

**EXPLORATORY RESEARCH  
ON THE SENIOR HEALTH CENTER CONCEPT --  
A Focus Group Study**

**REPORT**

**July 1998**

**BACKGROUND**

PeaceHealth Oregon Region is proposing to establish a Senior Health Center in the Eugene-Springfield area as part of the newly planned Barger Road Clinic in north west Eugene. The center plan to offer a more comprehensive range of health care and social services for seniors. To ensure the Senior Health Center are being developed appropriately from the patient perspective, PeaceHealth wanted to obtain input from seniors, and from the family members who care for them.

**OBJECTIVES**

1. To explore appeal of the overall Senior Health Center concept and specific services and features to be offered;
2. To gauge interest in using Senior Health Centers, exploring reasons for interest, or lack of interest;
3. To identify what, if anything, may have been omitted at this stage of Senior Health Center development;
4. To compare reactions of higher and lower risk seniors, of PeaceHealth patients with competing providers.
5. To explore the perspective of family members involved in caring for seniors.

## **METHODS**

### **Study Design Overview**

Four focus groups were conducted on July 7 and 8, 1998 -- three with seniors age 55 plus, one with family members involved in caring for a senior. Six to eight individuals participated in each session, for a total of 22 seniors and six family members. All senior participants were responsible for making most of the decisions regarding their own health care. All lived relatively close to one of the three proposed Senior Health Center sites. A mix of high, medium and low risk seniors were included in the sessions. Senior groups contained a mix of ages and genders. The family member session consisted of children, grandchildren or spouses of seniors who live in the three geographic areas, who are involved in the care of those seniors. A mix of senior and family member ages were represented. Copies of screening questionnaires and the discussion outline are included in the Appendix.

### **Sampling**

Focus group participants were drawn from the three census tracts in which proposed Senior Health Centers would be located: 2001 -- Marcola Road, Eugene; 2600 -- Barger Avenue, Eugene; 2901 -- Good Pasture Island Road, Eugene. A mix of residents from each census tract was included in the senior groups, while family member group participants cared for a senior living in one of the three areas.

### **Participant Qualifications**

Group I -- medium to high risk PeaceHealth senior patients, age 55 plus;

Group II -- low to medium risk PeaceHealth senior patients, age 55 plus;

Group III -- mix of high, medium and low risk senior patients from competing providers including McKenzie-Willamette Hospital/Health Care, Oregon Medical Group and independent physicians;

**Group Composition - SENIORS**

		<b>Group I</b>	<b>Group II</b>	<b>Group III</b>	
		<u>PeaceHealth patients</u>		<u>Com-</u>	
		<u>Higher</u>	<u>Lower</u>	<u>peting</u>	
		<u>Risk</u>	<u>Risk</u>	<u>Providers</u>	<u>Total</u>
<u>Gender</u>	Female	2	5	5	12
	Male	4	3	3	10
<u>Age</u>	55 - 64	1	2	2	5
	65 - 74	3	3	3	9
	75 plus	2	3	3	8
<u>Census tract</u>					
	2600 (Barger Avenue)	3	4	2	9
	2901 (Good Pasture Island Rd)	2	2	3	7
	2001 (Marcola Road)	1	2	2	5
<u>PCP affiliation</u>					
	PeaceHealth Medical Group	6	8	-	14
	McKenzie-Willamette Hospital	-	-	2	2
	Oregon Medical Group	-	-	3	3
	Other	-	-	3	3
<u>Chronic illnesses</u>					
	Less than 2	-	4	6	10
	2 or more	6	4	2	12
<u>Prescription medications</u>					
	Less than 5	3	7	4	14
	5 or more	3	1	4	8

Past 12 months:

<u>PCP visits</u>	Less than 5	2	8	4	14
	5 or more	4	-	4	8
<u>Specialist visits</u>	Less than 2	3	4	5	12
	2 or more	3	4	3	10
<u>ER visits</u>	Less than 2	4	7	7	18
	2 or more	2	1	1	4
<u>Hospital stays</u>	Less than 2	<u>6</u>	<u>8</u>	<u>8</u>	<u>22</u>
	TOTAL	6	8	8	22

**FAMILY MEMBERS**

		<b>Group IV</b>
<u>Seniors represented:</u>		
<u>Age</u>	55 - 64	4
	65 - 74	-
	75 plus	2
 <u>Census tract</u>		
	2600 (Barger Avenue)	1
	2901 (Good Pasture Island Road)3	
	2001 (Marcola Road)	2
 <u>Overall health</u>		
	Very healthy/active	1
	Somewhat healthy/active	4
	Somewhat unhealthy/inactive	1
 <u>Respondent: Age</u>		
	25 - 34	1
	35 - 44	1
	45 - 54	4
<u>Gender</u>	Female	5
	Male	1
	TOTAL	6

**FINDINGS**

**HYPOTHESES ABOUT CURRENT ISSUES WITH SENIOR HEALTH CARE**

- 1. Most seniors seem generally satisfied overall with the medical care they are receiving.**

When asked what they liked and what they disliked about the way in which they get medical care, the majority of participants 55 plus reported being relatively happy with their doctors and with the care they received. Most had been seeing the same primary doctor for many years and had developed a good relationship with him/her. Issues and concerns were apparent however, as follows.

**2. Insufficient "time with the doctor" appears to be a key issue for seniors currently.**

Many senior participants reported "not enough time with the doctor" as a primary health care concern. Seniors felt appointments were frequently "too short" and that doctors are often too "rushed." Several participants were frustrated about doctors who didn't have time to answer all their questions. Some felt like they were on a "conveyor belt." Family members too felt that doctor appointments were commonly "too short." Most participants wanted "30 minutes, at least" with the doctor, instead of the customary "10 to 15 minutes."

**3. Getting "passed around" from doctor to doctor appears to be a common frustration for seniors.**

Seniors in all three groups disliked having to see another doctor when their own was not available. They disliked dealing with doctors and staff who didn't know them. A few felt their own doctor was rarely available when they needed an appointment.

**4. Seniors are very reluctant to change doctors, it seems.**

All three groups raised issues around having to change their primary care physician. Most would only do so if their doctor retired, or died. When a doctor moves across town, most seniors (perhaps most patients of all ages) prefer to move with them rather than begin a new relationship with a different doctor.

**5. Common criticisms around appointments include long delays for getting an appointment in the first place, and long waits once seniors arrive for their appointment.**

Many senior participants said they called for an appointment only when absolutely necessary, noting that they usually wanted to be able to see their doctor "the same day." Some said it can take up to six or eight weeks to get an appointment. Several mentioned routinely having to wait "too long" for appointments, a phenomenon they tended to blame on "overbooking."

**6. For seniors, issues relating to health insurance include difficulties getting referrals, restrictions as to which doctors can be seen, the cost of health insurance and lack of coverage for prescription medications.**

Several seniors mentioned each of these complaints. Family members, in particular, were concerned about the cost of medications and lack of insurance coverage for them.

**7. Seniors tend to dislike having to go to different locations for different aspects of their health care.**

Two of the three senior groups mentioned the inconvenience involved in going to one place for their doctor appointment, another for blood work, another for prescriptions, and so on.

**8. Some seniors criticize the lack of follow-up after seeing a specialist.**

A few participants in one senior group felt that information from appointments with specialists was not communicated back to their primary care physicians.

**9. Family involvement in the health care of mobile seniors appears relatively slight.**

When asked who else was involved in helping them get medical care, the majority of these seniors claimed they took care of most of it themselves. Many lived alone in their own homes. Some lived with spouses. Very few lived with

family members or in assisted living situations. A small proportion said their family members would "encourage" or "nag" them to go to the doctor. (Note that while some of these seniors could be described as "high risk," all were at least ambulatory enough to come to a focus group discussion. Family members may be more involved in the care of less ambulatory seniors.)

**10. For family members, another key issue is "confusing" billing. Poor "communication" between doctors and insurance and lack of "transportation" also tend to be issues.**

Several family members commented on the "confusing" billing system of PeaceHealth Medical Group -- receiving multiple bills from different departments for appointments on the same day, for example. Billing was confusing to these family members, as well as to the seniors they helped care for.

## **REACTIONS TO THE SENIOR HEALTH CENTER CONCEPT**

### **THE CONCEPT**

*"Senior Health Centers would be established in this area to provide patient-centered primary care, consultation and educational services to seniors in Eugene, Springfield and Lane County.*

*These centers would provide specialized services coordinated by a Geriatrician (a physician trained to care for the older population) and a Care Management Team, that would include a Geriatric Nurse Practitioner or RN case manager and a social worker. Other providers -- such as pharmacists, therapists, home health care givers, nutritionists and specialty physicians -- would be included in the team as needed.*

*Senior Health Center patients would have an initial comprehensive assessment to evaluate their medical and social care needs. Caregiver and social support systems -- particularly necessary for more frail, elderly patients -- would also be assessed.*

*A Care Management Team would plan and coordinate a comprehensive range of services so patients can maintain, or improve, their current health and reduce the need for emergency or hospital care. This team would seek a greater understanding of each patient's living situation so that a comprehensive, holistic plan can be put in place. All the patient's care needs would be addressed by the team -- for example, transportation*

*needs, personal care needs, help with meals or household chores. One person on the team, usually the nurse, would help keep track of everything for the patient.*

*For healthy seniors, the team would assess their risk and provide education and other services that prevent "illness" and promote "wellness." Services not normally found at a primary care clinic -- such as nutritional counseling, medication and pharmacy advice, exercise and educational classes, and some specialty medical services -- would also be provided at Senior Health Centers.*

*Senior Health Centers would also offer group educational sessions and group care sessions. Possible benefits of group sessions are more time with the doctor and more time to discuss similar health problems with other people. Social events for seniors would also be arranged.*

*Upon entering a Senior Health Center, the patient would be greeted by receptionists trained in the special needs of the older patient. Appointments would be longer than the traditional visit and appointment schedules would be flexible to accommodate needs of caregivers as well as patients.*

*Hallways would be wider than usual, and equipped with hand rails. Examining rooms would be more spacious to accommodate wheelchairs and extra family members attending appointments. Special examining tables would make it easy to transfer patients from wheelchair to table.*

*Senior Health Centers would be a "one-stop-shop" with convenient access to durable medical equipment (walkers, wheelchairs, etc.), pharmacy services, x-ray and lab services."*

## **REACTIONS**

- 1. Overall reactions to the Senior Health Center concept were very favorable, particularly among PeaceHealth senior patients and their family members.**

Copies of the concept description were handed out in each session and read aloud to participants. The great majority of PeaceHealth senior patients, and practically all the family members of PeaceHealth seniors, responded very favorably to the Senior Health Center concept. Most senior patients of competitive providers reacted favorably to the overall concept too, at least initially.

- 2. The vast majority of seniors felt they would be likely to switch to a Senior Health Center if their primary care provider moved there (assuming it was covered by health insurance).**

As mentioned, these seniors were very likely to follow their primary physician if he/she moved to another practice. Several had done so, even to an inconvenient location "on the other side of town." Given the widespread appeal of the concept, it was not surprising that practically all participants felt they would indeed follow their doctor to a Senior Health Center. (At the same time, these seniors would be unlikely to go to a Senior Health Center if their primary physician did not practice there or if it was not covered by their health insurance.)

### **Perceived Benefits**

- 3. The "convenience" of "a one-stop-shop" was a most appealing aspect of the Senior Health Center concept.**

Commented on in all four groups, participants liked the idea of being able to go to one location for all their health care needs, rather than having to drive all over town for different appointments.

- 4. The "team approach" was also very appealing.**

The vast majority of participants across all four groups remarked unaided on the "Care Management Team" approach. Perceived benefits included the "senior oriented" doctors and staff, and the more "comprehensive assessment" which would consider "all the patient's care needs." The family members group liked the idea of "the nurse . . . keeping track of everything for the patient," coordinating and interpreting treatment so seniors would be more clear on what to eat or not eat, for example.

- 5. Help with "transportation" was viewed as an important benefit of this model.**

Seniors and family members commented on the importance of help with transportation. While many of the senior participants still drove themselves most acknowledged they would not always be able to do so. Family members saw transportation assistance as relieving part of their burden as caregivers.

**6. Help with other non-medical needs was also much appreciated.**

Participants felt services such as "personal care needs, help with meals or household chores" would be very valuable, particularly when they became more frail or elderly. Many were familiar with "meals-on-wheels" describing the importance of that program.

**7. The "preventative approach" of the Senior Health Center model was praised.**

Several seniors referred to the readiness with which their physicians seemed to prescribe drugs to alleviate symptoms, instead of dealing with the causes of illness. These participants were attracted to the idea of a center which would "provide education and other services that prevent 'illness' and promote 'wellness'." Interest in health care information was high, both for seniors and for family members.

**8. "Longer appointments" elicited much positive comment.**

As mentioned, a key issue for these seniors and for family members was the brief amount of time they were allotted with their physicians. About "30 minutes" with the doctor was considered desirable on average, depending on the severity or complexity of the situation (some situations required "45 minutes" some only "15 minutes," they said) rather than the "five or ten minutes" currently enjoyed by many.

- 9. Availability of "medical equipment (walkers, wheelchairs, etc.)" elicited positive comment.**

A few seniors noted that they liked the idea of being able to borrow or rent "durable medical equipment" from Senior Health Centers.

- 10. Family members felt using a Senior Health Center would eliminate the problem of underqualified, dishonest individuals working with seniors.**

In addition, a few anticipated consolidated, "less confusing" billing.

### **Perceived Limitations**

- 11. On the other hand, several seniors found the Senior Health Center concept "too good to be true," too "idealistic."**

A few participants in each senior group wondered how Senior Health Centers would be financed. They assumed the cost of more services and features would be prohibitive and that they would not be able to afford to go there. Many seniors noted that they would not use a Senior Health Center if the services were not covered by their health plan.

- 12. Seniors would be much less likely to use a Senior Health Center if their primary care physician did not practice there.**

Most of these participants felt they would not switch to a Senior Health Center if it did not include their primary physician.

- 13. Several participants were unclear as to whether primary care physicians would actually practice "on-site" at Senior Health Centers.**

Some wondered whether they would simply refer patients there for specialist attention and other services. Others did not understand the primary care physician's role with respect to the Care Management Team.

- 14. A few seniors criticized the "Care Management Team" approach for being akin to "socialized medicine," fearing they would "lose control" over their own treatment.**

The notion that they would be able to make their own decisions, and even choose to go outside the Senior Health Center for some services or specialists, was not obvious to some.

- 15. Some wondered at the makeup of the Care Management Team.**

These seniors wanted consistency of personnel for individual seniors, so they would be able to get to know the staff with whom they would be working.

- 16. A small number of participants felt Senior Health Centers would be too isolating.**

A few younger seniors felt there was already "too much separation" between older and younger people, preferring a mixture of different age groups. (An explanation that the Senior Health Center would be part of a regular clinic seemed to largely appease this concern.)

- 17. Other areas of confusion included flexibility of appointment schedules) "to accommodate needs of caregivers," whether Senior Health Centers would be "residential" or not, and the meaning of a "holistic" plan.**

At least a few seniors and family members were unclear about the meaning of these terms or phrases.

- 18. Additional questions expressed by family members included "the cost" of services and how they would be paid for, "admission criteria," the size of each Senior Health Center, and "ratio of staff to patients."**

Each of these concerns was mentioned by just a few family member participants.

## **REACTIONS TO PROPOSED LOCATIONS**

### **Proposed Locations**

- Barger Avenue and Altimont, Eugene
- Marcola Road, Springfield
- Good Pasture Island Road, Eugene

### **Reactions**

- 1. Seniors who live close to one of the three proposed Senior Health Center sites found these locations "very convenient."**

Towards the end of each session, a map was handed out indicating approximate locations of the three centers. Essentially all senior participants felt these locations were as convenient as they could be, given that they lived close by. (Note: All seniors resided in one of the three census tracts in which the centers would be located.) Family members of seniors responded similarly. They agreed that a Senior Health Center should be close to where the senior they cared for lived, rather than close to where they lived.

One group noted that two Senior Health Centers were proposed for north Eugene and none in south Eugene, suggesting one be located there.

- 2. Participants living in senior complexes might be inclined to use a visiting doctor "for more routine check-ups."**

Assuming the doctor who visited a senior complex one or two days a week was not their regular doctor, a few seniors felt they would be likely to visit him/her "for questions," routine "check-ups" and other "minor problems," but would continue using their customary physician for anything more serious.

## **REACTIONS TO SPECIALISTS AND SPECIALTY SERVICES**

- 1. Practically all seniors felt they would be likely to use the full range of specialists available at the same Senior Health Center as their regular doctor (assuming it was covered by health insurance).**

Even if they had seen a different specialist in the past, the great majority of seniors said they would be willing to go to someone else at the same location if their primary care physician suggested it. Some anticipated obtaining a referral would be more straightforward also. Scheduling the specialist appointment for them, in conjunction with their regular doctor visit, would clearly be an added benefit.

- 2. "Dentists" were suggested as an additional specialty to offer at Senior Health Centers.**

In addition to "ophthalmologists, podiatrists, cardiologists, orthopedists, neurologists and urologists," all groups suggested adding dental services to the specialties offered. Two groups suggested a "psychiatrist" or "psychologist." One group suggested a "colon doctor" or "gastroenterologist."

- 3. Several in the group of higher risk PeaceHealth senior patients wanted Senior Health Centers to offer "alternative" care.**

Desired practitioners/disciplines included "chiropractors," "acupuncture," "herbal medicine," "hypnosis" and "massage."

- 4. Almost all seniors were inclined to use the full range of services likely to be available at Senior Health Centers.**

The vast majority felt they would be interested in "hearing testing, physical, occupational and speech therapy, mental health services, laboratory services and imaging (x-ray) services."

**5. Several participants suggested a "pharmacy" be located at these Senior Health Centers.**

In addition, one senior group suggested "stress tests" be offered. And family members suggested "a cafeteria," an "exercise room" and a play room with "toys for grandchildren" who might be accompanying seniors to their doctor visits.

## **REACTIONS TO EDUCATION AND INFORMATION SERVICES**

**1. A "Health Information Center across the hall from the Senior Health Center" was a very attractive idea.**

**Most seniors, and family members, were interested in video/audio tapes which they could take home**

Each group was asked how interested they would be in accessing health information via a range of methods: classes, video/audio tapes, the Internet and a Health Information Center. A Health Information Center adjacent to the Senior Health Center -- described as offering "health information resources, including a range of computerized databases, reference books, and audio/visual library and pamphlets" -- was the most popular vehicle. The great majority of participants felt they would be likely to visit such a Health Information Center after their appointment, to learn more about diagnoses and possible treatments. Many also expressed interest in borrowing video and/or audio tapes, either from the Health Information Center or from their doctor's office, for use at home.

**2. Interest in attending health information classes was mixed: family members and lower risk seniors were the most interested, higher risk**

**seniors the least. Classes on "nutrition" and "health insurance" elicited most interest.**

Seniors and family members said they would be likely to attend classes on "nutrition." Seniors in all three groups were interested in classes on "health insurance," while family members were interested in "changes in Medicare" coverage. Other seniors suggested adding classes on "new advances in diagnoses and treatment," "prevention" and "alternative" remedies. Some interest was also expressed in classes on "living wills" (advanced directives), "exercise," "managing medications" and "grieving, loss, depression." Of no interest to these participants were classes on "home safety" or "family life."

In addition, family members suggested classes for them on "where to go for help," "housing," the "aging" process, what to expect in terms of "signs and symptoms," as well as assistance during "vacation" or time when they were not available to care for their senior.

**3. The few seniors already familiar with the Internet seemed interested in accessing health information in that way.**

A minority of participants currently had access to a computer and just a small number were familiar with the Internet. Only one or two seniors currently accessed health information via the Internet however.

**4. Seniors and family members expressed interest in classes on computers and the Internet.**

Although somewhat surprised that a Senior Health Center would offer classes on these technologies, several in each group said they would be interested in attending such classes.

5. **With assistance from a staff member, at least some seniors would be willing to complete a computer-assisted patient satisfaction survey at the doctor's office.**

Depending on the reason they were there and how they felt, a slight majority of participants said they would take part in an on-site survey if a staff member was available to show them how.

## **REACTIONS TO GROUP SESSIONS AND ACTIVITIES**

1. **"Group care sessions" elicited somewhat mixed reactions. A slight majority of seniors said they would be likely to participate in "group educational and group care sessions" that were facilitated by a physician.**

As described in the Senior Health Center concept, "possible benefits of group sessions are more time with the doctor and more time to discuss similar health problems with other people." Few participants understood immediately how "more time with the doctor" would manifest. When explained that a doctor or other health care professional would facilitate the group care sessions, just over half the seniors felt they would be inclined to participate in sessions on relevant issues. Some seniors liked the "support group" aspect of this format; a few had participated in cancer and other support groups in the past. Most, however, said they preferred to meet with the doctor one-on-one. A substantial number did not want to discuss their health care problems or ailments with other patients.

2. **Small sessions, with about "six to ten" participants, were clearly preferred.**

When asked about the acceptable maximum number of participants for group educational/care sessions, all four groups felt they should not be much larger than the focus group in which they were participating. A few said they would feel comfortable with up to 15 participants.

3. **Interest in "social events" arranged by Senior Health Centers was relatively slight.**

Most seniors were not interested in participating in social events arranged through Senior Health Centers. This feature was considered redundant in light of the range of social activities offered by area Senior Centers like the Campbell Center.

## **HYPOTHESES ABOUT STAFFING ISSUES**

- 1. Seniors and family members want "friendly," "courteous," "respectful," "straightforward" staff who are "informal yet professional" and "knowledgeable." A "sense of humor" is appreciated, as long as it's appropriate.**

Each group was asked what characteristics they prefer in the people who work at a doctor's office. "Friendly" and "personable" was a common theme -- "happy," "cheerful," "warm" and "smiling," a "positive attitude"; staff who "call you by name." Participants wanted "attentive," "courteous," "respectful" staff who "treat (seniors) as individuals" and "not like children." Staff should be "caring" and "compassionate," "calm," "not stressed" or "rushed." They have time for the patient, they said. "Frankness" was desirable -- staff should be "straightforward" and "honest." Seniors wanted medical personnel to be "knowledgeable" but also to admit when they don't have the answers and be "willing to find out." Seniors felt these characteristics would apply to all staff at a Senior Health Center, from the receptionist to the physician.

- 2. Seniors currently allow about "two hours" in total when they go to the doctor's office. Of this approximately "10 to 15 minutes" is spent with the doctor it seems.**

The great majority of seniors in all three groups allowed a total time of about two hours from check-in to check-out and making the next appointment. The bulk of this time, they said, was spent waiting. While a small number of seniors routinely enjoyed up to "45 minutes" with their physician, many claimed to spend only "five or ten minutes" with him/her.

- 3. A "30 minute" appointment appears to be considered ideal.**

When asked how much time they would like to spend with their doctors, participants said sometimes they only needed 15 to 20 minutes, sometimes as much as 45. All four groups agreed that "30 minutes" with the doctor was ideal, on average.

**4. Reactions to the "nurse calling you the day after your appointment" varies depending on the reason for the senior's appointment.**

Most seniors liked the idea of a follow-up call to see how they are doing after a more serious visit, but not usually after a general check-up or physical.

**5. Higher risk seniors would like someone from the Care Management Team to check on them anywhere from "a couple of times a week" to "two or three times a day." Lower risk seniors don't want to be checked on at all however.**

**Family members wanted someone to check in with them also, about "once a week."**

Participants were asked how often they would like someone from the Care Management Team to call and check on them, or the senior in their household. Desire to be checked on clearly depended on the severity of each individual's condition. Seniors represented by family members seemed to be relatively frail compared to those participating in the groups on their own behalf. Only those seniors with serious ailments -- two or three had cancer for example, one had a recent heart attack -- were interested in being checked on frequently. Others felt this could be a useful service later on.

## **HYPOTHESES ABOUT COMMUNICATIONS**

**1. Personalized, direct "mail" appears to be the most effective method of reaching seniors and family members about Senior Health Centers.**

The vast majority of participants suggested "a letter" or "mail" as the best way to reach them with information about Senior Health Centers. Others felt "news-paper" or "the six o'clock news" on television would be most effective for them.

2. **"Location," range of "services," "who the doctors are," and "cost"/"insurance coverage" appear to be the most important information to communicate about Senior Health Centers.**

When asked what was most interesting about Senior Health Centers, what information was most important for them to communicate, the majority of seniors and family members listed location, what services they would offer and what they would cost, what would/would not be covered by health insurance, and which physicians would practice there. Other information of interest included "transportation," the "one-stop-shop" benefit, "team approach," identity of "primary doctors," "ratio of doctors to patients," staff "qualifications" and identity of the "organization" behind the centers.

## **SUMMARY AND IMPLICATIONS**

### **HIGHLIGHT FINDINGS**

#### **Senior Health Center concept**

Reactions to the concept description were very favorable overall, particularly among PeaceHealth senior patients and their family members. If a primary care provider moves to a Senior Health Center (SHC), senior intent to follow was high (assuming insurance coverage continues).

"Convenience" of the "one-stop-shop" offered by the SHC concept was very appealing. These seniors (who live close to one of three possible sites) felt proposed locations were also "very convenient." Other attractive features included the "team approach," help with "transportation" and other non-medical needs, an orientation towards "prevention," "longer appointments" and the availability of "medical equipment."

On the other hand, there was some feeling that the SHC concept was just "too good to be true." Several felt such a comprehensive approach would be too expensive, and would probably not be covered by health insurance. Few seniors were inclined to use

an SHC if their primary physician did not practice there. A small number of seniors criticized the concept for being akin to "socialized medicine" and for lack of patient control. One or two seniors felt a center exclusively for seniors would create unhealthy "separation" between the ages.

Points of information in need of clarification included:

- where primary care physicians would practice -- on-site preferred over off-site;
- composition of the Care Management Team -- consistency preferred over varying;
- location in relationship to all ages clinic
- flexibility of appointment schedules for caregivers
- non-residential centers
- "holistic"
- cost of services and financing
- admission criteria
- ratio of staff to patients.

## **Specialists and Specialty Services**

Intent to use the full range of specialists -- ophthalmologists, podiatrists, cardiologists, orthopedists, neurologists, urologists -- was high, if available at the same SHC as a senior's primary physician. Many focus group participants suggested offering "dentists" also. Other suggestions included a "psychiatrist" or "psychologist," a "gastroenterologist," as well as "alternative care" specialists such as a "chiropractor" and practitioners of "acupuncture" and "herbal medicine."

Similarly, intent to use the specialty services offered -- hearing testing, physical, occupational and speech therapy, mental health services, laboratory and imaging services -- was high. Other suggestions included "pharmacy" services, "stress tests" and a "cafeteria."

## **Education and Information Services**

A Health Information Center adjacent to the SHC was very attractive to these seniors, as were health information video and audio tapes they could take home. Interest in attending health classes was somewhat mixed: more apparent among family members and low risk seniors, less so among high risk seniors. Classes on "nutrition" and "health insurance" elicited most interest. Other suggestions included "changes in Medicare coverage," "new advances" in diagnoses and treatment, "prevention" and "alternative" remedies."

Likelihood to access medical information via the Internet was relatively slim at present among this target audience, although some interest in computer and Internet classes was expressed.

## **Group Sessions and Activities**

"Group care sessions" elicited rather mixed reactions. A slight majority of seniors felt they would be likely to participate in group sessions, on relevant issues, if they were facilitated by a physician. A maximum of six to ten participants was considered

comfortable. Most seniors said they preferred to meet with the doctor one-on-one however. Interest in "social events" was low.

### **Staffing, Appointments, Follow-up**

These seniors and family members preferred staff who are "friendly," "courteous," "respectful," "straightforward" and "knowledgeable," who are "informal yet professional."

A "30 minute" appointment with the doctor is desired, as opposed to the "10 to 15 minutes" or less usually experienced.

A follow-up call from the nurse, the day after an appointment, was considered appropriate after more serious visits. Higher risk seniors would like someone from the Care Management Team to check on them anywhere from twice a week to twice a day, depending on the severity of their condition. Family members of seniors with serious conditions would appreciate regular calls also. Lower risk senior don't want to be checked on at all however.

### **Communicating with Seniors**

Personalized, direct "mail" was by far the most favored method for reaching seniors and their family members with information about Senior Health Centers. Items of most interest to focus group participants were "location," which physicians would practice there (specifically whether their doctor would), the range and cost of "services" offered, and whether they would be covered by health insurance.

## **CONSIDERATIONS**

1. **Continue development of Senior Health Centers to provide primary and specialty care, information/education and coordination of social services for seniors in the area.** Focus groups indicate this is a promising concept with much appeal for seniors in a range of risk categories, and for family members who care for seniors.

2. **Determine the optimum allocation of primary care physicians to each Senior Health Center.** Seniors are very likely to follow their primary care physician to a Senior Health Center, much less likely to use a center if their primary physician does not practice there. Ideally physicians would move to the clinic closest to where most of their senior patients live.
3. **Locating a Senior Health Center in south Eugene,** if sufficient seniors reside there to warrant it.
4. **Add "dental services" and "alternative" care.** Substantial interest in both appears to exist. Consider offering access to some forms of alternative treatment -- a Naturopathic or Homeopathic doctor, a Chiropractor, Acupuncturist and/or Massage Therapist, for example.
5. **Offer call-in services to nearby pharmacies.** Assuming Senior Health Centers will not include pharmacies since they already exist nearby, prescriptions could be called in for the patient to minimize further waiting for orders to be filled.
6. **Locate Health Information Centers adjacent to each Senior Health Center.** Resources would include video and audio tapes to take home, computer terminals and staff to assist information access via the Internet.
7. **Move Senior Class seminars to Senior Health Centers.** Include classes on prevention and wellness, nutrition, exercise, health insurance, changes in Medicare, new advances in medicine, alternative remedies, living wills, managing medication, grieving and loss, depression, and caring for a senior family member.
8. **Include direct mail among vehicles used to promote Senior Health Centers, personalized if possible.** Benefits to emphasize in communications include:
  - one-stop-shopping convenience
  - convenient locations
  - team approach
  - coordination and help with medical and non-medical needs
  - emphasis on prevention, wellness, education
  - more time with the doctor

- availability of medical equipment.

Elements to clarify:

- seniors can choose to go outside the center for services
- primary care physicians practice on-site
- cost of services/insurance coverage
- senior clinics would be adjacent to clinics for all ages.

9. **Test possible names for Senior Health Centers.** Further research could be conducted to determine the optimal name for this new concept. A list of potential names would be generated and then tested among seniors to explore meaning and best fit.