

Inclusive Care Practices and Policies Among Sexual and Gender Minority Older Adults

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ABSTRACT

As the health care and well-being of sexual and gender minority (SGM; i.e., lesbian, gay, bisexual, and/or transgender or gender non-binary) people in the United States receive federal and local-level attention, SGM older adults and caregivers continue to be left out of important health policy and care conversations. The current article describes policy issues and affirmative strategies related to inclusive care practices among SGM older adults and caregivers. In addition to the broader policies considered related to health and well-being, we include a discussion of local-level policy strategies to mitigate discrimination and promote inclusive care for SGM older adults and caregivers. [*Journal of Gerontological Nursing*, 48(12), 6-15.]

The health and well-being of sexual and gender minority (SGM; i.e., lesbian, gay, bisexual, and/or transgender or gender non-binary) people in the United States, including their access to and experiences with health care, is receiving increased attention politically at the federal, state, and local levels. In 2016, SGM adults were recognized by the National Institutes of Health (NIH) as a population that experi-

ences health disparities (Pérez-Stable, 2016), yet SGM older adults and SGM caregivers continue to be left out of many policy conversations. In the current article, we briefly review the health disparities experienced by SGM older adults and caregivers, focusing on policy issues at the federal and local levels and affirmative strategies related to inclusive nursing care practices and education to mitigate discrimination and promote inclusive

care for SGM older adults and caregivers (Table 1).

SGM is an umbrella term representing individuals who identify as lesbian, gay, bisexual (sexual minorities), and/or transgender or non-binary, and individuals whose gender identity, gender expression, or reproductive development varies from traditional, societal, cultural, and/or physiological norms (gender minorities) (NIH, 2022). The term *transgender* represents individuals who self-identify with a gender identity that does not align with the sex assigned to them at birth, and they can be of any sexual orientation. *Cisgender* refers to individuals with a gender identity that aligns with their sex assigned at birth. Hereafter, *non-SGM* refers to individuals who identify as heterosexual and cisgender.

HEALTH DISPARITIES AND DISCRIMINATION EXPERIENCED BY SGM OLDER ADULTS

An estimated 2 to 4 million SGM older adults live in the United States, with this number expected to double by 2030 (Caceres et al., 2020). The combined effects of the overall aging U.S. population and an increasing willingness by older adults to disclose their sexual orientation and gender identity in the wake of increased ac-

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TABLE 1

Background of Existing or Proposed Legislation and Actions for Nurses and Nursing Researchers for Sexual and Gender Minority (SGM) Older Adults

| Existing or Proposed Legislation | Background | Actions for Nurses and Nursing Researchers |
|----------------------------------|---|--|
| The Equality Act | <p>Federal legislation passed in the House of Representatives in 2019</p> <p>Currently being considered by the U.S. Senate</p> <p>Would ensure SGM older adults have comprehensive protection in health care under federal law</p> <p>Would address increased urgency to codify the rights of SGM people following <i>Dobbs v. Jackson</i></p> | <p>Advocate for inclusive policies at the organizational level to support health of SGM older adults</p> <p>Actively decrease biases in existing organizational policies</p> <p>Address knowledge gaps regarding communication and care approaches when working with SGM older adults</p> <p>Revise patient intake and assessment forms and electronic health records to include SGM-affirming language</p> <p>Engage in training on the importance of, how best to ask, and how to collect data about sexual orientation and gender identity</p> <p>Offer/require continuing education regarding culturally congruent care of SGM older adults (Models of education in SGM-affirming care from Services and Advocacy for LGBT Elders [SAGE])</p> <p>Incorporate focused education related to SGM health and health disparities and culturally congruent care in line with the revised <i>Essentials</i> from the American Association of Colleges of Nursing (2021)</p> <p>Support training initiatives specific to implicit bias, microaggressions, SGM-affirming approaches to care, and trauma-informed care</p> |
| Older Americans Act | <p>Federal legislation passed in 1965 to address lack of community social services for older adults</p> <p>Established grants to states for community planning and social services, research and development projects, and personnel training and established the Administration on Aging</p> <p>Authorizes service programs through a national network of state agencies on aging, area agencies on aging, service providers, and tribal organizations</p> <p>Reauthorization in 2020 included specific provisions for SGM older adult populations requiring agencies to include outreach to SGM older adults in the community</p> | <p>Address stigma and discrimination experienced by SGM older adults in health care and long-term care services and supports</p> <p>Engage SGM older adults in dialogue to address social and health needs from inequities and inadequate policy</p> |

ceptance of SGM people over time contribute to this exponential increase in the number of SGM older adults. SGM older adults have experienced current and historical discrimination in terms of lack of opportunities and legal protections for basic human rights (e.g., housing, employment, marriage, health care), which can have

a deleterious impact on their health (National Academies of Sciences, Engineering, and Medicine [NASEM], 2020).

Compared with their non-SGM peers, SGM older adults experience a higher prevalence of chronic disease and disability, including cardiovascular disease (Caceres et al., 2017;

Sherman, Dyar, et al., 2022) and cognitive impairment (Flatt et al., 2018; Fredriksen-Goldsen et al., 2018; Hsieh et al., 2021; McGovern, 2014); increased rates of depression and depressive symptoms (Nelson & Andel, 2020); and increased prevalence of risky health behaviors, such as smoking, excessive drinking, and poor diet

TABLE 1 (CONTINUED)

Background of Existing or Proposed Legislation and Actions for Nurses and Nursing Researchers for Sexual and Gender Minority (SGM) Older Adults

| Existing or Proposed Legislation | Background | Actions for Nurses and Nursing Researchers |
|---|--|---|
| Recognize, Assist, Include, Support, and Engage Family Caregivers (RAISE) Act | <p>Federal legislation passed in 2017 to create a national family caregiving strategy</p> <p>Tasks Department of Health and Human Services with creating a national family caregiver strategy incorporating family-centered approaches across care settings</p> <p>Includes support for caregivers with information and education, respite services, and financial well-being</p> | <p>Incorporate family- and person-centered approaches to care of SGM older adults to address unique experiences (e.g., higher likelihood of aging alone, decreased likelihood of having children or spouse to assist with care)</p> <p>Develop culturally congruent services and supports for SGM older adults and caregivers</p> |
| LGBTQI Data Inclusion Act | <p>Federal legislation passed in the House of Representatives in June 2022</p> <p>Would require federal agencies to include questions assessing sexual orientation and gender identity whenever demographic data are collected</p> <p>Would support Healthy People 2030 goal to increase number of national surveys collecting data regarding sexual orientation and gender identity</p> | <p>Assess sex assigned at birth, gender identity, and sexual orientation</p> <p>Explore novel recruitment methods to engage SGM older adults</p> <p>Enhance data collection among diverse SGM older adults</p> <p>Train and mentor early-career researchers in SGM aging research</p> |

(Potter & Patterson, 2019). For SGM older adults, these health disparities may be intensified by chronic exposure to stigma and discrimination, particularly regarding access to and use of health care; isolation and lack of support and feelings of belonging; and concerns about loss of independence, physically and financially, as they age (Chen et al., 2022). However, it is important to note that health inequities are not uniformly experienced across individual SGM communities, and gender minority older adults and several sexual minority communities (e.g., bisexual, pansexual, and queer adults) remain underrepresented in aging research (Cicero et al., 2020b; Flatt et al., 2022; NASEM, 2020). The limited breadth of aging research illuminating the health concerns of these historically underrepresented SGM communities may hinder the development of policies aimed to improve health and well-being.

SGM older adults report feelings of vulnerability in community settings

and fear of being targets of discrimination in terms of ageism, homophobia and transphobia, and/or racism (Chen et al., 2022). Within the SGM community itself, a recent study found that access varies according to one's particular SGM identity. Specifically, lesbians reported more community belonging than other identity groups and bisexual male respondents reported less community belonging than gay male respondents (Kittle et al., 2022b). SGM individuals of color face heightened health disparities and more barriers to health care (Cicero et al., 2019). For instance, a recent study showed that Black transgender women reporting at least one barrier to health care experience significantly higher polyvictimization, posttraumatic stress disorder, and depression compared with women who reported no barriers (Sherman, Balthazar, et al., 2022). In another study, African American SGM caregivers of people living with dementia reported significantly higher levels of depressive

symptoms than their White SGM peers (Anderson et al., 2021).

There is also fear among SGM older adults of having one's sexual orientation, gender identity, and/or HIV status disclosed and the impact of such disclosure on access to health care and long-term care services and supports (Chen et al., 2022). In a survey of 1,762 SGM adults aged ≥45 years, including 1,498 sexual minority and 264 gender minority respondents, more than one third (37%) of sexual minority and approximately two thirds (66%) of gender minority adults reported some level of concern about their health care being potentially compromised because of discrimination related to their SGM identity (AARP, 2020). However, findings from a more recent study (Kittle et al., 2022a) suggested a potentially positive relationship between disclosure of SGM identity to family members and friends and SGM adults taking part in health screenings, with more pronounced effects among

SGM individuals with higher levels of social support.

Given the fear of stigma and lack of safe, affirming, and supportive spaces to connect with other community members, SGM older adults may withdraw from community participation (Coleman, 2017), increasing social isolation. Risk of social isolation among SGM older adults is also affected by decreased access to social and emotional support exacerbated by loss of friends and chosen family from HIV/AIDS, strained relationships with one's biological families and religious communities, and an increased likelihood of being single (Flatt et al., 2018). Fear of losing physical and financial independence is heightened among SGM older adults, particularly for those without partners or children, and those experiencing racial and gender inequities in wages (Kim & Fredriksen-Goldsen, 2017). Finally, there remains lack of SGM research with an aging focus that takes an intersectional lens to understand the diversity of aging experiences within this cohort related to how systems of power and privilege affect one's lived experiences and health status across the lifespan in terms of gender, race, ethnicity, sexual orientation, (dis)ability status, and other sources of stigma and oppression (Flatt et al., 2022).

FEDERAL POLICY ISSUES

Current federal civil rights legislation does not offer protection in health care settings and may be compromised by so-called "conscience rules" that allow providers to deny care to SGM individuals based on the provider's religious beliefs. For example, counselors and therapists providing behavioral health care in independent practice in Tennessee are legally allowed to deny services to clients based on the provider's "sincerely held principles" (Conscientious Objections to Provisions of Counseling & Therapy Services, 2016, part [a]). The Equality Act (2021) is a piece of federal legislation that was passed in the House of Representatives in 2019

and is currently being considered by the U.S. Senate. If passed, SGM older adults would have comprehensive protection in health care under federal law (Equality Act, 2021). Passage of the Equality Act would also address the increased urgency to codify the rights of SGM people in the wake of the recent ruling by the U.S. Supreme Court on abortion (*Dobbs v. Jackson*, 2022) and its potential impact on SGM communities.

Increased concerns regarding a rollback of SGM rights relate to a statement by U.S. Supreme Court Justice Alito, who asserted rights not enumerated in the Constitution cannot be recognized as fundamental rights unless these have deep historic roots, creating concerns about the standing of rulings related to privacy (*Lawrence v. Texas*, 2003) and marriage equality (*Obergefell v. Hodges*, 2015) that have sustained the rights of SGM people. Although Justice Alito indicated the ruling in *Dobbs v. Jackson* (2022) only applies to the right to an abortion, U.S. Supreme Court Justice Thomas has called for a review of these previous decisions, which would have an impact on the legal standing of SGM people within the health care system, as well as affect access to care more broadly (Sagal, 2022). Although full repeal of the rulings in *Lawrence v. Texas* (2003) and *Obergefell v. Hodges* (2015) may not be an eminent threat, continual assaults on these rulings are a possibility given this was the pattern with *Roe v. Wade* (1973) (Kaval, 2022).

As of this writing, recent health-care related policies, such as the American Rescue Plan and Inflation Reduction Act (2022) that supplement provisions related to health care access found in the Affordable Care Act (i.e., increasing subsidies for health care coverage) or caps on out-of-pocket spending on prescription medications for Medicare beneficiaries, do not include any SGM-specific provisions (Kaiser Family Foundation, 2022).

Older Americans Act

For older adults living in the community, independently or with family or friends, long-term care services and supports are frequently funded with monies from the Older Americans Act (1965). Congress passed the Older Americans Act in 1965 in response to a concern about lack of community social services for older adults (Fox-Grage & Ujvari, 2014). The original legislation established authority for grants to states for community planning and social services, research and development projects, and personnel training and established the Administration on Aging to administer these funds (Fox-Grage & Ujvari, 2014). The Older Americans Act authorizes a wide array of service programs through a national network of state agencies on aging, area agencies on aging, service providers, and tribal organizations (Fox-Grage & Ujvari, 2014). Reauthorization of the Older Americans Act in 2020 included specific provisions for SGM older adult populations. The reauthorization requires state agencies on aging and area agencies on aging to undertake outreach to SGM older adults in the community, requiring data collection and reporting on the needs of SGM older adults in the communities served and whether these needs are being met (Services and Advocacy for LGBT Elders [SAGE], 2020).

Recognize, Assist, Include, Support, and Engage Family Caregivers (RAISE) Act

Informal caregiving of older adults by family and friends in the United States has an estimated, yet uncompensated, economic value of \$470 billion and remains a cornerstone of the long-term care of older adults in this country (Reinhard et al., 2019). This estimated value of unpaid care far exceeds the amount of funding received annually by nursing homes or home health agencies. As such, informal caregiving has an enormous impact on aging and long-term care policy at the federal level. In 2017, Congress

passed the RAISE Act in response to a report from the Commission on Long-Term Care urging adoption of a national family caregiving strategy (Lipson, 2015). In response to the RAISE Act, the U.S. Department of Health and Human Services was tasked with creating a national family caregiver strategy to incorporate family-centered approaches to care of older adults across care settings. The strategy includes support for caregivers in the form of information and education, respite services, and issues related to the financial well-being of caregivers (Administration for Community Living, 2021). Such a family- and person-centered approach to informal caregiving holds specific implications for the well-being of SGM older adults and their caregivers given their unique experiences, including a higher likelihood of aging alone in place and a decreased likelihood of having children or a spouse to assist with care (Flatt et al., 2018), as well as decreased use of existing caregiver support services among SGM caregivers (Anderson et al., 2021).

SGM adults are more likely to become caregivers than their non-SGM peers (one in five vs. one in six; AARP & National Alliance for Caregiving, 2015). Given that SGM people in the general population experience poorer physical and mental health (NASEM, 2020), the overlap of SGM and caregiver identities increases the likelihood of a negative impact of caregiving among this group (e.g., increased emotional or physical strain). Community- and population-based studies find SGM caregivers experience significantly higher levels of depression, disability, victimization, discrimination, and stress compared with non-SGM caregivers (Anderson et al., 2022; Boehmer et al., 2019; Fredriksen-Goldsen & Hoy-Ellis, 2007; Muraco & Fredriksen-Goldsen, 2014), likely increasing their risk for poor health and reduced quality of life (Chan & Leung, 2021).

Most services and supports for caregivers were designed without

SGM caregivers in mind and might not translate well for SGM caregivers because these resources do not consider the unique needs and experiences of SGM individuals who are also caregivers. SGM caregivers are different from their non-SGM caregiving peers in that SGM caregivers are significantly younger and more racially and ethnically diverse (Anderson & Flatt, 2018; Anderson et al., 2021; Anderson et al., 2022; Boehmer et al., 2019; Fredriksen-Goldsen & Hoy-Ellis, 2007; Kittle et al., 2021); more likely to help with medical and nursing tasks (e.g., managing medications, monitoring blood pressure) (Anderson & Flatt, 2018); more likely to work full time (Anderson & Flatt, 2018; Anderson et al., 2021; Anderson et al., 2022); find it more difficult to take care of their own health (Kittle et al., 2021); more frequently are non-spousal caregivers and care for friends (Anderson & Flatt, 2018; Anderson et al., 2021; Anderson et al., 2022); and experience higher levels of physical, emotional, and financial stress (Anderson & Flatt, 2018; Anderson et al., 2021; Anderson et al., 2022; Boehmer et al., 2019; Fredriksen-Goldsen & Hoy-Ellis, 2007; Kittle et al., 2021).

In a recent study, one third of SGM caregivers of people living with dementia reported high stress, 75% reported moderate-high stress, and 78% experienced depressive symptoms (Anderson et al., 2021). These high levels of stress and depressive symptoms were significantly correlated with reporting greater experiences of microaggressions discrimination related to their SGM identity and caregiver stigma (Anderson et al., 2021). The higher levels of stress experienced by SGM caregivers also may be related to less frequently seeking supportive services and disclosing their SGM identities (Anderson et al., 2021; Croghan et al., 2014), as well as several barriers unique to SGM caregivers. For example, SGM care partnerships may experience overlapping years of stigma (Jablonski

et al., 2013), including higher levels of caregiver stigma (Anderson et al., 2021; Anderson et al., 2022) and self-stigma (Chan & Leung, 2021), with fear of discrimination, denial of services, and/or receipt of poor-quality services leading to a reluctance to seek support (Fredriksen-Goldsen & Hoy-Ellis, 2007). Moreover, depression and stress have direct links to negative health outcomes, including hypertension and increased inflammation, which are independent risk factors for more significant disease, including Alzheimer's disease and increased all-cause mortality (Heppner et al., 2015).

Long-Term Care Policy Issues

Generally, long-term care policy at the federal level in the United States has focused on reducing costs of residential long-term care to state and federal Medicaid budgets. To do so, the onus is put on older adults and their families with the assumption that aging in place with informal care and community-based long-term care services and supports is feasible (Gaugler, 2016). This policy approach to long-term care assumes that older adults have informal caregiving support from family and friends as well as access to community services, but this may not apply to all older adults. SGM older adults are not only more likely to need assistance as they age given what we know about their health disparities and barriers to aging supports, but they are also less likely to have informal caregiving support because many do not have partners/spouses or children (Flatt et al., 2018). Approximately one in 10 SGM caregivers are caring for a friend or neighbor (Anderson & Flatt, 2018; Anderson et al., 2021), with SGM older adults more frequently relying on chosen family rather than biological family to meet caregiving needs. This reliance on diverse family structures is significant when one considers the lack of existing long-term care services and supports reflecting knowledge and understanding of the well-

being of SGM caregivers from diverse backgrounds, as well as the empirically determined needs and experiences of SGM caregivers (e.g., diverse family structures) (Anderson & Flatt, 2018). More research is particularly needed to understand the needs and experiences of caregivers who identify as a gender minority as well as some sexual minority communities (e.g., bisexual, pansexual, and queer caregivers). Services and supports developed for SGM older adults and SGM caregivers must be developed using an intersectional lens.

LGBTQI Data Inclusion Act

Collection and analysis of nationally representative health data is a vital tool used to direct public health policy initiatives. For example, the National Health Interview Survey (NHIS) has been conducted annually since 1957 and remains the primary source of health-related data in the United States. Data from the NHIS help guide and influence federal agencies in creating national initiatives for health and health policy as well as tracking health outcomes (Centers for Disease Control and Prevention [CDC], 2014b). However, data collection about SGM people in the United States continues to lag behind the documented needs. For example, the NHIS currently only assesses the experiences of sexual minorities and does not ask about gender identity. This assessment limits our understanding of the health experiences of gender minorities. Without these valuable data, inclusive policy to support the SGM population will remain elusive or limited (NASEM, 2020).

Recent estimates of the proportion of the population represented by SGM older adults are an underrepresentation (NASEM, 2020, 2022). For example, same sex couples were not included in the federal census until 2010. Even then, the census questionnaire did not ask specific questions about sexual orientation. Data were extrapolated by identifying couples of the same sex who indicated a mar-

ried or partnered relationship status (Deschamps & Singer, 2016). Gender minority individuals remain severely underrepresented, whereas intersex populations remain excluded from national surveys and, thus, excluded from person-centered services.

Following recommendations from a 2011 report from the Institute of Medicine (now NASEM), questions related to sexual orientation were added to the NHIS for the first time in 2013. Beginning in 2014, the CDC (2014a) Behavioral Risk Factor Surveillance System (BRFSS) offered states an optional module that assessed sexual orientation and gender identity. The BRFSS is the largest continuously conducted annual cross-sectional health survey implemented by the CDC in all states and participating U.S. territories. Although this annual health surveillance is not specific to older adults, data are collected at the state and territory level on the health and health behaviors of noninstitutionalized adults residing in the United States who are aged ≥ 18 years (Cicero et al., 2020a). The Healthy People 2030 goals include increasing the number of national surveys that collect data regarding sexual orientation and gender identity (U.S. Department of Health and Human Services, 2020). The LGBTQI Data Inclusion Act (2022) was passed by the House of Representatives in June 2022. This legislation would require federal agencies to include questions assessing sexual orientation and gender identity whenever demographic data are collected.

In the meantime, nursing and health sciences researchers can begin to address these gaps by taking on-board recommendations from Flatt et al. (2022) regarding inclusion of SGM older adults in aging research. These recommendations included assessing sex assigned at birth; gender identity and sexual orientation in aging studies; exploring novel recruitment methods to engage SGM older adults (e.g., community-driven approaches); enhancing data collection

among diverse SGM older adults; and training and mentoring early-career researchers in SGM aging research (Flatt et al., 2022).

LOCAL-LEVEL POLICY ISSUES

Many programs and policies designed to support older adults and their caregivers are developed and implemented at local and state levels. This development and implementation includes regulation of long-term care services and supports for such things as respite services, adult day services, mobile meals, and in-home care (Dawson et al., 2020). These services are often designed and implemented by state agencies on aging, area agencies on aging, and other entities funded via the Older Americans Act. As a result, there is great variability in the programs available (e.g., urban vs. rural) and, particularly, the inclusiveness of services and programs provided. Political ideologies at the state level in terms of voters, state legislatures, and political leaders drive variations in outcomes and policy initiatives. In politically conservative locations, the influence of political ideology can have a disparate impact on the health and well-being of SGM people, including SGM older adults, as described earlier with regard to so-called “conscience rules” at the state or local level.

Although many southern states remain politically conservative, this area of the United States has the largest population of SGM people, with an estimated 3.3 million SGM adults living in the region (Hasenbush et al., 2014). The health and health care policies in these states that lead to poorer health outcomes may exacerbate the health disparities experienced by SGM older adults. The same is true for SGM older adults living in rural areas. An estimated 2.9 to 3.8 million SGM adults live in rural communities across the United States (Movement Advancement Project [MAP], 2019). Rural areas of the United States face significant challenges regarding access

to health care and service providers, transportation, and economic stability, which have an impact on SGM older adults living in these communities (Butler, 2017; MAP, 2019; Pope et al., 2014). SGM older adults in rural areas often face additional challenges related to social, cultural, and political climates in rural communities, which are often conservative and unsupportive (MAP, 2019). SGM adults living in rural areas more frequently encounter stigma and health-related disparities than their non-SGM peers (Rosenkrantz et al., 2017), leaving SGM older adults more vulnerable to marginalization and discrimination in settings across the continuum of care (Butler, 2017; Williams et al., 2022).

INCLUSIVE PRACTICE AND IMPLICATIONS FOR NURSING EDUCATION

Given that sexual orientation and gender identity are social determinants of health and that for the second time since its inception Healthy People established national goals and measurable objectives to improve the health and well-being of SGM adults (U.S. Department of Health and Human Services, 2020), schools and colleges of nursing have a responsibility to incorporate SGM-related topics into their curricula. However, similar to the nursing workforce, nursing students are not provided with education regarding SGM cultural and clinical competencies (Hughes et al., 2022). Nursing educators do not need to wait until policies are in place that reflect the needs of SGM older adults to address this ongoing deficit.

For example, offering and requiring a certain number of hours of continuing education regarding culturally congruent care of SGM older adults may enhance the ability to cultivate a therapeutic nurse–patient relationship (Hughes et al., 2022). Such trust is key to overcoming stigma and discrimination experienced by SGM older adults in health care settings (Nowaskie & Sewell, 2021). By providing SGM-affirming care,

nurses can engage patients in important dialogues that address social and health needs brought on by inequities resulting from inadequate policy. SGM-affirming care is of particular relevance for nurses working in states without protective statutes in which SGM older adults are at increased odds of experiencing discriminatory care (Stein et al., 2020). National organizations, such as SAGE (2017), offer models of education in SGM-affirming care.

Nurses can advocate for inclusive policies at the organizational level to support the health care and well-being of SGM older adults. These policies could ensure safe and affirming health care environments for SGM older adults by actively decreasing biases in existing policies and ensuring the inclusion of educational topics that fill knowledge gaps regarding communication and care approaches when working with SGM older adults (Hughes et al., 2022). In addition, patient intake and assessment forms and electronic health records should include SGM-affirming language but, most importantly, nurses and other clinical providers need training on the importance of, how best to ask, and how to collect data about their patients' sexual orientation and gender identity (Hughes et al., 2022; NASEM, 2020).

There continues to be minimal progress in terms of incorporation of focused education related to SGM health and health disparities and culturally congruent care despite calls from national organizations (Hughes et al., 2022). The latest revisions to *The Essentials: Core Competencies for Professional Nursing Education* by the American Association of Colleges of Nursing (2021) present an opportunity for nursing education curricula to be updated to include SGM culturally congruent care given the requirement for nurses to understand the vulnerabilities and disparities experienced by marginalized populations. Initial and ongoing education of nurses is needed to remediate disparities in the health

and health care of SGM older adults. Education directed at increasing sensitivity, competence, and knowledge of nurses is needed for early identification of the unique health needs and challenges of SGM people across the lifespan (Beckie et al., 2022). Upstream policies and supportive practices are needed to improve access to care across all dimensions (Aday & Andersen, 1974). Given that nursing education should be evidence-based, enhanced research and focused and sustained educational initiatives, as well as specific training on topics including implicit bias, microaggressions, SGM-affirming approaches to care, and trauma-informed care, are needed (Beckie et al., 2022).

CONCLUSION

Although progress is ongoing and policies having an impact on SGM health and health care access continue to be drafted and debated, nurses and nursing researchers can take the lead in ensuring inequities experienced by SGM older adults are addressed in nursing education and practice. In addition, nurses can use their voices to advocate for effective, evidence-based policy that takes an intersectional approach to the unmet needs of SGM older adults and caregivers, particularly as it relates to gender minority older adults and several sexual minority communities (e.g., bisexual, pansexual, and queer adults) that remain underrepresented in aging research and policy.

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