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Working with LGBT Clients: Strategies for Geriatric Care Managers

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Working with LGBT Clients: Strategies for Geriatric Care Managers

By Kimberly D. Acquaviva, PhD, MSW

Serving Your Community

In your work as a geriatric care manager, have you provided care to someone who is lesbian, gay, bisexual, or transgender? If you haven’t already, chances are good that at some point in your career, you will. Every geriatric care manager in the United States has lesbian, gay, bisexual, and transgender (LGBT) older persons living in their community. Whether you serve an urban, suburban, or rural community, you have the opportunity (and the obligation) to provide LGBT clients with the same high-quality services you provide all your clients.

Geriatric care managers in communities around the nation are being called upon to provide quality, compassionate care to LGBT persons. It is helpful to understand the ways in which the experiences of LGBT persons may differ from the experiences of other individuals so that the care management process can be facilitated in a manner that acknowledges and respects the lived experiences of the client. Standards 1–4 of The Standards of Practice for Professional Geriatric Care Managers provide an excellent framework for working with LGBT clients:

Standard 1
Who is the Client?

“While the primary client usually is the older person whose care needs have instigated the referral to a professional geriatric care manager, all other affected by his/her care needs should be considered part of the ‘client system’ (NAPGCM, p. 3).”

For many LGBT clients and their families, the intake process may present the first barrier to accessing geriatric care management services. A seemingly innocuous social history question—“Are you married, single, widowed, or divorced?”—may present a dilemma to the LGBT person regarding whether they should “come out” (disclose that they are LGBT) to the care manager. Fearing discrimination from healthcare providers, many LGBT individuals have become accustomed to hiding who they are (and who they love) from the professionals who provide their care. The intake process helps to set the tone for the relationship between the geriatric care manager and the LGBT person and their family. This process has the potential to either leave people feeling welcomed and comforted or alienated and disconnected. Imagine that you are Estelle, an 80-year-old woman with cancer who is currently looking for a geriatric care manager. Your partner of 50 years, Katherine, is the most important person in your life and you want to spend as much time as you can with her in the time you have left. The geriatric care manager comes to your house, introduces herself, sits down, and begins asking questions. The geriatric care manager is kind and compassionate and you and Katherine both like her instantly. When the geriatric care manager asks you, “are you married, single, widowed, or divorced,” you don’t know what to say. Do you say “single” because you’re not legally married even though you have been with Katherine for 50 years? Do you say “married” and simply hope that the geriatric care manager understands and doesn’t ask you for the name of your husband?

This barrier is a relatively simple one to remove. Geriatric care managers can easily modify the “marital status” intake question to include “partnered” as one of the choices so that the question is more inclusive of individuals in same-gender relationships (as well as individuals in different-gender, unmarried relationships). Once a client shares that they are in a same-gender relationship, it is important to convey, through words as well as actions, that the relationship is valued and honored the same as the relationship of a married heterosexual couple. For Estelle, her family is Katherine and she deserves the same support that any other spouse would receive from the geriatric care manager. It is important for geriatric care managers to remember that there is no “typical” LGBT patient and family. Not all LGBT persons have a partner—some are single, some are widowed, and some are divorced or separated from a same-gender partner. LGBT persons may have been married to a person of the other gender, and in some cases, LGBT persons may still be married to a person of the other gender. Some LGBT patients have children—either through birth or adoption—and some LGBT patients have grandchildren. Some LGBT patients are extremely close to both their family of choice and their family of origin, while others may not have had contact with their family of origin since they left home (or were “kicked out”) as a teenager. Transgender patients may be male or female, may be gay, lesbian, bisexual, or heterosexual, and may not disclose their status as a transgender person during the geriatric care management...
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intake process. When checking off the “gender” box on the intake form, don’t rely on a subjective visual assessment of the client to determine gender. One suggestion is to make it a habit to say to all clients, “I believe people have a right to define themselves, so I like to ask each of my new clients what gender pronoun they’d like me to use to refer to them. What pronoun would you like me to use with you?” As a geriatric care manager, you need to keep an open mind in assessing who the client is and identifying who is part of the client system.

Standard 2
Fostering Self-Determination

“To the greatest extent possible, professional geriatric care managers should foster self-determination on the part of the older person, to enable the person to live in accordance with his or her personal values and goals (NAPGCM, p. 3).”

When working with LGBT clients (as with all clients), it is vital that geriatric care managers ascertain who has decision-making authority in the event that the patient is no longer able to communicate their needs and wishes. This process may be more challenging in a same-gender relationship where there is no automatic legal authority given to the partner, as happens with heterosexual married couples. If there is an advance directive or other legal document which states that the partner is the authorized decision maker, than that directive must be honored by the geriatric care manager. The situation becomes more complicated if there is no advance directive or if members of the family of origin (biological family – i.e. parents, siblings, adult children, etc.) contest the advance directive. This can cause extremely difficult and painful conflicts between members of the family of origin and family of choice, especially in the case of families who have been estranged from the client due to their unwillingness to accept the client for whom they are but suddenly want to have decision-making rights when the patient is dying. Sadly, it is not uncommon for people to be denied access to the hospital room where their life partner lays dying because the family of origin bars them from visiting. It is extremely important that individuals in same-gender relationships are encouraged to complete advance directives and other legal and financial planning documents to ensure their wishes are honored and that the basic rights of the partner are not denied.

Standard 3
Right to Privacy

“The professional geriatric care manager should respect the older person’s and, when applicable, the client system’s right to privacy by protecting all information that is given in confidence and all information of a confidential nature. It should be made clear to the older person and the client system, the limits of confidentiality as appropriate (NAPGCM, p. 4).”

LGBT clients may be wary of trusting a geriatric care manager because of past experiences they have had with health care professionals and others who have broken confidentiality and violated their right to privacy. These fears are not irrational ones – on the contrary, many LGBT individuals have lost their jobs, their families, their insurance, their housing, and their financial security as a direct result of such breaches of trust. Unless a client has signed an authorization to release information, do not share information about the client with members of the client’s family of origin, friends, neighbors, or anyone else. Unfortunately, individuals may try to obtain information about an LGBT client’s medical status, relationship status, and financial affairs, despite the fact that the LGBT client does not want this information shared with them. It is the role of the geriatric care manager to ensure that the client’s privacy is respected and protected. Therefore it is important to ask the client to identify the
individuals who are authorized to have access to the client’s information.

**Standard 4**

**Personal Integrity of the Older Person and Professional Geriatric Care Manager**

“The professional geriatric care manager should act in a manner that insures his/her own integrity as well as the integrity of the client system” *(NAPGCM, p. 4).*

Standard 4 is a bit more complicated that the other standards in that its guidelines grant geriatric care managers permission to “refuse to accept a new case or continue in a case in which she/he is already involved if the professional geriatric care manager believes that remaining in the situation would require compromising his/her own values, beliefs, or standards (p. 5).” Personally and professionally, I find this wording concerning because it could easily be used as a justification for discrimination, and not just in regards to LGBT clients. If a geriatric care manager feels that working with African-American clients would compromise their standards and thus refuses to work with any African-American clients, would that be acceptable practice under Standard 4, or would that be discrimination? What about if a geriatric care manager was a devout Christian and decided that working with Jewish clients compromised their beliefs? Can geriatric care managers decide not to work with LGBT clients because of their own religious beliefs about homosexuality? What constitutes a “situation” that “require[s] compromising” one’s values, standards, or beliefs? I would argue that it is never acceptable for a geriatric care manager to refuse to accept a new client or continue working with an existing client based on the client’s race/ethnicity, religion, gender identity/gender expression, sexual orientation, socioeconomic status, housing status, employment status, immigration status, or any other factor comprising an individual’s identity or history. When I teach nurses, doctors, and social workers, the message I give all of them is the same I give to geriatric care managers—you will have clients who believe different things than you do, look differently than you do, live different lives than you do, act differently than you do, and your role is not to judge them. Your role is to provide the best quality care and services to them, and if at any point you feel uncomfortable enough with a particular “type” of client that you are contemplating terminating services with them, you need to do two things immediately—(1) talk to a supervisor about what you are thinking and feeling, and (2) talk to a social worker or counselor to help you work through whatever issues you have with that particular “type” of client. Professional geriatric care managers should be able to work with clients whose beliefs, values, and standards differ from their own without worrying about their own values being compromised.

**Strategies for Increasing Inclusiveness**

There are many simple things that can be done to increase inclusiveness in work as a geriatric care manager:

- Change intake forms to be inclusive of same-gender relationships or partnered status.
- Determine who has the legal authority to make decisions in the event that the client can no longer do so.
- Ask the client to define his/her family of choice and family of origin and encourage him/her to identify any potential conflicts of which the geriatric care manager should be aware.
- Encourage the client to complete advance care planning, legal (will), and financial paperwork.
- Recognize the potential psychosocial issues related to families of origin and families of choice.
- Consider any medical issues related to transgender clients (i.e., female-to-male clients still need to be screened for breast cancer, male-to-female patients may still need to be screened for prostate cancer).

In working with LGBT individuals who have recently experienced the death of a partner:

- Support the partner, especially in the event that the death of his/her loved one isn’t acknowledged by the community as being a loss equal to the loss of a heterosexual spouse.
- Help the partner to express grief, especially if he/she is not “out” at work or in the community, as there may not be public acknowledgement of the loss.
- Advocate for the partner if his/her workplace does not have bereavement leave for unmarried partners.

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In training your staff:

• Teach staff about the unique needs of LGBT people at the end of life.
• Allow staff the opportunity to express their misgivings or fears about caring for a LGBT person.
• Reinforce with staff that it is their job to respect each and every patient and family and provide the highest quality care possible, regardless of how they feel about the patient’s sexual orientation or gender identity/expression.

Reaching Out to Your Community

Many LGBT individuals die without ever engaging the services of a geriatric care manager because of the fear of being rejected or disrespected. Since geriatric care management includes the family as the unit of care, geriatric care management may be intimidating for a LGBT person. As with any community that is underserved, it is important that geriatric care managers take steps to communicate support for the LGBT community. Agencies can staff a booth at the annual gay pride festival or place an advertisement in the local gay newspaper. Support for the LGBT community can be demonstrated by providing partner healthcare benefits and promoting a supportive work environment. Welcoming diversity begins with support for a diverse workforce. By caring for their own staff, geriatric care managers will communicate to the community that they are a welcoming organization open to meeting the unique needs of the people you serve.

Everyone deserves high-quality geriatric care management, yet many LGBT persons don’t receive it. You can open doors and build bridges to ensure that everyone in your community receives the care and services that meet their unique needs. If you do not provide geriatric care management services for LGBT individuals in your community, who will?

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