content/uploads/2011/07/LGBT-Stories-from-the-Field.pdf

O'Connell, James J. Premature Mortality in Homeless Populations: A Review of the Literature, 2005. Retrieved from http://www.nhchc.org.

Orel, N. (2006). "Community Needs Assessment: Documenting the Need for Affirmative Services for LGB Older Adults" In In D. Kimmel, T. Rose, and S. David, (Eds.), *Lesbian, Gay, Bisexual, and Transgender Aging: Research and Clinical Perspectives*. New York: Columbia Press. Pp. 227-246.

Peninsula Family Service Senior Peer Counseling Program 2013 Client Survey Findings. http://www.peninsulafamilyservice.org/wp-content/uploads/2013/09/Senior-Peer-Counseling-Program-Client-Survey-Results-May-2013-wave.pdf

Rand, D. (2004). *Financial Education and Asset Building Programs for Welfare recipients and Low-Income Workers: The Illinois Experience* Washington, D.C.: The Brookings Institution Center on Urban and Metropolitan Policy.

Redman, D. (2011, June). Fear, Discrimination, and Abuse: Transgender Elders and the Perils of Long-Term Care. *Aging Today*.

Rix, S., Baer, D., Figueiredo, C., McKenzie, S., & Shvedo, M. (2012). *Boomers and the Great Recession: Struggling to Recover* Washington, D.C.: AARP Public Policy Institute.

Said, C. (2013, October 25). Rents soaring across region. *San Francisco Chronicle.* Retrieved from http://www.sfgate.com

Salzer, M., Berkey, K., Dodson, J., Duckery, T., Warner, R., Rogers, J., Rogers, S., Simiriglia, K., Waddington, L., Whitecraft, J., Leibfried, T., (2002). Consumer-Delivered Services as a Best Practice in Mental Health Care Delivery and The Development of Practice Guidelines. Psychiatric Rehabilitation Skills, 6(3), 3, 355-382.

Salzer, M., & Liptzin Shear, S. (2002). Identifying Consumer-Provider Benefits in Evaluations of Consumer-Delivered Services. Psychiatric Rehabilitation Journal, 25(3), 281-288.

Singh, A. & Mistra, N. (2009, January-June). "Lonliness, Depression and Sociability in Old Age." *Industrial Psychiatry Journal*, 18 (1). 51-55.

Solomon, P. (2004). "Peer Support/Peer Provided Services Underlying Processes, Benefits, and Critical Ingredients." *Psychiatric Rehabilitation Journal,* 27(4), 392-401.

Tervalon, M. & Murray-Garcia, J. (1998, May) "Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education." *Journal of Health Care for the Poor and Underserved*, 9(2), 117-125.

Wootsen, P. C., Schindler, N., & Tran, T. T. (2010). *Financial Fraud and Abuse* (Rep. No. 8385). O: University of California.

Interviews

Anonymous (2013). Personal interview: Conversations with two senior gay men while providing individual support: Openhouse, San Francisco, CA.

Reno, D., (2013, April 10). Personal interview with volunteer group facilitator with Openhouse and Access Institute.

Voors, J., MFT, Queer LifeSpace (2013, May 23). Personal interview.

Relevant laws:

California Residential Care Facilities for the Elderly Act, California Health & Safety Code §§1569-1569.87

Long-Term Care, Health, Safety, and Security Act (1973). California Health & Safety Code §§1417-1439.8.

California Health & Safety Code §§1250-1339.70 (licensing of health facilities);

California Health & Safety Code §§1770-1793.91.

22 California Code of Regulations §§72001-72713.

22 California Code of Regulations §§87100-87793.

22 California Code of Regulations §87118 (in RCFEs), §72521 (for admission to SNFs), §72527 (regarding patient's rights in SNFs), §73519 (regarding administration of ICFs), and §73523 (regarding patient's rights in ICFs).

California Civil Code §51(b),(e)(5),(e)(6).

California Constitution Article XI, §§5, 7.

Older Americans Act (DATE). Public Law 109-365 §712

Older Californians Act (DATE). California Welfare & Institutions Code §9700, et seq

San Francisco Administrative Code Chapter 12A, San Francisco Police Code, Article 38, sec. 3811.

APPENDIX A – *BEST PRACTICES: STEPS TOWARD LGBT INCLUSION:* FROM ISOLATION TO INCLUSION: REACHING AND SERVING LGBT SENIORS

Setting a Tone of Respect

- Don't assume heterosexuality, even when you know the client is married, or has children or grandchildren.
- Creating a culture of respect for diversity begins with client intake and staff hiring.
- Don't assume that homophobia and transphobia affect only LGBT clients.

Sending an Inclusive Message

- Include sexual orientation and gender identity in your nondiscrimination statement, and print it on intake forms and other materials.
- Sample Nondiscrimination Statement: [Organization Name] is committed to serving all seniors regardless of race, ethnicity, sex, age, religion, national origin, mental or physical ability, sexual orientation, gender identity, ancestry, military discharge status, marital status, source of income, housing status or other protected classification.
- With all clients, use language that does not implicitly assume the client's sexual orientation or gender identity.
- Update your intake forms to ask if a senior identifies as gay, lesbian or bisexual. For sex or gender, add a third category for transgender.
- Update your intake forms to include "partner" rather than just spouse.
- Use LGBT-friendly statements and images in brochures and outreach materials.
- Place information about LGBT resources in orientation packets, community rooms and offices.
- Advertise your services in the LGBT press and through LGBT organizations.

Creating Safety

- Train staff on LGBT aging-related issues.
- Organize a diversity forum for the seniors you serve.
- Emphasize your policy on confidentiality.
- Respect the privacy of clients you think might be LGBT.
- Accept and respect the stated gender of a transgender client.
- Educate yourself and others in your organization about gender diversity and advocate for the inclusion of transgender seniors.

Advocating for LGBT Clients

- Encourage LGBT seniors to prepare directives, wills and other important legal documents.

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APPENDIX B – PROGRAM DESIGN RECOMMENDATIONS FOR ENHANCED ACCESS SERVICES

Overview

In Recommendation 3.1.., The Task Force recommends development and implementation of an Information , Referral, Enrollment Assistance, and Case Management referral program that provides a single place for LGBT Seniors to receive information, referral, and enrollment assistance for a wide range of available services. Those services should include, at a minimum, the following:

- Senior Rental and Eviction Protection Assistance
- Income Support Assistance
- Legal Advocacy and Financial Planning (e.g. Living Will, Power of Attorney)
- ACA enrollment assistance (60-64 yrs.)
- Medicare/MediCal/Long Term Care referral/enrollment assistance
- Healthcare Provider Referral (Optional)
- Health Promotion Information and Referral
- Social Service Program Information and Referral
- Social Service Case Manager Referral
- Healthcare Case Manager Referral
- Food Service Program Referral/Food Stamp Enrollment Assistance

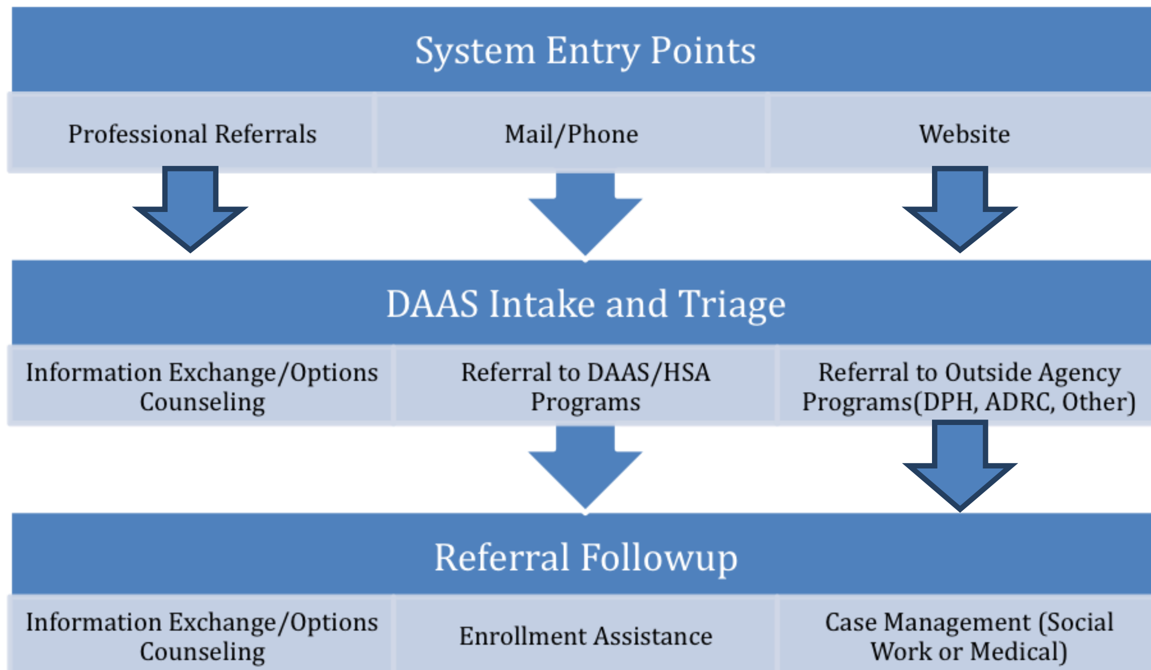
The program would be managed by the Department of Adult and Aging Services (DAAS) and would leverage and build on DAAS' existing Information and Referral program to achieve internal efficiencies, minimizing the need for new systems and personnel.

In addition, the program would contract with outside agencies (in addition to its ADRC agencies) to provide more complex information and enrollment assistance where appropriate, and to provide case management services in the area of social services and health care.

DAAS would contract with existing service providers and outside agencies, as necessary, to provide:

- Marketing and Outreach support. LGBT Seniors need to know about, trust, and use the program. To facilitate that, DAAS would contract with an external agency or agencies to develop and implement an effective marketing/outreach efforts, with measurable results.
- Cultural competency training. An outside agency with relevant expertise would be retained to train all service providers in DAAS and contracted agencies on an annual basis to ensure a welcoming, LGBT friendly environment at every step in the process.

Process Flow and Accountabilities



DAAS Responsibility:

- Development, implementation, maintenance of intake system and triage process
- Provide general information and triage internally/to other agencies as appropriate
- Staff intake and triage function, as well as enrollment assistance where appropriate
- Contract with outside agencies for service provision and cultural competency training
- "Qualify" outside agencies as LGBT friendly and culturally competent post annual training.
- Identify funding sources internally and externally (e.g. MediCal, CMS, etc.) that can be used to fund program components
- Manage marketing/outreach development and implementation (Media, Seminars, Newsletter)
- Perform program evaluation and audit of participating agencies periodically (e.g. backlog analysis) and fine tune program/program components on an ongoing basis

Participating Agency Accountabilities:

- Provide up to date subject matter specific information, timely referral, enrollment assistance, and case management services to DAAS referrals, as appropriate, in a sensitive, LGBT friendly manner
- Conduct staff training annually on LGBT cultural competency

- Maintain up to date information and tracking databases for DAAS referrals, and provide periodic reports as requested by DAAS
- Identify special or unique funding sources for program components managed by agency

Funding

DAAS intake and triage would be funded mostly from general funds, as would most enrollment assistance performed by DAAS, with the exception of enrolllment assistance for critically needed services where outside funding is available (e.g. MediCal enrollment for IHSS recipients, CMS funding for transitional care counseling, Older Americans Act grants). Foundation money would feasibly be available for marketing, outreach and cultural competency training. The healthcare reimbursement system is a potential source of funding for medical case management, and California Endowment money for ACA enrollment. It important to note that some funding sources would flow money through contracted agencies (e.g. for medical case management) and not DAAS. In addition, some of the contracted agencies would be in a posiiton to identify potential funding sources (such as foundation grants) of which DAAS would not necessarily be aware.

Implementation

DAAS coordinates specification of program scope, format, and process flow in cooperation with stakeholders and representative potential participating agencies, then identifies funding sources and human resource needs and develops a 3 yr program budget. Subsequent to program and funding specification, an RFP would be developed and distributed to outside agency participants, and seed money/grant funding would be sought for marketing, outreach, cultural competency training, and IT build out. Existing staff would be trained and additional staff hired as necessary. Given current information, referral volume, and likely initial modest increased utilization, 1 additional FTE is potentially adequate in the first operational year of the program. Outside agencies would be retained for outreach and cultural competency training.

The following actions will facilaitate the succces of the program over the long run:

- Significant marketing and outreach to educate and raise awareness
- Thorough training of DAAS staff to triage effectively
- Cultural competency training for all participating staff and agencies
- Staff follow up with clients to record outcomes (“Need to move beyond bean counting”)
- Effective funding source triage for the short and long term (e.g. General Fund for ops; foundations for marketing, outreach, follow up, program evaluation)

APPENDIX C – PROGRAM DESIGN RECOMMENDATIONS FOR LGBT SENIOR CASE MANAGEMENT SERVICES

Overview

A case management program will empower LGBT older adults in San Francisco living with physical, social, emotional and behavioral health challenges to obtain services that will enable them to remain in their homes and avoid institutionalized care. Furthermore, the provision, coordination, and planning of care will support and maintain the individual's optimal level of functioning promoting aging in the community.

Proposed Framework

The case management program should be designed to align with current DAAS or DPH case management services.

The case manager is responsible for the provision, planning and coordination of care as outlined by DAAS case management. Each case manager FTE is paired with a 0.5 FTE peer specialist, who is a fellow senior with similar cultural and life experiences, is recovery oriented who may serve as a role model, advocate, and is responsible for helping with linkages to supportive services. Service delivery should be aligned with the Mental Health Services Act (2004) and its guiding principles, which are person-centered, strength-based, culturally responsive, recovery-oriented with an emphasis on peer-to-peer support, and anchored in the community.

The program's target population will be underserved LGBT older adults in San Francisco living with bio-psychosocial health challenges. Consumers will meet the criteria set forth by the Department of Aging and Adult Services (DAAS) case management program in order to allow for funding through that source.

Funding

Likely funding sources include the Mental Health Services Act and the City's General Fund.

APPENDIX D – PROGRAM DESIGN RECOMMENDATIONS FOR LGBT SENIOR PEER COUNSELING PROGRAM

Overview

An LGBT Senior Peer Counseling Program will reach isolated, underserved LGBT older adults living with emotional and behavioral health challenges. Moreover, it provides an innovative service delivery framework for LGBT older adults who may be reluctant to seek traditional mental health services due a history of discrimination, marginalization, and the stigma associated with mental illness. Such a program would likely be contracted through the Department of Public Health. Program design could include student interns in addition to peer counselors.

A senior peer counselor is an older adult with similar cultural and life experiences, which offers a unique relationship that brings acceptance and trust. A peer counselor affirms and empowers a fellow senior to make choices and changes that enhances emotional and behavioral wellbeing. Peer support is grounded in the belief that people who faced, endured and overcome adversity can offer support, encouragement, hope and mentorship to others facing similar situations (Davidson, Chinman, Sells, & Rowe, 2006, p. 443). The peer-to-peer model is aligned with the Mental Health Services Act (2004) and its guiding principles, which are person-centered, strength-based, culturally responsive, recovery-oriented with an emphasis on peer-to-peer support grounded in the community.

Funding

Likely funding sources include the Mental Health Services Act and the City's General Fund.

APPENDIX E – PROGRAM DESIGN RECOMMENDATIONS FOR MENTAL HEALTH SERVICES

The San Francisco Department of Public Health and the Department of Aging and Adult Services shall prioritize additional resources for community based organizations serving LGBT older adults. The additional resources will be used to create and increase the number of programs that support and enhance the emotional and behavioral wellbeing of underserved LGBT older adult. These programs and services shall consist of **individual emotional and behavioral support, peer support groups, which includes abstinence-based and substance-use management groups; outreach, education, and early intervention programs based in a client empowerment model.** Service delivery will be aligned with the Mental Health Services Act (2004) and its guiding principles, which are person-centered, strength-based, culturally responsive, recovery-oriented with an emphasis on peer-to-peer support, and anchored in the community.

Implementation

Project: Individual Emotional Support, Peer Support Groups, Outreach and Early Intervention

July 2014 to June 2015

Activity	Time
Staff in place; Recruit Student Interns/Peer Specialist	July 1 to July 30
Develop Peer-Specialist Curriculum Schedule Support Groups	August 1 to September 1
Student Interns in place	August 1 to September 30
Train Peer-Specialist/Student interns	October 1 to November 1
Conduct Support Groups	November 1 to June 30
Early Intervention & Suicide Prevention	November 1 to April 1
Conduct Evaluation	April 1 to May 1
Prepare Final Report	June 1 to June 25

Project Budget and Terms

July 2014 to June 2015

Personnel	FTE	Budget Request

Program Manager	1.0	
Program Coordinator	1.0	
Peer Specialist	1.0	
Student Interns: 2x		

Funding

Likely funding sources include the Mental Health Services Act and the City's General Fund through DPH and DAAS.

APPENDIX F – PROGRAM DESIGN RECOMMENDATIONS FOR PEER SUPPORT PROGRAM FOR LGBT SENIORS

Overview

DAAS should develop a request for proposals to provide emotional and practical support, with a strong emphasis on Peer Support Volunteers who will be trained and matched with LGBT isolated older adults. In regards to clients' psycho-social needs, volunteers will support, affirm and strengthen clients' ability to make empowering, life and health-enhancing personal choices as well as to ease their isolation. Volunteers will also provide various types of practical support, such as assistance with shopping, home technology, errands, housecleaning, laundry, accompanying clients to medical or social services appointments, appointment reminders, as well as accompaniment to activities and events and other activities that promote quality of life in order to ease their isolation and ability to live independently.

Emotional and practical support volunteers should be required to undergo assessment and training prior to being matched with a client. The assessment should include discussion of the volunteer's physical and mental health status, and the ability of the volunteer to provide harm reduction-based, culturally competent peer support. Training for emotional and practical support volunteers should be comprehensive (min 20 hours) and include modules on cultural competency, boundaries, the peer support model and peer counseling/reflective listening, Aging 101, the grieving process, suicide ideation, clinical issues (including cognitive impairment), psychosocial issues, and the harm reduction model. This level of training is necessary for the in-depth emotional and practical support that volunteers will be expected to provide to clients.

Each client will be assigned to a staff Care Navigator, who will be the main point of contact for clients. The Care Navigator will work with the Volunteer Coordinator in matching clients with Volunteers. Care Navigation support includes the following: intake, follow up, on-going assessment, information and referral, on-going care coordination, matching and support of client-volunteer peer support matches, facilitation of peer support volunteer trainings, facilitation of drop-in services, support group facilitation, peer-based psychosocial support (including practical assistance and emotional support). Care Navigation qualifications are based on expertise in providing harm reduction-based coordination, advocacy, and/or psychosocial support to at-risk communities, and therefore these positions are not required to have specific licensure or graduate-level training. Care Navigators are evaluated for experience and competence in serving severe need populations and targeted communities.

Suggested FTE:

1.0 FTE Program Manager

2.0 FTE Care Navigators

1.0 FTE Volunteer Coordinator

Funding

The primary funding for this program is likely to be the General Fund. Supplemental funding sources might include SF Foundation and the HAAS Jr. Fund. Funds may also be sought through national pilot programs for alternative volunteer caregiving, such as Met Life Foundation and the AARP.

APPENDIX G – PROGRAM DESIGN RECOMMENDATIONS FOR DEMENTIA-RELATED RECOMMENDATIONS

This section provides detailed strategies for implementing recommendations from section 3.6. of this report.

1. Coordinate an LGBT targeted education and awareness campaign with the Alzheimer's Association about dementia and the issues it presents to LGBT persons. This would include topics and information on:

- Risk reduction
- Early identification of dementia
- What to expect as the disease progresses
- Services and resources
- Caregiver wellness and support
- Disease management for mild, moderate & advanced dementia, including end of life
- Advanced care planning
- Ethical issues
- Emergency preparedness and safety.

2. Create an informational campaign about the importance of advanced care planning, including:

- What is advanced care planning (ACP)
- Why is it especially important that people with dementia engage in ACP
- Who should be involved in the ACP process and why
- What specific issues should be covered during ACP:
    - Identification of a surrogate or decision-maker
    - Preferences regarding life support and CPR
    - Hospice and palliative care
- What steps are involved in ACP
- What is POLST (physician order for life sustaining treatment)
- Code status while in hospital

3. Work to create new and strengthen existing LGBT-specific dementia caregiver support services.

   - Create a coalition of LGBT organizations and allies that provide services to LGBT older adults and seniors, e.g., Openhouse, Shanit, Mairti, Lyon-Martin, Black Coalition on AIDS, Lesbian Health Resource Center, San Francisco Interfaith Council etc. This would reduce the risk of service duplication, increase cost effectiveness and create the widest possible outreach to diverse LGBT communities.

4. Create cultural competency training that is both LGBT sensitive and dementia care capable:

   - Encourage (mandate) LGBT sensitive senior/dementia capable training for all city departments and vendors delivering direct services to LGBT seniors.
   - Develop an LGBT sensitive/dementia capable training module for senior care facilities, such as independent and assisted senior housing, nursing homes, adult day health, dementia programs, and hospitals and in-home assistance businesses.
   - Create cultural competency training for first responders tailored to LGBT seniors living with dementia and their caregivers.
   - Ensure that Ombudsman services are LGBT sensitive/dementia capable.

APPENDIX H – POLICY RECOMMENDATIONS FOR LEGISLATION PROTECTING LGBT OLDER ADULTS IN LICENSED CARE FACILITIES

This proposed ordinance incorporates input from across the LGBT and long-term care advocacy communities. In particular, this draft relies significantly on the Lambda Legal publication: "Creating Equal Access to Quality Health Care for Transgender Patients: Transgender-Affirming Hospital Policies" (2013) *which is available on the Lambda Legal website.*

Ordinance amending the San Francisco Administrative Code by adding Chapter 12AA.

SEC. 12AA.1. SHORT TITLE.

This ordinance shall be known and may be cited as the "LGBT LONG-TERM CARE FACILITY RESIDENTS BILL OF RIGHTS."

SEC. 12AA.2. FINDINGS.

The Board of Supervisors of the City and County of San Francisco does hereby find and declare that.

a. Recent studies have shown that lesbian, gay, bisexual, and transgender (LGBT) seniors experience lifelong marginalization and discrimination, including in business establishments that provide care and services to seniors.

b. In 2013, Professor Karen Fredriksen-Goldsen of the University of Washington and the San Francisco LGBT Aging Policy Task Force published the report "*Addressing the Needs of LGBT Older Adults in San Francisco: Recommendations for the Future*." It is one of the most comprehensive and diverse studies of LGBT seniors ever conducted. 616 seniors participated, of whom 21% are LGBT seniors of color. This study produced the following results about the LGBT senior community in San Francisco:

    1. Many lack traditional sources of care, assistance, and support. Nearly 60% of participants live alone. Only 15% have children, and 60% indicated that these children would not be available to assist them. 63% are neither partnered nor married.

    2. Many report poor physical and mental health. Nearly one-third of the participants report poor general health; more than 40% report one or more physical disabilities; and—among male participants—33% are living with HIV/AIDS.

3. Despite these factors yielding a heightened need for care, LGBT seniors face discrimination and fear accessing services. Nearly half of the participants had experienced discrimination in the prior 12 months because of their sexual orientation or gender identity.

c. One area in which LGBT seniors face discrimination is in long-term care facilities. Discrimination in long-term care facilities is an unaddressed issue, according to "*Stories from the Field: LGBT Older Adults in Long-Term Care Facilities*," published in 2011 by the National Senior Citizens Law Center. That study found:

1. 78% of respondents felt it would be unsafe for an LGBT senior to be "out" in a long-term care facility.

2. 89% of respondents believed that staff would discriminate against an LGBT elder who was out of the closet in a long-term care facility.

3. 81% believed that other residents would discriminate against an LGBT elder in a long-term care facility.

4. 53% believed that staff would abuse or neglect an LGBT elder in a long-term care facility.

5. 43% of respondents reported personally witnessing or experiencing instances of mistreatment of LGBT seniors in a long-term care facility, including: verbal or physical harassment from other residents; refused admission or re-admission or being abruptly discharged; verbal or physical harassment from staff; staff refusal to accept medical power of attorney from resident's spouse or partner; discriminatory restrictions on visitation; or staff refusal to refer to a transgender resident by preferred name or pronoun.

d. California and San Francisco law both prohibit discrimination on the basis of actual or perceived sexual orientation, gender identity, gender expression, and HIV status in public accommodations. This includes business establishments that serve seniors, such as skilled nursing facilities, intermediate care facilities, residential care facilities for the elderly, and continuing care retirement communities.

SEC. 12AA.3. DEFINITIONS.

As used in in this Chapter, the terms:

a. "FACILITY" includes all business establishments that provide residential services and/or care to seniors, including skilled nursing facilities, intermediate care facilities, residential care facilities for the elderly, and continuing care retirement communities.

b. "FACILITY STAFF" includes all directors, medical personnel, administrators, employees, independent contractors, and others who enter a facility for the purpose of providing services or care to seniors residing there.

c. "SEXUAL ORIENTATION" has the same meaning as defined in Cal. Civil Code §51(e)(7).

d. "GENDER IDENTITY" has the same meaning as defined in Cal. Civil Code §51(e)(6).

e. "GENDER EXPRESSION" has the same meaning as defined in Cal. Civil Code §51(e)(6).

f. "TRANSGENDER" refers to people whose gender identity differs from their assigned or presumed sex at birth.

g. "GENDER NONCONFORMING" refers to people whose gender expression does not conform to traditional expectations of how a man or woman should appear or act.

h. "TRANSITION" means to undergo a process by which a person changes their physical sex characteristics and/or gender expression to match their inner sense of being male or female. This process may include a name change, a change in preferred pronouns, and a change in social gender expression through things such as hair, clothing, and restroom use. It may or may not include hormones and surgery.

SEC. 12AA.4. ADMISSION, TRANSFER, AND EVICTION.

a. Admission to a long-term care facility shall not be denied on the basis of real or perceived sexual orientation, gender identity, gender expression, or HIV status.

b. Decisions regarding transfer of a resident—within a facility or to another facility—shall not be made on the basis of a resident's real or perceived sexual orientation, gender identity, gender expression, or HIV status, other than as specified in this Chapter.

c. Decisions regarding eviction of a resident shall not be made on the basis of a resident's real or perceived sexual orientation, gender identity, gender expression, or HIV status.

d. Facilities shall employ procedures for admissions recordkeeping that are respectful of the gender identity, preferred names, and preferred pronouns of all residents and patients.

GUIDANCE

To facilitate compliance with this section, the City and County of San Francisco issues this guidance:

a. Facilities shall institute the following policy for electronic admitting / registration records.

1. In the existing "Gender" field in admission / registration records the facility staff person will record the individual's gender as the gender designation (Male or Female) that appears on the individual's medical insurance record, legal identification, or other source customarily used in admission / registration.

2. In addition, the admission / registration record will include an optional "Other," "Notes," "Special Needs," or similar drop-down menu that will include the following two sets of options:

A. "Transgender Male / Trans man / Female-to-Male (FTM)": This option is appropriate for a transgender person who has transitioned from female to male.

B. "Transgender Female / Trans woman / Male-to-Female (MTF)": This option is appropriate for a transgender person who has transitioned from male to female.

3. If the individual affirmatively states that he or she is transgender, the facility staff person will inform the individual that the facility, California law, and San Francisco law all prohibit discrimination based on gender identity and gender expression, and ask the individual if he or she would like their transgender status to be indicated in the admission / registration record. If the individual indicates that the information should be included, the facility staff person will select either from the two options listed in

subd. (i) and (ii) above from the drop-down menu to indicate the individual transgender status. If the facility staff person is unsure of which option to select, he or she should politely and discreetly ask the individual to verify whether the individual has transitioned from female to male or from male to female.

4. The facility staff person should not attempt to guess whether an individual is transgender or ask the individual whether he or she is transgender. An individual's transgender status should only be recorded on the drop-down menu if the individual volunteers the information and agrees that it should be recorded

5. In addition to the "Legal Name" field, admission / registration forms will include an optional field for an individual's "Preferred Name." All individuals should be asked if they have a "preferred name" or "nickname" that they would like to include in their admission / registration record.

6. If the individual affirmatively states that he or she is transgender, the facility staff person will inform the individual that the facility, California law, and San Francisco law all prohibit discrimination based on gender identity and gender expression and ask whether the individual would like to have his or her preferred name and pronouns recorded in the admission / registration record. If the individual indicates that this information should be recorded, the facility staff person should ask if the individual prefers male or female pronouns. The facility staff person will record that information by including "Male" or "Female" in parentheticals in the optional field that captures the individual's Preferred Name.

7. The electronic records system should be configured to notify providers and staff if the individual's preferred name and/or pronouns differ from the individual's current legally documented name and gender marker. The system should include a readily visible notification or alert flag that appears on the viewer's screen and indicates the individual's preferred name and pronoun.

b. Facilities shall institute the following policy for paper admitting / registration records.

1. Paper forms completed by the individual upon admission / registration should include the following questions concerning the individual's gender:

A. What is the gender designation on your medical insurance records? (1) Male; (2) Female

B. (Optional) Are you transgender? (1) Yes, I am a Transgender Male / Trans man / Female-to-Male (FTM); (2) Yes, I am a Transgender Female / Trans woman / Male-to-Female (MTF); (3) No

2. Paper forms completed by the individual upon admission / registration should include the following questions concerning the individual's name and pronoun:

A. What is your legal name?

B. (Optional) What is your preferred name or nickname?

C. (Optional) What is your preferred pronoun? (for example, he/him, she/her)

SEC. 12AA.5. HOUSING AND ROOM ASSIGNMENT.

a. The right of two people to share a room shall not be denied on the basis of real or perceived sexual orientation, gender identity, gender expression, marital status, or status as a registered domestic partner.

b. When room assignments are made according to gender, it shall be made in accordance with a resident or patient's gender identity.

c. An individual's gender identity shall be determined based on the individual's stated gender identity, regardless of whether this self-identified gender accords with their physical appearance, surgical history, genitalia, legal sex, sex assigned at birth, or name and sex as it appears in medical records; this self-identified gender will be respected notwithstanding the statements of family members, conservators, or attorneys-in-fact.

d. The gender identity of an individual who lacks capacity shall be determined based on a history of usage, including resident's presentation and mode of dress.

e. No resident will be denied admission if a gender-appropriate bed is not available.

f. Complaints from another resident related to a roommate's gender identity or expression do not constitute grounds for an exception to this section.

GUIDANCE

To facilitate compliance with this section, the City and County of San Francisco issues this guidance:

a. The City and County of San Francisco finds that the failure to grant room assignments to transgender residents in accordance with their gender identity is a form of discrimination that jeopardizes transgender residents' dignity and privacy. Gender-affirming room assignments are a crucial step toward breaking down barriers that have hindered transgender people's access to safe and inclusive long-term care.

b. The staff member in charge of assigning rooms shall determine a resident's self-identified gender prior to assigning the resident a room by reviewing the resident's admission / registration record. If upon admission it is impossible for the resident to inform the staff of his or her self-identified gender because he or she lacks capacity, then, in the first instance, inferences should be drawn from the resident's presentation and mode of dress. No investigation of the genitals of the person should be undertaken unless specifically necessary to carry out treatment.

c. That a transgender resident's physical appearance or genitalia differ from other residents who share the same self-identified gender is not a bar to assigning the resident to a room in accordance with his or her gender identity. Sufficient privacy can be ensured by, for example, the use of curtains or accommodation in a single side-room adjacent to a gender-appropriate ward.

d. Where residents are assigned to rooms based on gender, the facility staff member in charge of room assignments shall assign a transgender resident to a room in accordance with the resident's self-identified gender, unless the resident requests otherwise. Transgender residents shall be assigned to rooms in the following order of priority

    1. If a transgender resident requests to be assigned to a room with a roommate of the resident's same gender identity, and such a room is available, the request should be honored.

    2. If a transgender resident requests a private room and there is one available, it should be made available to the resident.

    3. If a transgender resident does not indicate a rooming preference, and a private room is available, the private room should be offered to the transgender resident. The offer should be explained to the resident as optional and for the purpose of ensuring the resident's privacy, safety, and comfort.

4. If a private room is not available and the transgender resident does not wish to share a room with a roommate, the transgender resident should be assigned to an empty double room with the second bed blocked.

5. If there is no private room or empty double room available, the resident should be assigned to a room with a resident of the gender with which the transgender resident identifies.

6. If there is no private or empty double room available and a transgender resident does not wish to share a room, other residents may be moved to make a private room available if doing so would not compromise the health or safety of the resident being moved.

7. If there is no private or empty double room available, the transgender resident refuses to share a room, and no other resident can safely be moved to make a private room available, the transgender resident should be allowed to remain in a temporary room until a private room becomes available or a safe transfer option is secured to another facility nearby.

e. Should facility staff receive complaints from a transgender person's roommate relating to room assignment, they should remedy the situation by using curtains or other room dividers to increase the privacy of both residents. A resident making ongoing complaints should be moved to another room as long as relocating the resident would be medically appropriate and safe.

SEC. 12AA.6. ACCESS TO RESTROOMS.

a. All residents of a facility may use the restroom that matches their gender identity, regardless of whether they are making a gender transition or appear to be gender-nonconforming.

   1. Transgender and gender-nonconforming residents shall not be asked to show identity documents in order to gain access to the restroom that is consistent with their gender identity.

   2. An individual's gender identity shall be determined based on the individual's stated gender identity, notwithstanding the statements of family members, conservators, or attorneys-in-fact.

   3. The gender identity of an individual who lacks capacity shall be determined based on a history of usage, including the resident's presentation and mode of dress.

b. Harassment of transgender and gender-nonconforming residents for using restrooms in accordance with their gender identity will not be tolerated.

SEC. 12AA.7. CONFIDENTIALITY AND PRIVACY.

a. The City and County of San Francisco finds that it is a source of fear for many lesbian, gay, bisexual, transgender people, and people with HIV/AIDS that private medical information regarding their sexual orientation, transgender status, or HIV status will not be adequately protected, as required by state and federal medical privacy laws.

b. Facilities should adopt procedures, policies, and training to ensure that facility staff members understand that information regarding a patient or resident's sexual orientation, transgender status, gender-transition history, and HIV status constitutes protected health information due all legal protections.

GUIDANCE

To facilitate compliance with this section, the City and County of San Francisco issues this guidance:

a. Facilities must revise privacy-related materials to ensure that the needs of LGBT residents are adequately met.

b. A resident's transgender status or history of transition-related procedures constitutes protected health information under HIPAA's implementing regulation (the 'Privacy Rule'), for example when it is coupled with identifying information, such as a name, photograph, or other medical history which could be used to identify the resident.

c. To protect this population, the following sample language is recommended for inclusion in facility privacy manuals and guidelines:

   1. Every physician, facility employee, and contractor who uses, discloses, or requests resident information, including information regarding a resident's gender identity or expression, transgender status, sexual orientation, or HIV status, on behalf of the facility, shall make reasonable efforts to limit disclosure of and requests for protected health information to any person not directly involved in the treatment of a particular resident to the minimum necessary to accomplish the authorized purpose of the use, disclosure, or request, in accordance with applicable federal and state law and regulations, including minimizing incidental disclosures. Procedures appropriate for implementing this policy vary based on the intended purpose of the use, disclosure, or request.

   2. Facility will ensure that every physician, employee, and contractor will have access to protected health information only to the minimum extent necessary and relevant to perform his or her specific job functions.

d. Each facility will include privacy issues affecting the lesbian, gay, bisexual, and transgender community in its HIPAA compliance materials and training.

e. Facility policies should be revised, as necessary, to make clear that any discussion or documentation of transgender status and transition-related services, any medical history related to transition, and similar information may involve protected health information, and as such would be subject to the facility's administrative, technical, and physical safeguards. For example, if a resident indicates in an admitting / registration record or in a subsequent conversation with staff that he or she is transgender, reasonable and appropriate safeguards (such as keeping the records in a folder where they are not easily accessible, or taking care to hold conversations about the resident's status in private) should be in place to ensure that no protected health information is intentionally or unintentionally disclosed or overheard by physicians, employees, independent contractors, other residents, or visitors.

f. The patient has the right to privacy and confidentiality during medical treatment or other rendering of care within the facility.

g. Persons not directly involved in the care or treatment of a transgender or gender-nonconforming patient should not be present during the patient's case discussion, consultation, examination, or treatment except for legitimate training purposes. Before observing or participating in a transgender or gender-nonconforming patient's case discussion, consultation, examination, or treatment for training purposes, trainees should be counseled on the contents of this Chapter. In all cases, discussion, consultation, examination, and treatment must be conducted discreetly.

h. Lesbian, gay, bisexual, and transgender patients have the right to refuse to be examined, observed, or treated by any medical staff or facility staff when the primary purpose is educational or informational rather than therapeutic; without jeopardizing the patient's access to medical care, including psychiatric or psychological care.

i. A facility is required under federal law to provide notification to an individual following a breach of that individual's unsecured protected health information under the Privacy Rule if it is information that poses a significant risk of financial, reputational, or other harm to the affected individual. Facilities should review their policies to ensure that any "breach" related to a lesbian, gay, bisexual, or transgender resident's protected health information is handled in accordance with these regulations and that LGBT residents are notified if their protected health information is inappropriately disclosed. Physicians, employees, and contractors should be trained accordingly.

j. Under the Privacy Rule, a covered entity must have in place and apply appropriate sanctions against members of its workforce (i.e., physicians, employees, and contractors) who violate the entity's policies and procedures and the Privacy Rule. Facilities should

specify that inappropriate use, disclosure or request of an LGBT resident's protected health information is both a violation of the facility's internal HIPAA policies and procedures, and a violation of the Privacy Rule, and that such violations will be subject to appropriate disciplinary action

k. The Privacy Rule requires that covered entities must provide a process for individuals to make complaints concerning the entity's policies and procedures by the Privacy Rule, and concerning the entity's compliance with such policies and procedures. A covered entity must document all complaints received, and their disposition, if any. Facilities should review their policies to ensure that a proper process is established for documenting and responding to complaints, and should ensure that LGBT residents are made aware of their right to complain about improper uses or disclosures of their protected health information.

SEC. 12AA.8. GENDER EXPRESSION.

a. All residents have the right to express their gender in ways that include:

   1. Being addressed or referred to by a preferred pronoun.

   2. Being addressed or referred to by a preferred name.

   3. To wear or be dressed in clothing, accessories, and cosmetics permitted to any resident.

b. An individual shall be permitted to express his or her gender notwithstanding the statements of family members, conservators, or attorneys-in-fact.

c. An individual who lacks capacity shall be permitted to express his or her gender identity, and that gender expression shall be determined based on a history of usage, including resident's presentation and mode of dress.

GUIDANCE

To facilitate compliance with this section, the City and County of San Francisco issues this guidance:

a. A transgender resident's preferred pronoun should be determined as follows:

   1. If the resident's gender presentation clearly indicates to a reasonable person the gender with which the resident wishes to be identified, the facility staff should refer to the resident using pronouns appropriate to that gender.

   2. If the facility staff member determines the resident's preferred pronoun on the basis of the resident's gender presentation, but is then corrected by the resident, the staff

member should then use the pronouns associated with the gender identity verbally expressed by the resident.

3. If the resident's gender presentation does not clearly indicate the resident's gender identity, the facility staff member should discreetly and politely ask the resident for the resident's preferred pronoun and name.

b. When a transgender or gender-nonconforming resident is admitted to the facility, they will be addressed and referred to on the basis of their self-identified gender, using their preferred pronoun and name, regardless of the resident's appearance, surgical history, legal name, or sex assigned at birth.

SEC. 12AA.9. ANTI-BULLYING.

a. The City and County of San Francisco finds that California and San Francisco law forbids discrimination against lesbian, gay, bisexual, and transgender seniors in any place of public accommodation, including business establishments that serve seniors.

b. Each facility shall adopt a policy that prohibits discrimination, harassment, intimidation, and bullying based on a resident's actual or perceived sexual orientation, gender identity, gender expression, or HIV status, or association with a person or group with one or more of these actual or perceived characteristics. The policy shall include a statement that it applies to all staff, residents, and visitors.

c. Each facility shall ensure that the existing complaint and grievance procedure within the facility is accessible to LGBT residents and patients for reporting bullying, harassment, verbal abuse, or physical abuse by peers, facility staff, or visitors. The facility shall also ensure that LGBT residents receive the same protections against retaliation and the same confidentiality and privacy protections.

d. The resident's right to associate with other residents, including the right to sexual intimacy, shall not be infringed upon based on the resident's sexual orientation, gender identity, or gender expression.

GUIDANCE

To facilitate compliance with this section, the City and County of San Francisco issues this guidance:

a. Should a lesbian, gay, bisexual, or transgender resident complain that the resident's roommate is subjecting him or her to harassment based on the resident's sexual orientation, gender identity or gender expression, the Long-Term Care Ombudsman and the San Francisco Human Rights Commission should be alerted, and a facility staff member trained in handling resident complaints and issues of LGBT cultural competency (*see below,* Sec. 12AA.14--"FACILITY LIAISON") should remedy the situation by relocating the LGBT resident's roommate to prevent continued harassment, as long as

relocating the roommate would be medically appropriate and safe. If the roommate cannot be relocated, the LGBT resident should be moved. The LGBT resident's health is not to be compromised by any unsafe room assignment.

b. This Guidance recommends the following language for a facility nondiscrimination policy: *"[Name of facility] does not discriminate nor does it permit discrimination on the basis of actual or perceived sexual orientation, gender identity, gender expression, or HIV status, or based on association with another's actual or perceived sexual orientation, gender identity, gender expression, or HIV status."* The facility is advised to post this policy alongside its current nondiscrimination policy, in all places and on all materials where that policy is posted.

c. The City and County of San Francisco finds abuse and bullying of LGBT seniors by facility staff is prohibited by California and San Francisco law. Towards that end, this Guidance recommends:

1. Facility staff will not use language or tone that a reasonable person would consider to demean, question, or invalidate a resident's actual or perceived sexual orientation, gender identity or expression.

2. Facility staff will not ask questions or make statements about a transgender or gender-nonconforming person's genitalia, breasts, other physical characteristics, or surgical status except for professional reasons that can be clearly articulated. Information about a patient's transgender status or any transition-related services that the patient is seeking and/or has obtained is sensitive medical information, and hospital staff members will treat it as such.

SEC. 12AA.10. MEDICAL CARE.

a. Lesbian, gay, bisexual, and transgender residents have the right to competent, considerate, and respectful care in a safe setting that fosters the patient's comfort and dignity and is free from all forms of abuse and harassment, including abuse or harassment based on sexual orientation, gender identity, or gender expression.

b. If a resident determines that he or she is transgender, the individual has the right to notify chosen staff members or medical providers of his or her transgender status. The resident shall be informed that his or her transgender status will be treated as private medical information but some disclosures of the information may be permitted or required under state and federal law.

c. No resident shall be asked about his or her transgender status, sex assigned at birth, or transition-related procedures unless such information is directly relevant to the resident's care. If it is necessary to the resident's care for a health care provider or other facility staff member to inquire about such information, the provider or staff member shall explain to the resident: 1) why the requested information is relevant to the resident's care; 2) that the information will be kept confidential but some disclosures of the information may be permitted or required under state and federal law; and 3) that the resident should consult the facility's HIPAA Policy for details concerning permitted disclosures of resident information.

d. The San Francisco Human Rights Commission in conjunction with the Long-Term Care Ombudsman Office shall publish a list each year of medical providers available to provide medical care to transgender residents and patients of facilities in San Francisco.

e. No employee or independent contractor entering a facility to provide care to seniors shall deny equitable and appropriate medical or non-medical care to a resident on the basis of actual or perceived sexual orientation, gender identity, gender expression, or HIV status.

f. Residents shall be provided with all necessary medical care appropriate to their body's organs and needs.

SEC. 12AA.11. VISITATION.

a. No facility shall bar visitation by an individual on the basis of the visitor or resident's sexual orientation, gender identity, or gender expression.

b. If a family member, conservator, or attorney-in-fact aims to bar an individual from visiting because of their sexual orientation, gender identity, or gender expression, and that person's visitation is desired by the resident—expressly or as evident by prior visitation if the resident lacks capacity—that individual shall be permitted to visit the resident.

c. Visitation for purposes of sexual intimacy shall not be barred on the basis of someone's sexual orientation, gender identity, or gender expression.

d. When a resident is experiencing a severe or final illness, his or her partner—whether legally recognized or not—shall be permitted to visit outside of normal visiting hours for as long as the resident or the partner wishes, including staying over night in the room, if reasonable.

SEC. 12AA.12. ADVANCE HEALTH CARE DIRECTIVES.

a. Facility staff and service providers shall respect all Advance Health Care Directives executed by the resident pursuant to California law.

b. Upon admission to a facility, staff shall make available to residents a sample Advance Health Care Directive document that includes LGBT-inclusive language.

c. Facility staff shall respect the powers conferred by an Advance Health Care Directive and shall not discriminate against either the resident or agent on the basis of either individual's sexual orientation, gender identity, or gender expression in the carrying-out of those powers.

GUIDANCE

To facilitate compliance with this section, the City and County of San Francisco issues this guidance:

(a) Residents who identify as lesbian, gay, bisexual, and transgender may benefit from the following sample insert for an Advance Health Care Directive:

> *During any period of treatment, I direct my physician and all medical personnel to refer to me by the name of [NAME] irrespective of whether I have obtained a court ordered name change and/or I have changed my name on any identity documents.*
>
> *During any period of treatment, I direct my physician and all medical personnel to use the male/female pronoun in reference to me, my chart, my treatment, etc., irrespective of whether I have obtained a court approved gender change, or changed my gender marker on any identity documents, or have or have not undergone any transition related medical treatment.*
>
> *During any period of treatment, I direct my physician and all medical personnel that if I am unable to maintain my masculine/feminine appearance, to the extent reasonably possible, to maintain my masculine/feminine appearance.*

SEC. 12AA.13. LAYPERSON GUIDE TO ENFORCEMENT AND IMPLEMENTATION.

The Long-Term Care Ombudsman and the San Francisco Human Rights Commission shall publish a layperson guide to this Chapter within six months of the enactment of this ordinance.

SEC. 12AA.14. FACILITY LIAISON.

a. The City and County of San Francisco finds that it is a top priority for business establishments serving LGBT seniors to be culturally competent to serve this community.

b. The City, thus, recommends that each facility should choose a staff member to serve as an LGBT liaison. The name of this liaison will be submitted to the San Francisco Human Rights Commission and the Long-Term Care Ombudsman. This liaison shall attend a once-yearly training to be organized by the Long-Term Care Ombudsman and the San Francisco Human Rights Commission concerning the contents of this Ordinance and LGBT cultural competency generally.

SEC. 12AA.15. LONG-TERM CARE OMBUDSMAN POLICY MANUAL.

Within six months of enactment of this ordinance, the long-term care ombudsman office shall issue internal policies and procedures in accordance with this ordinance for carrying out its provisions.

SEC. 12AA.16. SEVERABILITY.

If some provisions of the law, or certain applications of those provisions, are found to be unconstitutional or preempted by state or federal law, the remaining provisions, or the remaining applications of those provisions, will, nonetheless, continue in force as law.

APPENDIX I – SAMPLE ADVANCE HEALTH CARE DIRECTIVE FROM TLC

STATE OF [NAME],)
) **ADVANCE HEALTH CARE**
) **DIRECTIVE**
COUNTY OF [NAME])

I, [NAME] , Declarant, being at least eighteen years of age and a resident of and domiciled in the County of [NAME], State of [NAME], make this Directive this the _____ day of ___________, 2013. My name at birth was [NAME].

If at any time I have a condition certified to be a terminal condition by a licensed physician, and the physician has determined that my death could occur within a reasonably short period of time without the use of life sustaining procedures or if the physician certifies that I am in a state of permanent unconsciousness and where the application of life sustaining procedures would serve only to prolong the dying process, I direct the below instructions be followed.

I. INSTRUCTIONS CONCERNING ARTIFICIAL NUTRITION AND HYDRATION

A. INITIAL ONE OF THE FOLLOWING STATEMENTS

If my condition is terminal and could result in death within a reasonably short time,

__________ I direct that nutrition and hydration BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

__________ I direct that nutrition and hydration NOT BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

B. INITIAL ONE OF THE FOLLOWING STATEMENTS

If I am in a persistent vegetative state or other condition of permanent unconsciousness,

__________ I direct that nutrition and hydration BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

__________ I direct that nutrition and hydration NOT BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

In the absence of my ability to give directions regarding the use of life sustaining procedures, it is my intention that this Declaration be honored by my family, friends and physicians and any health facility in which I may be a patient as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences from the refusal.

I am aware that this Declaration authorizes a physician to withhold or withdraw life sustaining procedures. I am emotionally and mentally competent to make this Declaration.

II. APPOINTMENT OF AN AGENT

I may give another person authority to enforce this Directive on my behalf. I wish to allow the following person to do so:

Name of Agent with Power to Enforce: ____
Address: ____
Telephone Number: ___________________________

III. APPOINTMENT OF AN ALTERNATE AGENT

If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my alternate agent:

Name of Alternate Agent with Power to Enforce: ______________________________________
Address: ____
Telephone Number: ___________________________

IV. PEOPLE WHO SHOULD HAVE NO AUTHORITY

During any period of treatment, I direct my physician and all medical personnel to not give any of the following named individuals any authority, actual or implied, in regards to my treatment, care, visitation or final wishes: ____

____

____

V. RESPECTFUL RELATIONS

During any period of treatment, I direct my physician and all medical personnel to refer to me by the name of [NAME] -irrespective of whether I have obtained a court ordered name change and/or I have changed my name on any identity documents.

During any period of treatment, I direct my physician and all medical personnel to use the **male/female** pronoun in reference to me, my chart, my treatment, etc., irrespective of whether I have obtained a court approved gender change, or changed my gender marker on any identity documents, or have or have not undergone any transition related medical treatment.

During any period of treatment, I direct my physician and all medical personnel that if I am unable to maintain my **masculine/feminine** appearance, to the extent reasonably possible, to maintain my **masculine/feminine** appearance.

VI. FINAL WISHES

I direct all coroners, funeral home employees, health care workers, and participants involved in the preparation of my death certificate to designate my name as [NAME] irrespective of whether I have obtained a court ordered name change and/or I have changed my name on any identity documents.

I further direct all coroners, funeral home employees, health care workers, and participants involved in the preparation of my death certificate to designate my sex as **Male/Female** irrespective of whether I have obtained a court order and/or I have changed my gender on any identity documents.

During any memorial service or preparation thereof, I direct all coroners, funeral home employees, health care workers, and participants to refer to me by the name of [NAME] irrespective of whether I have obtained a court ordered name change and/or I have changed my name on any identity documents.

During any memorial service or preparation thereof, I direct all coroners, funeral home employees, health care workers, and participants to use the **male/female** pronoun in reference to me, irrespective of whether I have obtained a court approved gender change, or changed my gender marker on any identity documents, or have or have not undergone any transition related medical treatment.

During any memorial service or preparation thereof, I direct all coroners, funeral home employees, health care workers, and participants to maintain my **masculine/feminine** appearance, to the extent reasonably possible, to maintain my **masculine/feminine** appearance.

Upon death, I wish / do not wish (circle one) to donate any viable organs, tissues, or parts for transplant. My donation is for the following purposes (strike out any of the following you do not want): Transplant, Therapy, Research, Education.

I wish to be buried / cremated (circle one) with the following wishes for my tombstone / ashes:

VII. REVOCATION PROCEDURES

THIS DECLARATION MAY BE REVOKED BY ANY ONE OF THE FOLLOWING METHODS. HOWEVER, A REVOCATION IS NOT EFFECTIVE UNTIL IT IS COMMUNICATED TO THE ATTENDING PHYSICIAN:

(1) BY BEING DEFACED, TORN, OBLITERATED, OR OTHERWISE DESTROYED, IN EXPRESSION OF MY INTENT TO REVOKE, BY ME OR BY SOME PERSON IN MY PRESENCE AND BY YOUR DIRECTION. REVOCATION BY DESTRUCTION OF ONE OR MORE OF MULTIPLE ORIGINAL DECLARATIONS REVOKES ALL OF THE ORIGINAL DECLARATIONS;

(2) BY A WRITTEN REVOCATION SIGNED AND DATED BY ME EXPRESSING MY INTENT TO REVOKE;

(3) BY MY ORAL EXPRESSION OF MY INTENT TO REVOKE THE DECLARATION. AN ORAL REVOCATION COMMUNICATED TO THE ATTENDING PHYSICIAN BY A PERSON OTHER THAN ME IS EFFECTIVE ONLY IF:

(a) THE PERSON WAS PRESENT WHEN THE ORAL REVOCATION WAS MADE;

(b) THE REVOCATION WAS COMMUNICATED TO THE PHYSICIAN WITHIN A REASONABLE TIME;

(c) MY PHYSICAL OR MENTAL CONDITION MAKES IT IMPOSSIBLE FOR THE PHYSICIAN TO CONFIRM THROUGH SUBSEQUENT CONVERSATION WITH ME THAT THE REVOCATION HAS OCCURRED.

TO BE EFFECTIVE AS A REVOCATION, THE ORAL EXPRESSION CLEARLY MUST INDICATE MY DESIRE THAT THE DECLARATION NOT BE GIVEN EFFECT OR THAT LIFE SUSTAINING PROCEDURES BE ADMINISTERED.

(4) BY MY EXECUTING ANOTHER DECLARATION AT A LATER TIME.

X. EFFECT OF A COPY: A copy of this Declaration has the same effect as the original.

____

[NAME]
DECLARANT

STATEMENT OF WITNESSES

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this **ADVANCE HEALTH CARE DIRECTIVE** is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this Directive in my presence (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this Directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly nor an employee of an operator of a residential care facility for the elderly. I affirm that I am qualified as a witness to this Directive under the provisions of the California Death With Dignity Act in that I am not related to the Declarant by blood, marriage, or adoption, either as a spouse, domestic partner, lineal ancestor, descendant of the parents of the Declarant, or spouse or domestic partner of any of them; nor directly financially responsible for the Declarant's medical care; nor entitled to any portion of the Declarant's estate upon his death, whether under any will or as an heir by intestate succession; nor the beneficiary of a life insurance policy of the Declarant; nor the Declarant's attending physician; nor an employee of the attending physician; nor a person who has a claim against the Declarant's estate as of this time. If the Declarant is a resident in a hospital or nursing care facility at the date of execution of this Declaration, at least one of us is an ombudsman designated by the State Ombudsman, Office of the Governor.

FIRST WITNESS:

Print Name: ____

Address: ____

Signature of Witness: ____

Date: ____

SECOND WITNESS:

Print Name: ____

Address: ____

Signature of Witness: ____

Date: ____

APPENDIX J – SAMPLE LAST WISHES WORKSHEET

Last Wishes Worksheet

Here are some suggested items to include. Some may not be appropriate for everyone, and some may require additional provisions.

1.	I want the following person / people to make decisions regarding what happens to my body after I die.	(*name*)____________________ (*relationship)*____________________ (*address*) ____________________ (*phone#*) ____________________ (email)____________________ I have told this person that I want her or him to exercise this power: Y/N List additional people here, if desired:
2.	I do NOT want the following person / people involved in decisions regarding what happens to my body after I die.	(*List names and relationships*)
3.	I have a pre-paid or pre-arranged funerary plan (e.g., a pre-paid burial plan)	Y / N (Where those documents are kept) (Who has those documents)
4.	I want the following name to be used for all funerary purposes (obituary, headstone, memorial service, etc.)	(*name*)
5.	If you are a veteran, does your service record reflect your name change? (As a veteran	Y/ N

	you are entitled to a free headstone, so this will ensure that the correct name is displayed)	
6.	Please describe the clothing, makeup, and accessories you would want to be placed on your body for memorial purposes.	1. I direct my agent to maintain my masculine appearance. 2. I direct my agent to maintain my feminine appearance. 3. I direct my agent to maintain my genderqueer appearance. 4. I have specific instructions regarding my clothing, makeup, and accessories: (*state specific instructions here*):
7.	I want the following person to conduct any memorial services on my behalf.	(*name*)____________________ (*relationship*)____________________ (*address*) ____________________ (*phone#*) ____________________ (email)____________________ I have told this person that I want them to exercise this power: Y/N List additional people here, if desired:
8.	I do NOT want the following person / people to conduct any memorial services on my behalf.	(*List names, relationships, and affiliations*)
9.	I want the following items to be included in any memorial services held on my behalf.	(*List readings, musical selections, or other materials*)
10.	I want the following person / people to draft and submit an obituary.	(*names and relationships*) (*particular publications*)

		(*specific content to include*)
11.	I want the following people to be notified of my death.	(*name*)_______________________________________ (*relationship)*__________________________________ (*address*) _____________________________________ (*phone#*) _____________________________________ (email)_______________________________________ (*List other people*)
12.	To the degree permitted by law, I do NOT want the following people to be notified of my death.	(*List names and relationships*)