Healthy Aging in Community for Older Lesbians

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Abstract

Purpose: In Boston and Outer Cape, Massachusetts, we explored the expectations of lesbians 60 years and older regarding healthy aging and community importance.

Methods: Focus groups were conducted with participants after completing an anonymous demographic questionnaire. Thematic analysis was used to generate themes and identify how they varied by urban versus rural settings.

Results: Group discussions focused on community, finances, housing, and healthcare. Primary concerns included continued access to supportive and lesbian communities as a source of resilience during aging.

Conclusion: Concerns about discrimination and isolation mirror themes found in national research. The study findings suggest a need for more research into the housing and transportation needs of lesbians approaching later life, with a focus on how those needs relate to affordability, accessibility, and proximity to social support and healthcare. These findings also suggest the need for substantial investments in strengthening the LGBT-related cultural competence of providers of services for the elderly.

Key words: aging, community, healthcare, healthy aging, housing, lesbian.

Introduction

AS THE U.S. population grows older at unprecedented rates, efforts to ensure adequate care for elders are underway. Within the aging population are communities of sexual and gender minority people mostly hidden from view and misunderstood by the general population. In a prominent review of LGBT health, the Institute of Medicine noted the scarcity of knowledge about LGBT aging and, until quite recently, the lack of attention to LGBT aging in the field of gerontology.^{1–3} LGBT elders are an understudied group, and even less is known about the unique challenges that lesbians face as they age. Lesbians in later adulthood have been overlooked in research, programs, and healthcare planning.

With this exploratory qualitative study, we aimed to identify factors that facilitate or pose barriers to older lesbians' healthy aging and to gain insights into their needs and preferences for where and how they hope to live as they age. We build on the limited but growing literature on older lesbian adults, which highlights health disparities, economic insecurity, and reluctance to utilize mainstream aging and health services. We also extend the emerging framework of aging

in the community to include lesbian elders. We consider the rapidly changing policy context relevant to LGBT aging and the unprecedented opportunities created therein.

Studies often combine LGBT individuals into one group, thereby making it difficult to discern how outcomes vary by gender, sexual identity groups, and age. With recent studies of stronger methodological rigor, variations between subgroups begin to come to light; however, some of these relate to adults in young/middle adulthood. Therefore, some of the literature presented here captures data on LGBT adults across the life course. There is a paucity of research that focuses on older lesbian adults, and this study addresses this gap.

Health disparities

Available research suggests that older lesbian women are an at-risk, yet resilient, population. Compared to their heterosexual counterparts, lesbian seniors are more likely to experience disability, depression, obesity, and cardiovascular disease.^{1,4} These health disparities can be explained by the phenomenon of minority stress, caused by external events and conditions (e.g., experiences of antigay or lesbian

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prejudice), expectations of such events, the internalization of societal attitudes, and concealment of one's sexual orientation.⁵ Lesbian seniors have grown up and dealt with pervasive societal ignorance and antagonism.¹

In addition to minority stress, health disparities may relate to financial insecurity. Lesbians are more likely to have lower incomes and more economic concerns when compared to gay male peers; compared to heterosexual women, lesbians are less likely to have financial support from a retirement account or benefits from their (former) husbands.⁶ In a study comparing same-sex and heterosexual couples in California, partnered lesbians had a slimmer chance (28%) of getting dependent coverage compared to married heterosexual women, which may have related to lower use of healthcare services.⁷

LGBT older adults are often wary of utilizing elder services and more likely to delay seeking medical care because of perceived discrimination and providers' lack of cultural competency.^{8–10} A national survey conducted in 2010 found that 75% of respondents said that if they were to live in elder care institutions, they would not disclose their LGBT status.¹¹ A majority of LGBT older adults anticipate that they will face discrimination and neglect from long-term care staff because of sexual orientation.¹² Overall, lesbian elders are statistically more likely to face financial hardship, lack access to culturally competent medical care, and experience negative health outcomes due to their stigmatized identity.

Aging in community

In a survey conducted by the AARP, 85% of seniors said that they prefer to live in their own homes.¹³ Accordingly, the public health model of aging in place focused mainly on physical and safety adaptations that enable seniors to remain in their homes and avoid institutional care.¹⁴ Recent research has pointed to the importance of social and emotional connection in healthy aging as a way to mitigate the negative physical and mental health effects of isolation.¹⁵ This mirrors data showing that seniors identify their social activity as the most important aspect of healthy aging.¹⁶ Accordingly, a focus on aging in community has emerged, involving strategies to ensure seniors' ability to engage with friends and social networks in their communities.¹⁷

For many aging LGBT people, connections with family of origin have been broken due to lack of acceptance. Although limited, existing literature shows that LGBT individuals, compared to heterosexual peers, are at increased risk of social isolation and less likely to have children or partners.^{6,18,19} This risk may be particularly high for LGBT seniors who are homebound or living in rural settings, having to travel far to attend LGBT events or access formal healthcare services sensitive to their specific needs.²⁰

An important factor contributing to the resiliency of LGBT individuals is the creation of "chosen families,"^{21,22} and other social networks that provide connections and support.^{18,19,23–25} Maintaining these connections is important for LGBT older adults to achieve high life satisfaction.²⁶ A recent study of Massachusetts congregate meal sites found that lesbian and gay seniors placed higher value on opportunities for social engagement than their heterosexual counterparts and, in fact, often traveled long distances to multiple sites to have time with others.²⁷

Methods

In this study, we conducted four focus groups of lesbians 64–71 years of age: two in an urban area (Boston) and two in a rural area (Outer Cape Cod). The goal was to explore, through individual stories and shared discussion, their needs, concerns, and preferences for where and how to live as they age. Participants were recruited through public distribution of flyers and through e-mail. Lesbians in a relationship could not attend the focus group with their partner. Focus groups varied from 4 to 10 participants. On the Cape, 2 and 1/2 weeks passed between the two focus groups; in Boston, 3 weeks passed between the first and second focus groups. The Institutional Review Board of The Fenway Institute approved the study.

Data collection

At the beginning of each focus group, lasting ~90 minutes, participants filled out an anonymous demographic questionnaire and gave verbal informed consent. A single investigator facilitated all four groups according to a written protocol of questions, although each group evolved in its own way and discussions were somewhat open-ended. Questions included, but were not limited to, the following: Would you prefer to continue living in your current home as you age? If you would not prefer to remain living in your current home, what other kind of living arrangements would you prefer? What kind of assistance would you require to stay in your house as you grow older? What are some of the most important factors that influence where you'd like to live as you age? Is access to healthcare a concern? At the end of each group, one participant received a \$50 gift card from a random drawing. Focus group conversations were recorded digitally, transcribed, and coded in word processing software.

Data analysis

The aim of data analysis was twofold: first, to generate themes related to older lesbians' needs, concerns, and preferences for how and where to live as they age; second, to identify how the themes varied by respondents' location in the urban versus rural settings. To this end, the strategy of thematic analysis was used.²⁸ One member of the research team systematically coded the data, and two other members of the research team reviewed the transcripts and provided consultation on coding. Having three people collaboratively develop the theme codebook, confer about the emerging hierarchy of concepts, and regularly debrief helped to guard against researcher bias and enhanced the rigor and trustworthiness of the data. The approach was inductive in that the authors developed an initial list of codes from the data, connecting each newly created code to the respondents' words as reflected in the transcript. After initial themes were identified, the data were reviewed multiple times to compare it to the identified themes. New codes were identified until data analysis reached saturation, such that the data confirmed the existing categorical structure of themes and subthemes. A three-level codebook was developed from the data, consistent with strategies suggested by Miles and Huberman, which allowed for identifying major themes and hierarchies of related concepts.²⁹

Participant demographics

All participants were born female and identified as women, had an average age of 68 with a range of 64–71, and all were white and non-Hispanic. Demographics were similar across the two geographic areas (Tables 1 and 2). Despite demographic similarities in urban and rural locations, several characteristics varied by location. Rural participants were more likely than urban counterparts to be married or partnered. Urban participants were more likely to live alone and twice as likely to live with pets.

TABLE 1. CHARACTERISTICS OF DAILY LIVING

	<i>Total</i>	<i>Rural</i>	<i>Urban</i>
Total number of participants	26	14	12
Average age	68 years	67 years	70 years
Employment			
Employed full-time	2 (8%)	1	1
Employed part-time	2 (8%)	2	0
Retired	13 (54%)	6	7
Volunteer part-time	2 (8%)	0	2
Other	2 (8%)	2	0
Retired and volunteered part-time (both selected)	3 (13%)	1	2
Relationship status			
Married	5 (20%)	4	1
Partnered	7 (28%)	5	2
Single	10 (40%)	3	7
Divorced	2 (8%)	0	2
Other	1 (%)	1	0
Annual household income			
\$10,001–\$30,000	4 (17%)	2	2
\$30,001–\$50,000	5 (21%)	2	3
\$50,001–\$70,000	5 (21%)	3	2
\$70,001–\$90,000	2 (8%)	1	1
\$90,001–\$110,000	1 (4%)	1	0
\$110,001–\$130,000	0 (0%)	0	0
\$130,001–\$150,000	3 (13%)	1	2
\$150,001–\$170,000	1 (4%)	1	0
\$170,001–\$190,000	2 (8%)	1	1
Over \$190,000	1 (4%)	0	1
Household size (including participant)			
1	8 (36%)	3	5
2	13 (59%)	7	6
3	1 (4%)	1	0
Type of housing			
Apartment, condo, or room in a building open to people of all ages	11 (48%)	3	8
Single family house	12 (52%)	8	4

In this table, respondents could choose only one response per question.

1. 16% of respondents were employed, 54% were retired—the remainder volunteered part-time, were retired and also volunteered part-time, or noted “other.”

2. 36% lived alone, 59% in a home with one other person, and one in a home with three or four persons. Those who lived in a single family house made up just over half (52%); the remainder (48%) lived in an apartment, condo, or room in a building open to people of all ages.

3. Household income varied from \$50,000 or less (38%), \$50,001–\$110,000 (33%), and \$110,001–\$190,000 (29%).

Using a model of healthy aging for LGBT elders, the demographics questionnaire asked participants to rate their overall health.³⁰ Most participants (60%) said they were Surviving and Thriving, seven (28%) were Working At It, and three (12%) were Avoiding Health Problems (Table 2). The absence of ailing participants was to be expected, given that they had to come to a central location to participate. There were no differences based on geographic location.

Results

Respondents identified needs, preferences, and barriers related to aging organized around four themes: community, finances, housing, and healthcare.

Community

The importance of community emerged as a ubiquitous theme. Several participants moved to their current residence to participate in a robust LGBT-friendly social network and to feel relatively safe from discrimination in a progressive sociopolitical climate. For those same reasons, they preferred to age in their current community, where they could feel accepted, continue to build friendships, and draw upon lesbian communities as a source of strength and hope. The significance of social support was addressed 68 times across the four focus groups and was the single most referenced theme. Participants suggested that social support was one key to their health, as one participant remarked, “Health to me....means I can get to healthcare, yes, but it means I also can get to social events.” Related to this, a majority of participants preferred to have friends provide them with assistance when needed, instead of formal elder care services.

One person from the Outer Cape said, “I think it’s one of the wonderful things about this area...you do have the opportunity to build community before we desperately need it in our old age, and we have a chance to know who our friends are and to build the connections that enable you to know who you’d be comfortable having in your house.” With a few exceptions, most respondents lived far away from family. A minority of participants ($n=2$) considered moving closer to, or living with, children or siblings; however, most preferred not to live with family.

Demographic questionnaire findings corroborate the importance of social support. Over half indicated that they had several sources of support to call upon when they needed help. Participants in urban settings (75%) were more likely to select multiple sources of support compared with women in rural settings (43%) and were more likely to contact their friends and children for help. Women from the Outer Cape were more likely to reach out to partners and neighbors.

Participants expressed substantial fear about future isolation. Decreased mobility associated with aging, including inability to drive, raised the risk for isolation, especially in rural areas. They voiced fear about being forced by disability or illness to enter assisted living or nursing homes, where they might face isolation and stigma. One participant stated, “The worry is you get sick, you have to go to some institution or something, and there’s nobody like you there.” Another reported that a friend of hers had to go back into the closet when she entered a nursing home.

TABLE 2. SHARED LIVING AND CONCERNS FOR THE FUTURE

	<i>Total</i>	<i>Rural</i>	<i>Urban</i>
Total number of participants	26	14	12
Average age	68 years	67 years	70 years
With whom do you live?			
No one—I live alone	7 (30%)	3	4
Partner—all the time	12 (50%)	9	3
Partner—some of the time	0 (0%)	0	0
Child(ren)	2 (8%)	1	1
Grandchild(ren)	1 (4%)	0	1
Parent(s)	0 (0%)	0	0
Other family	0 (0%)	0	0
Other nonfamily	1 (4%)	0	1
Pets	6 (25%)	2	4
Who would you feel comfortable asking for help? [check all that apply]			
Spouse partner	11	8	3
Child(ren)	6	2	4
Other family members	2	1	1
Friends	16	6	10
Neighbors	6	4	2
Aging service providers or volunteer helpers	8	4	4
Others	2	0	2
I don't have anyone I feel comfortable asking for help	2	0	2
Do you talk to those you live with about where you'll live as you get older?			
Yes, we have made plans for the future	4 (29%)	3	1
Sometimes, but we have made no plans	6 (43%)	3	3
No, we have not talked about this	4 (29%)	2	2
How seriously are you thinking about where you'll live as you get older?			
Very	14 (58%)	7	7
Somewhat	8 (33%)	5	3
Not at all	2 (8%)	1	1
Taking into account each aspect of healthy aging, which category do you think best represents you?			
Avoidance of health problems	3 (12%)	1	2
Surviving and thriving	15 (60%)	8	7
Working at it	7 (28%)	4	3
Ailing	0 (0%)	0	0

In this table, respondents could check multiple responses in asking for help—percentages are not reported. In the other four question areas, only one response could be selected and percentages are reported.

1. Regarding whether or not participants talked to others about where to live when getting older, only four had made plans for the future, six had sometimes talked about where to live when getting older, and four had not talked about this. Among a total of 26 participants, only 14 answered this question and only 4 were making plans for the future.

2. When asked how seriously participants thought about where they would live as they became older, 14 (58%) reported “very,” 8 (33%) reported “somewhat,” and 2 (8%) said “not at all.”

3. All but one participant answered the question about healthy aging: 3 participants (12%) thought that “avoidance of health problems” best fitted her aging; 15 (60%) considered themselves to be “surviving and thriving”; 7 (28%) were “working at it”; and none considered herself to be “ailing.”

Finances

Although they want to remain in supportive communities and retain independence, many participants worried that they will not have the financial resources to do so. Several reported economic vulnerability, which they attributed to several factors, including healthcare and health insurance expenses, high cost of living, potential loss of

employment, property taxes, gender pay inequity, and the cost of in-home services. A small number of participants ($n=4$) continued to work full- or part-time, whereas others were retired or relied on employed partners. Several had little financial cushion, and the loss of either paid work or of a partner's income was described as potentially devastating and catastrophic. All groups expressed concerns about the high cost of future housing options, health

insurance, and home-based services, issues of increasing importance as they age.

Housing

A primary concern was the limited availability of housing that would meet their long-term needs in terms of accessibility, affordability, and proximity to social support. They focused on the need to develop new affordable options, which could include cohousing and congregate housing options. Those interested in congregate housing noted that it would be a helpful way to continue having a supportive community of friends and share resources, with particular attention to the needs of low-income individuals. Those not inclined to congregate housing stated that they wanted to maintain their privacy and independence. For all focus groups, the discussion regarding housing centered on staying connected to friends and seeking affordable options to remain in their communities.

Most participants discussed their difficulties navigating stairs and associated risk of falls and cited this as a main reason they would consider moving into more accessible living space. Some had already moved into one-floor living arrangements with access to elevators, while a few women had adapted their homes to permit one-floor living. Four women wanted to create space for live-in help when the need arises, with some having a preference for another lesbian to fulfill that role.

Healthcare

Given the rural nature of the Outer Cape and the abundance of healthcare options in Boston, participants on the Outer Cape had greater concern about the accessibility and quality of healthcare, particularly specialty care. Major topic areas related to healthcare included access, quality, in-home services, and caregiving. Boston participants commented positively on access to healthcare, pointing out the wealth of healthcare and transportation options in the area. In contrast, lack of convenient access was a major topic for Outer Cape participants, with many comments about the need to travel long distances to obtain specialty healthcare or to see a preferred provider. As one participant put it, "It's a long way to go if you need to go often and you're not feeling well." Overwhelmingly, respondents accepted inconvenience and risks associated with distance from healthcare for the purpose of staying in a supportive community. Many noted the importance of the available formal and informal networks to assist with transportation to medical appointments.

Discussions on quality of healthcare included two main dimensions. First, participants on the Outer Cape made 27 comments regarding concern about quality specialty care for conditions associated with aging such as joint replacements and knee or back surgery. Second, both Outer Cape and Boston participants preferred lesbian or lesbian-friendly providers. Comments on the latter aspect of quality focused on cultural competence, that is, the importance of providers' sensitivity and acceptance to respondents' specific needs, especially recognition of their partners as family members, the ability to address sexuality issues, and acceptance of them as lesbians.

Discussions in all four focus groups illustrated apprehension about current or inevitable future need for some kind of "paid help" for home-based services, referring mainly to

help with errands, shopping, meals, driving to appointments, and housecleaning. A fear of in-home services by people outside of the gay community arose: "I think one issue would be if you thought that somebody was coming who was not in the gay community, you're going to have to de-gay your house." In light of these concerns, they favored relying on friends and lesbian-friendly services. Only two planned to rely on their children for assistance, but not extensive caregiving; others stated that ultimately they could not rely on their children.

Discussion

In this small convenience sample of self-identified lesbian women, all participants identified as Caucasian and none reported to be ailing. Accordingly, the results of this pilot study cannot be generalized. However, results provide rich information about the needs and concerns of this sample of lesbian elders in rural and urban communities, how they vary by location, and suggests implications for practice, policy, and future research.

Foremost in the minds of study participants was a commitment to maintaining lesbian community throughout older adulthood. Their reflection showed the importance they attached to social activities, as well as their creativity in building informal networks of care as a means to support one another through the challenges of aging. Each group agreed that living close to other lesbians for social connection and emotional support was critical, even if it meant paying more for housing in Boston or being geographically isolated from specialized medical care on the Outer Cape. These reflections reinforce the focus on aging in the community.

Certainly for many older adults, the threat of losing independence is often terrifying, and in this respect, these older lesbians are no different from any other seniors. However, lesbians who are now in their 70s and 80s have a particular history with being forced into independence as they lost traditional support systems. For this generation of lesbians, the thought of losing that hard-won independence takes on new meaning and emotional depth. It may be, at least in part, for this reason that older lesbians in the focus groups were committed to creating social networks of support, while many envisioned alternative housing that builds on the strength of lesbian community.

The decision to stay in their current communities involved different sacrifices for those in urban and rural settings. Those living in Boston prioritized proximity to social networks, even if that meant financial sacrifices to live in a city with high housing costs. Most of those on the Outer Cape valued their supportive community and accepted that the location necessitated limited access to a full range of quality healthcare resources.

Many elders find it uncomfortable to think about future hardships and the challenges of aging. Lesbian elders, however, have an additional unique concern about culturally competent care, which can pose a barrier to asking for help when needed. Their reluctance to have in-home services, where they might face discrimination, or to enter any elder care institution where they might feel forced to conceal their identity heightens their vulnerability. This additional vulnerability for lesbian elders demands the attention of local and national agencies, which can be of tremendous assistance to promote and ensure exceptional culturally competent care. There is

evidence of a shortage of nondiscriminatory and culturally competent providers, especially in rural areas of the country where lesbians are less concentrated.³¹

A U.S. Department of Housing and Urban Development (HUD) rule issued in 2011 and finalized in 2012 guarantees equal access to HUD programs, regardless of sexual orientation or gender identity.³² This includes senior housing that is funded by HUD or subject to a Federal Housing Administration (FHA)-insured mortgage. An increasing number of LGBT elders are seeking housing in LGBT senior housing developments, or mainstream subsidized housing that is LGBT-friendly. The findings of this pilot study suggest that there is a need for more research into the housing needs of lesbians approaching later life, with a focus on how those needs relate to affordability, accessibility, and proximity to social support and healthcare.

Conclusion

Both the Outer Cape and Boston have thriving lesbian communities, situated within a state that is welcoming to LGBT communities and has supportive public policies. However, concerns about discrimination and isolation mirror themes found in national research. The paradigm of aging in community appears appropriate for this respondent group; however, the concept of community must be affirmative, including affordable housing and transportation, so that lesbians can access chosen family and have the assurance that they will not face discrimination from services for the elderly and medical providers.

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References

1. Institute of Medicine: The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding. Washington, DC: The National Academies Press, 2011.
2. Fredricksen-Goldsen KI, Muraco A: Aging and sexual orientation: A 25-year review of the literature. *Res Aging* 2010; 32:372–413.
3. Scherrer KS: Images of sexuality and aging in gerontological literature. *Sex Res Social Policy* 2009;6:5–12.
4. Fredricksen-Goldsen KI, Kim H, Hoy-Ellis C: Living arrangement and relationship status as predictors of health among older LGBT adults: The impact of social support. *Gerontologist* 2011;51:98.
5. Meyer IH: Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychol Bull* 2003;129:674–697.
6. MetLife®: Out and aging: The Metlife study of lesbian and gay baby boomers. 2006. Available at www.metlife.com/assets/cao/mmi/publications/studies/mmi-out-aging-lesbian-gay-retirement.pdf (accessed September 18, 2015).
7. Ponce NA, Cochran SD, Pizer JC, Mays VM: The effects of unequal access to health insurance for same-sex couples in California. *Health Aff (Millwood)* 2010;29:1539–1548.
8. Claes JA, Moore W: Issues confronting lesbian and gay elders: The challenge for health and human services providers. *J Health Hum Serv Adm* 2000;23:181–202.
9. Johnson MJ, Jackson NC, Arnette JK, Koffman SD: Gay and lesbian perceptions of discrimination in retirement care facilities. *J Homosex* 2005;49:83–102.
10. Taylor I, Robertson A: The health needs of gay men: A discussion of the literature and implications for nursing. *J Adv Nurs* 1994;20:560–566.
11. Abrahms S: What happened to the welcome mat? Nursing homes and gay elders. AARP. 2012. Available at <http://blog.aarp.org/2012/08/09/sally-abrahms-nursing-homes-gay-residents/> (accessed September 18, 2015).
12. Justice in Aging: LGBT older adults in long-term care facilities: Stories from the field. 2010 (updated and re-released 2015). Available at www.justiceinaging.org/customers.tigertech.net/wp-content/uploads/2015/06/Stories-from-the-Field.pdf (accessed September 18, 2015).
13. National Conference of State Legislatures and the AARP Public Policy Institute: Aging in Place: A state survey of livability policies and practices. Washington, DC: AARP Public Policy Institute. Available at www.aarp.org/ppi (accessed October 9, 2015).
14. Vasunilashorn S, Steinman BA, Liebig PS, Pynoos J: Aging in place: Evolution of a research topic whose time has come. *J Aging Res* 2012;2012:120952.
15. Pantell M, Rehkopf D, Jutte D, et al.: Social isolation: A predictor of mortality comparable to traditional clinical risk factors. *Am J Public Health* 2013;103:2056–2062.
16. Montross LP, Depp C, Daly J, et al.: Correlates of self-rated successful aging among community-dwelling older adults. *Am J Geriatr Psychiatry* 2006;14:43–51.
17. Black K, Dobbs D, Young TL: Aging in community: Mobilizing a new paradigm of older adults as a core social resource. *J Appl Gerontol* 2015;34:219–243.
18. Fredriksen-Goldsen KI, Kim H-J, Emlen CA, et al.: The Aging and Health Report: Disparities and Resilience among Lesbian, Gay, Bisexual, and Transgender Older Adults. Seattle, WA: Institute for Multigenerational Health, 2011.
19. MetLife: Still out, still aging: The Metlife study of lesbian, gay, bisexual and transgender baby boomers. 2010. Available at www.metlife.com/assets/cao/mmi/publications/studies/2010/mmi-still-out-still-aging.pdf (accessed September 18, 2015).
20. King S, Dabelko-Schoeny H: “Quite frankly, I have doubts about remaining”: Aging-in-place and health care access for rural midlife and older lesbian, gay, and bisexual individuals. *J LGBT Health Res* 2009;5:10–21.
21. Grossman AH, D’Augelli AR, Hershberger SL: Social support networks of lesbian, gay, and bisexual adults 60 years of age and older. *J Gerontol B Psychol Sci Soc Sci* 2000; 55:171–179.

22. Orel N: Community needs assessment: Documenting the need for affirmative services for LGB older adults. In: Lesbian, Gay, Bisexual, and Transgender Aging: Research and Clinical Perspectives. Edited by Kimmel D, Rose T, David S. New York: Columbia University Press, 2006, pp 227–246.
23. Masini BE, Barrett HA: Social support as a predictor of psychological and physical well-being and lifestyle in lesbian, gay, and bisexual adults aged 50 and over. *J Gay Lesb Soc Serv* 2008;20:91–110.
24. Muraco A, Fredriksen-Goldsen K: “That’s what friends do”: Informal caregiving for chronically ill midlife and older lesbian, gay, and bisexual adults. *J Soc Pers Relat* 2011;28: 1073–1092.
25. Shippy RA, Cantor MH, Brennan M: Social networks of aging gay men. *J Men’s Studies* 2004;13:107–120.
26. Addis S, Davies M, Greene G, et al.: The health, social care and housing needs of lesbian, gay, bisexual and transgender older people: A review of the literature. *Health Soc Care Community* 2009;17:647–658.
27. Porter K, Keary S, VanWagenen A, Bradford J: Social network and nutritional value of congregate meal programs: Differences by sexual orientation. *J Appl Gerontol* 2014 Nov 6. pii: 0733464814546042 [Epub ahead of print]; DOI: 10.1177/0733464814546042.
28. Boyatzis RE: Transforming Qualitative Information: Thematic Analysis and Code Development. Thousand Oaks, CA: SAGE Publications, Inc., 1998.
29. Miles M, Huberman AM: Qualitative Data Analysis: An Expanded Sourcebook. Thousand Oaks, CA: SAGE Publications, Inc., 1994.
30. Van Wagenen A, Driskell J, Bradford J: “I’m still raring to go”: Successful aging among lesbian, gay, bisexual, and transgender older adults. *J Aging Stud* 2013;27:1–14.
31. Obedin-Maliver J, Goldsmith ES, Stewart L, et al.: Lesbian, gay, bisexual and transgender-related content in undergraduate medical education. *JAMA* 2011;306:971–977.
32. U.S. Department of Health and Human Services: Healthy People: Understanding and Improving Health. Washington, DC: US Government Printing Office, 2010.

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