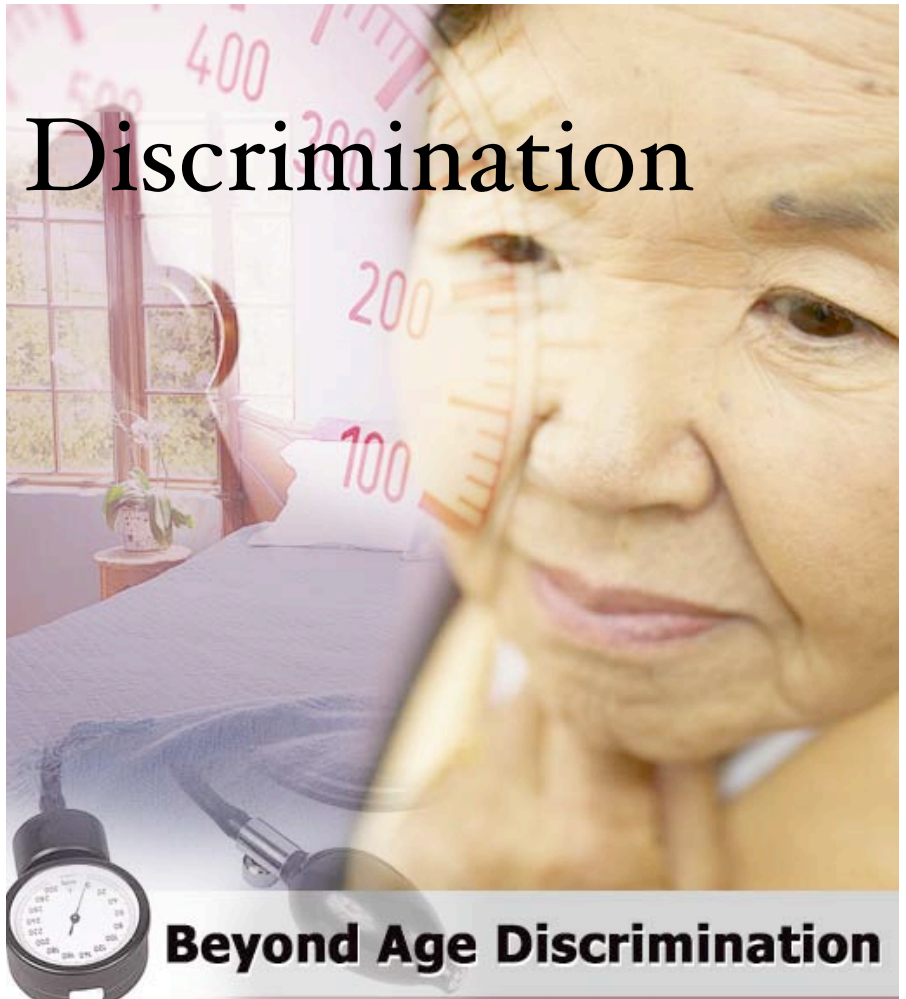


THE RIGHTS STUFF

QUARTERLY PUBLICATION OF THE MINNESOTA DEPARTMENT OF HUMAN RIGHTS • JULY 2009

Beyond Age Discrimination

As Minnesotans grow older, many become vulnerable, dependent upon others — in nursing homes and as recipients of an array of social services — to meet their basic needs. Are they vulnerable to discrimination as well?



Beyond Age Discrimination

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As I See It



Commissioner Velma Korbelt shares her point of view on a variety of topics in this blog

Aging with Grace... and Dignity

As I approach my middle years, I have been thinking about a lot of things that probably occupy the thoughts of other people as they approach a milestone at the summit, or on the down-slope of the hill:

Will I be able to afford retirement? Have I done enough to prepare my children to be responsible, contributing members of society? What do I need to do to keep myself physically fit and healthy to avoid illness and disease as I age? In the event my health fades and I am forced to rely on someone else for my care, will I be cared for with dignity and respect?

For many Minnesotans, growing old means becoming vulnerable, or dependent upon others to meet their basic needs. As they age and become dependent on nursing homes or a variety of social service organizations for long-term care, are they vulnerable to illegal discrimination as well?

There have been too many stories in the news about elderly persons being mistreated by the



Commissioner Velma Korbelt

people who are responsible for providing their care. But what about the senior who is a Muslim, who is not allowed to pray five times a day? What about a member of the GLBT community who cannot live out her life the way she has always lived? Whether an elderly person requires long-term care in or out of their home, who

will ensure that they are treated with dignity and respect?

Fortunately, in Minnesota we have the Minnesota Human Rights Act

(MHRA), which provides that no person shall be discriminated against on the basis of race, color, creed, religion, national origin, sex, marital status, disability, status with regard to public assistance, familial

status, sexual orientation or age. The MHRA provides protection from discrimination to persons from birth to death. I understand that many elderly persons might believe that the protection of their civil rights come second to their concern about stretching their fixed income to cover their bills—that they would rather endure discriminatory treatment than try to change it. But at the Human Rights Department, we don't see it that way. Every person is entitled to dignity and respect, regardless of their age or circumstances.

In her later years, when my mother would remark about being treated poorly by someone, she would say to me, "Don't you worry – they will get where I am soon enough. And it won't be so funny then." When I am an old woman I may have to worry about finding just the right red hat that doesn't go with my purple dress, but thanks to the MHRA's protections, I will not have to worry about my ability to live, and grow old with grace...and dignity.

*I invite you to read the current issue of our on-line newsletter, *The Rights Stuff*, where we take an in-depth look at the issues of aging and discrimination.*

Case of the Month

Department of Human Rights finds probable cause that Ames Construction engaged in disability discrimination and reprisal



When a non-white janitor complained about finding a noose — then a picture of a person hanging from a noose — in his workplace, a manager allegedly told him to get over it and “fit in”

What the charging party alleged:

When he was interviewed for a job as a custodian, Joshua Feldten acknowledged that because of a disability, he would need people to show him how to do things, rather than reading written directions. He was hired in March 2006; three months later, he began to have problems at work. He lost his driver’s license following a traffic violation, and a company manager became upset that he would not be able to drive to deliver water to job sites. He argued that driving had not been one of his duties when he was hired, and asked the manager for a job description — it was never provided.

Soon he began to have problems with a coworker, who insisted upon giving him work directions, although the coworker had no authority to do so. The coworker would repeatedly become angry with Feldten, call him “dumb,” swear at him, and at one point vowed to make his “life a living hell.” “Every f***ing day you are in here at the same time doing the same f***ing thing. It’s getting f***ing old. That’s it!” the coworker shouted, grabbing a broom out of Feldten’s hand and throwing it.

Feldten complained about this treatment to the manager, who seemed to dismiss his concerns. “We all call each other dumb around here,” the manager said. A few months later,

Charging Party

Joshua Feldten
Apple Valley, MN

Respondent

Ames Construction
2000 Ames Dr.
Burnsville, MN 55306

Case number 50618, closed
5-29-09

Feldten — who is of East Indian descent and dark skinned — found a noose under the seat of his coworker. He mentioned that he felt uncomfortable about the noose to another coworker, who told him to get over it. The next day, while cleaning the break room, Feldten found a piece of paper depicting a person hanging from a noose. He spoke again with the manager, complaining that his coworker was continuing to harass him and calling him stupid. “Maybe this isn’t the right place for you,” the manager responded. The manager mentioned that he had learned from a co-worker that Feldten has complained about the noose. You need to get over it and “fit in,” the manager suggested.

Four days later, on Nov. 7, 2006, Feldten was fired. “You need to work

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out whatever issues are affecting you,” the manager said. The company was not a “good fit” for him, he added. Later that day, Feldten received an official “separation notice,” signed by the manager, which stated another reason for his termination. “Hired for janitorial and wash truck duties — does not have a proper driver’s license CDL.” That was not the reason, Feldten believed — the manager knew he had lost his driver’s license five months before firing him. And he had never been told that driving trucks would be one of his job duties.

Feldten filed a charge of discrimination with the Minnesota Department of Human Rights. Other, white employees had not been subjected to the kind of harassment he had faced, Feldten charged. When he had complained about the way he was being treated by a coworker, no action had been taken. He had been fired several days after complaining about a noose in the break room, a situation no one had investigated. As for the company’s concern about his driver’s license, Feldten noted that a white employee whose duties had included driving had also lost his license, but had not been terminated. He had been harassed, treated differently, and ultimately terminated, because of his race, national origin, and disability.

What the Department’s investigation found:

In answering the charge, the employer argued that it had not terminated Feldten because of a disability or any discriminatory reason; he had been fired because he

did not grasp his job tasks and had a hard time remembering things and following directions, the employer maintained.

The Department noted in its investigation that Feldten admits he has a hard time remembering things and following directions. These limitations are the result of a disability — attention deficit hyperactivity disorder (ADHD) and mild retardation. However, Feldten was nonetheless capable of performing the essential functions of his job as a custodian, had his

The employer argued that it had not terminated Feldten because of a disability or any discriminatory reason; he had been fired because he did not grasp his job tasks and had a hard time remembering things and following directions, the employer maintained.

employer provided him with a reasonable accommodation as required under the Human Rights Act.

Feldten had requested a copy of his job description, and asked his employer to meet with his “job coach,” who was helping him to improve his self-sufficiency at work. The employer had failed to fulfill or even consider either request, and could document no effort to explore a reasonable accommodation for

Feldten, though it could have done so without an undue hardship, the Department determined. Thus, the Department found probable cause to believe that Feldten’s disability was a factor in his termination, in violation of the Human Rights Act.

Despite the stray remarks and isolation incidents — including the noose and its visual depiction — there was not sufficient evidence to establish that Feldten’s race or national origin were factors in his termination, the department found. The name-calling and teasing Feldten endured may have been insulting, but the incidents were not severe or pervasive enough to support a claim of a hostile work environment under the Human Rights Act.

However, by retaliating against Feldten after he had complained about race discrimination and requested an accommodation, the employer had violated the Human Rights Act, the department’s investigation showed. Although Feldten’s complaint may not have been the sole reason he was fired, it was a motivating factor in the employer’s decision. Thus, the employer had engaged in reprisal, in violation of the Act, the department’s investigation found.

(Note: The case was closed by the Department of Human Rights on 5-29-09; in lieu of settlement, the charging party elected to sue privately.)

Human Rights Day Conference At a Glance

When:

Friday, December 4, 2009

Where:

Saint Paul RiverCentre

Conference Theme:

Where Do We Go From Here

-- Dr. Martin Luther King Jr., 1967

Keynote Speaker:

Dr. Frank Wu, author of *Yellow: Race in America Beyond Black and White*, and co-author of *Race, Rights and Reparation: Law and the Japanese American Internment*.

Conference Cost:

Early Bird discount rate: \$175 per person for registrations received by Friday, October 2, 2009.

Individual rate: \$200 per person (for registrations after Early Bird rate expires).

Group rate: \$175 per person. For 8 or more people registered at the same time. Includes table with organization name.

"Where Do We Go From Here?"

Human Rights Day 2009 Update

The Minnesota Department of Human Rights 26th Annual Human Rights Day conference will feature two dozen workshops on some of today's most important human rights issues. The conference will be held Friday, December 4, 2009, at Saint Paul RiverCentre.

Among the topics for this year's currently scheduled workshops:

- *Employer's Guide to Reasonable Accommodation*
- *Climate Change, Climate Justice*
- *Civil Rights and the Minnesota Muslim Community*
- *Stereotype Discrimination Faced By Working Women*
- *Civil Rights Protections under Federal Law*
- *"We don't take Section 8" — Does it violate the MHRA?*
- *Combating Bias by Building Strong Community & Police Partnerships*
- *Mediating Discrimination Claims*
- *Homeownership Best Practices for Emerging Markets*
- *Rights Based Approach to Social Justice Work*
- *Your Rights under the National Labor Relations Act*
- *Understanding Mental Illness*
- *Immigration Relief for Vulnerable Populations*
- *Disability Employment Issues in the Current Economy*
- *Human Rights Dimensions to the Immigrant Experience*

The conference will feature a

keynote address by author and Wayne State University Law School Dean Dr. Frank Wu. Wu is the author of *Yellow: Race in America Beyond Black and White*, and co-author of *Race, Rights and Reparation: Law and The Japanese American Internment*.

The conference theme, "Where Do We Go From Here?" was inspired by a speech Dr. Martin Luther King delivered in Atlanta, GA in 1967. King said, "Many of the ugly pages of American history have been obscured and forgotten... America owes a debt of justice which it has only begun to pay. If it loses the will to finish or

slackens in its determination, history will recall its crimes and the country that would be great will lack the most indispensable element of greatness — justice."

For the third consecutive year, the Department will also be holding a poster contest for students in Grades K-12, in collaboration with

partners and sponsors. Contest rules and entry forms are available on the Department's web site.

The conference is sponsored by the Minnesota Department of Human Rights and the League of Minnesota Human Rights Commissions.

Conference workshops, times and other information are subject to change. Check the department's web site for the latest conference updates.



Dr. Frank Wu

Beyond Age Discrimination

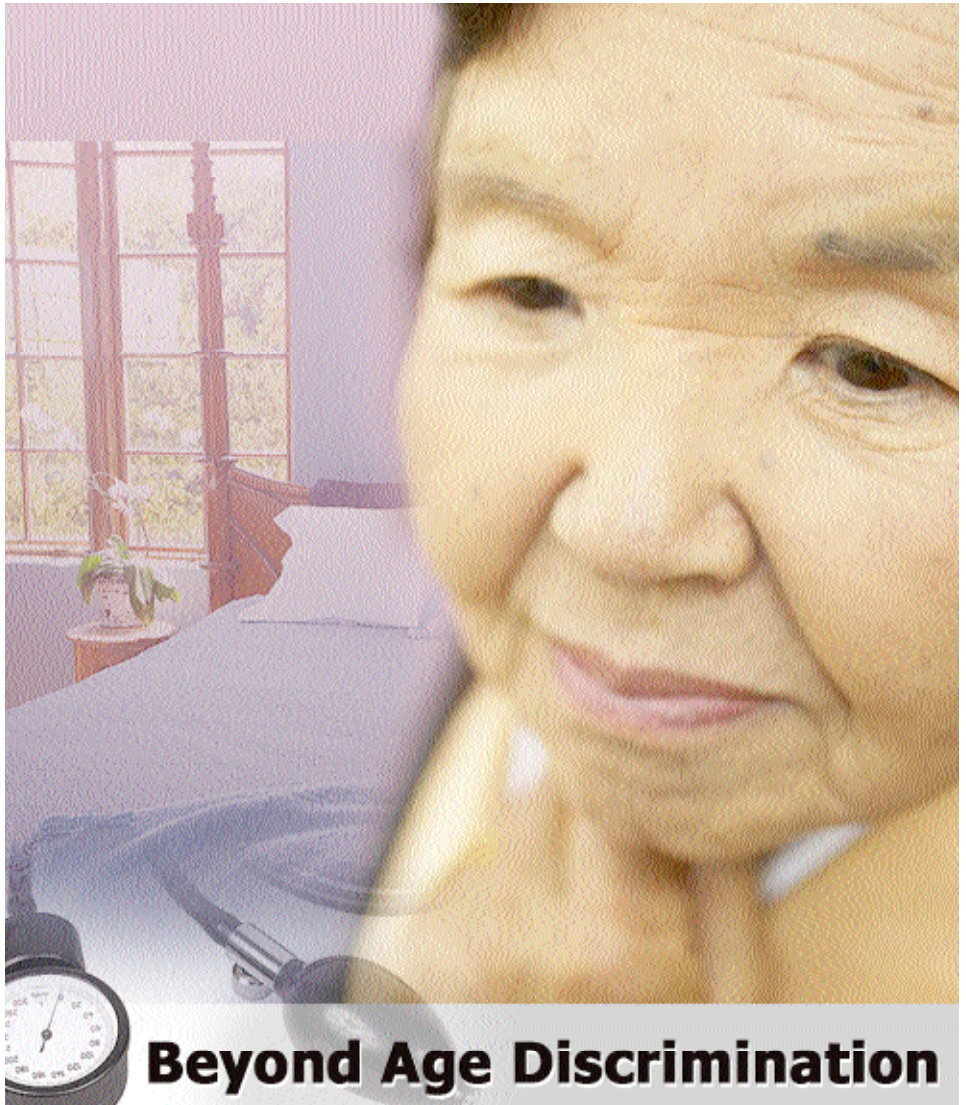
As Minnesotans grow older, many become vulnerable, dependent upon others — in nursing homes and as recipients of an array of social services — to meet their basic needs. Are they vulnerable to discrimination as well? In this edition of The Rights Stuff, we look beyond age bias to other, less-talked-about issues facing older Minnesotans, from discrimination based on religion to sexual orientation.

The issue is complex, and there are many voices that need to be heard. On these pages, we present a selection of viewpoints to help start a conversation about the rights of older Minnesotans to enjoy respect for their culture, religion and civil rights, as part of the care they will increasingly require.

Each time the home health aid comes to visit his apartment, an older gay male removes pictures of his partner from his bookshelf, fearing that if his caregiver knows he is gay, he may no longer get good care. In a nursing home, when it is time for an older Muslim patient to pray, his caregiver interrupts — he must take his scheduled medication, right now, the caregiver insists. In another nursing home, a resident from Ghana is unable to obtain the food that is appropriate for his culture. And in yet another nursing care facility, an older male who has developed a relationship with another male patient is beaten severely by a third, who cannot stand to see two men holding hands.

Discrimination happens. And when it happens to older Minnesotans who may be especially vulnerable for health or other reasons, there would appear to be plenty of laws, regulations and agencies to protect them. A Minnesota Patients' Bill of Rights (MS 144.651) provides broadly for

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Beyond Age Discrimination

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quality of life and appropriate care, and declares that a patient has the right “to every consideration of your privacy, individuality, and cultural identity as related to your social, religious, and psychological well-being.” There is also a federal bill of rights, part of the Nursing Home Reform Act passed by Congress in 1987, that guarantees residents in nursing homes a number rights, including the right to voice grievances without discrimination or reprisal.

Then there is the Minnesota Human Rights Act (MHRA), which prohibits discrimination in public accommodations,

public services, housing (and employment and other areas), and also applies to hospitals, nursing homes, assisted living facilities, home health care services —

virtually any medical or social service a senior citizen could require. It is illegal under the MHRA to treat a patient adversely because of their religion, race, national origin, color, creed, sexual orientation, age, and other characteristic protected under the Act.

The Act is enforced by the Minnesota Department of Human Rights, which has the authority to investigate charges of discrimination in health care settings. Other state agencies with more specific responsibilities and ties to health care complaint investigations include the Office of Health Facility Complaints — part of the Minnesota Department of Health

— and the Office of the Ombudsman for Long Term Care, a program of the Minnesota Board on Aging. There are other agencies that could also have a role in investigating civil rights complaints and/or advocating on behalf of vulnerable, older Minnesotans who face discrimination — because of their religion, national origin, sexual orientation or some other factor — in Minnesota’s nursing homes and other senior care facilities.

But while the abuse and neglect of seniors generates headlines and has the attention of policymakers and the public, rarely does an incident of illegal discrimination capture anyone’s attention — or

result in a case that an agency can document and investigate.

There are stories and anecdotal examples of situations that would appear to violate the Human

Rights Act, the Patients Bill of Rights and perhaps other laws and regulations. But cases? “I’ve been in this job for about 16 years and I can’t remember getting a complaint of discrimination against an older American,” says Joann Da Silva, who is responsible for civil rights investigations and complaints in Department of Human Services (DHS) programs. Other agencies, including the Minnesota Department of Human Rights, experience a similar dearth of discrimination charges involving vulnerable older Minnesotans in health care settings.

That’s not because discrimination is not a problem in nursing homes and elsewhere, say advocates, who believe many seniors

are too intimidated — and afraid of losing the care they have — to complain when their rights are violated.

A staff attorney for OutFront Minnesota, a GLBT (Gay, Lesbian, Bisexual and Transgender) advocacy organization, Phil Duran believes that fear is particularly acute among the older gay population. “If you’re sitting in a nursing home and you are feeling very vulnerable and dependent on these people, are you going to sit there in your hospital bed with tubes sticking out of your arms and say, “Hey, I’m gay, you need to treat me better.?”” asks Duran.

Even when discrimination is blatant, older GLBT people may not want to pursue a charge. “On some level, there is an expectation that they’re going to be discriminated against... frequently people in our community, for any number of reasons, are just willing to let it go,” says Duran (see interview, page 15). “And I think older people are particularly susceptible to that kind of an approach.”

When Muslims are treated by health care providers in a manner that is disrespectful to their religion and culture, they are also reluctant to raise their voices in objection. “Most people are afraid to complain, because they do not want to be singled out as troublemakers,” says Owais Bayunus, President of the Islamic Center of Minnesota (see interview, page 10). “They are dependent upon their caregivers, and they are afraid they will be treated badly in some other way by those people about whom they are complaining. I think this is true when anyone is complaining about discrimination — he thinks twice, before he opens up his mouth.”

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The reason for treatment that appears religiously and culturally insensitive may not always be an intent to discriminate. Bayunus recalls visiting his mother, who had been in nursing home after suffering a paralyzing stroke, and being concerned about her treatment. “They would uncover her in front of other people who were there in the same room,” he recalls. “I had asked many times that a sheet be used, or a curtain around the bed, so it would not be in front of everybody.” But the fact that she was Muslim may have had nothing to do with the treatment to which he objected, Bayunus believes.. “It may not be because of Islam that they were not taking care. It may just be because people wanted to do the job quickly, that they did not care much about modesty and these things.”

While patients regardless of religion may be uncomfortable with doctors who seem to have too little time, when health care is delivered in a hurry the consequences may be especially troubling for those from other cultures — whose elders, especially, may be unfamiliar with, and not necessarily inclined to trust, western medicine. This can lead to unfortunate misunderstandings, says Barbara Greene, a consultant who has worked extensively with the Somali community in Minnesota (see story, page 11.)

“In a health care system where someone is watching the door, or they’re speaking to the patient or an interpreter, but one hand is on the doorknob and they are ready to leave — that’s really a strong indication that your provider has other priorities, and you’re really not being cared for well, or listened to,” says Greene.

But still, they don’t complain. Or they haven’t, most of the time.

There are some who believe, however, that the tendency of some vulnerable older Minnesotans and their families to accept treatment that may violate their civil rights is about to change. There are a host of factors, which appear to be converging at the same time, that could eventually turn a trickle of discrimination complaints into a flood, some believe

Between now and 2030, Minnesota will see a profound increase in the number of people

over 65, accompanied by an unprecedented demand for health and long term care as baby boomers retire. Minnesota’s elderly minority and immigrant

population will also grow dramatically, as will their demand for services.

“This is the first generation that the family went to the nursing home,” notes Sue Mua, Hmong Liaison for Galtier Health Care, which operates a program especially for Southeast Asian elders (see story page 13). Somali elders entering nursing homes and long-term care facilities also represent the first generation to do so. As it becomes more common for a Hmong or Somali elder to enter a nursing home, these cultures may be better able to navigate their way through our health care and social service system, and more inclined to raise questions if care is not culturally appropriate.

As for the GLBT community, as more members of the baby-boom generation begin to seek long-term

care, they may well be a lot more assertive than those who now find themselves in a nursing home, often afraid to speak up about sexual orientation issues. For those who are GLBT, “there is a huge generational difference in terms of approach to their own lives and their own expectations,” says Duran. “Many of the people who are currently GLBT senior citizens are people who came of age in the 50s or early 60s... where hiding was not merely a choice, but the only obvious choice. Later generations have obviously

grown up with some very different expectations.”

It is clear that we are in uncharted waters. By 2030, one out of every four Minnesotans will be over 65; and their diversity and

their expectations will reflect the social and culture changes that began, arguably, in the sixties and led to a new understanding of civil rights, gay rights, elder and health care rights.

Sherilyn Moe, ombudsman specialist for the Office of Ombudsman for Long Term Care, suggests that as demographic changes find more people from more places —from Southeast Asia, Africa, or the Middle East— seeking long term-care, discrimination will become more of an issue.

Ombudsman Cheryl Hennen notes that while caregivers are required to receive vulnerable adult training, “they are not mandated to receive training related to cultural diversity,” a situation she believes should change, given “where we are in this

“They are dependent upon their caregivers, and they are afraid they will be treated badly in some other way by those people about whom they are complaining.”

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time and place in our society.”

And, especially, where we’re about to be. The senior boom has begun, as the first generations of baby boomers retire. They are likely to live longer than any previous generation, and by 2050, Minnesota will have the largest number of people ever over 85. A lot of them will eventually be in nursing homes or other senior care facilities — living next to people from other cultures, receiving care from people from other cultures and countries.

How will they all get along? How will health care providers and others ensure that Minnesotans of all cultures and persuasions will enjoy the right “to every consideration of your privacy, individuality, and cultural identity as related to your social, religious, and psychological well-being,” as provided in the Patients’ Bill of Rights — and the right to be free from discrimination, as provided under the Minnesota Human Rights Act?

“I think this issue is going to bubble up,” says Ombudsman Moe.

And it will bubble up — and need to be addressed — well before 2030.

Viewpoints From:

OWAIS BAYUNUS

President, Islamic Center of Minnesota

PHIL DURAN

Staff Attorney, OutFront, Minnesota

BARBARA GREENE

Multicultural Care Consultant, Custom Health Consultants

CHERYL HENNEN

Office of Ombudsman for Long Term Care

SUE MUA, Hmong Liaison and

TOM THOMPSON, Executive Director
Galtier Health Center

BARBARA SATIN

Transgender Activist and Founder, GLBT Generations

KAREN TAYLOR

Director of Training Services and Advocacy, SAGE
(Services for Gay, Lesbian, Bisexual & Transgender Elders)

Religion and National Origin

OWAIS BAYUNUS

Comments from the President, Islamic Center of Minnesota

In a series of interviews, Minnesotans offer their perspectives and experiences on issues facing older Americans seeking care with dignity and respect for their individuality, cultural identity and human rights.

Question: When older Muslims find themselves in nursing homes or receiving other kinds of care, are they encountering discrimination in these settings?

You don't have a great deal of open discrimination, obvious discrimination. But people are human beings, and they are affected by the news that they watch. And the news media has done so much in a negative direction about Muslims in the past few years, that it has affected the thinking of the common man. Muslims pray five times a day. So what happens is, when older people go to the hospital or to other places, if somebody wants to pray, some (caregivers) will wait until the prayers are over. But some will be so rude that they will say, "no, this medication has to be taken right now."

Somebody can wait ten or fifteen minutes for medication. But once you start the prayer, religiously you cannot stop it, unless there is a real grave situation — like your house is on fire or the mosque is on fire — but not just because it is time for medication, or food, or something else.

I myself have been called, quite a few times, to pray for some who are

terminally ill in the hospital. And when I would pray for them, I would notice that there is some kind of — something that you feel. I would say 80 percent of people I would see would be very welcoming and respectful to your religious things, and the prayers you are making for the person. But some people will come and will try to talk to the patient at that time, even seeing that the prayer is going on.



Owais Bayunus

Question: When you find that respect is lacking, does the problem involve individual employees, or do you believe it exists also among administrators or those at higher levels in health care organizations?

It also comes sometimes from the administration. It is getting much less with time, and the majority of the people are very good.

Question: In addition to the problems you have seen in hospitals, have you found that nursing homes and assisted living facilities may also have problems understanding and respecting the religious needs of Muslims?

My own mother had been in a nursing home, after she had had a paralyzing stroke, and there were certain things

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the people were not taking care of. For example, they would uncover her in front of other people who where there in the same room — I had asked many times that a sheet be used, or a curtain around the bed, so it would not be in front of everybody. There are things that are important from the religious point of view — I'm sure that religious Christians and religious Jews must also be more modest in these things. But it may not be because of Islam, that they were not taking care. It may just be because people wanted to do the job quickly, that they did not care much about modesty and these things.

“It may not be because of Islam, that they were not taking care. It may just be because people wanted to do the job quickly.”

Question: In your experience, are nursing homes usually able to accommodate a Muslim resident's need to pray five times a day?

It should not be difficult. In Islamic prayer, people do not need to be in a specific place in order to pray. In a nursing home, if they can come out of a bed and sit on the chair, they can pray right beside their bed. They can also pray lying in bed — it's allowed in Islam, in case you cannot get out of bed, if you have had a stroke or something like that.

Question: When an older Muslim person has an issue — as when someone is trying to get them to

take their medication at prayer time — how often do they complain about this treatment?

Most people are afraid to complain, because they do not want to be singled out as troublemakers. They are dependent upon their caregivers, and they are afraid they will be

treated badly in some other way by those people about whom they are complaining. I think this is true when anyone is complaining about discrimination — he thinks twice, before he opens up his mouth. So much of the time, people just say all right, just to keep good relations with other people.

BARBARA GREENE

Comments from a Multicultural Care Consultant

Question: You have worked extensively with the Somali community in hospice and other settings. Do you find that the needs of that community, and their experience with health care, may be different than for other groups?

Often the needs of Somalis may be quite different than other populations in terms of how to discuss end of life care, and who to include in those conversations. And how to respect the Muslim faith, and belief that Allah ultimately will make the decisions about not only if someone will pass away, but when and how. Sometimes there are conflicts between a physician who may determine that a person is terminally ill and may have only a couple of months to live, and the belief that a physician does not govern the universe, and does not determine when someone will live or die. That goes to a much greater power. Calling someone terminally ill can also be seen as a sign that providers have given up on care, that they will

not serve this person to the best of their ability — that they are letting this person die. One problem is, there are not many hospice or end-of-life-care communications in the Somali language. So we have been trying to create materials in the Somali language, in partnership with the Somali community, so that they are appropriate.



Barbara Greene

Question: I understand there is a cultural reluctance among some Muslims to turn to an institution, such as a nursing home, rather than keeping an older person home with the family. Is there a similar reluctance to seek hospice care?

Somewhat, but I think it's from a different viewpoint. For Somali families as well as others, not giving up — and going on to additional treatments and sometimes invasive or other kinds of care — is a sign of your love for that person. Giving up, or saying, “there is nothing more I

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can do for you, father or mother or brother,” can be perceived as a lack of love.

I think that sometimes the western model, even though it tries to be very compassionate and caring, underestimates the strength of those concerns. The family does not want to be seen as not caring for their grandfather, because they are giving up, or giving up too early. Sometimes, as health care providers, we forget the power of those bonds.

Question: When we talk about “family” in terms of Somali and Muslim culture, who is included? Who might be present at “family visiting hours?”

There really aren’t family hours in a lot of cultures. The family is integral, and the family should always be there, or should always be permitted to be there. They are part of this individual. So having hours is really foreign and not welcoming.

What is family? Often hospitals and clinical settings have a very narrow range, and it’s a very limited view of family compared to most of the world. So those are things that we try to really work with hospital systems and providers in recognizing, along with things about having food available for family members, having more chairs, or a little bit bigger space. There are probably going to

be a lot more people in a room — young children, many generations, being there for long periods of time, reading the Koran, praying and talking. When there are a lot of people there, it’s a sign that they are really loved.

The family decides how they want to care for their loved one, what kind of care they want, in what kind of environment, and the hospice team follows their lead. It takes time to determine who the family spokespeople, or decision-makers, are. With some Somali families here, for example, elders may be still in Somalia or Mogadishu, or maybe in Germany. So sometimes long-distance conference calls with the hospice team and the physician are really needed, so that all parties are included.

Question: You have talked about the need to provide culturally appropriate care. What would be inappropriate care? What have you seen happening, that shouldn’t be?

There are some mismanaged or unfortunate experiences with Somalis in the health system — there are some great breaches of trust, because of language and other differences. Being available timewise is important — focusing on the family, really listening, being present goes a long way. In a health care system where someone is watching the door, or they’re speaking to the patient or an interpreter, but one hand is on the

doorknob and they are ready to leave — that’s really a strong indication that your provider has other priorities, and you’re really not being cared for well, or listened to.

Question: What would be an example of culturally appropriate care?

Culturally appropriate care would include the Imam in the care — recognizing that the Imam is a very holy person, and that your role as a physician or nurse, while important, may be secondary. It would also be having a medical interpreter there. It would be not using children or family members as interpreters — any family member — no matter how good their English is. It is a very poor practice, and is not reliable, and often has very serious implications for the child or the family member. Family members may find it very difficult to tell their loved ones some bad news, and often people don’t even know the words — hospice is a word that doesn’t exist in Somali. So new words are being created.

Culturally appropriate care would also include things like having prayer rugs available, having copies of the Koran available. Being aware of diet, and gender issues — generally women need to be cared for, if possible, by women. Being aware of the importance and the respect that go to elders. Those are some key examples.

Question: How widespread are those practices that are not culturally sensitive and should not be happening? How far are we

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along recognizing the needs of this community?

Different people are going to answer that very differently. I guess my response is, we are really fortunate in the Twin Cities and the state of Minnesota to have a health care community that is extremely committed to cultural competency. Not all health care systems place this as their highest priority, but there are true leaders, internationally and nationally, in this state, that have broken ground in their practices, that continue to change large systems to be respectful and appropriate.

“What is family? Often hospitals and clinical settings have a very narrow range, and it’s a very limited view of family compared to most of the world.”

Cultural competency is not an initiative, it’s not a program. It’s a way of delivering care that’s responsible for all the care that you give. It’s a slow, steady, commitment that health care systems take on — a long term commitment to training, and to being involved with the community, because the community are our teachers.

We’ve made great steps. And we’ve got still a long way to go.

CARING FOR THE HMONG

Comments from Executive Director Tom Thompson and Hmong Liaison Sue Mua, Galtier Health Center



Sue Mua and Tom Thompson at Galtier Health Center

If you are Hmong and in need of long-term nursing care, there is a good chance you may end up at a facility tucked into a neighborhood just a few blocks west of the State Capitol, which has more Hmong senior citizens than senior care program in Minnesota.

Galtier Health Center is the place a hospital calls when looking to refer a Hmong patient for nursing home care. Not that all its residents are Hmong — Vietnamese, Somalis, Hispanics, as well as Caucasians have been among its clientele. “We specialize in diversity. Whatever race they are, we take them,” says Tom Thompson, Galtier Health Center

administrator. But the 125-bed facility is unique in having 16 staff who speak Hmong, and at present, 32 Hmong patients in their Southeast Asian Program, which has been admitting and caring for elders in the Hmong community since it started nine years ago.

“The population is a challenge,” says Galtier Hmong Liaison Sue Mua, who has been with the facility since the program began. “This is the first generation in which a family member went to a nursing home. It’s a challenge for families as well.

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Everything has changed.”

Traditionally, as in many cultures, Hmong elders who become unable to care for themselves have been cared for at home, by family members. But as the Hmong population has adapted to American society, for many families home care for an aging parent with serious medical issues is no longer a realistic option. That leaves many families feeling regret and perhaps some guilt, as they turn to a nursing home — even one with a program designed to meet their specific needs. “It is really difficult for them accept, but they know there is no other way,” says Mua.

Often, when physicians first suggest a senior care facility, Hmong families will decline and try to care for Mom or Dad at home. But the results can be frustrating, and sometimes tragic. “A lot of them (Hmong elders) don’t take their blood pressure medicine when they are home — they don’t believe so much in Western medicine. So they end up with strokes,” Mua explains.

It is not unusual for Galtier to get a series of calls from a hospital seeking a place for a Southeast Asian patient. There will be the first call inquiring if a bed is available. “Then the hospital will call back and say the family took them home.” Before long, the aging parent will be

back in the hospital, and the hospital will call Galtier again. The family may make several attempts to care for the parent, who will be in and out of the hospital, until the finally agree to a nursing home.

“This is the first generation in which a family member went to a nursing home... Everything has changed.”

At least at Galtier, they will have a staff with whom they can communicate in their native language, and caregivers who understand and respect their cultural and spiritual traditions. “Sometimes the Hmong end up in other centers, and nobody can speak to them — nobody speaks their languages,” says Mua.

The facility provides for spiritual needs, whether residents are Christian, or practice traditional Hmong beliefs, as do 90 percent of the facility’s Hmong population. A Christian minister visits some of the patients, but a Shaman provides spiritual guidance and comfort for most.

Traditionally, the Shaman was the healer, who would provide herbal remedies, and Hmong elders may still trust traditional healing more than Western medicine. “Their whole life, they have used herbal medicine. They think the new medicine might not help them,” says Mua. Her job includes explaining in detail how the medicine can help, and when appropriate, to discuss alternatives

for care, including hospice. “They might not know what a hospice is,” she says. There is no word in Hmong for hospice. And if there was such a word — and a pamphlet translated into Hmong that explained what it meant — it would not be helpful to most Galtier Hmong elders, who cannot read.

The culture’s oral tradition poses other challenges as well. Hmong elders do not eat “American” food, but strongly prefer their traditional cuisine and cooking methods. “For a long time we looked for a Hmong cookbook, but we couldn’t find one,” says administrator Thompson. “But one just came out, we bought it, and we’re going to make some Hmong recipes.”

It may be just in time — diet is a major concern among the residents, and while some may have adapted and accepted much, including Western medicine, they are not about to compromise at mealtimes.

“Their whole life, they have used herbal medicine. They think the new medicine might not help them.”

“Of course, we have to have rice at every single meal,” says Thompson, who

has a large rice cooker in the kitchen. He recalls one time, about four years ago, Galtier ran out of rice on a Sunday. The Hmong residents were appalled — and ready to demand their dietary staple. “They wanted to march to the Capitol — they were so upset that we didn’t have rice,” Thompson remembers. “We haven’t run out of rice, since.”

Sexual Orientation

PHIL DURAN

Comments from the Staff Attorney from OutFront, Minnesota

Question: What are the most important issues confronting the GLBT community as GLBT people get older?

Before we get to that — there is a huge generational difference in terms of approach to their own lives and their own expectations. Many of the people who are currently GLBT senior citizens are people who came of age in the 50s or early 60s, an era where being gay was understood in such phenomenally different terms — where hiding was not merely a choice, but the only obvious choice. Later generations have obviously grown up with some very different expectations. But many GLBT senior citizens right now approach an issue or a concern with a default assumption of, “I have to just suck it up, because if I come out, it will just make things worse.”

If I’m just coming out now at 60, for example, have I been married all this time? Have I got a spouse? Have I got kids? Grandkids? If I have kids or grandkids, what does it mean if I come out to them? Am I afraid of losing my children, my grandchildren? If you’ve got 60 years of hiding and you perceive rightly or wrongly that you’re putting your relationship with your kids and your grandkids at risk, what’s the choice



Phil Duran

you’re going to make?

One of the obvious issues that virtually any older person is going to deal with is health care. For example, in home health-care situations, you’ve got an agency who’s

sending a nurse or an aid into a person’s home to provide care for them. Many older GLBT people are afraid that if they have pictures of their partner on the shelf, or if they have books that relate to the GLBT community,

the aid will refuse to provide care, or will mistreat them in their own home. So they’ll go to some lengths to hide their identity as GLBT people, so as not to jeopardize the care that they need. There is a perceived need of having to choose: am I “out,” or am I going to get care?

Question: Is there reason to believe that this fear is that realistic — that care providers might refuse to provide care for individuals who acknowledge that they are GLBT?

Yes. There have been anecdotal

situations where GLBT people have had that exact experience. It’s a very delicate situation — some of these home health care aides come from other cultures where there is no background with GLBT people, or to the extent that there is, it’s not a positive one. So you put these individuals together in this situation, and there is a tremendous concern

about how that’s going to play out.

And when you get into institutional settings, again, there is tremendous fear. If you’re in a nursing home, for example, is

your partner going to be able to visit? Your partner is not “family.” If there is a crisis or concern, this person is not viewed as your family member because there is not a blood, marriage, or adoption tie.

Question: Despite protections against discrimination under state and federal law, it appears that there are very few complaints filed by older GLBT individuals over treatment received in nursing homes, or in any other healthcare situation. Does that surprise you?

What is the person going to do? If you’re sitting in a nursing home and you are feeling very vulnerable and dependent on these people, are you going to sit there in your hospital bed with tubes sticking out of your arms and say, “Hey, I’m gay, you need

“There have been instances where people feel that the care that they’ve received is less than what their neighbor gets, because they are or seem to be gay, lesbian, bisexual or transgender.”

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to treat me better.” Or are you going to suck it up? And a person in their 80s who has grown up in that era may not even be willing to articulate that there is a problem.

Question: Have cases come to your attention in which seniors have been abused or mistreated because of their sexual orientation or gender identity, in health care settings?

Yes. And one of the things that we find frequently in GLBT people, regardless of age, is that there are always going to be people who will experience a problem, and not want to pursue it. On some level, there is an expectation that they're going to be discriminated against, or even if it's not precisely a Human Rights Act violation — it may be a patient bill of rights issue. But frequently people in our community, for any number of reasons, are just willing to let it go. And I think older people are particularly susceptible to that kind of an approach.

Question: When GLBT people experience discrimination in a nursing home or other health care setting, what form is it likely to take?

It could be derisive comments. It could be that a provider will say, I don't want to work with this person — either because “they're gay, and I don't like gay people,” or “they're gay, therefore they must have AIDS.” There have been instances where people feel that the care that they've received is less than what their neighbor gets, because they are or seem to be gay, lesbian,

bisexual or transgender. And that there are also situations, particularly with trans people, where there may be unique medical issues. They may be taking hormones, for example, as part of the transition process — but maintaining those prescriptions and getting those medications is seen as secondary, so there's an uphill battle to deal with some of that. A lot of these things ultimately do get worked out, but it is obviously difficult for the GLBT person.

Question: How prevalent are situations in which a GLBT person living in a nursing home finds that other residents aren't comfortable with their sexual orientation or identity?

BARBARA SATIN

Comments from a Transgender Activist

What are the expectations of members of the GLBT (Gay, Lesbian, Bisexual and Transgender) community as they think about growing older and possibly finding themselves in a nursing home or otherwise dependent upon others for care?

If you go back in history, it was significantly worse for the GLBT community then, than it is today. So many people, as they have aged, have gone through some really difficult times as gay and lesbian, bisexual and transgender individuals. That has shaped their expectation of how

Of course they (the other residents) grew up in the 50s and 60s also, with those kinds of attitudes, and may feel they don't want a gay neighbor, roommate or whatever. But the reality is that a lot of GLBT people, if they've gotten to 80, are survivors. And this may be something they don't really care about, something they may even have come to expect, sadly. We all deal with the idea that people may not particularly like us because of our sexual orientation or gender identity, and that's par for the course. But it can lead to situations where again, the patient defaults to, “I can't rock the boat. I can't stand up for myself because I won't have support among my peers, let alone support among the providers.”

they are going to be treated when they need to depend on other people for senior care services, healthcare, a nursing home, or even medical care. Their expectation is that they are going to receive that same kind of inappropriate behavior or discriminatory behavior.

Is that expectation or fear of discrimination realistic?

It has been. It's changing. And part of what I and an organization called GLBT Generations do is to work with senior care providers and educate them around the issues that

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Barbara Satin

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GLBT people face as they age — trying to help develop an environment where senior care providers are sensitive to the issues, and, hopefully, are willing to modify their services or train their staff to be sensitive. That's slowly beginning to happen.

You really have two things going on. We have the old GLBT generation that is currently looking at services, and these are the ones who for the most part are apprehensive about how they're going to be treated if

people know that they are G, L, B or T. We did a survey about four years ago among the Twin Cities GLBT community, and 95 percent of the respondents said their expectation is that they're not

going to be treated well by service providers. What's interesting is that 95 percent of them also said they want to access these services.

The other thing is that since 1993, Minnesota has had a Human Rights Act that protects GLBT people. So for 16 years, we've had a large segment of all our community that has lived knowing that they have rights, and that they need to affirm those rights. So the new generation, the baby boomers coming through beginning now, are coming through with a whole different attitude. Their expectation is that we need services, and we expect that we will be treated appropriately. And if we

aren't we will do what we need to do to make sure that we are treated right. There is a whole different mindset among a younger aging population that is going to be far more — I won't say militant — but affirmative in the way in which they push for receiving services.

When you talk about the older generation being afraid they won't be treated well, what does that mean? What is it that they fear?

That they're going to be judged by care providers, that they're going to be lectured about what some people would call their lifestyle, their choices. That they may not receive treatment to the full extent — they may feel that the service provider is shortchanging them because they are G, L, B or T. They may find that service

providers will say that we don't want to provide services to you. Or they may find that while management may say that we serve all, staff may for a variety of reasons — not the least of which would be religious convictions — have some real problems in providing home care, or Meals on Wheels, or even treating someone in a doctor's office, who is GLBT, with appropriate respect.

Do you see evidence that older people in the GLBT community, who are seeking services, aren't being treated with appropriate respect now?

I think things have improved

dramatically.

What do you make of the fact that agencies charged with handling complaints about health care and related services for seniors report few complaints about mistreatment and sexual orientation?

There are not a lot of situations that get to that point. In many cases, GLBT old people will not identify as G, L, B or T, because of the expectation that they're not going to be treated appropriately. So if they can fly under the radar, access services without identifying their sexual orientation, many of them want to do that, rather than run a risk. On the other hand, when somebody does provide services that aren't appropriate, it may well be that GLBT people will not come forward, because it requires them to identify further.

A lot of the current old are hesitant to even venture out as GLBT people when they access services. They'll stay isolated until something turns into a traumatic situation. Where people under other circumstances would probably just go to the doctor, when you're GLB or T, you may stay away simply because you don't want to run the risk of somebody identifying you, or you having to do something to identify yourself as a different sexual orientation or gender identity.

Have you heard of cases in which a service provider has refused to provide services to a person because of that person's sexual orientation?

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Yes. That happens. I have to say that as churches work harder in becoming welcoming to a wide variety of congregants, whether it's around race or other cultural identities, many also have become far more willing to at least explore what it means to be welcoming to GLBT people. But there are still a number of churches and denominations that believe that who we are is sinful. And they not only hate the sin, in many cases they hate the sinner.

As we think about nursing homes, assisted living facilities, home health care, and other services that GLBT seniors might need, are some of these services more problematic than others?

I think nursing homes and assisted living facilities are more problematic, simply because you are so dependent on others for your care in those settings. At least in home care, it's your home, and you're in effect inviting somebody in to provide you with services in your setting. But that also has its problems — somebody can come in who is not comfortable dealing with you, and then you're in a situation of having to say you no longer want those services.

I can give you one iconic example. I am a member of a church in Minneapolis called Spirit of the Lakes, and one of our members was a transgender woman who on a Sunday evening suffered a stroke at her home. In going to Hennepin County Medical Center, and then to the VA Hospital for services, and then to a nursing home for recovery,

basically she was told that they wanted not Gale, but Glenn. They wanted to treat the person of masculine identity, even though this was a transgender woman.

People have raised the issue: we have a Human Rights Act in Minnesota — why didn't he push for appropriate treatment? Well, when you're facing a life threatening situation, and you've got people who are willing to help you under certain circumstances, you're probably going to give in to those circumstances, even though they may not be what in a normal situation you'd agree to.

The trans community is probably the more challenged one of the four (gay, lesbian, bisexual and transgender). Because for many in the transgender community, you're talking about a presentation that can't be denied. If you're gay, lesbian or bisexual you can sort of fly under the radar if you want to.

Question: What do you see happening as those in the GLBT community who have grown up in a new era begin to enter nursing homes, or seek other senior care services? Do you foresee a confrontation as they demand appropriate care?

I would hope that's not what's going to happen. I would think that senior care providers are going to see that the GLBT community is a substantive market, and many of them are going to want to be part of that, and have that clientele as part of their service.

We have seen a change in society around people's understanding of

sexual orientation and of gender identity. So now, we're not dealing in most cases with people who have no understanding of who we are as a community. They just don't know how to reach out, and how to establish their credibility. They may want to serve, but they're not sure how to get people to accept the fact that they would be getting good, appropriate services. That's one of the things that GLBT Generations has worked on. We've developed a curriculum, in collaboration with the Metropolitan Area Agency on Aging, the Department of Human Services and the state of Minnesota, that is available to senior care providers.

When you talk about the need to educate service providers, what is it that they need to know that a lot of them don't seem to know now?

In many cases they need to understand that the traditional family situation may not be in place, that there is a partner rather than a wife or a husband, and that the decision-making may be coming from a partner of 25 or 30 years. That there is this underlying fear that many have that they're not going to be treated appropriately, that they're going to be put in situations where the climate is "hetero-sexist" — where everything is sort of straight, so that even the application forms may not indicate that the service provider is aware of the fact that there may be a partner, rather than a husband and wife.

Question: Are we finding that increasingly, same-sex partners are getting the rights and

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recognition that would be given to a spouse, with respect to visitation, decision-making and other issues?

It is changing. And I'm thrilled about that — not too many years ago that it just was completely the opposite.

Now, in most hospital settings in the Twin Cities, immediate family would include a partner. So if someone had to go into an intensive care unit, a partner would be allowed to be a part of that. I think it's happened in the Twin Cities simply because we have a relatively strong, vibrant and large GLBT population, and people have just become aware of it, and comfortable with being open to our community.

Question: Nursing homes may often have staff who may come from other places and other cultures, cultures that may not always understand sexual orientation and gender in the same way. How does this affect things?

You get at that through education and training, but also through the commitment of management. You can do all sorts of training of staff, but if management is not committed to what we're trying to accomplish, you're going to end up with situations where a staff worker may do something inappropriate, because they don't believe or agree that this (GLBT) person is deserving of appropriate treatment.

There is also another side of this: particularly when you're dealing with nursing homes and assisted living facilities, oftentimes the clients themselves are pretty homophobic

or transphobic. That is another issue. And how that's handled will be critical to how the GLBT client feels about their treatment.

One of the things we're trying to develop at GLBT Generations is some form of seal of approval, a "lavender label" for senior care providers who have gone through the training that we've developed, or other trainings that are appropriate. They can use that as a marketing tool to market to the GLBT community; we can use it as a way to

provide information to members of our community, or their relatives, who are looking for appropriate care. We can say, here are a list of nursing homes that are lavender labeled providers, or home care providers who have gone through the lavender label program. That's not in place yet; we're hoping to get there over the next year or year and a half. We don't expect that all care providers are going to be flocking to get a "lavender label," but some will. And that's important.

KAREN TAYLOR

*Comments from the Director of Training Services and Advocacy
SAGE (Services for Gay, Lesbian, Bisexual & Transgender Elders)*

Question: Your website suggests that often providers do not know how to provide services to the LGBT (Lesbian, Gay, Bisexual and Transgender) community in culturally sensitive ways. How prevalent is the problem?

There was a study in Milwaukee that found that LGBT older adults were five times less likely to access health and human services and senior services because of their past experiences with bad treatment, or because of fears of how they might be treated in the future. There is a huge number of LGBT older adults who are at a pretty severe economic level. One of the most common things they run into is just taking a look at an intake form. If an intake form asks only if you are married, divorced, widowed or single, it's a strong indication that

this is not a place that is going to be helpful, or understanding about how to work with particular issues.

Also, 80 percent of all the unpaid caregiving in this country is done by family members. We actually build our aging services on the assumption that someone can pick up the older person from the hospital, or pick up their prescriptions, or help prepare that first meal as they're back home. But two-thirds of all LGBT older adults live alone, they're four times less likely to have children. So those built-in assumptions mean that they have two choices: either they need to be more dependent on formal care, which means coming out, or they're less likely to seek out services until it becomes an



Karen Taylor

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emergency.

What kinds of services are they not accessing because of concern about how they'll be treated?

I'm talking about Meals on Wheels and senior centers, as well as institutional settings. But really, the majority of seniors in this country live in their communities independently, and the access that they need for basic services is going to come through congregate settings. If you have senior centers that provide congregate meals and socialization opportunities, the socialization assumes that everybody in the setting is heterosexual, and is going to be talking about family and kids.

How have things changed? Has the increased visibility and acceptance of the LGBT community, over the past couple of decades, lessened the fear or reduced discrimination?

Sure, things have changed a lot. But we grow up with the things that we have learned out of life experiences. I grew up at a time when homosexuality was not considered a mental illness — but a 70-year-old was 40 before it was taken off the list of mental illnesses. That person, in their working years and for all of that time, knew that if somebody found out they were gay, they could be institutionalized. All of the people around them, their family members, their neighbors, all knew the same thing. So even if the law has changed, whether or not that person's potential for change is there depends on how flexible they are, and the community in which we put

them. Once we hit 65 and we start to go to these senior centers, the peers in those senior centers also grew up at a time when homosexuality was illegal, where you could be fired for being gay, where you could lose your housing, where you could lose custody of your children. We need to pay attention to the environments in which we put older people.

One other thing that is really important to talk about, since gay marriage has been such a big hoo-hah in the news, is that all of our states have different criteria on what we do around domestic partnership or marriage. There is a lot of confusion.

To what extent are domestic partners in LGBT relationships unable to visit their partners in health care settings, or otherwise participate in health care decisions?

It depends on the state and how each state interprets the Defense of Marriage Act. We had to pass a law in New York state to allow a same-sex partner to decide on disposal of remains of a recently deceased person. The laws covered their domestic partnership, their health-care proxy, and their will, but there was a case in which family members did not really appreciate that they had an aunt who'd been in a 30-year relationship with a female partner. So they went to the funeral home,

took the remains and buried the body on private property — there wasn't anything that stipulated that the partner had any rights at that point. This is one reason why same-sex marriage would be so much easier if it was federally protected.

I know Minnesota has had a nondiscrimination act (the

Minnesota Human Rights Act) since I was born there.

There has been a lot of work done around employment, work environments, and school environments. But the challenge is, seniors get forgotten. It isn't

that the laws aren't there; it's whether the laws are enforced in senior settings.

How do you account for the fact that there appear to be very few charges of discrimination filed by older LGBT people, based on their sexual orientation or identity, in any senior care setting?

It's the fear — that then you would lose all support. One of the things that we're looking at with our attorney general here in New York is whether the ombudsmen are being called, or whether the local gay organizations are being called. Because who is called would depend on who feels safer, where.

I can give you a pretty standard example of the kind of story I hear over and over again — a true story

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of a lesbian couple, one of whom was severely diabetic and had a leg amputated. They had a home health aide who they really liked, and they really appreciated the quality of care that she was providing. But the challenge they had was, at any time when she wasn't actually performing the service with them, she wanted to sit down and read the Bible with them, all the Leviticus and the anti-gay stuff. They didn't want to lose her care, and they didn't know how they could address that. So they never told the service that sent the home health aide — they felt that they could just live through it. Then three months into it, they finally called us. They said, "Can you help us figure out how to do deal with this.? The home health aide felt she was doing the right thing, because of course (in her view) all gay people are going to go to hell and maybe they didn't know that. So she was trying to be helpful. It's one of those instances where you ask, okay if this person is removed, will the next one be worse? There is a lot of gritting the teeth and bearing it.

Question: Recent polling data suggests that young people are more accepting of sexual orientation issues. Is it possible that some day, we won't need to have this conversation?

It certainly does appear that as the culture shifts, societally there is a greater acceptance. What's an interesting challenge for older LGBT people is that there may be a greater acceptance of sexual

orientation and gender diversity, but not for old age. We know there is a lot of ageism in our culture — you know, there's the idea that people don't like to think about two 70-

year-olds having sex — that's considered "really disgusting." And then when you say, "Do you plan to have sex when you're 70?" the answer is always "Well, of course."

State Government

CHERYL HENNEN

Comments from a representative of the Office of Ombudsman for Long Term Care

Question: In the course of complaint investigations at the Office of Ombudsman for Long Term Care, do concerns about religious practices and sexual orientation come to your attention?

We haven't had a whole lot of casework when it comes to nursing homes refusing to accommodate religious customs, culture, or religious practice.

As for sexual orientation, I think in the time I've been here I've heard of one case — at the Veterans Home. We had a gentleman beat up by another gentleman, because he realized he was gay. In this case, two gentlemen had entered into a really intimate relationship on their floor. That was allowed in private, and they would sit at a park bench at times, and hold hands. Another gentleman would witness this, and one day he beat one of them up very, very badly. The provider gave counsel to both parties, and the gentleman who was the perpetrator, who beat up the gentleman who was gay, was removed from the facility.

So that is a good example — I actually was impressed with the provider's response. I haven't heard of a lot of complaint investigations that have been done in relationship to somebody not having their right to pursue their sexual orientation in a nursing home.

Question: If a man and a woman — or a same-sex couple — want to live together in the same room and have a sexual relationship in a nursing home, is that generally permitted? How do nursing homes deal with such situations?

A nursing home can have admission policies that talk about having a person of the same sex in the room, that kind of thing. I haven't heard anybody trying to take that on as discriminatory. Usually, if we get the case work, the families are the ones fighting such a relationship, and trying to convince their loved one that, "no, you don't want to do that." They somehow must think mom and dad dropped their sexuality when they walked through the nursing

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home door.

We've had a number of nursing homes call and say, we have this couple that wants to be intimate all the time. And we don't know what to do because it infringes on the rights of another person — a lot of times someone is in a double room. So now what do we do?

Question: What do they do?

Many times they try to help the parties come to an agreement — that during this time, on these days, one party will be out at an activity, and “you won't be here, so do you mind if we have the room to ourselves?” We have had some casework where the couples want to switch rooms, so that when a room opens up, one can move in with a loved one.

Question: What kinds of complaints are most likely to be brought to the Office of Ombudsman for Long Term Care?

When you look at nursing home residents from minority communities and what comes to our attention... We have a gentleman I talked to from Ghana, and one of his major complaints is not being able to be served the food that he is accustomed to, according to his culture. There is a real lack of understanding, I believe, on the part of the provider, that this man has the right to be able to exercise his cultural beliefs, customs, etc.

What's interesting is, many people from minority cultures are actually

the caregivers in our nursing homes. I get a lot of complaint work on that, where people who are white are calling to say, “I don't want that person providing me with care — they're from a different country, their skin is dark, they can't even speak English, I have no idea what they're saying to me.”

Because caregivers are of different cultural beliefs and customs, there may just be a lack of proper understanding of what each other defines as, “this is how I take good care of you.” But we see a lot of that coming from residents — they get upset about who their caregivers are.

That can call into question, OK, what are a nursing home's training requirements here? How are you providing adequate support and training for your staff, so that they can continue to provide quality care, in what sometimes can be a hostile environment from their care receivers? You can get a mishmash of an answer to that question.

Question: Are nursing homes required to provide training in human rights and diversity issues?

You mean for nursing home staff? No. They are mandated to get vulnerable adult training, but they are not mandated to receive training related to cultural diversity. And it seems like, with where we are in this time and place in our society, that really should be mandated training, wouldn't you say?

Facts and Figures

From the Office of Ombudsman

In Fiscal Year 2008 (October 1, 2007 – September 30, 2008), the Office of Ombudsman for Long Term Care investigated a total of 104 complaints in a broad category that includes exercising preference or choice and/or civil or religious rights, including an individual's right to smoke. Of that total:

About 5 percent involved a person's right to exercise their choice of religion. Some examples: individuals having regular access to a religious leader, or foods prepared in a certain manner according to religious requirement and customs.

About 2 percent involved complaints by persons exercising their right to cross dress. All cases eventually were resolved to the satisfaction of the resident.

About 10 percent involved single residents wanting to share a room with and/or date another resident of the opposite sex. The complaints in most cases involved family members opposing the desire of their loved one to share a room, or be involved in an intimate relationship, in a nursing home setting.

Beyond Age Discrimination: Other Voices

Comments from other Minnesotans involved with elder care and civil rights

Saeed Fahia

Executive Director, Confederation of Somali Community in Minnesota

In addition to respecting the requirement for Muslims to pray, senior care providers need to be sensitive to cultural issues, including culturally appropriate gender roles, says Fahia. “I have at one time worked with one of the homes, what they were worried about was, there was an elder there, he was an older man — there was a Somali woman working there, and he didn’t want to deal with her at all. It was embarrassing for him.”

Sherilyn Moe

Ombudsman specialist, Office of Ombudsman for Long Term Care

Although the Office of Ombudsman for Long Term Care has received few complaints about religious discrimination in nursing homes, the situation is likely to change as Minnesota’s increasing diverse population reaches the age when many may seek long term care, says Moe. “I think that now with various communities from the Middle East and North Africa, that will become more of an issue. I think it is going to bubble up.”

Ethan Roberts

Director of Government Affairs Program, Twin Cities Jewish Community Relations Council

While some in the Muslim community may need to struggle to ensure that elders can obtain

culturally appropriate care in nursing homes and other facilities, Jews rarely encounter religious discrimination in such settings. “I could see why it could be an issue for the Muslims as a newer community, with traditions which are maybe not well understood by the greater community,” says Roberts. But older Jews typically find themselves in places such as Shalom Home in St. Paul that serve Kosher meals and otherwise provide for their Jewish residents’ spiritual needs. “I guess the bottom line is that there is no story here in terms of the Jewish community — that I’m aware of,” Roberts declares. While anti-semitism still rears its head to affect young and old, “in the context of Jewish history, this is a pretty good time to be a Jew. And Minnesota is a really good place to be Jewish.”

Joann Da Silva

Civil Rights Coordinator, Minnesota Department of Human Services

“I’ve been in this job for about 16 years and I can’t remember getting a complaint of discrimination against an older American,” says Da Silva, who is responsible for civil rights investigations and complaints in Department of Human Services (DHS) programs.” DHS and the Department of Health both have responsibility for nursing homes, but complaints about discrimination in such facilities, religious or otherwise, rarely come to DHS — last year the department received none. These days, the

majority of complaints that Da Silva receives are in the “income maintenance” area — or what used to be called “welfare,” she explains. “You’ve got, quite frankly, a lot of the average middle-class folks needing services, and not being eligible, because they still have too many assets and they have some income coming in. So people are quite desperate out there in terms of that.”

Stella French

Director, Office of Health Facility Complaints, Minnesota Department of Health

In Minnesota, a Patient’s Bill of Rights enumerates a number of rights guaranteed to those in a variety of health care settings, including “the right to every consideration of your privacy, individuality and cultural identity related to your social, religious, and psychological wellbeing.” If a Muslim were denied the opportunity to pray at appropriate times, that could be a violation of patients’ rights, and the Office of Health Facility Complaints (OHFC) could potentially investigate such a violation. But apparently, OHFC has never been called upon to do so. “We have not gotten any of those complaints here. They’ve never risen this far,” says director French. OHFC typically deals with allegations of maltreatment such as abuse and neglect. “The nuances, the rights and that kind of stuff, are handled by the Ombudsman’s office.”

RESOURCES: AGING AND CIVIL RIGHTS

Aging Services of Minnesota

Aging Services of Minnesota (formerly Minnesota Health & Housing Alliance) is Minnesota's largest association of aging services organizations.

<http://www.agingervicesmn.org/>

The Minnesota Board on Aging

The Minnesota Board on Aging (MBA) is the gateway to services for Minnesota seniors and their families. MBA listens to senior concerns, researches for solutions, and proposes policy to address senior needs.

<http://www.mnaging.org/>

American Society on Aging

Resources, publications, and educational opportunities are geared to enhance the knowledge and skills of people working with older adults and their families.

<http://www.asaging.org/>

Office of the Ombudsman for Long Term Care

A program of the Minnesota Board on Aging, the Ombudsman investigates complaints concerning the health, safety, welfare and rights of long-term care consumers, works to resolve individual concerns and to identify problems and advocate for changes to address them.

<http://www.mnaging.org/admin/oom.htm>

Office of Health Facility Complaints

The Office of Health Facility Complaints, part of the Minnesota Department of Health, serves the general public. Complaints, questions, or concerns must relate to licensed

facilities: hospitals, nursing homes, boarding care homes, supervised living facilities, assisted living, and home health agencies

<http://www.health.state.mn.us/divs/fpc/ohfcinfo/contohfc.htm>

Office for Equal Opportunity Minnesota Department of Human Services

Ensures that applicants and clients have equal access to services, handles discrimination complaints, and provides training and technical assistance.

<http://www.dhs.state.mn.us/>

ElderCare Rights Alliance

Established in 1972 and located in Bloomington, MN, ElderCare Rights Alliance offers guidance, advocacy, and education to families, community members, elders, and professionals, and provides confidential services for victims of elder abuse.

<http://www.eldercarerights.org/>

AARP (American Association of Retired Persons)

Non-profit advocacy organization for seniors provides research and policy guidance on long-term care and related health issues.

<http://www.aarp.org/research/>

SAGE (Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders)

SAGE is the world's oldest and largest non-profit agency addressing the needs of lesbian, gay, bisexual, and transgender elders.

<http://www.sageusa.org>

OutFront Minnesota

OutFront Minnesota serves the GLBT and allied community with a wide variety of programs and services

<http://www.outfront.org/>

GLBT Generations

Organization works on raising the visibility of GLBT elders; has conducted a Twin Cities area GLBT needs assessment survey.

Email: info@glbtgenerations.org

Galtier Health Center

A provider of long-term skilled nursing care and short-term rehabilitation solutions, facility offers a Southeast Asian program and a bilingual staff, including a full-time Hmong interpreter.

<http://www.galtiercare.com/>

Somali Family Care Network

Links to resources for Somalis in Minnesota and throughout the country.

<http://www.somalifamily.org/SCBOContacts.htm>

The Minnesota Department of Human Rights (MDHR)

MDHR investigates charges of discrimination in public services and public accommodations — categories that include public and private nursing homes and other senior care facilities — in addition to investigating charges in employment, housing, business, credit and other areas.

<http://www.humanrights.state.mn.us>

FURTHER READING

Status of Long Term Care in Minnesota 2008 A Report to the Minnesota Legislature

This document summarizes the status of long-term care for older persons in Minnesota and was developed in response to a legislative mandate (M.S. 144A.351) to biennially update the legislature.

http://www.dhs.state.mn.us/main/groups/aging/documents/pub/dhsi6_142277.pdf

Minnesota Department of Human Services Civil Rights Plan

The purpose of the DHS Civil Rights Plan is to ensure that applicants, clients and members of the public are not discriminated against on the basis of: race, color, national origin, sex, sexual orientation, age, creed, religion, political beliefs, disability or status with regard to public assistance.

<http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-5362-ENG>

2005 White House Conference on Aging: Report to the President and the Congress

The White House Conference on Aging occurs once a decade to make aging policy recommendations to the President and Congress, and to assist the public and private sectors in promoting dignity, health, independence and economic security of current and future generations of older persons.

http://www.whcoa.gov/press/05_Report_1.pdf

Complaint Investigations of Minnesota Health Care Facilities, Minnesota Department of Health, April 2008

A Report to the Minnesota Legislature explaining the investigative process and summarizing investigations from July 1, 2004 to June 30, 2007 and Information on Deficiencies Issued by OHFC from October 1, 2006 to September 30, 2007.

<http://www.health.state.mn.us/divs/fpc/2008ohfcfinalrpt.pdf>

The Nursing Home Reform Act

The federal Nursing Home Reform Act, part of the Omnibus Budget Reconciliation Act of 1987, requires the provision of certain services to each nursing home resident and establishes a Residents' Bill of Rights. To receive Medicaid and Medicare payments, nursing homes must be certified by states to be in compliance.

Citation:

http://edocket.access.gpo.gov/cfr_2006/octqtr/pdf/42cfr483.10.pdf

Summary:

<http://www.ltombudsman.org/uploads/OBRA87summary.pdf>

Fact Sheet:

<http://www.aarp.org/research/legis-polit/legislation/aresearch-import-687-FS84.html>

Minnesota Board on Aging 2005 Survey of Older Minnesotans

In 2005 the Minnesota Board on Aging conducted a statewide survey of persons aged 50 and over in Minnesota. The MBA conducts such a survey approximately every five years

<http://www.mnaging.org/advisor/survey.htm>

Minnesota Patients' Bill of Rights

Covers and explains the rights of patients and residents in Minnesota health care facilities, as defined by the Legislature in M.S. 144.651.

http://www.health.state.mn.us/divs/fpc/consumerinfo/mn_pts_rights_eng_reg.pdf
<https://www.revisor.leg.state.mn.us/statutes/?id=144.651>

Minnesota Nursing Home Residents Bill of Rights

A summary of the rights of nursing home residents under Minnesota law.

<http://www.eldercarerights.org/vertical/Sites/{F5272FA7-6789-44D6-ABA5-5E7EEE615DD6}/uploads/{CA2E8A90-596D-4DCC-8442-6EC49CF7CD2C}.PDF>

MDHR unveils revamped, accessible web site

“Making the site accessible was our highest priority,” says Commissioner

The Minnesota Department of Human Rights (MDHR) on July 9 will introduce a completely redesigned web site, developed over two years to make human rights information quicker to find and more

find, and presented in a manner that’s attractive, logical, and consistent with state and federal accessibility guidelines.”

In addition to a new home page which provides links to the latest and most requested content, the new site is organized in seven sections: About Us, Your Rights, File a Complaint, Employers, Youth, Education & Outreach, and Settlement. Because the site has been reorganized, those who have previously “bookmarked” their favorite pages may find these links no longer work, but the content should still be available and easy to find on the new web site. The URL (or web address) of the web site remains the same: <http://www.humanrights.state.mn.us>.

“We believe the look and feel of the new web site supports our role as a professional, impartial investigative agency.”

The new home page also prominently states the department’s mission: “to make Minnesota discrimination free,” and makes it clear that the department’s job is to enforce a state law, the MHRA, a role that distinguishes it from other human rights organizations and their web sites.

“It’s important that people understand that MDHR is a government agency, charged with serving everyone in Minnesota, and not an advocacy organization,” Korbelt said. “We believe the look and feel of the new web site supports our role as a professional, impartial investigative agency.”

Other important features of the new web site include:

- An “intake section” featured prominently on the home page offers visitors a first step toward filing a charge or complaint with the department;
- “Contract Compliance for Employers” and “Education and Outreach,” two key

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accessible, especially for individuals with disabilities.

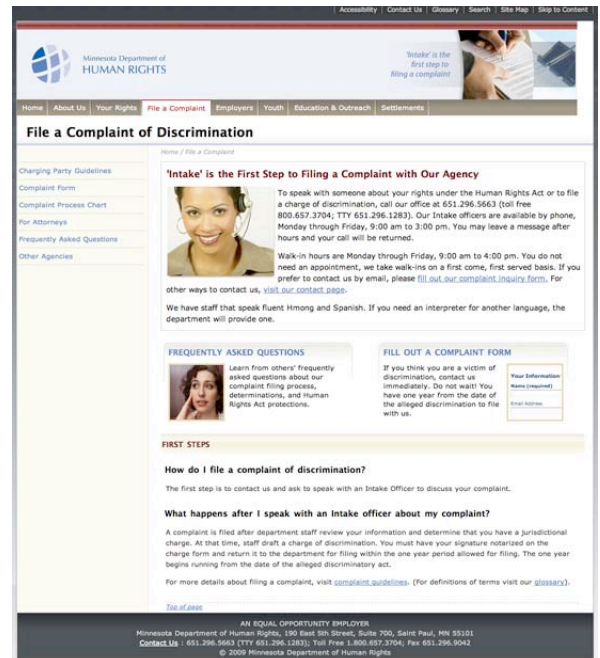
“Making our web site as accessible as possible was our highest priority,” said Velma Korbelt, Commissioner of the Department of Human Rights. “The content of our site remains strong, with a wealth of information about the department and the rights and responsibilities of citizens under the Minnesota Human Rights Act (MHRA). But now this content should be easier to

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divisions of the department in addition to Intake and Enforcement, are also prominent on the home page;

- “Quicklinks” on the home page provide a direct route to the latest and most requested content;
- Throughout the web site, images, charts and diagrams have text equivalents to make the site more accessible for individuals with disabilities;
- The site’s navigation lets the user know where he or she is, in terms of the site’s content and structure, at all times;
- Pages can be printed in a manner that is optimized for the printed page, rather than the screen; the printed pages are less cluttered and easier to read than previously;
- The site generally follows Section 508 guidelines to ensure that content is accessible to those who use screen-readers and other assistive technologies;
- The web site continues to feature the Department’s quarterly online newsletter, the Rights Stuff, in pdf format; however, past newsletter articles are better integrated with the rest of the web site and easier to find;
- Modern, streamlined code should allow pages to load faster, eliminate errors, and ensure compatibility with a wide variety of web browsers.

As the site was being tested, feedback was sought from those in the disability community and was highly positive. “You have done your homework and should be congratulated,” said David Andrews, Chief Technology Officer for Minnesota State Services for the Blind. “Thanks for all the work you obviously did to make the site accessible to all people with disabilities — not just blind and visually impaired persons.”



Upcoming

MDHR

Trainings and

Showcases

Month	Event	Location
July 21	Training Showcase	Duluth
August 20	Training Showcase	Dakota County
September	Community Forum	Winona
October	Training Showcase	Austin
December 4	Human Rights Day Conference	St. Paul

Check the Department’s web site for dates and times to be determined and the latest information on upcoming events.



By Rights...



Commissioner Korbel answers your human rights questions

To submit a question to this column, visit the Department's web site where the column regularly appears, or send your question to: The Minnesota Department of Human Rights, 190 East 5th Street, Suite 700, St. Paul, MN 55101. Attn: By Rights.

We will not publish your name or the names of individuals or companies you identify, but you must include your name and phone number.

Note: If you have a human rights question but would prefer that your question not be published, call the Department at 651-296-5663 or 1-800-657-3704 (toll free) and ask for Intake.

CAN PREVIOUS EMPLOYERS STILL GIVE YOU A BAD REFERENCE?

To the Commissioner:

My son was terminated by a previous employer some months ago. I talked to his manager about the termination, and she told me she would not give him a bad reference. But my son is still looking for a job, and we just found out this is not the case — the previous employer has been giving him a bad reference. I thought there were laws in place that don't allow previous employers to give out bad references. I thought all the previous employer could do was to verify wages, dates of employment and position/title. Can you please confirm this for me?

The Commissioner says:

Unless your son was terminated or is being given a bad reference because of his race, national origin, religion, a disability, or another characteristic protected under the Minnesota Human Rights Act, your question falls outside of our jurisdiction and expertise. That said, we know no law that prevents an employer from giving an unflattering reference. It is true that many employers as a matter of policy choose to restrict their comments about former employees to verifying the basic facts you've mentioned. But not all employers follow this practice, nor are they required to do so. If your son has reason to believe that his

former employer is providing information that is untrue or is acting out of malice, your son may choose to discuss his concern with a private attorney. The Department of Human Rights cannot give legal advice.

CAN EMPLOYER REQUIRE HMONG EMPLOYEES TO SPEAK ONLY ENGLISH?

To the Commissioner:

I am Hmong and a temporary employee for a company in Saint Paul. Since I began there, I have heard complaints from two employees I work with, who say it is not fair that I and my Hmong coworkers speak in our language when we meet and greet each other. The majority of people working for the company are Hmong, but I've been told that numerous people who do not speak Hmong have gone to the HR and have reported it as rude and disrespectful in the workforce. I've also been told that HR is trying to do something about the situation, and may soon require us to speak only in English. I have never worked for a company that has done this before — most companies would be happy to know that I am bi-lingual. Can companies not allow their employees to speak another language, even though they are capable of speaking, reading, and writing English perfectly?

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The Commissioner says:

An employer can require employees to speak only English while on the job if there is a valid business justification for this requirement. An employer might require employees to speak English when communicating with English-speaking customers, or with their supervisor, or where work efficiency or safety concerns require that everyone communicate in the same language. But the fact that some English-speaking employees consider the speaking of another language to be somehow discourteous does not qualify as a valid business justification. To enforce an English-only rule based solely on the preferences or prejudices of English-speaking employees might be a discriminatory practice prohibited under the Minnesota Human Rights Act.

MUST EMPLOYER PROVIDE PREGNANT EMPLOYEE WITH “LIGHT DUTY?”

To the Commissioner:

I am pregnant and a paramedic, a very physically demanding job. What is my employer’s obligation to provide “light duty” to me when I progress to the point of being unable to do my job? I have an opportunity to go into our dispatch center, but on a part-time basis and a reduced hourly rate.

The Commissioner says:

If your employer has at least 15 employees, they must make reasonable accommodation to the pregnancy-related restrictions of which you make them aware, unless every accommodation would impose an undue hardship on their operations. They are entitled to

documentation of the existence of your restrictions and the medical necessity of alternative assignments.

Your employer is not required to remove essential functions of your current position, in order to accommodate you, nor must they create a position for you if you are unable to continue in your job, as modified. One potential accommodation would be to temporarily place you in a vacant position, within your restrictions, for which you are already qualified. Employers are not required to maintain a higher pay rate in a different position, but a case might be made for that if the respective pay ranges overlap.

At some point, a job-protected leave of absence may be the only suitable accommodation and, if your employer is large enough, job protection may also be available under the federal Family and Medical Leave Act (FMLA).

Should you wish to pursue the specifics of your situation with a department representative, please contact our intake unit at 651-296-5663 or 1-800-657-3704 to discuss your situation in more detail.

MUST COMPANY PROVIDE SEPARATE FACILITIES FOR NEWLY-HIRED WOMEN ON CONSTRUCTION CREW?

To the Commissioner:

A local company’s outside crew has been all male for many years. Now two females have applied for positions on the crew. If the females are hired, does this company have to provide any different amenities on the job site (mini-biffs, as an example) for the females vs. males?

The Commissioner says:

The Minnesota Human Rights Act

does not require employers to have any specific policies with respect to amenities for males and females on the job. The Act does require employers to not discriminate based on gender — with respect to hiring, pay and all other terms and conditions of employment including amenities. If there is a locker room where employees shower or change clothes, unisex use would not be acceptable, but scheduled men’s and women’s access might be a reasonable alternative to building a separate facility. We would need a lot more information to determine how the requirement to not discriminate would apply in the situation you describe. If you are an employee and believe the company’s provisions for these amenities are discriminatory based on your gender, you may wish to contact our intake unit at 651-296-5663 or 1-800-657-3704 and tell us why you think so.

CAN FAST-FOOD RESTAURANT FIRE MY DAUGHTER FOR “ROLLING HER EYES”?

To the Commissioner:

My daughter is 15 years old and employed at a fast-food restaurant. Yesterday the manager asked her how she likes the job, and she said it was going well. Then the manager told her she was going to have to let her go in a week or two, because other employees say that she rolls her eyes at them, and that she has been giving away ice cream. How can you let someone go because others say she rolls her eyes? She is the only Black employee they have, and has been treated unfairly since she’s been there. What are her rights and what can she do about

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this?

I also wonder why they've been paying her in cash — her first check was in cash, and when I told her to ask them about getting a check and a check stub so she could see her hours, they said they didn't have her time card. Should they be paying her in cash?

The Commissioner says:

*If your daughter has been treated unfairly in comparison to other employees, and if the reason for this adverse treatment is that she is black and the other employees are not, that would likely be considered discrimination based on race, which is illegal under the Minnesota Human Rights Act. It's important to understand that the Act does not necessarily prevent employers from behaving unfairly or from terminating employees for "unfair" reasons. An employee **can** be "let go" because of the way she "rolls her eyes" — in fact, unless discrimination is involved, employers are generally free to terminate an employee at any time for any reason, just as an employee can generally quit a job at any time. But if you believe your daughter's race was a factor in her dismissal, you may wish to contact our intake unit at 651-296-5663 or 1-800-657-3704 on her behalf, and tell us why you think so.*

We can't speak to whether or not it was proper that your daughter was paid in cash — unless she was the only one paid in cash and discrimination was the reason. You may want to contact the Minnesota Department of Revenue, which has an interest in ensuring that employers properly withhold taxes and keep adequate records of wages paid and taxes withheld. You can contact that department at 651-282-9999 or through the web at www.taxes.state.mn.us.

CAN THEY FIRE MY KIDS BECAUSE THEY'RE FIRING ME?

To the Commissioner:

I was terminated from my position as a District Manager. My daughter was terminated by the company at the same time, as was my son, because of their relationship to me. I understand Minnesota is a "at will" employment state, but I wonder if terminating other staff because they are related to an employee being let go is legal? There are no documented or other performance issues.

The Commissioner says:

*You raise an interesting question. If your **spouse** had been terminated merely because that person was your spouse, that would be discrimination based on marital status, and illegal — unless the employer could show that a compelling business reason required your spouse's termination. But while the Human Rights Act prohibits discrimination in employment based on marital status, it does not include "familial status" as a protected characteristic in employment. Thus, it is not a violation of the Act for your employer to terminate your children merely because they also terminated you, even if there are no performance issues.*

CAN MY COLLEGE FORCE ME TO LIVE ON-CAMPUS?

To the Commissioner:

I'm a sophomore attending a private college. I would like to live off campus next year, but for some reason you have to have special permission to live off campus. Does the college have a right to force students to live on campus?

The Commissioner says:

If a college were to require some students and not others to live on campus, and if race, gender or another protected characteristic was the reason for these differing requirements, there would be a potential violation of the state Human Rights Act. But there appears to be no illegal discrimination in the situation you describe, which would appear to apply equally to all students. We know of no law that would prohibit a private college from requiring students to live on campus, but unless discrimination is involved, the question is outside of our jurisdiction and expertise. To explore it further, you may choose to contact a private attorney.

HOW LONG CAN I WAIT TO FILE A CIVIL SUIT?

To the Commissioner:

How long after an employee is let go from work does he or she have to file a civil law suit against a company?

The Commissioner says:

A civil suit alleging a violation of the Minnesota Human Rights Act must, according to the Act, be filed within one year of the date the discrimination took place. If an employee is terminated for a discriminatory reason, ordinarily the one-year time limit would date from the day he or she received notice of the termination. The statute of limitations may be different if one is suing for wrongful termination for a reason other than discrimination. For information about issues outside the scope of the Human Rights Act, you may wish to consult a private attorney.

MDHR COMMUNITY PARTNERS

The Department of Human Rights works collaboratively with community partners committed to our common vision of a discrimination-free Minnesota.



The League of Minnesota Human Rights Commissions
Website: www.hrusa.org/league



Tolerance Minnesota
Website: www.minndakjrc.org/wp/stand-up-for-israel/tolerance-minnesota/



The Human Rights Resource Center
Website: www.hrusa.org



The Advocates for Human Rights
Website: www.mnadvocates.org/



Advocating Change Together (ACT)
Website: www.selfadvocacy.org

The Minnesota Department of Human Rights is not responsible for the content of external websites.