LGBTQ+

Older Adult Survey Report

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AS A SENIOR RETIRED PERSON, I'M STILL VERY MUCH "IN THE CLOSET." I WISH THINGS COULD BE DIFFERENT AND THAT I COULD HAVE A RELATIONSHIP WITH A MAN."

– Oregon LGBTQ+ Older Adult Survey participant

ACKNOWLEDGEMENTS

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Finally, we want to extend our deepest gratitude to the lesbian, gay, bisexual, transgender, queer, and Two Spirit older adults who shared their experiences and who so respectfully and selflessly participated in the project. Our goal is that this project will lead to greater visibility and increased access to needed services for this community. We offer our sincerest thanks to all who made this project possible through their time and many contributions.

Sincerely,

Karen Fredriksen Goldsen, PhD
Director, Oregon LGBTQ+ Project
Director, Goldsen Institute
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EXECUTIVE SUMMARY

The state of Oregon is experiencing steady growth among the older adult population, with increasing diversity by race and ethnicity, as well as by sexual orientation, gender identity, and gender expression.[1] Yet to date, LGBTQ+ older adults remain a largely invisible population, with little knowledge of their unique challenges, needs and resources. The Oregon Department of Human Services's (ODHS) State Plan on Aging recognizes the importance of improving outreach and developing and supporting services and programs to promote the well-being of disadvantaged populations.[2] This study was commissioned by the ODHS Office of Aging and People with Disabilities and conducted in collaboration with community-based agencies to examine statewide Oregon Behavioral Risk Factor Surveillance System (OR-BRFSS) data and to administer a community-based survey to understand the risks, needs and strengths of demographically diverse LGBTQ+ Oregonians aged 55 and older, including those not represented in previous studies.

KEY FINDINGS

Based on estimates from the OR-BRFSS, approximately 3.4% of Oregonians aged 55 and older identify as lesbian, gay, or bisexual (LGB) which includes 3.2% of women and 3.8% of men. This is higher than the national estimate of 1.3% – 2% for this age group.[3] The findings presented here are for LGB populations only since the sample size of transgender older adults in OR-BRFSS is too small for data analysis. LGB older adults in Oregon are a demographically diverse population, and compared to their heterosexual counterparts are more likely to be:

- Younger (65.7 vs. 67.4 years old)
- People of color (10.7% vs. 8.1%)
- Living at or below 200% of the Federal Poverty Level (FPL; 42.5% vs. 36.6%), despite higher levels of education and comparable employment rates, which is likely due, at least in part, to lack of economic opportunities and discrimination they have faced
- Less likely married/partnered (48.3% vs. 62.2%)
- More likely to live alone (36.9% vs. 28.5%)
- Health disparate, experiencing heightened risk of poor physical and mental health, disabilities, and comorbidities
- More likely to experience financial barriers to medical care (10.5% vs. 7.2%)

Access to Services

Based on the community survey, which was completed by 1,402 demographically diverse LGBTQ+ adults aged 55 and older, we found that the services and programs needed most are:

• Medical and health services
• Social support programs
• Mental health/substance use treatments
• Food assistance
• Medication assistance
• Transportation

More than half of the survey participants have service needs that are not met. The most common challenges they experience in accessing services include:

• Difficulty in applying or fear of not meeting qualifications
• High costs
• Services experienced or perceived as not being LGBTQ+ inclusive
• Lack of availability and difficulty locating and accessing services

Unmet legal planning needs are particularly high among those with lower incomes and Hispanic, Black/African American, Asian and Pacific Islander, and Native American/Alaska Native participants. Most do not have last wills, testaments, or powers of attorney for health care and have not completed documents for end-of-life care planning.

Adverse Experiences

Nearly 60% of Oregon's LGBTQ+ older adult participants have experienced discrimination within the last year. Most experienced discrimination due to the perception of the following:

• Sexual orientation or gender identity or expression (56%), age (42%), and gender (30%)
• Risks of discrimination are notably high among Black/African Americans (91%), Asian and Pacific Islanders (94%), and Native American/Alaska Natives (86%)

More than one in five (21%) participants do not disclose their sexual or gender identity to healthcare, aging, or other service providers. The American Medical Association has stated that healthcare providers' failure to ask, and healthcare consumers' failure to disclose, can have adverse health consequences.[4]

Nearly a quarter (24%) of LGBTQ+ older adult participants have experienced elder abuse in the past year. More than three-quarters (76%) did not report the experience to the authorities.

The most common barriers to reporting abuse are:

- Distrust of authorities' fair treatment of LGBTQ+ people (26%)
- Feeling ashamed because of the experience (20%)
- Lack of knowledge on how to report (16%)
- Fear of having to disclose their identity (16%)

Oregon has the 9th highest rate of suicide mortality in the nation.[5] More than a fifth (21%) of the LGBTQ+ older adult participants have experienced suicidal ideation in the past year, which is significantly higher than in the general population.[6] Those at greatest elevated risk of suicidal ideation are:

- Black/African Americans, Asian and Pacific Islanders, Native American/Alaska Natives
- Those aged 55-64, those with lower incomes, those living in frontier areas, and gay men

Transgender, queer, and sexually diverse participants and those living with HIV are at heightened risk of poor general health. LGBTQ+ older adult participants reported high rates of smoking and excessive drinking, especially among gay men, those aged 55-64, those with lower income, Black/African Americans, Asian and Pacific Islanders, Native American/Alaska Natives, and those living in urban areas.

Economic and Housing Stability

One-third of LGBTQ+ older adult participants have difficulty paying bills or buying nutritious meals due to financial instability, with elevated risks among those who are younger, people of color, those living with HIV, and those living in frontier areas.

Economic concerns and social exclusion impact LGBTQ+ older adults' ability to live in safe and supportive environments,[7,8] significantly increasing the risk for social isolation and its negative health and mental health consequences.[9]

Nearly two-thirds (64%) of participants are not confident that they will be able to continue living in their current housing. The most frequently reported reasons include:

- Concerns about their health (38%)
- Risk of foreclosure or eviction (36%)
- Aging related needs (29%)
- Unsafe housing or environment (11%); rising crime rate in their current neighborhood (9%)
- Desire to move with family or friends (11%)

Housing instability is more likely among gay men; those younger; those who earn lower incomes; those residing in urban areas; and Black/African Americans, Asian and Pacific Islanders, and Native American/Alaska Natives.

Impacts of COVID-19

COVID-19 has disproportionately impacted marginalized communities across the U.S.

• Many LGBTQ+ older adult participants adapt well and demonstrate resilience in the face of the pandemic; almost all (95%) received a vaccine, and more than half (52%) learned how to use a new technology device.

• More than 25% of LGBTQ+ older adult participants know someone who has died of COVID-19.
• The vast majority are worried about their health, the health of family members, and losing social connections.
• Transgender adults, Hispanics, Native American/Alaska Natives, and those in frontier areas are most likely to report concerns about losing social connections.
• Since the COVID-19 pandemic, participants report decrease in use of many needed services, including social support programs (45%) and adult day programs (41%).

Social Resources and Resilience

LGBTQ+ older adult participants demonstrate a unique ability to "bounce back."

• More than 70% of LGBTQ+ older adult participants have three or more people they can count on for social and emotional support.
• More than 40% attend faith, spiritual, or religious services.
• The majority are actively engaged in LGBTQ+ communities through helping others (79%); receiving help (62%); and being involved in advocacy activities (60%).
• A high level of resilience exists among LGBTQ+ participants, with those aged 75 and older reporting the highest resilience.
• Despite close relationships and communities, nearly 20% report lack of social support, which is highest among Black/African Americans (27%), Asian and Pacific Islanders (23%), and Native American/Alaska Natives (24%).
• Lack of high-speed internet access and the need for technical assistance is greater among participants with lower incomes and Black/African Americans, Asian and Pacific Islanders, and Native American/Alaska Natives.

CONCLUSION: LEAVE NO ONE BEHIND

LGBTQ+ older adults in Oregon are an underserved yet resilient population. These study results shed new light on the diversity and cumulative risks facing this aging population. A comprehensive approach is paramount to transforming public policies, services, education, and research to address the growing population of LGBTQ+ older adults.

Moving forward, it will be critical to further extend the initial work and advocacy of LGBTQ+ organizations to promote partnerships between these communities, aging agencies, and state and local policy makers to develop a comprehensive approach to addressing aging and health needs of LGBTQ+ older adults. This survey has set a standard for state agencies to listen to the voices of experience in the community and to work together to identify challenges and strengths in order to develop impactful strategies, programs, services, and resources to meet those needs. As these partnerships are developed, it is critical that they represent the diversity of these communities, both by demographic and background characteristics as well as by geographic regions. As illustrated in the findings in this report, there are elevated needs across these communities as well as pockets of risk within specific subpopulations that need to be addressed, including by sexual orientation and identity, gender, gender identity and expression, race/ethnicity, age, HIV status, geographic region, and socioeconomic status.

To reduce and prevent social isolation it is also imperative to target services to LGBTQ+ older adults living alone without adequate services or support. In addition, technology support is necessary to provide virtual access and devices to reduce social isolation, support connectivity, and ensure that no one is left behind as more services and supports are offered remotely.

It will be crucial to identify culturally inclusive programs, services, and policies that have been successful in meeting the needs of LGBTQ+ older adults in other areas across the nation. Leveraging such lessons learned will help support the development of models and programs that can be implemented in urban, rural, and frontier communities in Oregon where LGBTQ+ inclusive services are needed. Many participants, for example, report feeling unwelcome and unsafe in accessing aging, health, and human services, and many have experienced overt discrimination and bias within the last year. To reduce such barriers to care, cultural inclusivity training for aging, healthcare, and human service providers and legal professionals is vital. It will also be important to replicate and administer the survey over time to monitor changes and evaluate progress in reducing aging, health, economic, and social disparities.

It is critical to prioritize the needs of older adults in LGBTQ+ organizations and communities and to participate in local, state, and federal planning processes to secure resources for much-needed service development, including housing, transportation, and support programs. It is fundamental that policymakers and key stakeholders initiate and support programs policies and research initiatives to better address the needs of underserved LGBTQ+ older adults and their families.

INTRODUCTION

Oregon is a growing and thriving state with a total population of 4,289,439 in 2021.[10] As the 27th most populous state in the U.S.,[10] Oregonians are proud of their natural resources and conservation efforts. The state enjoys stunning natural wonders, including more than 300 miles of coastline as well as the Cascade mountains, and has continually been rated in the top 10 most energy efficient states in the nation by the American Council for an Energy Efficient Economy.[11]

Natural beauty, the lack of a state sales tax, and a growing economy all contribute to the continued population growth in Oregon. According to Oregon state level estimates, the population of Oregon is expected to reach 5.5 million by 2050, a notable increase from 4.2 million.[12] According to Oregon's State Department of Administrative Services, 77% of the population growth has been due to net in-migration. In general, higher population growth is associated with a healthy economy, characterized by high employment and overall economic prosperity.[1]

The ongoing growth of Oregon's population plays an important role in the expanding diversity among Oregon's residents. The state of Oregon is becoming increasingly diverse, by age, race, and ethnicity as well as by sexual orientation and gender identity and expression. According to the most recent Oregon State Plan on Aging,[2] approximately 987,650 state residents are 60 years and older. While the growth in this population continues, there are changes in the trends of growth among older Oregonians. According to Population Research Center,[13] the growth rate of the population aged 55-64 decreased from 1.6% between 2016-2017, to 1.5% for 2017-2018, and then to 0.7% in 2018-2019. The growth rate of the population aged 65 and older decreased from 4.2% between 2016-2017, to 3.5% in 2017-2018, and remained at approximately 3.5% during 2018-2019. While the rates of growth for these population segments are slowing, the overall growth in the older population continues to climb. For the 55-64 age group, the growth rate was 534,102 (13.1%) in 2016 and 554,909 (also 13.1%) in 2019. Among those 65 and older, it was 685,119 (16.6%) in 2016 and 765,541 (18.2%) in 2019. An important factor in the growth of Oregon's older population is the recognition of its diversity. The current state plan on aging specifically calls for a way to improve outreach to older adults of color, tribal elders, older adults with disabilities, and LGBTQ+ older adults.[2]

Due in part to in-migration, Oregon continues to become increasingly diverse with regards to the racial and ethnic make-up of the state. In 2018, 75.3% of Oregonians identified as White, with the largest racial and ethnic minority group being Hispanic, at 13.3%. This is an increase from 2.5% in 1980 and 8.0% in the year 2000. Hispanic population growth has been outpacing growth in all other racial groups. Since the year 2000, the Hispanic population has doubled. Of the non-White and non-Hispanic racial groups, the Asian and Pacific Islander group is the larg-

est in Oregon, comprising 5.1% of the population. Black/African Americans make up approximately 2% of the state population, while Native American/Alaska Natives make up 1.1%. People who identify as multiracial (two or more races) account for 3.3% of the population. People of color in Oregon tend to be younger and the majority identify as Hispanic or mixed race.[1]

Along with Oregon's increasing diversity by age and race/ethnicity, it is becoming increasingly heterogenous with regards to sexual orientation and gender identity and expression. Oregon has the highest LGBTQ+ population proportion of any state after the District of Columbia.[14] The Oregon State Plan on Aging acknowledges the importance of recognizing the needs of LGBTQ+ older adults and improving outreach to this population.[2] Yet at this time, empirical data on LGBTQ+ older adults living in Oregon is extremely limited. In order to improve our understanding of their aging and health needs, the Oregon LGBTQ+ Older Adult Survey was created and designed to meet the following goals: 1) assess health disparities among LGBTQ+ adults aged 55 and older in Oregon, utilizing the Oregon BRFSS data; and 2) using community-based survey data, examine the key health, economic and social indicators, aging and health service needs, and the resilience, strengths, and challenges facing these communities to identify their needs and those at greatest risk.

The results of this pioneering survey of older LGBTQ+ adults in Oregon will provide critical information needed to address the needs of this growing population. The empirical data from this report will provide support for new and existing programs, policy development and implementation, and will assist Oregon's governmental and private sector officials as well as LGBTQ+ organizations, community members, and other stakeholders in serving an increasingly diverse population that includes the needs of LGBTQ+ older adults.

HEALTH DISPARITIES REVEALED

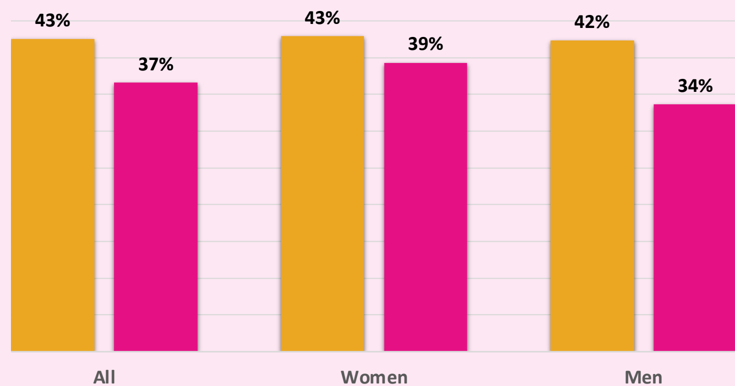
Lesbian, gay, bisexual, transgender, queer/questioning, and other sexual and gender diverse (LGBTQ+) populations in the United States are growing in both diversity and size.[3] To understand this growth and to assess key health and social indicators, we analyzed data from the Oregon Behavioral Risk Factor Surveillance System (OR-BRFSS). The OR-BRFSS is a population-based, random-digit dialed phone survey of Oregonians aged 18 and older; as such, the findings presented in the report are generalizable and representative of the state's population. Despite the OR-BRFSS being one of the earliest population-based health surveys to include a self-report sexual orientation measure, and the recent addition of gender identity measure, the sample size of transgender adults is not sufficient to compute meaningful estimates. For this report we compared lesbian, gay, and bisexual (LGB) Oregonians aged 55 and older with their heterosexual peers. We found key differences in demographic, social, economic, and health characteristics that have important implications for aging and health in Oregon's LGB communities.

Age and gender. Based on the OR-BRFSS, we estimate that 3.4% of Oregonians aged 55 and older self-identify as lesbian, gay, or bisexual, including 3.2% of women and 3.8% of men. Overall, LGB individuals are on average younger than their heterosexual age peers (65.7 vs. 67.4 years old) and more likely to be people of color (10.7% vs. 8.1%). Lesbian and bisexual women tend to be younger than heterosexual women (64.8 vs. 67.9 years old), whereas gay and bisexual men are more likely to be people of color than heterosexual men (14.3% vs. 9.0%).

Economic characteristics. LGB older Oregonians have higher rates of a completed college education when compared to their heterosexual age peers (71.8% vs. 67.2%) yet are more likely to live at or below 200% of the federal poverty level (FPL)[25] (42.5% vs. 36.6%), despite comparable rates of employment (32.2% for both groups). Lesbian and bisexual women are more like-

Rates of Poverty by Sexual Orientation, Adults 55 and Older (OR-BRFSS)

LGB   Heterosexual



ly than heterosexual women to have a college education (74.5% vs. 66.3%), with no significant differences in employment or annual household income. Gay and bisexual men are more likely to live at or below 200% of the FPL than heterosexual men (42.3% vs. 33.6%). There are also no differences in their completion of a college education or their rates of employment.

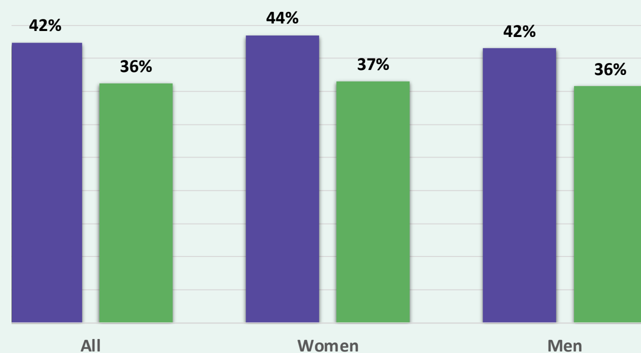
Social characteristics. Overall, LGB older Oregonians are less likely to be married or partnered (48.3% vs. 62.2%), and more likely to live alone (36.9% vs. 28.5%) than their heterosexual peers. We find no difference in the number of children under the age of 18 in LGB and heterosexual households (1 child for every 10 households). We find no differences in relationship status, living arrangement, or number of children among LGB and heterosexual women. However, gay and bisexual men are less likely to be married or partnered (45.0% vs. 68.5%), more likely to live alone (41.4% vs. 24.8%) and have fewer children than heterosexual men (0.08 vs. 0.13).

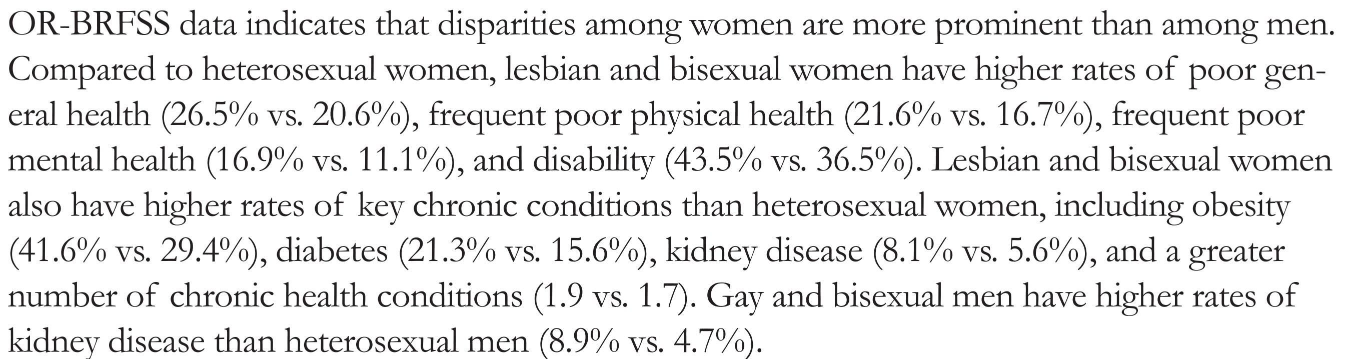
Health outcomes. The National Institutes of Health[15] have formally designated sexual and gender minorities (i.e., LGBTQ+) as health disparate populations. Analyzing data from the OR-BRFSS, we found significant disparities in several domains of physical and mental health among LGB older Oregonians.

LGB older adults are at elevated risk for poor health outcomes, compared to their heterosexual age peers. LGB adults report significantly higher rates of poor general health (24.8% vs. 21.4%), frequent poor mental health (13.8% vs. 9.7%), disability (42.4% vs. 36.2%), and key chronic conditions, including obesity (35.7% vs. 30.1%), diabetes (22.3% vs. 17.5%), asthma (17.6% vs. 14.5%), and kidney disease (8.5% vs. 5.2%). LGB older adults also indicate a greater number of chronic conditions than their heterosexual peers (1.8 vs. 1.7).

Rates of Disability by Sexual Orientation, Adults 55 and Older (OR-BRFSS)

LGB Heterosexual





OR-BRFSS data indicates that disparities among women are more prominent than among men. Compared to heterosexual women, lesbian and bisexual women have higher rates of poor general health (26.5% vs. 20.6%), frequent poor physical health (21.6% vs. 16.7%), frequent poor mental health (16.9% vs. 11.1%), and disability (43.5% vs. 36.5%). Lesbian and bisexual women also have higher rates of key chronic conditions than heterosexual women, including obesity (41.6% vs. 29.4%), diabetes (21.3% vs. 15.6%), kidney disease (8.1% vs. 5.6%), and a greater number of chronic health conditions (1.9 vs. 1.7). Gay and bisexual men have higher rates of kidney disease than heterosexual men (8.9% vs. 4.7%).

Health behaviors. The OR-BRFSS data shows few differences between LGB and heterosexual older adults' health behaviors. For example, both groups have comparable rates of cigarette smoking (12.6%), binge drinking (10.1%), and using e-cigarettes (24.8%). LGB older Oregonians do report higher rates of cannabis use than their heterosexual counterparts (16.7% vs. 9.2%), particularly among women (23.2% vs. 7.9%). Gay and bisexual men are more likely to engage in physical exercise than heterosexual men (31.8% vs. 21.2%).

Health care access and preventive care. LGB older adults in Oregon are more likely to experience financial barriers to medical care than heterosexual older adults (10.5% vs. 7.2%). However, they do not differ in the other access indicators, such as health care coverage (95.2%) or having a personal primary care provider (91.4%). Considering preventive care, LGB older adults are more likely to have received HIV tests in their lifetimes, as compared to their heterosexual peers (47.0% vs. 20.4%). We did not identify a significant difference in rates of past-year flu vaccination (47.7%), colorectal screening within the past two years (47.1%), or women receiving a mammogram within the last two years (75.0%). Older gay and bisexual men get annual routine checkups at higher rates than heterosexual men (81.2% vs. 75.3%).

Moving forward. These analyses of OR-BRFSS data illustrate that LGB older adults in Oregon are a resilient yet at-risk population who are experiencing significant economic, social, and health disparities based on population level data. To better understand the risk and protective factors that influence the aging and health of LGBTQ+ older adults and their needs, we reached out to Oregonian LGBTQ+ adults aged 55 and older via community-based agencies and social media to conduct a statewide community survey to better understand the specific factors facing these communities. While most previous aging-related research has often collapsed LGBTQ+ older adults under a single umbrella, our Oregon LGBTQ+ Older Adult Survey gathered important information from 1,402 LGBTQ+ older adults. This large number of socio-demographically diverse participants enables us to provide an in-depth examination of the health and life experiences, and unique challenges and strengths by subgroups within Oregon's LGBTQ+ communities.

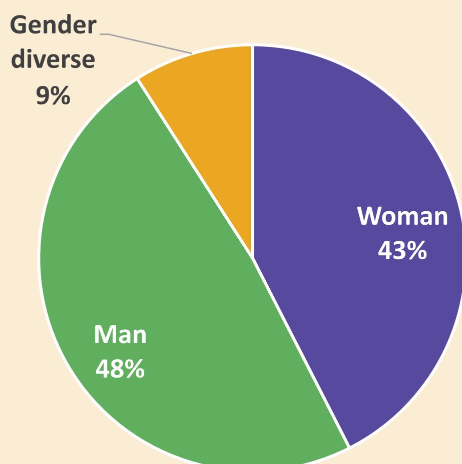
WHO PARTICIPATED?

The LGBTQ+ communities in Oregon state are significantly diverse by sexual orientation, gender identity and expression, age, race and ethnicity, income, education, and geographic location. This study illustrates this diversity, as seen in the demographically diverse sample secured by this project. The 1,402 participants aged 55 and older represent one of the most demographically diverse samples of sexual and gender minority older adults to date. A foundational goal of this project was to understand the needs across these diverse communities, including those in hard-to-reach communities that are traditionally not included in population-based or other previous studies. Therefore, the community-based sample was not designed to generalize, but rather to ensure that we reach those that are often most invisible within these demographically diverse communities.

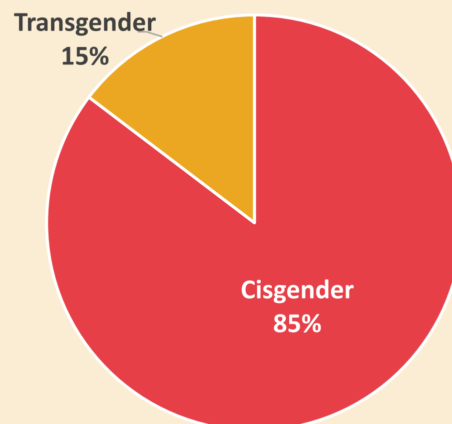
Age. The mean age of this study's participants is 64 years old (SD = 6.9). Nearly two-thirds of participants (63%) are between 55 to 64 years of age, 29% are age 65 to 74, and 9% are age 75 and older.

Sexual orientation. Close to a third (32%) of the 1,402 older LGBTQ+ Oregonians who participated in our study self-identify as lesbian, 44% identify as gay men, 8% as bisexual (6% bisexual women vs. 2% bisexual men), and 16% as queer or sexually diverse. Additionally, 1% identify as Two Spirit, the historical indigenous construction of sexuality and gender as non-binary and co-existing within the same human body.[16]

Gender of LGBTQ+ Participants



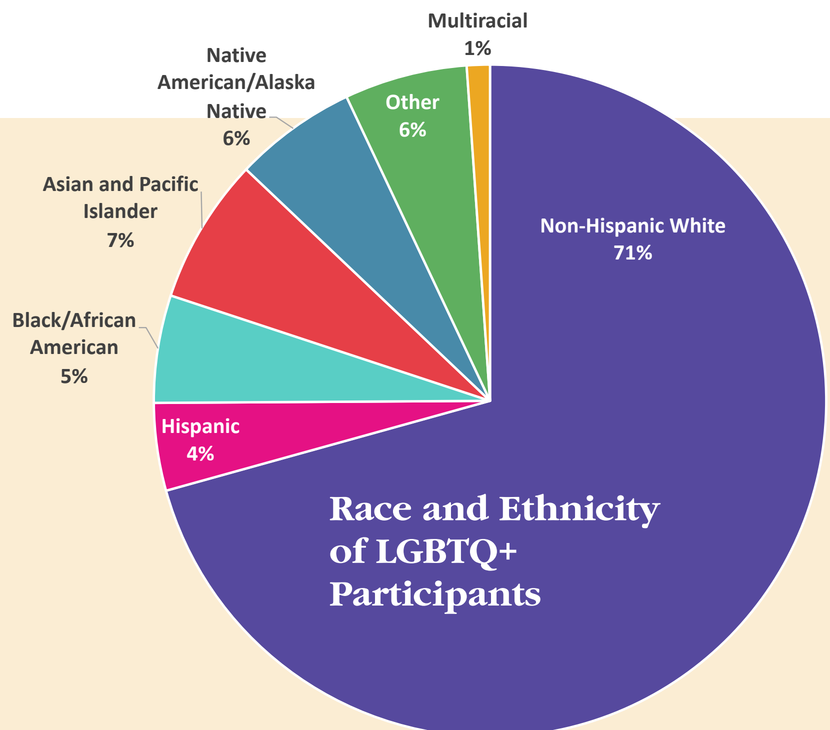
Gender Identity of LGBTQ+ Participants



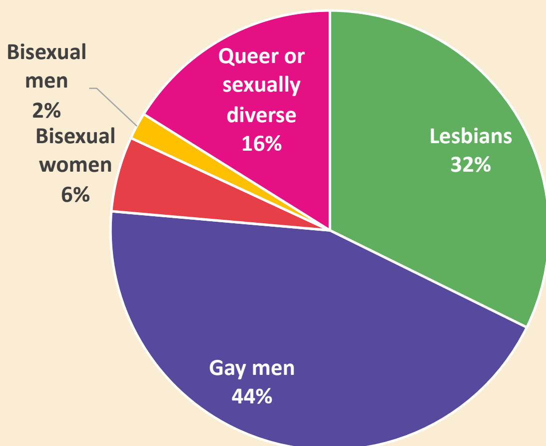
Gender and gender identity and expression. About 43% of LGBTQ+ participants identify as women, 48% as men, and 9% as gender non-conforming, gender non-binary, or gender diverse. About 15% of participants identify as transgender. Among older transgender Oregonians, 29% identify as women, 9% as men, and 62% as gender non-conforming, gender non-binary, or gender diverse.

Race and ethnicity. Participants are more diverse by race and ethnicity than in most previous LGBTQ+ surveys,[17] with 29% of LGBTQ+ participants identifying as people of color. Among LGBTQ+ participants of color, 4% identify as Hispanic, 5% as Black or African American, 7% as Asian or Pacific Islander, 6% as Native American (including American Indian/Alaskan Native), 6% as other, and 1% as two or more races. Seventy-one (71%) identified as non-Hispanic White.

National origin and language. Although few studies of LGBTQ+ aging, health, and wellness collect information on nativity or language,[18] three percent of the participants in this study report being born outside of the United States or U.S. Territories. More than a quarter (26%) of participants speak a language other than English with their families, and 7% speak a language other than English with their friends.



Sexual Orientation of LGBTQ+ Participants



IT IS IMPORTANT TO HELP OREGONIANS FEEL WELCOMED AND SAFE IN COMMUNITIES THAT CAN MEET THEIR INCREASING CARE NEEDS."

Income and poverty. Taking both household income and size into account, over 36% of participants have incomes at or below 200% of the federal poverty level (FPL).[30] Nearly one in five (18%) of participants report having an annual household income of $20,000 or less, 33% between $20,001 and $50,000, and 25% between $50,001 and $80,000. Twenty-five percent (25%) report an income greater than $80,000 per year.

Education. Despite high levels of poverty, the participants were relatively well educated, which is similar to national trends of education. More than half of participants (53%) have at least a 4-year college degree, 28% have attended some college, 11% have a high school degree, and 8% have less than a high school education.

Employment. More than four out of ten participants (44%) currently have paid employment. For those aged 65 and older, nearly three quarters (71%) of participants are retired; about a fifth (22%) are employed or self-employed; 2% are out of work; 4% are unable to work; 1% are homemakers or students. For those aged 55-64, one-fifth (20%) are retired; about 58% are employed or self-employed; 13% are out of work; 8% are unable to work; 1% are homemakers or students.

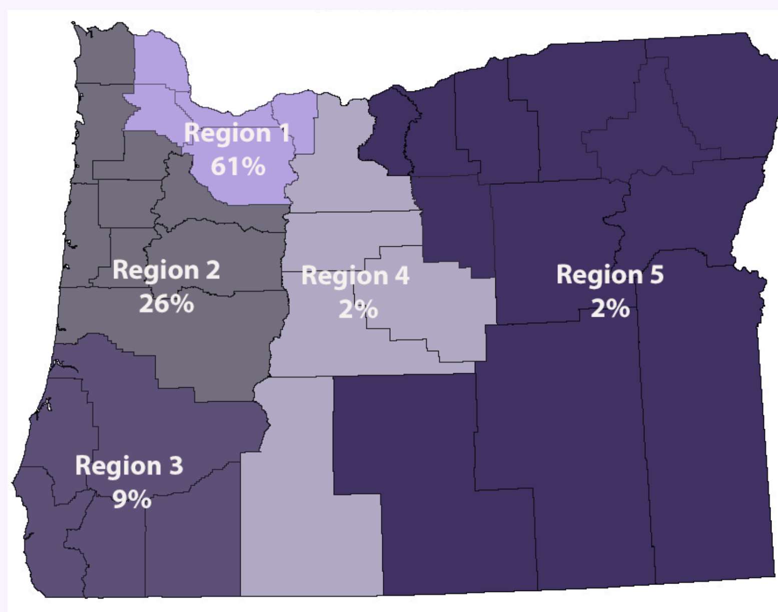
Marital and partnership status. About 59% of participants are currently married or partnered. Of those, 36% are legally married, 17% are partnered, and 6% are in registered domestic partnerships. Of the participants who are single (41%), 7% are divorced, 4% are widowed, 1% are separated, and 2% have never married or partnered.

Veteran status. More than one in ten (12%) participants have served in the military, including 11% of women, 13% of men, and 12% of gender diverse adults. Over one-fifth (22%) of transgender adults have served in the military.

Region. The National Academies of Science, Engineering, and Medicine[20] have identified geography as a priority research area for better understanding LGBTQ+ health and well-being. The large majority of participants (82%) in this study live in urban areas, while 17% live in rural areas and 1% in frontier areas. Rural areas are defined as being at least ten miles from a population center of 40,000 or more people. Frontier areas are designated as having six or fewer people per square mile.[21] Geographic locations within which participants reside are grouped into five regions by county. Counties were grouped by taking into consideration human service agency boundaries and geographic, economic, and cultural similarities (see Key Terms for more information).

- Region 1 (61%): Columbia, Multnomah, Clackamas, and Washington
- Region 2 (26%): Clatsop, Tillamook, Yamhill, Polk, Marion, Lincoln, Benton, Linn, and Lane
- Region 3 (9%): Douglas, Coos, Curry, Josephine, and Jackson
- Region 4 (2%): Hood River, Wasco, Jefferson, Crook, Deschutes, and Klamath
- Region 5 (2%): Sherman, Gilliam, Morrow, Umatilla, Union, Wallowa, Wheeler, Grant, Baker, Lake, Harney, and Malheur

DISTRIBUTION OF LGBTQ+ PARTICIPANTS BY REGION



I AM SCARED OF RETIREMENT AND HOW I WILL SURVIVE IN TERMS OF HOUSING. THE LONG-TERM FACILITY I VISIT FEELS COMPLETELY HETERONORMATIVE AND CONSERVATIVE."

ACCESS TO AGING, HEALTH, AND OTHER SERVICES

KEY FINDINGS

- Over half of participants had unmet needs for at least one service, including aging, social, medical and health services, and/or social support services in the past year.
- Services with the highest rates of unmet needs include social support services, mental health/substance use treatments, information and referral services, adult day programs, medical and health services, and housing services.
- Common barriers to using services include difficulty in applying or potentially not qualifying, high cost, not being LGBTQ+ friendly, lack of availability, location or difficulty accessing services.
- The rate of overall unmet needs is highest among gay men, younger participants (aged 55-64), racial and ethnic minorities, and those living at or below 200% of the FPL.
- The pattern of service needs varies by region.

Access to quality aging, health, and other services and care is important to mitigate various life challenges, prevent adverse consequences, and promote well-being. Although services for older adults exist, many LGBTQ+ older adults have unique needs and may be fearful of mainstream services due to previous experiences and the risk of discrimination and prejudice.[17] In order to better understand the unique service needs of LGBTQ+ adults, we asked Oregonians aged 55 and older about their unmet needs and assessed what services are most needed and not used.

Priority service needs for the LGBTQ+ community. LGBTQ+ older adults are less likely to have some types of traditional support available to them, as they are less likely to have biological children compared to their straight peers. They are also more likely to be estranged from family-of-origin members and consequently may need more community support services.[17] Participants reported which services they needed most in the past 12 months. The most needed services for LGBTQ+ participants are medical and health services (67%), social support services (64%), mental health/substance use treatments (48%), food assistance (38%), transportation (35%), medication assistance (35%), and information and referral for seniors (34%).

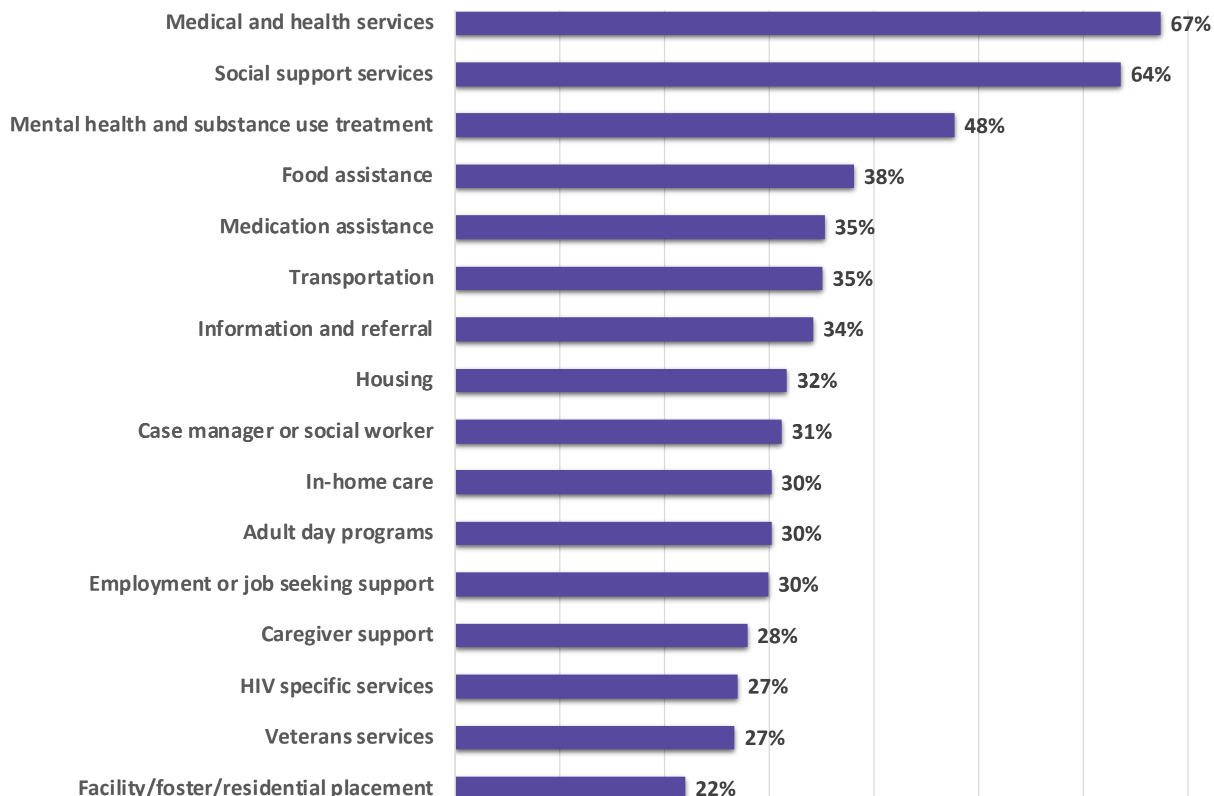
There is all too often a disconnect between needing services and actually being able to access them. About 54% of survey participants report having one or more unmet service needs. The services with the highest rates of unmet needs (i.e., needed but not used) are social support services (41%), mental health/substance use treatments (30%), information and referral services (28%), adult day programs (28%), medical and health services (27%), and housing services (27%). All other service areas also have about a quarter of participants reporting their needs having not been met. Common reasons for not using services include difficulty in applying or potentially not qualifying (46%), high costs (39%), services not being LGBTQ+ friendly (32%), lack of availability (29%), and location or difficulty accessing services (29%). The rate of overall unmet needs is the highest among gay men (70%), followed by queer and sexually diverse adults (54%), transgender adults (51%), bisexual women (46%), bisexual men (41%), and lesbians (36%).

THERE IS VERY LITTLE SUPPORT FOR TRANSGENDER WOMEN IN MY AGE RANGE. I BELIEVE THIS KEEPS TRANSWOMEN AND TRANSMEN, SUCH AS MYSELF, FROM COMING OUT AND SEEKING THE CARE WE OFTEN DESPERATELY NEED."

I AM CONFIDENT IN USING TECHNOLOGY, WHAT I LACK IS SECURE AND RELIABLE HIGH-SPEED INTERNET. I WAS REFUSED A TELEHEALTH APPOINTMENT BECAUSE MY WI-FI IS NOT SECURE.”

Comfortability of service use as a LGBTQ+ adult. Self-disclosure can provide opportunities for community and social support, can be a positive protective factor for mental health,[22] and can assist in accessing appropriate health care.[23] As such, it is important for LGBTQ+ adults to be comfortable being “out” in service environments, which can be a challenge for many services and programs. Even well intentioned providers may fail to recognize and address historic and current barriers to accessing services,[24] which can be a major barrier for older LGBTQ+ adults.[25] The services with the highest discomfort rate include residential facilities and placement services (29%) and case management or other social work services (28%), followed by transportation (25%), employment or job seeking support (24%), adult day programs (21%), caregiver

Rates of Service Needs Among LGBTQ+ Participants



support (21%), veterans services (20%), food assistance (19%), housing (19%), social support (16%), and information and referral for older adults (16%). When all services are considered, the average level of discomfort is 1.5 on a scale of 1 (= very comfortable) to 4 (= very uncomfortable). The level of discomfort is highest among queer and sexually diverse adults (average = 1.8) and transgender adults (average = 1.8), followed by bisexual women (average = 1.6), lesbians (average = 1.5), and gay men and bisexual men (average = 1.4).

End-of-life plans. LGBTQ+ older adults are less likely to have children to help care for them, and many LGBTQ+ caregivers and care receivers are not related by blood or marriage.[26] This means that caregivers often have limited legal power, unless they are designated as a health care proxy.[27] Thus, end-of-life plans are vital to ensure that an individual's wishes are followed. About 68% of participants have at least one of the following end-of-life plans in place, including a will (42%), power of attorney for health care (42%), end-of-life care plan such as Portable Orders for Life-sustaining Treatment (29%), trusts (17%), and funeral plans (12%). More than a half of queer and sexually diverse adults (56%) and bisexual women (51%) do not have any of these end-of-life plans; 44% of transgender adults, 37% of bisexual men, 31% of lesbians, and 21% of gay men do not have any of the plans.

Health care coverage. Almost all participants (99%) have some form of health care coverage. About 43% of participants have Medicare; 19% Medicaid; 43% private or employer-sponsored insurance; 9% military health care plan; and 1% Indian Health Services.

Key differences between groups. Younger participants (55-64) have needed services at a higher rate than older participants, and the rates of their unmet service needs are also high. Approximately 65% of those aged 55-64, 40% of those aged 65-74, and 26% of those aged 75 and older have experienced unmet needs for one or more services. Overall, about 80% of LGBTQ+ participants aged 75 and older have some form of end-of-life plans, including a will (66%), power of attorney for health care (63%), end-of-life care plan (55%), funeral plans (36%), and trust (26%). However, the percentages decline with younger participants: 52%, 55%, 40%, 20%, and 17% for those aged 65-74, respectively; 34%, 34%, 21%, 6%, and 16% for those aged 55-64.

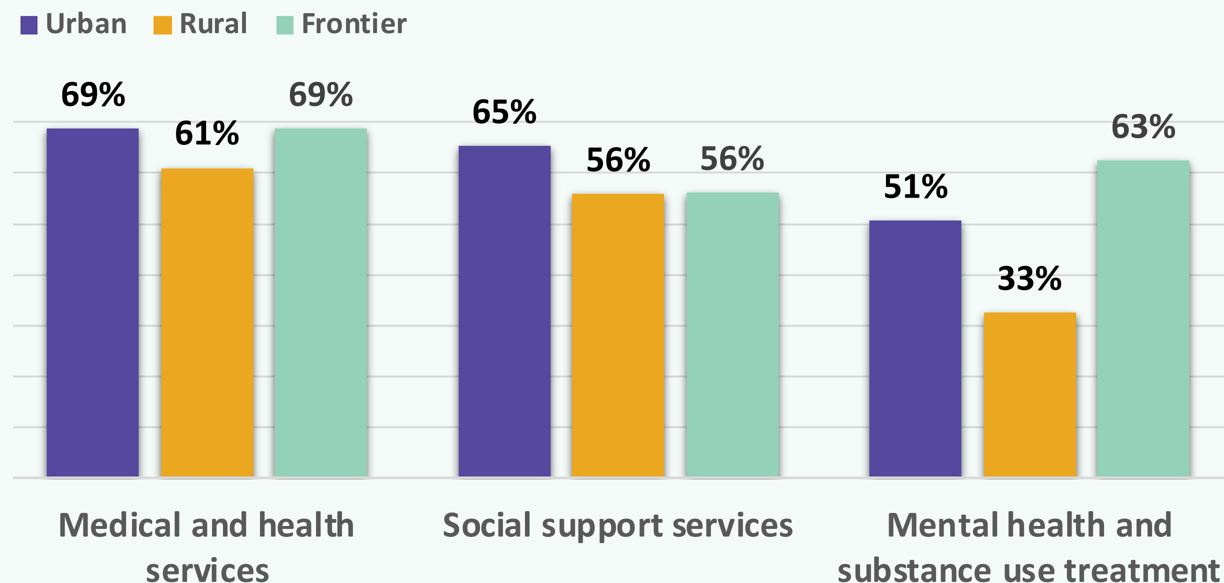
Racial and ethnic minority participants show higher rates of unmet needs for services. More

ACCESSING A MENTAL HEALTH THERAPIST DURING THE PANDEMIC HAS BEEN A MAJOR ONGOING DIFFICULTY.”

than nine in ten Asian and Pacific Islanders (92%) report having their service needs unmet, followed by 86% of Black/African Americans, 84% of Native American/Alaska Natives, 60% of Hispanics, and 44% of non-Hispanic Whites. Racial and ethnic minority participants are less likely to have end-of-life care plans. The rates of having a will and power of attorney for health care are 48% and 48%, respectively, for non-Hispanic Whites; 32% and 29% for Native American/Alaska Natives; 28% and 35% for Black/African Americans; 25% and 24% for Asian and Pacific Islanders; and 23% and 32% for Hispanics. Non-Hispanic Whites are most likely to have end-of-life care plans (33%), followed by Native American/Alaska Natives (27%), Asian and Pacific Islanders (22%), Hispanics (21%), and Black/African Americans (16%).

Living at or below 200% of the FPL is associated with higher rates of service needs, unmet service needs, and lower rates of end-of-life plans. The level of discomfort in using services as a LGBTQ+ person is higher for those living at or below 200% of the FPL.

The patterns of service needs appear to vary by region. The needs for social support programs, medication assistance, food assistance, and transportation for participants in urban areas are relatively higher than those in rural areas. The need for mental health services/substance use treatment is highest among those in frontier areas, followed by those in urban areas and rural areas. Rates of unmet service needs for participants in Region 1 and Region 2 are consistently higher than those in the other regions. For example, the rates of needs for medical and health



services and social support programs are 75% and 72% in Region 2, respectively; 66% and 63% in Region 1; 62% and 58% in Region 5; 58% and 45% in Region 3; and 50% and 57% in Region 4. The need for mental health services/substance use treatment is high for those in Region 5 (50%), Region 1 (47%), and Region 2 (58%), while 32% of those in Region 4 and 24% of those in Region 3 need the services. The level of discomfort in using services as a LGBTQ+ person is the highest for those in Region 4, followed by Region 5, Region 2, Region 3, and Region 1.

Provision of medical and other service needs for those living with HIV has increased dramatically over the last two decades. Funding for HIV services in the U.S. has increased from $10.7 billion in 1999 to $26.3 billion in 2017,[28] yet those living with HIV have many unmet needs. Participants living with HIV report a higher rate of need for medication assistance (53%) when compared to those living without HIV (34%), and almost all of them (96%) say that their needs have been met. Those with HIV are less likely to have a will (30%) than those living without HIV (43%).

HEALTH AND WELL-BEING

KEY FINDINGS

- The majority report that their quality of life and general health is good, while over a fifth of participants report that their quality of life and general health is poor.
- Higher rates of poor general health are reported by those living with HIV, those ≤ 200% FPL, and transgender adults.
- Over one out of five participants report past-year suicidal ideation, including half of Asian and Pacific Islanders.
- Nearly one in three participants report subjective cognitive impairment with higher rates found among all racial and ethnic minority groups.

Many LGBTQ+ older adults experience adverse events and conditions, including lifetime victimization, stigma, and barriers to healthcare that can lead to greater risk of poor physical and mental health outcomes.[29,30] As noted previously, evidence from the Oregon Behavioral Risk Factor Surveillance System (OR-BRFSS) shows that LGBTQ+ older Oregonians face disparities in key health outcomes relative to their heterosexual counterparts. By asking participants about their quality of life, physical health, mental health, cognitive health, and health behaviors, we can better understand how these overall health disparities may differ across sexual orientation, gender identity, race and ethnicity, and other background characteristics.

Quality of life and general health. Despite lifetimes of navigating stigma and adverse experiences, the majority of older LGBTQ+ participants rate their quality of life (80%) and general health (75%) as good. Nonetheless, about a quarter (25%) of participants report poor general health, including 25% of gay men, 23% of lesbians, 22% of bisexual men, and 17% of bisexual women. Transgender (34%) and queer and sexually diverse older adults (32%) report the highest rates of poor general health.

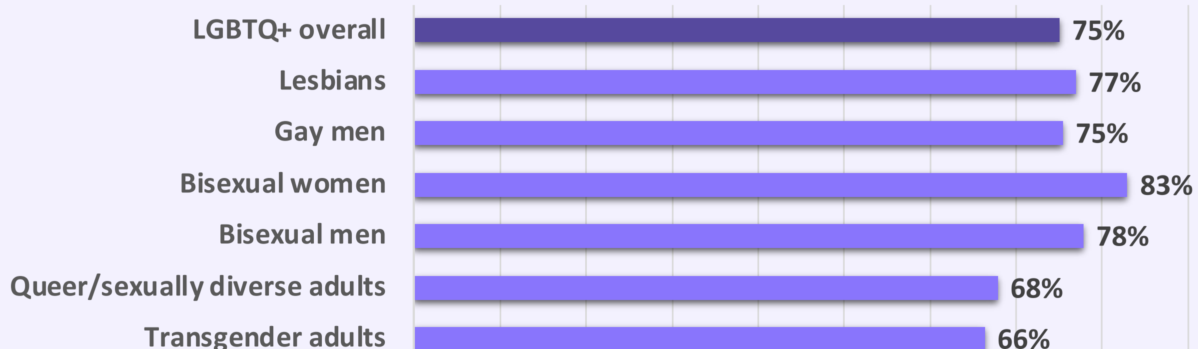
Physical health. About 12% of participants are at risk of frequent poor physical health (i.e., 15 ≥ days of poor physical health in past month[31]), with 15% at risk of frequent limited activities (i.e., 15 ≥ days of limited activities in past month[31]). The highest rates of frequent poor physical health and frequent limited activities are reported by older transgender adults (23% & 24%, respectively), bisexual women (20% & 25%), and queer and sexually diverse adults (18% & 24%). Overall, about 8% of participants report living with HIV, including 19% of bisexual men, 17% of gay men, and 4% of queer and sexually diverse adults.

I AM 78 AND INCREDIBLY FRUSTRATED. I EXPERIENCE FREQUENT COGNITIVE IMPAIRMENTS, CONFUSION, PHYSICAL DISCOMFORT, PAIN AND STRESS. I FEEL SOCIALLY ISOLATED AND I MISS THE ACTIVE LIFESTYLE I USED TO HAVE. I ALSO MISS SOCIAL INTERACTIONS I HAD FROM VOLUNTEERING WITH YOUTH PROGRAMS."

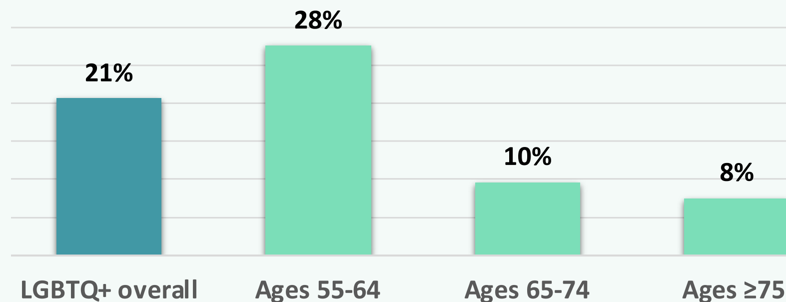
Mental health. Among all survey participants, about 13% report frequent poor mental health and 21% report past-year suicidal ideation. The risk of poor mental health is highest among transgender older adults (26%) and queer and sexually diverse adults (19%). Whereas gay men show the lowest risk of frequent poor mental health, they are at the highest risk of past-year suicidal ideation (29%). More than one in five bisexual women (21%) and transgender adults (21%) and 18% of queer and sexually diverse adults report having past-year suicidal ideation.

Cognitive health. Individuals experiencing subjective cognitive impairment have been shown to be at higher risk for developing neurocognitive disorders such as Alzheimer's disease.[32] Nearly one-third of survey participants (32%) report experiencing serious difficulty concentrating, remembering, or making decisions because of physical, mental, or emotional conditions. The rate of cognitive impairment is particularly high among bisexual women (41%), followed by queer and sexually diverse adults (37%), transgender adults (35%), gay men (33%), lesbians (26%), and bisexual men (19%).

Percentage of LGBTQ+ Participants with Good General Health



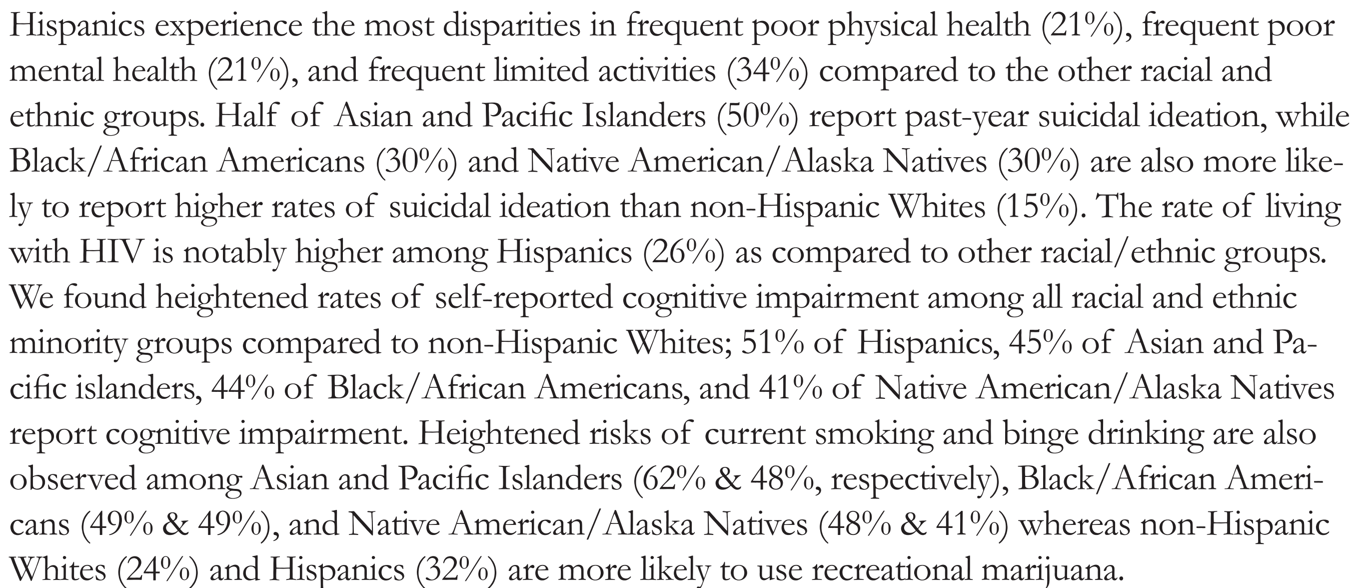
Rates of Suicidal Ideation in the Past Year by Age Group Among LGBTQ+ Participants



Health behaviors. More than one in five (21%) of survey participants smoke tobacco; 19% binge drink; and 21% engage in recreational marijuana use. Some LGBTQ+ subgroups appear to be at risk for specific adverse health behaviors. Gay men are most likely to report current smoking and binge drinking (37% & 33%, respectively).

Approximately 5% of LGBTQ+ participants report drug abuse, which was assessed by asking if, in the past 30 days, participants have used prescription drugs more than prescribed, have used drugs other than those required for medical reasons, or injected any drug other than those prescribed for them. The highest risk of drug abuse is observed among queer and sexually diverse adults (8%) and transgender adults (7%). These findings highlight the necessity of accessible, affordable, and culturally sensitive services for smoking cessation and alcohol and substance misuse, including environmental strategies.[33]

Key differences between groups. Similar to the bulk of health disparities research, we find that disparities in health vary across outcomes by age and other demographic factors among LGBTQ+ survey participants. Adults aged 75 and older endorse a higher rate of good quality of life (88%), are more likely to report frequent poor physical health (20%), and frequent limited activities (23%) as compared to those aged 55-64 (10% & 13%), and aged 65-74 (14% & 17%). Participants of the youngest age group (those aged 55-64), however, are more likely to report suicidal ideation (28%), cognitive impairment (37%), current smoking (30%), and binge drinking (26%) than older age groups. The rate of using recreational marijuana is the highest among those in the age 65-74 group (25%), followed by those aged 75 and older (22%) and aged 55-64 (19%). Of the LGBTQ+ older adult participants, Asian and Pacific Islanders (63%) and Black/African Americans (66%) show the lowest rates of good quality of life, while 75% of Native American/Alaska Natives, 77% of Hispanics, and 85% of non-Hispanic Whites report good quality of life.



Hispanics experience the most disparities in frequent poor physical health (21%), frequent poor mental health (21%), and frequent limited activities (34%) compared to the other racial and ethnic groups. Half of Asian and Pacific Islanders (50%) report past-year suicidal ideation, while Black/African Americans (30%) and Native American/Alaska Natives (30%) are also more likely to report higher rates of suicidal ideation than non-Hispanic Whites (15%). The rate of living with HIV is notably higher among Hispanics (26%) as compared to other racial/ethnic groups. We found heightened rates of self-reported cognitive impairment among all racial and ethnic minority groups compared to non-Hispanic Whites; 51% of Hispanics, 45% of Asian and Pacific islanders, 44% of Black/African Americans, and 41% of Native American/Alaska Natives report cognitive impairment. Heightened risks of current smoking and binge drinking are also observed among Asian and Pacific Islanders (62% & 48%, respectively), Black/African Americans (49% & 49%), and Native American/Alaska Natives (48% & 41%) whereas non-Hispanic Whites (24%) and Hispanics (32%) are more likely to use recreational marijuana.

Participants living at or below 200% of the FPL show lower rates of good quality of life (68%), and higher rates of poor general health (35%), frequent poor physical health (16%), frequent poor mental health (16%), HIV (11%), suicidal ideation (30%), and cognitive impairment (41%). These participants are more likely to report current smoking (31%) and binge drinking (24%) and less likely to report use of recreational marijuana (17%).

Survey participants residing in rural areas have heightened risk for frequent poor physical health (18%) and activity limitations (25%). The rate of HIV is the highest among those in urban areas (9%). Those in frontier areas are at the highest risk of suicidal ideation (38%), followed by those in urban areas (22%) and rural areas (14%). The rates of current smoking and binge drinking are particularly high among those in urban areas (23% & 21%, respectively).

Those in Region 2 are at heightened risk of frequent poor physical health (14%) and cognitive impairment (37%). Those living with HIV are more likely to reside in Region 1 (12%). The rate of past-year suicidal ideation is the highest among those in Region 5 (31%) and Region 2 (27%). Heightened risks of current smoking and binge drinking are found in Region 2 (27% & 21%, respectively), Region 4 (27% & 15%), and Region 1 (21% & 20%).

Those living with HIV are at heightened risks of poor general health (35%) when compared to those without HIV (24%). Those living with HIV show higher rates of drug abuse (11%) and use of recreational marijuana (37%) than those without HIV (4% & 19%, respectively). Further research is needed to better understand associations of marijuana use and the continuum of care for people living with HIV.[34]

“

I AM CONCERNED ABOUT MY FUTURE AS I, AND THE PEOPLE IN MY COMMUNITY, GROW OLDER.

I WORRY ABOUT WHO WILL TAKE CARE OF US, AND I WONDER WHO I’LL BE ABLE TO TURN TO FOR HELP AS MY BODY GETS MORE FEEBLE.”

ADVERSE EXPERIENCES

KEY FINDINGS

- Overall, almost 60% of participants have experienced discrimination in the past year, with Black/African Americans, Asian and Pacific Islanders, and Native American/Alaska Natives showing the highest rates.
- By sexual orientation and gender identity, gay men and transgender adults are at the highest risk of discrimination.
- More than 20% of participants do not disclose their sexual or gender identity to health care and other service providers.
- Nearly a quarter of participants have experienced some form of elder abuse in the past year, and less than a quarter of those reported the abuse to the authorities.
- Over one third of Asian and Pacific Islanders and Black/African Americans may be at risk of self-neglect; nearly a quarter of gay men, and almost 20% of those aged 55-64 may be at risk for self-neglect.

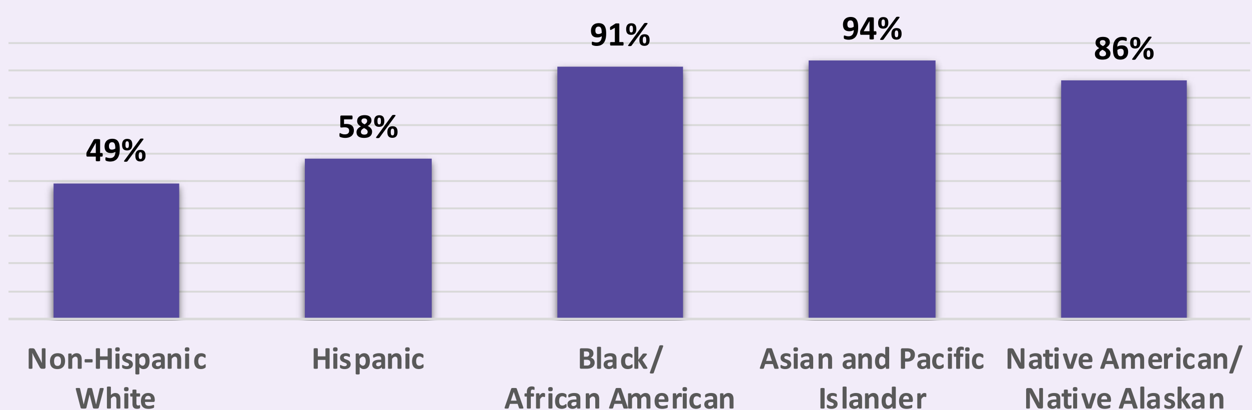
LGBTQ+ older adults often face higher lifetime rates of maltreatment, discrimination, and victimization.[17,29,30] These adverse experiences do not occur in isolation. Many LGBTQ+ older adults came of age when legal discrimination, arrest, and harmful medical treatments aimed at changing sexual orientation or gender identity were commonplace. Furthermore, many older LGBTQ+ Black/African American, Indigenous, and People of Color have experienced discrimination related to sexual orientation and gender identity and expression in the larger community, as well as race, ethnicity, and/or Indigeneity in both the larger community and within LGBTQ+ communities.[35] Adverse experiences, such as discrimination, elder abuse, and stigma have been shown to have substantial negative effects on LGBTQ+ older adults' health outcomes.[29,30,36]

Discrimination. Despite increased social acceptance in recent years, LGBTQ+ discrimination remains pervasive and widespread. Overall, close to 6 out of 10 participants have experienced discrimination in the past year. All groups show high rates of discrimination; gay men show the highest rate (69%), followed by queer and sexually diverse adults (54%), bisexual women (53%), lesbians (52%), and bisexual men (46%). Transgender adults also report high rates of discrimination (64%). The reasons attributed to discrimination include sexual orientation or gender identity or expression (56%), age (42%), gender (30%), disability status (13%), and race and ethnicity or nationality (11%).

Discrimination related specifically to sexual orientation or gender identity or expression is the highest among transgender adults (72%) and gay men (66%). Participants reported in which settings they most often experience discrimination due to their sexual orientation or gender identity or expression. Approximately 58% report that LGBTQ+ discrimination has occurred in a public place such as a store, sidewalk, or public transportation. About 27% of participants who are currently employed report LGBTQ+ discrimination in their job or place of employment. Twenty-one percent of those currently living in a residential setting such as senior housing, assisted living, adult foster homes, or a nursing home report LGBTQ+ discrimination in their housing; and 18% of those who used medical or health services report LGBTQ+ discrimination in these services.

Non-disclosure of sexual orientation or gender identity. Research has found that experiencing high rates of victimization and bias are often associated with fear of disclosing one's sexual orientation or gender identity and expression.[37] Conversely, long-term concealment of sexual orientation has been associated with increased risk for depression and chronic health conditions among older lesbian, gay, and bisexual adults.[38] Participants reported whether they have disclosed their sexual orientation or gender identity to biological family members, close friends or other chosen family members, and neighbors. The rate of not being "out" to neighbors (31%) is the highest. About a fifth of participants also do not disclose their identity to biological family (21%) and close friends or other chosen family (19%). We find that about 40%

Rates of Discrimination in the Past Year Among LGBTQ+ Participants



of participants have not fully disclosed their sexual or gender identity across differing types of relationships. The rate is notably high among bisexual men (81%), followed by gay men (50%), queer and sexually diverse adults (47%), bisexual women (47%), and lesbians (19%). The identity non-disclosure rate for transgender adults is 38%.

Research also shows that LGBTQ+ older adults often fear (and experience) discrimination, harassment, and social exclusion if they disclose their identities in healthcare and social service settings.[24] Participants reported whether they have disclosed their sexual or gender identities in health and other service settings, as well as in care facilities or residential settings. More than a fifth of participants (21%) do not disclose their sexual or gender identity to health care and other service providers, which can have adverse health consequences. The rates of identity non-disclosure to health care and other service providers are also high among bisexual men (37%), queer or sexually diverse adults (32%), bisexual women (27%), gay men (25%), and transgender adults (19%) while the rate for lesbians is 8%. In addition, nearly half of participants who live in a facility or residential setting (47%) do not disclose their identity to peers. The rate is the highest among bisexual men (80%), followed by bisexual women (69%), queer or sexually diverse adults (62%), gay men (45%), transgender adults (42%), and lesbians (35%).

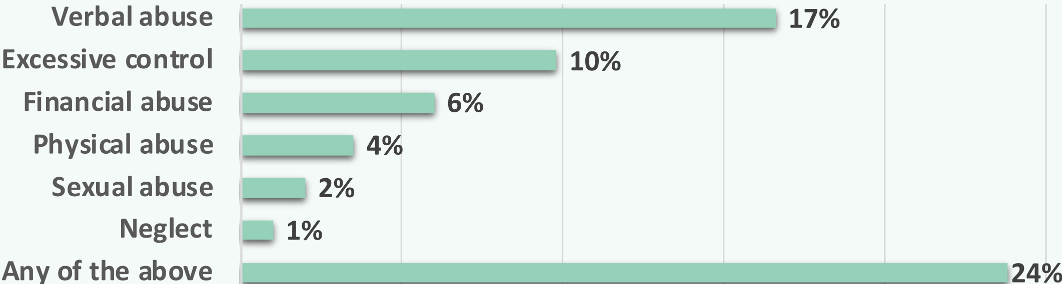
I AM STRESSED AND SADDENED BY THE HARASSMENT MY ASIAN SPOUSE HAS ENDURED DURING THE PANDEMIC."

Elder abuse. Current research on abuse and neglect among older LGBTQ+ adults is extremely limited, yet is likely to be as pervasive (if not more so) among cisgender and heterosexual older adults, as LGBTQ+ adults are vulnerable to unique types of abuse. For example, they may fear "being outed" and some may conceal their identities from neighbors, fearing potential abuse.[39] Nearly a quarter of participants (24%) have experienced at least one of six types of elder abuse in the past year: physical abuse, verbal abuse, sexual abuse, excessive control, financial abuse, and neglect by caregiver; this rate is much higher than estimates for older adults in general.[40] The most common types of elder abuse are verbal abuse (17%), excessive control (10%), and financial abuse (6%). Of those who have experienced abuse, the majority (62%) have been abused by a stranger; 12% by biological, legal, or chosen family members; 10% by an intimate partner or spouse; and 9% by their friend(s).

Of participants who have experienced abuse as an older adult, 24% have reported the incident(s) to the authorities. Some of the barriers identified by those who did not report elder abuse are distrust in the authorities' fairness with treatment of LGBTQ+ people (26%), feeling ashamed as a result of the experience (20%), lack of knowledge on how to report such incidents (16%), and fear of having to disclose their sexual and/or gender identities (16%). Of survey participants who have experienced older adult abuse, approximately 77% have pursued support. Most have sought support within close relationships. Nearly half (47%) have turned to friend(s); 30% to an intimate partner or spouse; 15% to legal or biological family members; and 12% to chosen family members. About 16% have also sought support from healthcare or mental health professional(s); and 9% from law enforcement.

Bisexual men (42%) and queer and sexually diverse adults (37%) show the highest risk of experiencing older adult abuse, followed by bisexual women (33%), lesbians (24%), and gay men (17%). Transgender older adults also experience higher rates of abuse (42%) when compared to cisgender older adults (21%).

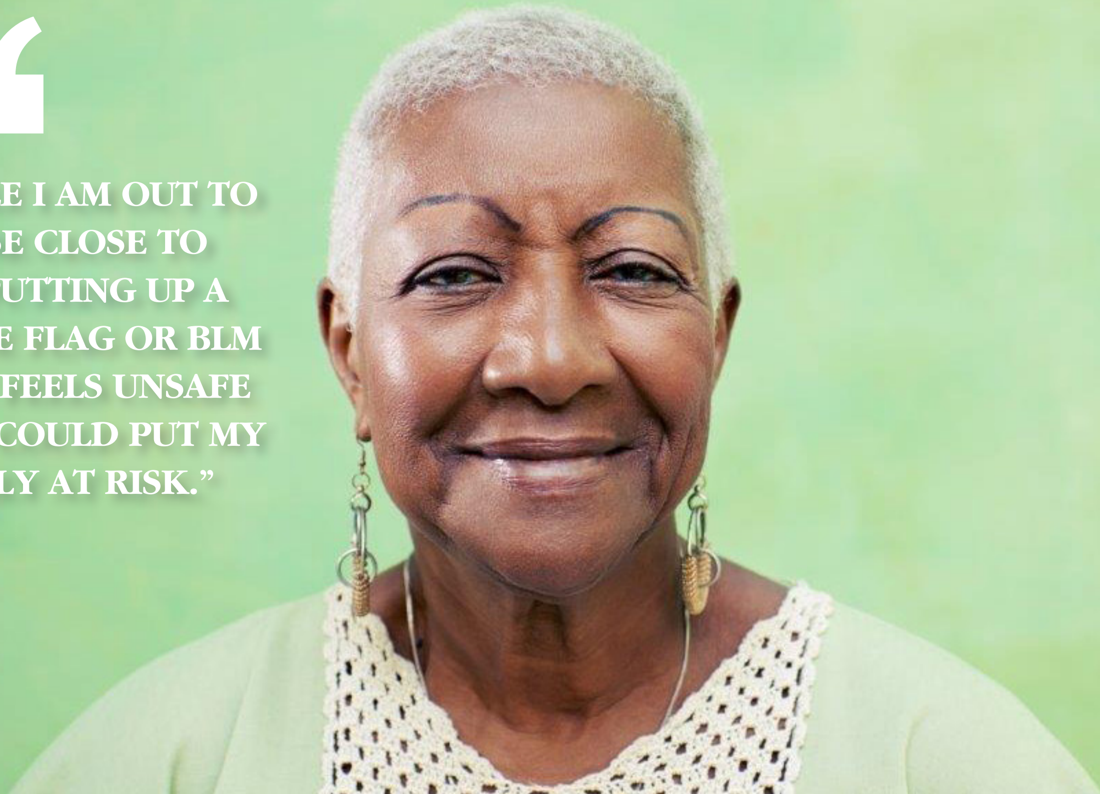
Rates of Elder Abuse in the Past Year Among LGBTQ+ Participants



Self-neglect. Social isolation and exclusion contribute to the potential for self-neglect. LGBTQ+ older adults may be at higher risk for self-neglect when they lack adequate support to meet their basic needs. More than 1 out of every 10 participants (13%) report that they have recently experienced not having their own basic needs met, such as lack of food, cleanliness, or safety. The rate of self-neglect is notably high among gay men (24%).

Key differences between groups. Experiences of and types of discrimination and abuse also vary by different sociodemographic characteristics among LGBTQ+ older adults. The age 55-64 group (69%) show the highest rate of discrimination in the past year; followed by the age 65 -74 group (45%) and the age 75 and older group (34%). Ageism is endemic within LGBTQ+ communities, particularly among men.[41] The most common reason for discrimination reported by the youngest group is sexual orientation or gender identity or expression, while age is the most commonly cited reason for discrimination among older age groups.

Almost half (49%) of the age 55-64 group do not disclose their sexual and gender identities to biological family members, friends, and neighbors, compared to 27% of those aged 65-74, and 22% of those aged 75 and older. The rate of identity non-disclosure to health care and other service providers is also higher among the youngest group (25%) when compared to the 65-74



(14%) and 75 and older age groups (11%). Participants from the age 55-64 group report higher rates of self-neglect (19%), compared to 4% of those aged 65-74.

Asian and Pacific Islanders (94%), Black/African Americans (91%), and Native American/Alaska Natives (86%) have the highest rates of experiencing discrimination, followed by Hispanics (58%), and non-Hispanic Whites (49%). Native American/Alaska Natives, Black/African Americans, and Asian and Pacific Islanders fully disclose their sexual or gender identities at lower rates to biological family, friends, and neighbors as well as to health care and other service providers compared to Hispanics and non-Hispanic Whites. Hispanics (47%) report the highest rates of older adult abuse, followed by non-Hispanic Whites (25%), Native American/Alaska Natives (20%), Black/African Americans (16%), and Asian and Pacific Islanders (5%). The rate of self-neglect is high among Asian and Pacific Islanders (37%), Black/African Americans (34%), Native American/Alaska Natives (28%), and Hispanics (20%), compared to 7% of non-Hispanic Whites.

Not surprisingly, participants' socioeconomic position also plays a role in the likelihood of adverse experiences. Those living at or below 200% of the FPL report higher rates of discrimination (67%), elder abuse (27%), and identity non-disclosure (57%) as compared to those living above 200% of the FPL (55%, 22%, and 31%, respectively).

Participants in urban areas experience discrimination at the highest rate (62%) when compared to those in rural (45%) and frontier areas (38%). Those in frontier areas are more likely to conceal their identity to health care or other service providers, and peers in care facilities or residential settings (47% & 83%, respectively) as compared to those in urban (20% & 46%) and rural areas (24% & 57%). Self-neglect is more common among participants who reside in urban (15%) than those in rural areas (7%).

Participants living in Region 2 (66%) and Region 1 (60%) report the highest rate of discrimination, followed by Regions 3, 4, and 5 (43%, 37%, 31%, respectively). Those in Region 5 show the highest rate of identity non-disclosure to biological family, friends, and neighbors (52%) as well as to health care or other service providers (50%). Heightened risk of self-neglect is reported by those in Region 2 (18%).

Interestingly, participants living with HIV show a lower rate of discrimination experiences than participants without HIV (47% vs. 60%), but a higher rate of older adult abuse (35% vs. 23%). Participants who are HIV-positive demonstrate lower rates of identity non-disclosures to biological family, friends, and neighbors than participants who are HIV-negative (25% vs. 42%), as well as to health care or other service providers (5% vs. 22%).

"I'M A CASE MANAGER AND I HAVE DIFFICULTY PLACING MY LGBTQIA CLIENTS WITHIN ANY COMMUNITY IN OREGON. THEY OFTEN DECLINE FACILITY PLACEMENT BECAUSE THEY DON'T FEEL WELCOME AND THEY FEAR DISCRIMINATION. WE NEED MORE LONG-TERM CARE FACILITIES FOR OUR AGING LGBTQIA COMMUNITY."

ECONOMIC AND HOUSING STABILITY

KEY FINDINGS

- Approximately 40% of LGBTQ+ participants live at or below 200% of the FPL.
- More than one in three participants have experienced financial stress in the past 12 months.
- Rates of poverty and financial stress are highest among bisexual men.
- About one-third of those who sought employment report that the COVID-19 pandemic and related health concerns have been substantial barriers to employment.
- About two out of three participants are not confident that they will be able to continue living in their current housing due to health and economic reasons.
- Participants aged 55-64, and 75 and older are more likely to live at or below 200% of the FPL.
- Participants of color show higher rates of financial and housing instability, higher rates of having household incomes at or below 200% FPL, fewer financial assets, and higher unemployment rates than non-Hispanic Whites.

Many LGBTQ+ older adults have experienced discrimination in employment and housing in their lifetimes, and many are currently experiencing economic insecurity.[42] Lower socioeconomic status (SES) can make it harder for LGBTQ+ adults to access healthcare, while higher SES is positively associated with both physical and mental quality of life in LGBTQ+ older adults.[22] This report has shown that participants living at or below 200% of the FPL tend to report a lower quality of life and higher rates of poor general health. Additionally, housing for LGBTQ+ older adults is consistently one of the most needed services for LGBTQ+ older adults.[17]

Income (poverty) and assets. Despite typically higher levels of education and similar employment, qualifications, and experience as their cisgender and heterosexual counterparts, sexual and gender minority older adults have lower incomes.[43] As stated previously, LGBTQ+ older adults living at or below 200% of the FPL report lower rates of good quality of life, higher rates of poor general health, frequent poor physical health, frequent poor mental health, frequent activity limitations, HIV, suicidal ideation, and cognitive impairment. About four out of ten (36%) LGBTQ+ participants live at or below 200% of the FPL given their household size, which is 8% higher than the Oregon state average (28%) in 2019. In addition, almost a third of partic-

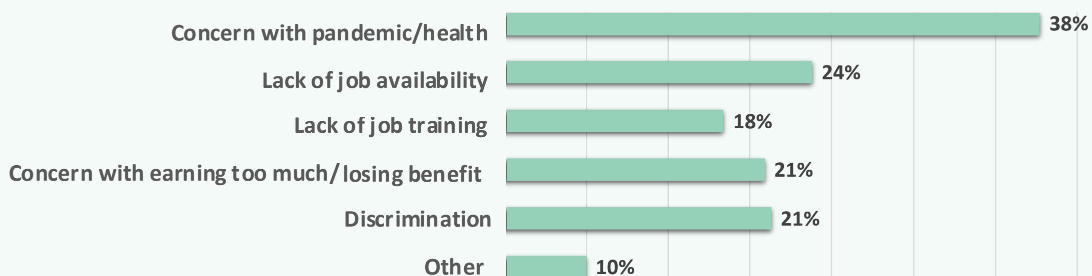
I AM EXTREMELY WORRIED ABOUT MY FUTURE. I'M TERRIFIED OF LIVING UNSHELTERED, AND OF DYING THAT WAY."

ipants (29%) report low assets and a net worth of less than $10,000. The poverty rate is highest among bisexual men (56%), followed by gay men (41%), queer and sexually diverse adults (41%), bisexual women (40%), transgender adults (36%), and lesbians (26%). While about 17% of lesbians report that their assets are less than $10,000, about a third of the other participants live with low assets: 34% of gay men and queer and sexually diverse adults; 33% of bisexual men; 30% of bisexual women; and 26% of transgender adults.

Financial stress. Participants with higher levels of education and lower income were likely to experience greater financial stress. Overall, more than a third (34%) of participants report experiencing at least one financial stressor in the past 12 months, either difficulty paying bills, buying nutritious meals, or both. About 19% of participants report difficulties in paying bills due to income instability, and more than a quarter of participants (28%) report having been worried or stressed out about having enough money to buy nutritious meals. Financial stress is the highest among bisexual men (44%) and gay men (41%), followed by bisexual women (38%), queer and sexually diverse adults (36%), transgender adults (35%), and lesbians (24%).

Employment/retirement. Overall, 39% of LGBTQ+ participants are retired, while 44% are either employed for wages (31%) or self-employed (13%). Of those employed, more than half (53%) work full time (35 hours or more per week), about 9% are unemployed, and 37% of participants sought employment in the past 12 months. Approximately 20% of retirees also sought employment during the past 12 months. More than one-third (38%) of those who

Barriers to Employment in the Past Year Among LGBTQ+ Participants

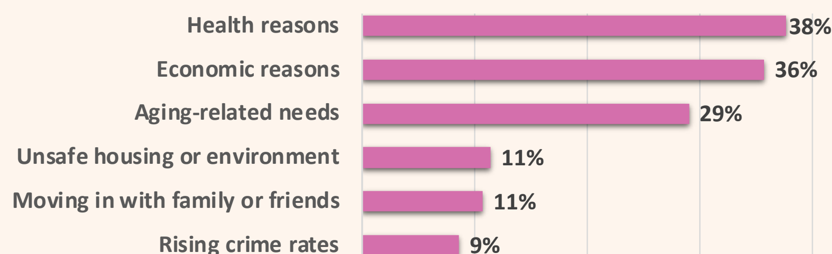


sought employment report that the COVID-19 pandemic and related health concerns have been substantial barriers to employment. Other barriers include lack of job availability (24%), discrimination (21%), concern about earning too much/losing benefits (21%), and lack of job training (18%). Gay men report the highest rates of unemployment (14%) and job seeking (57%).

Housing type and insecurity. The need for LGBTQ+ friendly senior housing has been expressed frequently, as has the need for affordable housing.[44] About three-quarters of participants (76%) live in a house, apartment, or condominium, while a quarter of them live in another type of housing arrangement, including senior housing (6%), assisted living facilities (3%), adult foster homes (3%), nursing homes (3%), residential hotels (4%). Less than 1% of participants report that they are homeless. Overall, 19% of participants own their residence with their mortgage paid off; 32% own their residence and are still paying their mortgage; and 21% rent. More than two thirds of lesbians own a house with their mortgage paid off (28%) or are still paying their mortgage (41%); 24% and 34%, respectively, of transgender adults, 22% and 30% of queer and sexually diverse adults; 15% and 40% of bisexual women; 15% and 33% of bisexual men; and 11% and 24% of gay men respectively have paid off or are still paying their mortgage.

Nearly two-thirds of participants (64%) are not confident that they will be able to continue living in their current housing. For those who are less confident, or not confident, about their current housing, 38% report health reasons as a primary reason for their intention of moving in the future. Other reasons include economic stress, including risk of foreclosure or eviction (36%); aging related needs (e.g., grab bars or elevators) (29%); wanting to move in with family or friends (11%); unsafe housing or environment (11%); and rising crime rate in their current neighborhood (9%). Lack of confidence in current housing is particularly high among gay men (75%) and is also high among other groups: 59% of transgender adults and queer and sexually diverse adults, 56% of bisexual men, 55% of bisexual women, and 54% of lesbians.

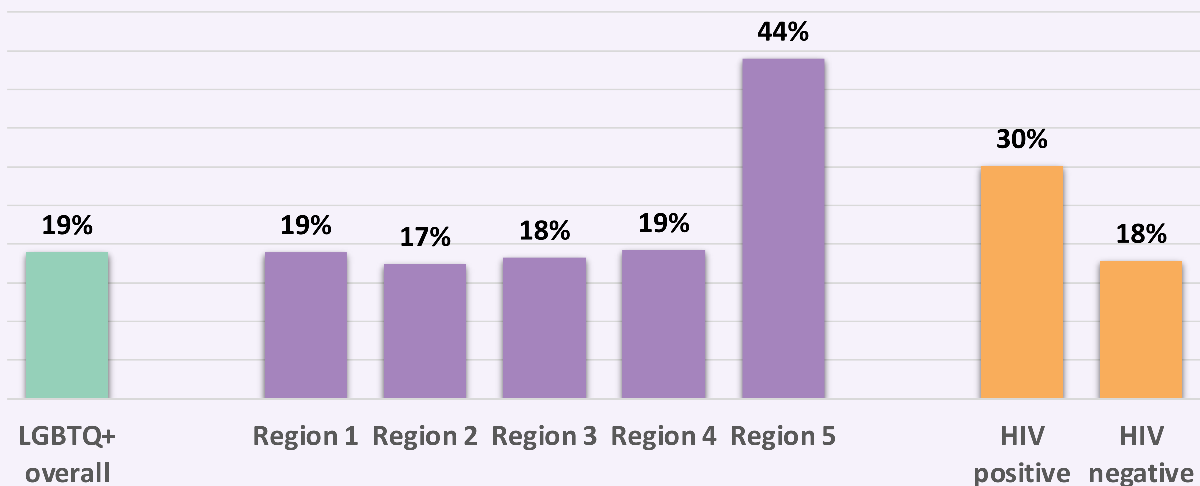
Reasons for Potential Change in Housing Among LGBTQ+ Participants



About 15% of participants want to change their living situations, and barriers to changing them include not being able to afford other housing (33%), being afraid to leave their current living setting (12%), not knowing where to find housing (4%), and being afraid to be alone (6%).

Key differences between groups. Participants aged 55-64 (39%) and 75 and older (38%) are more likely to live at or below 200% of the FPL. Those aged 55-64 also report the lowest levels of financial assets (34% having asset <$10k), the highest rates of financial stress (42%), and the highest unemployment rates (14%). They also show the highest level of lack of confidence in their current housing (70%).

Participants of color show heightened risk of financial and housing instability. They show higher rates of household income at or below 200% of the FPL, lack of financial assets, and higher rates of unemployment as compared to non-Hispanic Whites. Native American/Alaska Natives report the highest rates of financial stressors (64%), followed by Asian and Pacific islanders (59%), Black/African Americans (56%), Hispanics (49%), and non-Hispanic Whites (27%). Lack of confidence in living in current housing is the highest among Asian and Pacific Islanders (95%), Native American/Alaska Natives (85%), and Black/African Americans (81%), as com-



pared to Hispanics (58%) and non-Hispanic Whites (57%). Participants living at or below 200% of the FPL report almost three times greater rates of financial stressors (57%) than those living above 200% of the FPL (21%), and a half of them have less than $10,000 in assets. Participants living at or below 200% FPL report being more worried about housing stability (79%) than their counterparts living above 200% of the FPL (55%).

Living in frontier areas is associated with a higher rate of difficulty paying bills (47%). Those in urban areas (67%) report the highest rate of lack of confidence living in current housing.

The rate of living at or below 200% of the FPL is highest in Region 2 (43%), followed by Region 3 (40%), Region 5 (39%), Region 1 (33%), and Region 4 (18%). Participants in Region 5 (50%) also have high rates of financial stress. Lack of confidence living in current housing is the highest in Region 2 (67%) and Region 1 (66%). Participants with HIV are more likely to live at or below 200% of the FPL (46%) and have trouble paying bills (30%) than those without HIV (36% & 18%, respectively).

"AS A QUEER OLDER PERSON LIVING IN SUBSIDIZED HOUSING, I FEEL VERY REMOVED FROM ANY SPECIFIC SUPPORT. ALONG WITH THE USUAL SUBSIDIZED HOUSING ISSUES, THERE IS A LARGE RELIGIOUS POPULATION IN MY COMMUNITY AND I DON'T FEEL COMFORTABLE. WE DON'T HAVE CHOICES WHEN APPLYING FOR HOUSING."

IMPACTS OF COVID-19

KEY FINDINGS

- A majority of participants know someone who has been diagnosed with COVID-19 and over a quarter know someone who has died of the disease.
- Almost all participants received at least one dose of a COVID-19 vaccine; those in rural areas and those living at or below 200% of the federal poverty level (FPL) report lower vaccination rates.
- In terms of race and ethnicity, Black/African Americans, Asian and Pacific Islanders, and Native American/Alaska Natives report higher rates of unmet needs for COVID-19 related services.
- Participants report an overall decrease in use of social support programs, adult day programs, and transportation services due to COVID-19; there was an overall increase in reported use of food assistance.
- Expanded telehealth options were offered at lower rates to gay men, Black/African Americans, Asian and Pacific Islanders, and Native American/Alaska Natives, and those living at or below 200% FPL.

The coronavirus pandemic has impacted lives around the globe. Reduced availability and access to needed services may place additional strain on LGBTQ+ older adults already experiencing social exclusion, stigma, or other health related risk factors.[45] Furthermore, existing barriers faced by many racial and ethnic groups, those living in poverty, and those in rural or frontier communities may lead to disparate impacts of the pandemic,[46] requiring innovative partnerships and community health approaches.[47] LGBTQ+ Oregonians aged 55 and older report many ways in which they have experienced changes brought by the pandemic, as well as resilience in the face of this historic challenge.

Experiences of COVID-19. COVID-19 is not the first pandemic that has disproportionately impacted this community; the AIDS pandemic in the 1980's and '90's was devastating for gay and bisexual male communities.[45] The majority of LGBTQ+ participants (61%) know someone who has been diagnosed with COVID-19; more than a quarter (27%) know someone who has died of the disease. More than 70% of lesbians (77%), queer and sexually diverse adults (75%), and bisexual women (71%) know someone who has been infected, while 52% of bisexual men and 44% of gay men do. The likelihood of knowing someone who is infected is higher among

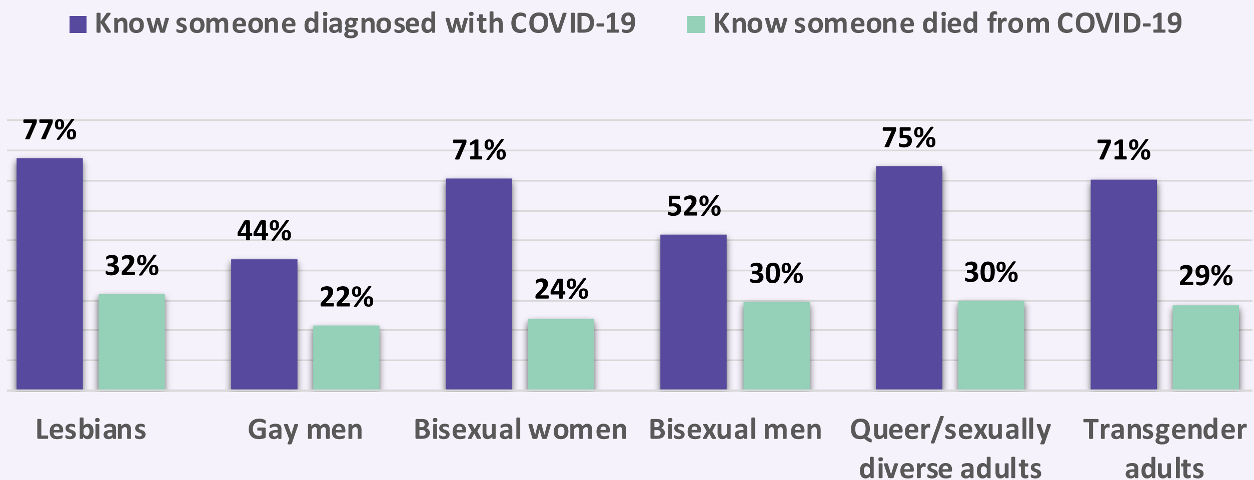
AS A GEN X OLDER ADULT, WE HAVE MANY DIFFERENT EXPERIENCES, STRENGTHS AND NEEDS. WHILE MANY OF US HAVE BEEN SELF-SUFFICIENT AND COMFORTABLE WITH CHANING TECHNOLOGY, WE FEAR THAT HELP WILL BECOME LESS AVAILABLE, OR THAT WE WON'T QUALIFY FOR HELP AS WE GET OLDER."

SOCIAL ISOLATION HAS BEEN THE BIGGEST SINGLE IMPACT OF THE PANDEMIC."

transgender adults (71%) when compared to cisgender adults (59%). About a third of lesbians (32%) know someone who has died of COVID-19, followed by queer and sexually diverse adults (30%), bisexual men (30%), bisexual women (24%), and gay men (22%); 29% of transgender adults know some who has died of the disease. The self-reported infection rate is 8% among the participants with certainty (3%), or probably infected (5%); and heightened rates of COVID-19 infection are found among bisexual women (14%), queer and sexually diverse adults (13%), and transgender adults (12%).

More than 4 out of 5 participants (84%) report that they are worried about the health of family members due to the coronavirus pandemic, and 80% worry about what will happen in the future, 78% worry about their own health, 74% worry about losing social connection, 59% worry about their own financial situation, and 51% worry about getting help from family, friends, or others.

COVID-19 vaccination. Along with other public health measures, vaccination is one of the most important steps in protecting the health of individuals and communities from COVID-19.[48] Almost all participants (95%) have received either a single-dose vaccine or at least the first dose of a two-dose vaccine. More than 8 out of 10 participants who have not received



the COVID-19 vaccine (85%) report that they do not plan to receive one; 8% need help with scheduling vaccination. While the vaccination rate is high across all sexual orientation groups, we observed relatively lower rates among queer and sexually diverse adults (84%), bisexual women and men (92% and 93%, respectively), and transgender adults (92%) while 99% of gay men and 98% of lesbians are vaccinated.

COVID-19 related services and programs. More than half of participants (56%) have needed COVID-19 related services and programs during the pandemic, and 33% have used the services. Over a fifth of participants (23%) have needed the services but their needs have not been met. Gay men show a notably high rate of unmet needs (47%). More than 9% of service users affirm that they have not felt comfortable using COVID-19 services and programs as a LGBTQ+ person. Transgender adults (18%) and queer and sexually diverse adults (15%) show relatively higher rates of discomfort.

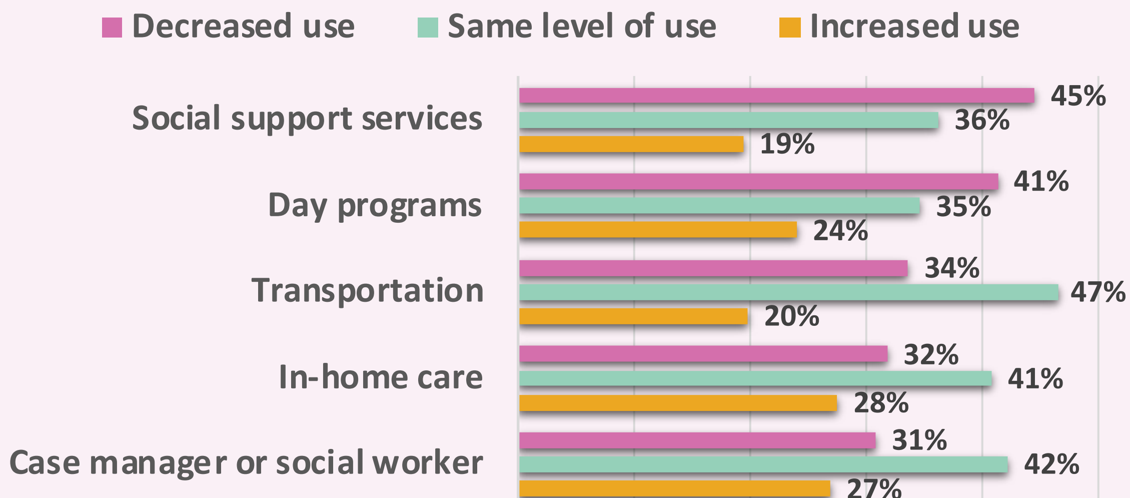
Changes in service use. One of the challenges of understanding the changes in LGBTQ+ older adults utilization of services is knowing whether such changes are due to changes in the provision of services (i.e., some agencies temporarily or permanently stopped providing in-person services, while others switched to virtual services). In addition, older adults in particular may be more reluctant than younger people to access in-person services due to fear of contracting COVID-19. Participants reported on how their use of each of 17 different services has changed

BECAUSE OF THE PANDEMIC, I HAVE LOST THE MEANINGFUL IN-PERSON INTERACTIONS WITH MY CHOIR, NEIGHBORS, AND FRIENDS."

since the beginning of the pandemic. A higher number of participants report a decrease rather than an increase in using social support programs, adult day programs, and transportation services. Over 40% of participants (44%) report a decrease in using social support programs while 19% report an increase. Forty-one percent (41%) report a decrease in using adult day program while 24% report an increase. Thirty-four percent (34%) report a decrease in using transportation services, and 20% report an increase. For food assistance and mental health and substance use services, more participants report an increase in their use rather than a decrease. Nearly 40% of participants (39%) report an increase in using food assistance and 21% report a decrease. Thirty-six percent (36%) report an increase in using mental health and substance use services and 20% report a decrease.

Expansion of technology use. As a nation, we have seen significant expansion of telehealth services in response to the COVID-19 pandemic. Over two thirds (68%) of the participants report that their health care providers have offered new or expanded options for telehealth services. Gay men (48%) are less likely to have been offered options for telehealth services than lesbians (86%), bisexual women and men (85%), and queer and sexually diverse adults (81%). Transgender adults have also been offered telehealth services at a heightened rate (84%).

More than a half of survey participants (52%) have learned how to use a new technology device (e.g. iPad), application, or computer programs since the COVID-19 pandemic began. Gay men have learned how to use a new technology device at a rate of 65%, followed by bisexual wom-

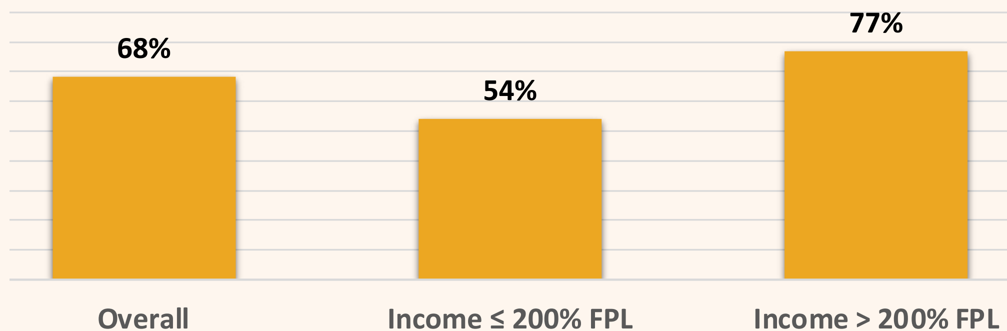


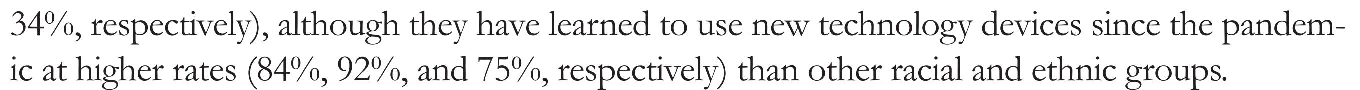
en (56%), bisexual men (52%), transgender adults (42%), and lesbians and queer and sexually diverse adults (40%).

Key differences between groups. Like other groups, LGBTQ+ older adults are a very heterogeneous group that often differ in important ways. Whereas participants from age 65-74 (73%) and 75 and older groups (61%) are more likely to know someone who has been infected with COVID-19, those from age 55-64 group show heightened concerns about their future (83%), losing social connections (77%), financial situations (67%), and getting help (59%). Those from age 55-64 group are least likely to have been offered telehealth services (60%) as compared to those from older age groups, and they show the highest rate of unmet needs for COVID-19 related supports and services (34%).

Mirroring some national trends, Hispanics are more likely than other ethnic groups to have been infected by COVID-19 (15%) and to know someone who has been infected (76%) and have died due to the disease (40%). Hispanics are worried about their families' health and financial situations at the highest rates (96% and 82%); Black/African Americans (75%) and Asian and Pacific Islanders (75%) are most likely to be worried about getting help from friends and family members. Black/African Americans (67%), Asian and Pacific Islanders (82%), and Native American/Alaska Natives (61%) report the highest rates of unmet needs for COVID-19 related services. They are also the least likely to have been offered telehealth services (28%, 13%, and

Rates of Telehealth Services Offered During the Pandemic Among LGBTQ+ Participants by Income Level





34%, respectively), although they have learned to use new technology devices since the pandemic at higher rates (84%, 92%, and 75%, respectively) than other racial and ethnic groups.

Socioeconomic positions are a significant driver of health and related disparities.[49] Participants who live above 200% of the FPL are more likely to know someone who has been infected by COVID-19 (70%) and who have died of the disease (30%). They also have higher vaccination rates (98%) and higher rates of worrying about the health of family members (87%). Living at or below 200% of the FPL is associated with a heightened rate of worry about financial situations (73%) and getting help from others (65%). Participants living at or below 200% FPL are also more likely to have had their COVID-19 related service needs unmet (34%) and less likely to have been offered telehealth services (54%), although they are more likely to have learned new technology devices (60%).

Geographic location also plays a major role in healthcare access and services during the COVID-19 pandemic.[46] Participants from frontier areas show a higher likelihood of knowing someone who was infected by COVID-19 (99%) and who died of the disease (53%). Those from rural areas show the lowest COVID-19 vaccination rate (90%). Those living in urban areas are more likely to have had experienced unmet needs of COVID-19 related services (26%) and less likely to have been offered telehealth services (66%), although they are more likely to have learned new technology devices (54%).

Participants from Region 4 (23%) show the highest rates of being infected by COVID-19 and knowing someone who has been infected by COVID-19 (77%). Those from Region 5 show the highest rate of knowing someone who has died of COVID-19 (44%), followed by Region 3 (31%) and Region 1 (28%). COVID-19 vaccination rate is lowest among those from Region 4 (85%) and Region 3 (89%). Participants from Region 2 (33%) and Region 1 (22%) are most likely to have had their COVID-19 service needs unmet. Participants from Region 2 show the lowest rate of being offered telehealth services (59%), followed by Region 5 (70%), Region 1 (71%), Region 3 (76%), and Region 4 (85%) while those from Region 2 are most likely to have learned new technology devices (60%).

Comorbidity – the likelihood that having one chronic health condition makes an individual more likely to develop additional chronic health conditions – is especially pertinent in the era of COVID-19. Participants living with HIV are more likely to know someone who is or has been COVID-19 positive (70%) and are more likely to have had their COVID-19 related service needs met (96%). They have been offered telehealth services at a higher rate (84%), yet are less likely to have learned new technology devices (34%) since the pandemic.

SOCIAL RESOURCES AND RESILIENCE

KEY FINDINGS

• Overall, LGBTQ+ participants report a high degree of resilience.

• Almost 80% report helping others in the LGBTQ+ community.

• Overall, more than 80% report getting needed social support; while over 20% of gay men, queer and sexually diverse, and transgender participants do not receive needed social support.

• Over 40% attend faith, spiritual, or religious services; just over 10% report turning to a faith community for support.

• Nearly 25% do not have access to reliable high-speed internet; almost 40% of gay men do not have adequate internet access.

• LGBTQ+ older adults show high levels of resilience with nearly three-quarters (72%) reporting that they bounce back quickly after hard times.

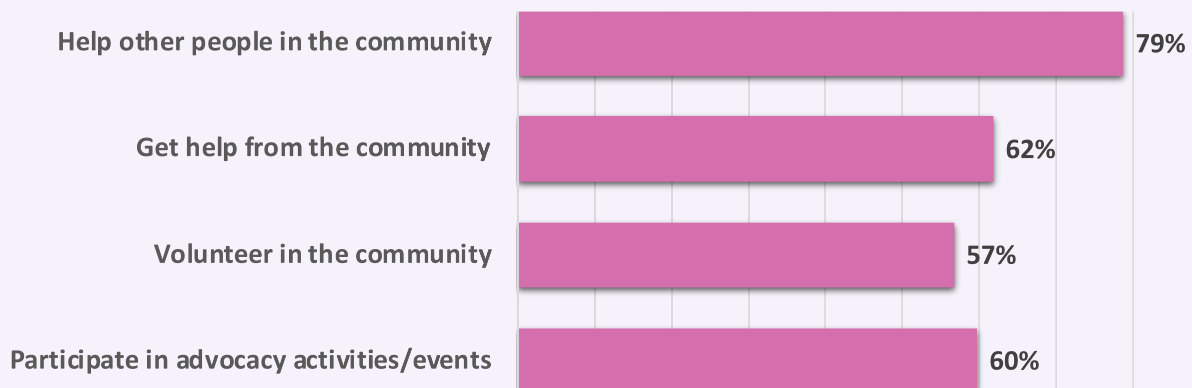
• While Black/African Americans, Native American/Alaska Natives, and Asian and Pacific Islanders demonstrate significant strengths with larger social networks and more engagement in spiritual and religious activities, they also face significant challenges with lower rates of social support, lower LGBTQ+ community engagement, and fewer resources for virtual support.

Social network and support. Although lack of social support does not necessarily equate to social isolation, it does increase the risk of it.[50] Social isolation has been recognized as equally dangerous as smoking a pack of cigarettes every day, in terms of its impact on early onset of disease and premature death.[51] Over 7 out of 10 (71%) LGBTQ+ participants have three or more people they can count on for practical help, such as picking up groceries or talking about a problem. The highest rates of having three or more people that can be counted on for practical help are reported by bisexual men (78%) and gay men (76%), followed by lesbians (72%), queer and sexually diverse adults (60%), bisexual women (58%), and transgender adults (58%). In terms of types of social networks in which LGBTQ+ adults seek support, many participants count on their friends (70%), a partner or spouse (41%), and neighbors (37%). In comparison, less than 10% of participants consider biological/legal family (11%) or children (17%) as people who provide support. In addition, LGBTQ+ adults' expectations toward community supports are generally low; 14% for a therapist or support group, 11% for faith-based communities, 4%

for social service providers, agencies, or organizations, 2% for paid caregivers through Medicaid or other public programs, and 1% for privately paid caregivers. Despite their support network, about 17% of participants do not get the social and emotional support they need, with gay men (22%), queer and sexually diverse adults (22%), and transgender adults (21%) reporting the highest rates of lack of social and emotional support when compared to bisexual men (15%), bisexual women (14%), and lesbians (10%).

LGBTQ+ community engagement. Feeling like one belongs to a LGBTQ+ community and has strong social networks is a significant protective factor for older adults in terms of physical and mental health.[25] Furthermore, research strongly suggests that providing social support has positive effects on health.[52] Nearly 4 out of 5 (79%) of LGBTQ+ participants help others, and 62% receive help from the LGBTQ+ community. The majority of LGBTQ+ adults (60%) engage in ongoing advocacy activities, and 57% participate in community volunteering. On a scale of 1 to 6 (1 = strongly disagree; 6 = strongly agree), the average level of LGBTQ+ community engagement is 3.9 for all participants. The level of LGBTQ+ community engagement is the highest among bisexual men (average = 4.3), followed by lesbians (average = 4.0), bisexual women (average = 4.0), queer and sexually diverse adults (average = 4.0), and transgender adults (average = 4.0) and gay men (average = 3.7).

LGBTQ+ Community Engagement Among LGBTQ+ Participants



Resilience. Many LGBTQ+ adults have developed "crisis competence," a type of resilience wherein successfully navigating a lifetime of trials and tribulations related to being a sexual or gender minority in an overtly heterosexist world better prepares LGBTQ+ older adults to successfully deal with subsequent trials and tribulations.[53] Overall, LGBTQ+ participants have high levels of resilience. Nearly three-quarters (72%) report that they bounce back quickly after hard times. About two-thirds of participants report that it is not hard to snap back when something bad happens (60%), or that they usually come through difficult times with little trouble (60%). On a scale of 1 – 6 (1 = strongly disagree; 6 = strongly agree), the average level of resilience is 4.0 for all participants. Lesbians (average = 4.1) show the highest level of resilience. Levels for other groups are as follows: gay men (average = 3.9), bisexual women (average = 4.0), bisexual men (average = 3.9), queer and sexually diverse adults (average = 3.9), and transgender adults (average = 3.8).

MY WIFE AND I HAVE LIVED IN SOUTHERN OREGON FOR ABOUT FOUR YEARS AND WOULD LIKE TO SOCIALLY CONNECT TO OTHER LGBTQ+ INDIVIDUALS.

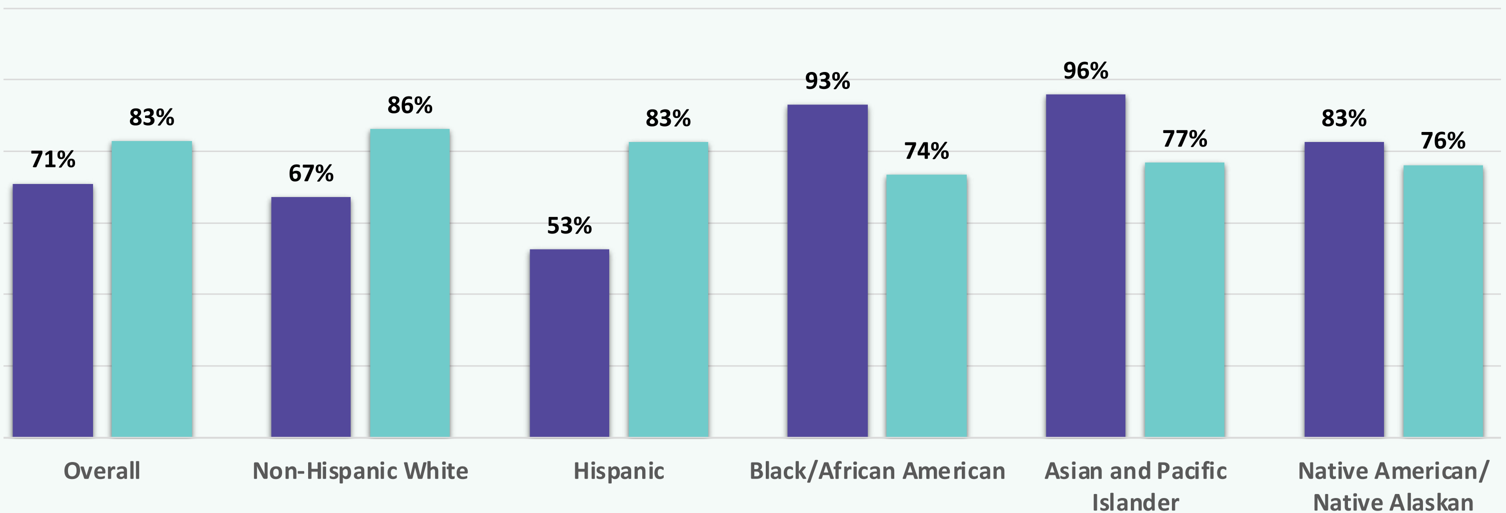
THERE IS A NEED IN THIS AREA FOR ADULTS 50+ TO HAVE OPPORTUNITIES TO CONNECT WITH EACH OTHER."

Spiritual/religious activities. Despite historic and ongoing marginalization from many mainstream religious denominations, many LGBTQ+ people find solace and comfort in spiritual and religious beliefs and practices.[54] Some 41% of LGBTQ+ participants attend faith, spiritual, or religious activities either in person or virtually. Among the adults attending such activities, over three-quarters attend from 1-3 days (37%) or 4-8 days (39%) per month, while 24% attend more than nine days per month. Gay men (49%) are the most likely to attend spiritual or religious activities, followed by 34% of lesbians, 40% of bisexual women, 37% of bisexual men, 32% of queer and sexually diverse adults, and 34% of transgender adults.

Technology access and needs. Access to internet is high among participants. Over three quarters (77%) have reliable high-speed internet access. However, 34% report that they need assistance with technology, such as accessing or using computers or smartphones (25%) or connecting virtually with groups, services, and support networks (21%). Transgender participants report higher rates of internet access (88%), while gay men report lower rates of internet access (61%). Bisexual men (41%) and gay men (39%) are most likely to need assistance with using or accessing technology, followed by bisexual women (36%), queer and sexually diverse adults (31%), transgender adults (30%), and lesbians (27%).

Confidence in technology use. Most participants report being somewhat to very confident in using technology, including using email (87%), connecting with people using video-chat (81%), scheduling an appointment with health providers online (84%), attending a virtual/telehealth appointment (82%), and using a virtual support network such as message boards or social media (79%). Gay men show a lower confidence rate overall at around 70% for each skill. Lesbians and transgender adults have higher rates of confidence at around 90% for all skills.

Key differences between groups. Participants aged 55-64 (74%) are more likely to report knowing three or more people to whom they can turn to for support, as compared to those aged 65-74 (65%), or 75 and older (67%). However, those aged 55-64 are least likely to get needed social support (79%), in contrast to those aged 65-74 (87%), or those 75 and older (94%). Participants aged 55-64 report lower rates of being able to rely on a spouse or partner for support (35%) and are more likely to turn to friends (75%) or neighbors (45%). Over half (53%) of those age 65-74, and almost half of those aged 75 and older (48%), report turning to a spouse or partner for support. Furthermore, support from children also varies by age. While 23% of those age 65-74 and 29% of those age 75 and older turn to children for support, only 12% of those age 55-64 turn to children for support. The levels of LGBTQ+ community engagement and resilience are the highest amongst those aged 75 and older. Those aged 55-64 (45%) are more likely to attend faith, spiritual or religious activities relative to those aged 65-74 (35%), or 75 and older (33%). However, those aged 75 and older (17%) report higher rates of turning to faith communities for support, followed by those aged 65-74 (15%). Those aged 75 and older showed the highest rates of internet access (94%) followed by those aged 65-74 (91%). However, those aged 75 and older (39%) reported higher rates of needing assistance accessing or using



> **“I LIVE IN A RURAL AREA. I KNOW THERE ARE OTHER GAY PEOPLE AROUND BUT I HAVEN’T MET ANY YET.”**

technology.
Black/African Americans (27%), Native American/Alaska Natives (24%), and Asian and Pacific Islanders (23%) report heightened rates of lack of social support, compared to Hispanics (18%) and non-Hispanic Whites (14%), while they report higher rates of having more than three people to turn to for support (93%, 83%, and 96%, respectively). In terms of type of support network, while all racial and ethnic groups are most likely to rely on friends, the rates for Black/African Americans (80%), Native American/Alaska Natives (84%), and Asian and Pacific Islanders (92%) are higher than those for non-Hispanic Whites (67%) and Hispanics (47%). However, Black/African Americans, Native American/Alaska Natives, and Asian and Pacific Islanders are less likely to turn to family members, including partners or spouses, children, and biological and chosen family members. The average levels of LGBTQ+ community engagement for Black/African Americans (average = 3.7), Asian and Pacific Islanders (average = 3.7), and Native American/Alaska Natives (average = 3.7) are lower than for Hispanics (average = 3.9) and non-Hispanic Whites (average = 3.9), although they are more likely to be involved in spiritual and religious activities (70%, 67%, and 61%, respectively). The average level of resilience was the highest among non-Hispanic Whites (average = 4.1), followed by Hispanics (average = 3.8), and was slightly lower among Black/African Americans (average = 3.7), Asian and Pacific Islanders (average = 3.7), and Native American/Alaska Natives (average = 3.7).

Black/African Americans, Asian and Pacific Islanders, and Native American/Alaska Natives also report lower rates of high-speed internet access (42%, 35%, and 50%, respectively) and confidence in technology use, including emailing (55%, 54%, and 69%, respectively), video-chatting (58%, 56%, and 65%, respectively), online scheduling with health providers (72%, 55%, and 65%, respectively), attending telehealth appointments (69%, 57%, and 60%, respectively), and attending virtual support networks (70%, 52%, and 56%, respectively).

By income, 77% of those living at or below 200% of the FPL report lower rates of receiving needed social support. Those at this income level also reports lower rates of turning to partners or spouses (19%), children (14%), or legal or biological family members (8%) for support as opposed to those whose incomes are above 200% of the FPL (54%, 18%, & 13%, respectively). Those at or below 200% of the FPL also report higher rates of relying on neighbors for support (45%), versus 33% of those with incomes above 200% of the FPL. Those at or below

200% of the FPL report a higher rate of attending faith, spiritual, or religious services (47%), and a lower level of resilience (average = 3.7). Those at or below 200% of the FPL also report lower rates of adequate internet access (67%), higher need for assistance using or accessing technology (45%), and lower confidence in using technology.

Those in urban areas (73%) report larger social networks. Participants from frontier areas report higher rates of LGBTQ+ community engagement, and are more likely to attend faith, spiritual, or religious services (63%), followed by those in urban areas (42%) and rural areas (34%). Notably, those in urban areas report lower rates of adequate internet access (76%) relative to those in frontier (87%) and rural (86%) areas.

By region, those in Region 2 (77%) report larger social networks followed by those in Region 5 (73%). Those in Region 5 show the highest level of LGBTQ+ community engagement while they are most likely to attend faith, spiritual, or religious services (54%). Participants in Region 2 (69%) report the lowest rate of adequate internet access, followed by those in Region 1 (79%).

Those living with HIV report smaller social network sizes, with nearly a half (49%) having two or less people they can turn to for support. Those living with HIV are more likely to get help from the LGBTQ+ community (77%), while only 25% attend faith, religious, or spiritual ser-

CONCLUSION

LGBTQ+ older adults in Oregon are an underserved yet resilient population. These study results shed new light on the diversity and cumulative risks facing this aging population. A comprehensive approach is paramount to transforming public policies, services, education, and research to address the growing population of LGBTQ+ older adults.

Moving forward, it will be critical to further extend the initial work and advocacy of LGBTQ+ organizations to promote partnerships between these communities, aging agencies, and state and local policy makers to develop a comprehensive approach to addressing aging and health needs of LGBTQ+ older adults. This survey has set a standard for state agencies to listen to the voices of experience in the community and to work together to identify challenges and strengths in order to develop impactful strategies, programs, services, and resources to meet those needs.

As these partnerships are developed, it is critical that they represent the diversity of these communities, both by demographic and background characteristics as well as by geographic regions. As illustrated in the findings in this report, there are elevated needs across these communities as well as pockets of risk within specific subpopulations that need to be addressed, including by sexual orientation and identity, gender, gender identity and expression, race/ethnicity, age, HIV status, geographic region, and socioeconomic status.

To reduce and prevent social isolation it is also imperative to target services to LGBTQ+ older adults living alone without adequate services or support. In addition, technology support is necessary to provide virtual access and devices to reduce social isolation, support connectivity, and ensure that no one is left behind as more services and supports are offered remotely.

It will be crucial to identify culturally inclusive programs, services, and policies that have been successful in meeting the needs of LGBTQ+ older adults in other areas across the nation. Leveraging such lessons learned will help support the development of models and programs that can be implemented in urban, rural, and frontier communities in Oregon where LGBTQ+ inclusive services are needed. Many participants, for example, report feeling unwelcome and unsafe in accessing aging, health, and human services, and many have experienced overt discrim¬ination and bias within the last year. To reduce such barriers to care, cultural inclusivity training for aging, healthcare, and human service providers and legal professionals is vital. It will also be important to replicate and administer the survey over time to monitor changes and evaluate progress in reducing aging, health, economic, and social disparities.

It is critical to prioritize the needs of older adults in LGBTQ+ organizations and communities and to participate in local, state, and federal planning processes to secure resources for much-needed service development, including housing, transportation, and support programs. It is fundamental that policymakers and key stakeholders initiate and support programs policies and research initiatives to better address the needs of underserved LGBTQ+ older adults and their families.

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APPENDIX A - METHODOLOGY

To better understand health disparities, key social and economic indicators, aging and service needs, and the resilience and strengths among LGBTQ+ adults aged 55 and older in Oregon State, we analyzed two datasets. Population-based data from the Oregon State Behavioral Risk Factor Surveillance System (OR-BRFSS) was merged and analyzed for the years 2013 through 2018.[55] We also conducted the first statewide survey of LGBTQ+ older adults in Oregon. Data analyses were performed using Stata/SE 14.2.

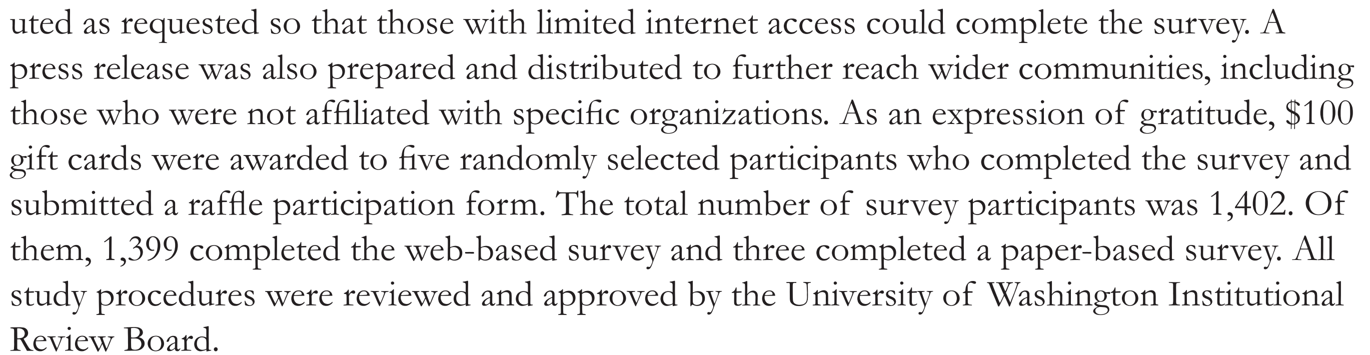
OR-BRFSS

The Behavioral Risk Factor Surveillance System is an annual telephone survey conducted by all U.S. states, in partnership with the Centers for Disease Control and Prevention. Noninstitutionalized individuals aged 18 and older are selected each year through stratified random sampling. Households are selected using landline numbers, and one adult from each household is randomly selected. Since 2011, cell phone numbers have also been used to directly contact individuals.[55] Due to the 2013 modification of OR-BRFSS's sexual orientation measure, we aggregated the data from 2013 to 2018 for aged 55 and older (N = 32,714). Valid responses to the sexual orientation question yielded a study sample size of 29,787. Sampling weights provided by the OR-BRFSS were used to address any sampling bias.

For data analysis, we estimated the weighted prevalence of health indicators (i.e., health outcomes, chronic conditions, health behaviors, preventive health care, and health care access) for both LGB and heterosexual adults aged 55 and older. LGB adults were compared with their heterosexual counterparts. Significance tests for logistic regressions were performed adjusting for age, and a p-value less than .05 was considered statistically significant.

Oregon LGBTQ+ Older Adult Survey

This is the first statewide project to assess the health, economic, and social disparities, as well as the resilience and strengths, of LGBTQ+ adults aged 55 and older living in Oregon. We conducted an anonymous, web-based survey over a three-month period from May 18 to August 18, 2021. The UW research team worked closely with ODHS staff and the Advisory Committee to promote participation of older LGBTQ+ Oregonians including hardest-to-reach populations such as the oldest old, racial and ethnic minorities, and those who reside in rural and frontier areas. To this end, a contact list of community agencies and organizations in Oregon serving LGBTQ+ older adults and people of color was built, and study invitations and flyers were distributed via the contact list and social media. The survey materials were translated into eight different languages (Arabic, Korean, Russian, Simplified Chinese, Somali, Spanish, Traditional Chinese, and Vietnamese). Paper questionnaires were distrib-



uted as requested so that those with limited internet access could complete the survey. A press release was also prepared and distributed to further reach wider communities, including those who were not affiliated with specific organizations. As an expression of gratitude, $100 gift cards were awarded to five randomly selected participants who completed the survey and submitted a raffle participation form. The total number of survey participants was 1,402. Of them, 1,399 completed the web-based survey and three completed a paper-based survey. All study procedures were reviewed and approved by the University of Washington Institutional Review Board.

For data analysis, descriptive statistics (i.e., frequencies, means, and ranges) of background characteristics, health promoting and risk factors, and service needs were initially estimated. Next, similarities and differences by sexual orientation, gender identity, age group, race/ethnicity, household income, region, and HIV status were examined via ANOVA and chi-squared tests, as appropriate. A p-value less than .05 was considered statistically significant.

Although extensive efforts have been made to reach out to demographically diverse LGBTQ+ communities for data collection, there are some limitations to the Oregon LGBTQ+ Older Adult Survey. People who have limited access to high-speed internet, who are not comfortable with accessing web-based surveys, and who have experienced health, social, and economic disparities may have faced barriers to online survey participation. For example, in the survey data, participants aged 55-64 and residing in urban areas are over-represented, and these skewed distributions are more salient among people of color. The research design and sampling procedures of the community-based survey limit the generalizability of the findings.

Limited subgroup analyses due to small response sizes were also a challenge. It is essential to secure a sufficient number of subgroup participants by demographic characteristics for reliable data analysis. Broadly, the extensive outreach efforts were successful and allowed examinations of most key study measures by sexual orientation, gender identity, age groups, income, region, and HIV status. However, some measures, particularly those asked only of applicable participants (e.g., follow-up questions asked of those who experienced elder abuse), have response sizes that are insufficient for reliable statistical analyses of similarities and differences among subgroups (e.g., race/ethnicity, region).

In addition, an extremely small response size may provide identifiable information and violate confidentiality requirements. Thus, data was suppressed when the numerator was less than 5. Future studies should consider these challenges associated with the measures for which data were not reported due to small response sizes. Lastly, self-reported data is based on participants' perceptions and memory and do not replace objective measures.

APPENDIX B - KEY TERMS

Barriers to changing living situation. Participants who indicated their wish to change the number of people living in their household were further asked to select barriers to making the change.

Barriers to employment. Participants who reported seeking employment in the past 12 months indicated specific barriers to employment that they had experienced in one or more situations, including: lack of job availability, lack of job training, concern of earning too much/losing benefits, concern due to the pandemic/health, and discrimination.

Barriers to service use. Participants who had needed but did not use one or more services indicated specific barriers that they experienced, including: not LGBTQ+ friendly; not racially or culturally affirming; too expensive; difficult to apply or may not quality; location or difficult to access; not available.

Binge drinking. Having five or more drinks on one occasion during the past 30 days.[56]

Chronic conditions. Assessed by asking if participants had ever had a doctor, nurse, or other health professional diagnose them with any of the following conditions: arthritis, diabetes (excluding prediabetes and diabetes during pregnancy), hypertension (excluding hypertension during pregnancy), asthma, high cholesterol level, cardiovascular disease (i.e., heart attack, angina or coronary heart disease, and/or a stroke), respiratory issues (i.e. chronic obstructive pulmonary disease [COPD], emphysema or chronic bronchitis), kidney disease (excluding kidney stones, bladder infection or incontinence), and cancer.

Cisgender. A term used to describe a person whose gender identity aligns with those typically associated with the sex assigned to them at birth.[57]

Cognitive impairment. Yes or no response to question asking if participants had serious difficulty concentrating, remembering, or making decisions.[58]

Comfortability using services. The extent to which participants felt comfortable using services they needed as an LGBTQ+ person in the past 12 months. Dichotomized into comfortable (very, somewhat) and uncomfortable (very, somewhat). Participants reported comfortability for each service they had used, including: social support; in-home care; food assistance; transportation; adult day programs; case manager or social worker; mental health services/substance use treatment; caregiver support; information and referral for seniors; medical and health services; housing; veterans services; employment or job seeking support; HIV specific services; medication assistance; facility/foster/residential placement; other.

Confidence in using technology. Participants indicated their confidence level with the following: using a computer or other device (cell phone, tablet, computer, etc.) to send/receive email; using a video chat service (FaceTime, Zoom, etc.) to communicate with those in their personal life; scheduling an appointment with a health provider online; attending a virtual or telehealth appointment; communicating with a virtual support network (message boards, social media groups, etc.). Dichotomized into confident (very and somewhat confident) and unconfident (a little and not at all confident).

COVID-19. Participants were asked about their experiences with COVID-19, including questions about their health (infection), the health of those they know (infection and death), vaccination status, their concerns due to the pandemic, and their increased, maintained, and decreased use of various services (i.e., social support; in-home care; food assistance; transportation; adult day programs; case manager or social worker; mental health services/substance use treatment; caregiver support; information and referral for seniors; medical and health services; housing; veterans services; employment or job seeking support; HIV specific services; medication assistance; facility/foster/residential placement; faith, spiritual, or religious service) We also assessed their needs and use of COVID-19 related supports and services, comfortability in using them, and whether their health care providers had offered or expanded telehealth

services. Participants also indicated whether they learned how to use a new technology device, application, or computer program during the pandemic.

Disability. Endorsement of any of the following six conditions was defined as a disability: being deaf or having serious difficulty hearing; being blind or having serious difficulty seeing (even with glasses); having serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition; having serious difficulty walking or climbing stairs; difficulty dressing or bathing; having difficulty doing errands alone, such as visiting a doctor's office or shopping, because of a physical, mental, or emotional condition.[59] Variables to assess disability accordingly have been available in OR-BRFSS since 2016.[58]

Discrimination and bias. Participants were asked if they were treated unfairly or discriminated against in the past 12 months and selected their perceived reasons from the following: gender, gender identity, gender expression, sexual orientation, race or skin color, speaking a language other than English, immigration status, ancestry or national origin, age, disability, poverty, and/or some other reason.

Drug abuse. Affirmation to any of the following statements: participants "used prescription drugs more than prescribed"; "used drugs other than those required for medical reasons"; "injected any drug other than those prescribed for you" in the past 30 days.

E-cigarette use. Use of e-cigarettes or other electronic vaping products at least one time in the past 30 days.[58]

Education. Determined by the highest level of education completed using the following categories: less than high school, high school or GED, some college (less than four years of college), four years of college (bachelor's degree), or more than four years of college (master's degree or higher).

Elder abuse. Participants selected incidents that they had experienced in the past 12 months: physically hurt, pushed, punched, or assaulted in any way or physically threatened by someone; felt that someone was controlling or harassing them; verbally abused or threatened by someone; touched, grabbed, or groped without their consent, or forced to do sexual acts; left without basic needs by someone who was supposed to take care of them; scammed or felt forced or tricked to give someone money or property. Participants who experienced any of the incidents indicated whether they had reported the incidents to authorities and who they turned to for support, if they did turn to anyone.

Employed, unemployed, or retired. Participants selected one of the following categories: retired, employed (i.e., employed for wages and self-employed), unemployed (i.e., out of work for one year or more and out of work for less than one year), homemaker, a student, or unable to work.

End-of-life plans. Participants selected all end-of-life plans that they had completed: will; trust; power of attorney for health care; end-of-life care plan such as Portable Orders for Life-Sustaining Treatment; funeral plans.

Food insecurity. Assessed with a question, "How often in the past 12 months would you say you were worried or stressed about having enough money to buy nutritious meals?"[60] Dichotomized as yes (always, usually, sometimes) or no (rarely, never).

Frequent activity limitations. Number of days during the past 30 days when poor physical or mental health kept participants from doing their usual activities, such as self-care, work, or recreation. Dichotomized into 15 days or more vs. less than 15 days.[31]

Frequent poor physical and mental distress. Number of days during the past 30 days when physical (including illness and injury) or mental (including stress, depression, and problems with emotions) health was not good. Both were dichotomized into 15 days or more vs. less than 15 days.[31]

Frequent use of marijuana. Twenty or more days using marijuana in the past 30 days.[58]

Frontier areas. Any geographic areas having six or fewer people per square mile.[21]

Gender. Participants selected their current gender by selecting one or more of the following categories: woman (including transgender woman, transfemi-

nine), man (including transgender man, transmasculine), gender diverse (including gender non-binary and gender non-conforming), and not listed above.

Gender diverse. A term used to describe diversities in gender and gender identities and expressions, including those whose self-identification of gender does not align with binary gender (women versus men).[57] Gender diverse people were coded to include those self-identifying as gender non-conforming/gender non-binary/gender diverse, other gender, and/or multiple gender.

Gender identity. One's innermost concept of self as a man, woman, a blend of both, or neither – how individuals perceive themselves and what they call themselves.[57] One's gender identity can be the same or different from their sex assigned at birth.

General health. Participants were asked how, in general, they would rate their health.[58] Response categories were dichotomized as poor (poor, fair) and good (good, very good, excellent).

Household assets. Household assets after accounting for debts was categorized as: less than $10,000, $10,000 to less than $50,000, $50,000 to less than $100,000, $100,000 to less than $500,000, and $50,000 or more.

Household income. Household income before taxes in 2020 was categorized as: $20,000 or less; $20,001 through $30,000; $30,001 through $40,000; $40,001 through $50,000; $50,001 through $60,000; $60,001 through $70,000; $70,001 through $80,000; greater than $80,000. Income was dichotomized by factoring household income with household size to determine whether participants were above 200% of the federal poverty line (FPL) or at or below 200% of the FPL in 2020.[19]

Housing instability and reasons. Participants indicated how confident they were that they could continue living in their current housing for as long as they would like. Answers were dichotomized to indicate confident (very confident) or unconfident (somewhat or a little confident, or not confident at all). Participants who reported housing instability (being unconfident) selected the specific reasons from the following: health reasons; economic reasons (risk of foreclosure or eviction); aging-related needs; unsafe housing or environment; wanting to move in with family or friends; rising crime in neighborhood; other.

Identity concealment. Participants indicated how many of the following people they had disclosed their sexual and/or gender identity and expression to: healthcare and other service providers; close friends or chosen family; other biological family; neighbors; and peers in facility or residential setting. Dichotomized into concealed (no one, almost no one) or disclosed (some people, most people, almost everyone, everyone).

Income instability. Yes or no response to question of whether participants had any months in the past 12 months when they struggled to pay bills because income was lower than normal.[58]

Internet access. Degree of agreement to the statement, "I have access to reliable high-speed internet through a computer, phone, or other device" (1 = strongly disagree to 6 = strongly agree). Dichotomized into agree or disagree.

LGBTQ+ bias. How often in the past 12 months participants had been treated unfairly or discriminated against due to their sexual orientation or gender identity or expression. Dichotomized into yes (often, sometimes, rarely) or no (never). Participants who indicated unfair treatment or discrimination selected the specific settings where they experienced each instance of LGBTQ+ bias: medical or health services; aging services; other social services; job or place of employment; faith, spiritual, or religious setting; housing; public place; interaction with police or law enforcement; other.

LGBTQ+ community engagement. Assessed with mean scores of four items (I help other people in the community; I get help from the community; I volunteer in the community; I participate in advocacy activities/events) on a 6-point Likert scale (1 = strongly disagree to 6 = strongly agree).[61] Cronbach's alpha was 0.73. Each item was also dichotomized to indicate agreement or disagreement with each statement.

Marital and partnership status. Participants selected current relationship status from the following: married, legally recognized; partnered, not married; registered domestic partnership, not married; single; divorced; widowed; separated; other.

Obesity. Participants who indicated that they had a BMI of 30 or higher (calculated from weight and height) were defined as obese.[62]

Physical activity. Yes or no response to the question of whether during the past month participants had participated in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise, other than in their regular job.

Quality of life. Participants were asked how, in general, they would rate their quality of life. Dichotomized as poor (very poor, poor, fair) and good (good, very good, excellent).

Queer. A term often used to express a range of identities and orientations. Queer is often used as an umbrella term, including for those who do not identify as exclusively straight and/or those who are sexually diverse and/or who have non-binary or gender-expansive identities. This term was previously used as a slur but has been reclaimed by many parts of the LGBTQ+ movement.[57]

Race and ethnicity. Categorized into non-Hispanic White, Hispanic (Latino/a/x or Spanish origin), Black (or African American), Asian and Pacific Islander, or Native American (includes American Indian and Alaskan Native).

Recreational marijuana. Endorsement of the statement: "I used marijuana or cannabis at least one time for non-medical reasons" in the past 30 days.

Region. Geographic locations within which participants reside were grouped into five regions by county. Region 1 (Columbia, Multnomah, Clackamas, and Washington) – Primarily urban with the largest population density in the state although Columbia Co. is not a major population center. Washington, Multnomah and Clackamas make up a "Metro" region and often work together on regional and governmental projects. There are economic and political similarities across this area. There are no federally recognized Native American tribes in this region, but it has the largest population of "urban Indians." Region 2 (Clatsop, Tillamook, Yamhill, Polk, Marion, Lincoln, Benton, Linn, and Lane) – Willamette Valley and coastal. These combined counties also represent a large population base with many similarities across counties. This encompasses the "Willamette Valley" and also northern coastal counties as aging services agencies serve much of this combined area. There are two federally recognized Native American tribes in this region. Region 3 (Douglas, Coos, Curry, Josephine, and Jackson) – Southwest Oregon has some distinct regional characteristics, geographically, politically, and culturally. This area is a mix of rural and coastal with some population centers throughout the region. This area benefits from tourism, with mountains, rivers and ocean areas and also has a relatively large retiree population. There are three federally recognized Native American tribes in this region. Region 4 (Hood River, Wasco, Jefferson, Crook, Deschutes, and Klamath) – This area is mostly rural, with some population centers. These counties have some distinct differences but also share common threads. There is a large agricultural base and outdoor tourism and recreation. There are two federally recognized Native American tribes and citizens of many more federally recognized tribes in the Columbia River Gorge area in the north. Region 5 (Sherman, Gilliam, Morrow, Umatilla, Union, Wallowa, Wheeler, Grant, Baker, Lake, Harney, and Malheur) – This area is composed of mostly frontier counties with some population centers. Population density is relatively low. Agriculture and ranching are dominant. This area also has large areas that are medically underserved, and people often travel long distances for medical, dental and other services. There are two federally recognized Native American tribes in this region.

Resilience. Assessed with mean scores of three items ("I tend to bounce back quickly after hard times"; "It is hard for me to snap back when something bad happens"; "I usually come through difficult times with little trouble") on a 6-point scale (1 = strongly disagree to 6 = strongly agree; =0.76).[61] Items were dichotomized to indicate agreement or disagreement.

Rural areas. Any geographic area at least ten miles from a population center of 40,000 or more people.[21]

Self-neglect. Yes or no response to the question of whether participants experienced not having their own basic needs met, such as lack of food, cleanliness, or safety, in the past 30 days.

Service needs. Participants were asked whether they had needed the following services in the past 12 months: social support; in-home care; food assistance; transportation; adult day programs; case manager or social worker; mental health services/substance use treatment; caregiver support; information and referral for seniors; medical and health services; housing; veterans services employment or job seeking support; HIV specific services; medication assistance; facility/foster/residential placement; other.

Sexual orientation. An induring or immutable enduring emotional, romantic or sexual attraction to other people.[57] An individual's sexual orientation is independent of their gender identity. Participants selected their sexual orientation from the following categories: lesbian, gay, bisexual, queer, pansexual, same gender loving, heterosexual or straight, asexual, and not listed above.

Sexually diverse. A term referring to diversities in sexual orientation and sexual identities and expressions.[57] Sexually diverse people were coded to include those self-identifying their sexual orientation as something other than lesbian, gay, bisexual, or queer, including pansexual, same gender loving, asexual, and other sexual orientations and identities.

Smoking. Current smokers were defined as those who are currently smoking some days or every day and have smoked at least 100 cigarettes in their lifetime.[63]

Social support. Assessed with a question, "How often do you get the social and emotional support you need?"[58] Answers were dichotomized to indicate "always, usually, or sometimes" vs. "never or rarely.".

Spiritual/religious activity. Whether or not participants attended faith, spiritual, or religious services or activities in person or virtually at least one time in the past 30 days.

Subjective cognitive decline. Yes or no response to question asking if participants had experienced confusion or memory loss that was happening more often or getting worse.[58]

Support network size. Summed number of people that participants turned to for support, encouragement, or short-term help (such as to run an errand or get a ride), from the following categories: friends, children, legal/biological family, chosen family, neighbor, faith community, informal caregiver, paid caregiver, service provider, support group, and other. Participants provided the number indicating how many people in each category they had turned to. Dichotomized into '3 or more' and 'less than 3'.

Technology access and needs. Degree of agreement to the statements, "I need assistance or training with accessing and using technology (computer, phone, etc.)" and, "I need assistance to connect virtually with groups or other services and supports." (1 = strongly disagree to 6 = strongly agree). Each was dichotomized into agree or disagree, and agreement with either of the two was also assessed.

Transgender. An umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation. Therefore, transgender people may identify as straight, gay, lesbian, bisexual, etc.[57] In this study, those who identified themselves as transgender and/or those who did not identify with the same gender assigned to them at birth were considered transgender.

Two Spirit. The historical and contemporary indigenous construction of sexuality and gender as non-binary and co-existing within the same human body. [16] Yes or no response to question asking whether participants consider themselves Two Spirit.

Unmet service needs. Services that participants needed but did not use in the past 12 months.

Veteran status. Yes or no response to question asking whether participants had served in the military.

Work hours. Participants selected one of the following for weekly hours of work in paid employment: 1-14 hours; 15-34 hours; 35 hours or more.

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