

Community Health Needs Assessment | 2016

ELDER HEALTH NEEDS IN FRANKLIN COUNTY: *A FOCUS GROUP AND INTERVIEW REPORT*



Prepared for

Baystate Franklin Medical Center

By

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Elder Health Needs in Franklin County:

A Focus Group and Interview Report

Date: Focus groups held on February 26, June 22, and June 28, 2016. Interviews held in May and June 2016.

Primary Hospital/Insurer: Baystate Franklin Medical Center

Facilitator(s)/Interviewer: Jessica Payne (February 2016 focus group and eight June 2016 interviews); Kim Gilhuly (two June 2016 focus groups)

Note Taker: Keleigh Waldner (February); Kim Gilhuly (June 22); Joan Lowbridge-Sisley (June 28)

Participants: 40 adults over 60, 5 adults between 41-50, and one person younger than 40.

I. EXECUTIVE SUMMARY

Overview. Over 50 adults participated in focus groups and interviews in Franklin County, the majority of who were over age 60, white, and straight. Focus groups targeted Greenfield area and hill town residents in order to engage urban, rural and low-income populations, while interviews targeted low income, immigrant, and non- English-speaking residents in Greenfield. Participants were recruited through flyers distributed at senior facilities/agencies, emails, Facebook postings, and outreach through the New England Learning Center for Women in Transition and the Center for New Americans. Focus groups and interviews were conducted in English, although three interviews were conducted with Spanish interpreters.

Findings reflect the complexity of elder health needs relative to available resources. Commonalities in the needs and barriers experienced by elders are more pronounced than differences relative to urban vs. rural residence, but appear to be especially heightened for low income and non-English speaking immigrants.

Health needs. Key elder health needs included access to providers--especially geriatric specialists; coordination of care among providers; socialization opportunities; home care; education about available resources and chronic disease management; transportation; interpretation services and access to bilingual service providers (in clinics, hospitals, senior centers and other outreach settings); communication between patients/providers; and cultural competency training for providers.

Mental health is a persistent issue for elders. The isolation and loneliness that many seniors experience can lead to depression, anxiety, and sometimes substance use disorders. Some experience a stigma around growing older, and struggle to connect with, and get support from others in their community.

Resources and PCP/ER use. Socialization through Senior Centers / Area Council on Aging improves mental health and wellbeing and connects elders to peers, services and education, but these

resources need to be more broadly marketed so more people are aware of them. Participants also benefit from access to online information, minute clinics, and nurse help lines. Most participants stated that they only go to the doctor for annual physicals or if they are feeling very sick, and especially avoid the Emergency Room. Long wait times for doctor's appointments due to a lack of providers and reliance on ambulances due to lack of transportation also lead to use of the Emergency Room.

Barriers. Barriers to being healthy and accessing healthcare included poor coordination of care; lack of providers for physical and mental health needs of older residents; poor continuity of providers; difficulty navigating health insurance system; costs of co-pays and medication; the fragmented nature of the health care industry leading to multiple doctor's visits, poor follow up and after care, confusion, and lack of communication between providers. Other barriers included: limited transportation options for seniors to get to health providers and healthy living options such as farmer's markets, senior centers, and other resources (especially but not exclusively for low income and rural elders); and poor internet service and cell phone reception in rural areas to connect to patient portals and providers.

Participants noted a need for more culturally competent care providers, bilingual providers (especially for mental health), translation services, and outreach and education to low-income populations, communities of color, and immigrant communities. There are extra barriers for people who do not speak English (e.g. senior centers or other programs where only English is spoken) and those who come from war torn countries with limited and/or corrupt healthcare systems that instill ongoing distrust and hesitance to access medical professionals.

Research for this report was made possible by Baystate Franklin Medical Center and the Franklin Regional Council of Governments.

A selection of participant quotes is included in the attached Appendix.

A. Participant Demographics

- In total: 54 Franklin County seniors, of which 53 were white and 1 was Asian, with 5 identified as Hispanic; 42 women and 12 men; 48 identified as straight and 6 as GLBTQ.
- 3 Focus Groups: 46 white adults over 60 years old participated in the focus groups, with only one identified as Hispanic/Latino. 37 participants identified as female and 9 identified as male. 39 participants identified as straight, 6 identified as lesbian, gay, bisexual, or other (GLBTQ). Information on country of origin was not collected. All participants spoke English. Participants came from towns of: Athol, Greenfield, Heath, Leverett, Shelburne, Shelburne Falls, and Petersham (this represents some though not all possible towns as this information was not gathered for all participants).
- 8 Interviews: 2 adults aged 51-60 and 6 adults over 60 were interviewed. Participants included 1 Asian adult and 7 white adults, with 4 (half) identifying themselves as Hispanic/Latino. 5 participants identified as female, 3 as male, and all 8 participants identified as straight. Countries of origin included: Argentina, El Salvador, Puerto Rico, Egypt, Moldova, and North Korea, with primary languages spoken including: Arabic, Korean, Moldovan, and Spanish. Participants came

from towns of: Greenfield, Montague, and Turners Falls.

B. Areas of Consensus

Health Care System Needs

- There are not enough doctors and geriatric specialists in the area and transiency of providers is a problem.
- Elders struggle to cover costs of co-pays and to navigate limitations of insurance coverage
- Elders need health education about medication management, chronic illnesses, and available safety net programs
- Limited coordination of care within health system and among providers --- hospitals, specialists, primary care practitioners. Patients struggle when health problems require multiple providers, appointments, and co-pays. Too much is left to the individual, which can be especially challenging for elders.
- More communication between providers and patients is required to build trust, explain diagnoses, follow up, etc.
- Home care is needed to support medication management, recovery, self-care, family management of care, and socialization.
- The length of time people wait before they can get in to see a health care provider is a significant problem.
- More minute clinics and urgent care centers would benefit elders.

Mental Health Needs

- Coping with age-related issues and chronic illness can be challenging and require support.
- Isolation and loneliness are detrimental to health and mental wellbeing; human interaction is therapeutic.
- Opportunities for socialization and having a sense of community are important to the health of older adults. Senior centers and support groups provide a venue for socialization and support.
- Elders have different support needs for substance use disorders than youth or younger adults.

Other Resource Needs

- Transportation options are a key healthcare need for elders, especially in rural settings and among low- income elders.
- Lack of broadband internet and cell coverage in rural areas is a barrier to the way that modern health care is offered.
- LifePath, Senior Centers, Council on Aging, and Triad have incredible services for those who know about them, but the services could be marketed so more people would know about them.
- Cultural competency, translation and interpretation services, and programs and services offered for non- English speakers would aid better health for new residents of the U.S. in Franklin County.

C. Recommendations

- Recruit more doctors and providers who are committed to staying in Franklin County.
- Make it easier for seniors to get “one-stop” medical care, i.e., do not require different doctor visits for different symptoms and hire more gerontologists who can deal with the myriad needs of seniors.
- Provide home care to elders to support medication management, recovery, self-care, and health at home, while also addressing need for connection with providers, socialization, and reduced need for appointments that require travel.
- Require clear and better communication from health care providers in their follow up care, instruction on medication, new diagnoses, and discharge information post-hospital.
- Improve access to transportation options for seniors.
- Create more opportunities for socialization, including support groups, transportation to programs, and outreach to those who don’t tend to leave home (due to language, physical, social, transportation and other barriers).
- Offer more educational programming focused on chronic disease self-management, health resources, and health literacy (i.e. to improve understanding of use of service, PCPs, ER, etc.).
- Market services available at Life Path, senior centers, Triad, Councils on Aging, etc.
- Improve opportunities to address mental health issues, including support groups, access to bilingual therapists, more open conversations about emotional challenges many elders face.
- Establish more urgent care and minute clinics.
- Assist older adults in navigating the health care system and insurance industry.
- Advocate for better health insurance coverage in order to decrease co-pays.
- Increase access to bilingual providers and translators (in all areas, including mental health).
- Increase health education targeted to low income, immigrant, and non-English speaking elders.
- Improve cultural competency of providers, including culturally competent home care.
- Improve access to electronic health information (i.e. call-in line, patient portals), and train seniors on how to use them.

II. SUMMARY OF KEY ISSUES

QUESTION	SYNTHESIS OF RESPONSES
<p>1. What supports and services do elders in our community need to support good health?</p>	<p><u>Better and more health care services</u></p> <ul style="list-style-type: none"> • More doctors – gerontologists, doctors who stay so you can develop a long term relationship, nurse practitioners, general practitioners, dentists, and doctors who make house calls • Better communication by doctors and other providers – more time with the doctor, doctors who pay attention to you, providers who use plain language; improved relationship building and nurturing of patients by providers; better follow up related to referrals, patient questions, etc. <p><u>Access to health care</u></p> <ul style="list-style-type: none"> • Transportation to get to doctor’s appointments and the hospital. Many elders don’t have access to a car, have had to give up their license, do not have sufficient funds for gas, have difficulty driving in inclement weather, and in rural areas there is limited public transportation • Bilingual providers, translation services, and culturally competent health education for elders, esp. for those from countries with limited health systems <p><u>Social services</u></p> <ul style="list-style-type: none"> • Opportunities for socialization (i.e. senior centers, senior living facilities, etc.) • Home care to help with isolation, medication, physical therapy, recovery, trouble shoot health status, assess stress factors, case management support, socialization and relationship building <p><u>Other issues that were raised:</u> financial help to pay for medications not covered by insurance; case management and assistance navigating the health care system and health insurance; and mental health support.</p>

QUESTION	SYNTHESIS OF RESPONSES
<p>2. What support and services do elders in our community need but have a hard time accessing?</p>	<p><u>Services elders need but are difficult to access</u></p> <ul style="list-style-type: none"> • Services for chronic and multiple illness • Outreach programs to visit seniors who cannot get out of their homes • Socialization opportunities • Addiction and recovery services targeted to older adults • Benefit programs like SNAP, hearing aids, and other programs • Health care and emergency services – when in a rural area, accessing health services is not easy and there are very few EMTs • Programs offered in languages other than English and translation services <p><u>Barriers to access</u></p> <ul style="list-style-type: none"> • Long wait lists delay timely treatment • Transportation to appointments, senior center, and other places. • Home-bound – seniors need services to come to them, and delivery services • Due to a lack of marketing seniors don't know about existing services, positive activities, and don't know how to use the services that do exist • Difficulty navigating the system to gain benefits and sign up for health insurance. You have to be a forceful advocate to make the system to do what it's supposed to do • Lack of broadband internet, cell phone coverage, and unreliable land lines in rural areas • Extra costs of medication that is not fully covered • Lack of senior programs offered and providers or translators for non-English speakers, especially for mental health. <p><u>Other issues that were raised:</u> More time and relationship building with care providers to instill trust; more emphasis on wellness (not only treating illness) and fear of getting services taken away.</p>
<p>3. What kinds of issues do elders tend to go to their doctor for, and when might they have an issue but not call their doctor, and why?</p>	<p><u>People go to their doctors for:</u></p> <ul style="list-style-type: none"> • Annual physicals, if they see a specialist regularly, when something is necessary or a crisis <p><u>Barriers to getting regular care</u></p> <ul style="list-style-type: none"> • Not enough doctors, no choice of doctors (required to choose from list) • Communications and coordination of care between hospitals, specialists, emergency providers. You end up having to transit info from one provider to the next • Difficulty navigating insurance and determining what is covered • Cost – high co-pays for medication and care; rules about what can be discussed with what kind of doctor (resulting in multiple visits and costs); general fear of insurance companies and extra costs • Fear or lack of understanding of prognosis for both English and non-English speakers • Lack of trust or strong relationships with practitioners is important for all elders. Many immigrants coming from countries with corrupt or nonexistent health care have ongoing fear, mistrust and lack of positive experiences dealing with a health system <p><u>Other issues that were raised:</u> Access to and capacity to pay for health care; fear of ending up in nursing home.</p>

QUESTION	SYNTHESIS OF RESPONSES
<p>4. When do elders generally go to the emergency room and why?</p>	<p><u>People avoid the ER at all costs</u> – for many reasons: the wait is too long; troubles getting someone to drive them; fear of costs; you get sicker if you go to a hospital.</p> <p><u>People use the ER when:</u></p> <ul style="list-style-type: none"> • Health issues: A serious injury like a broken ankle, if they are having a hard time breathing • Access issues: On the weekend or after hours, when the doctor’s office is closed and there is no other care available and people need care quickly; there is too long a wait for a doctor’s appointment and the health problem escalates while waiting; an ailment has become unbearable and don’t know what else to do • When they are afraid their health issue is life-threatening.
<p>5. How could these issues be prevented, or handled better? What could help elders avoid going to the hospital when it isn’t necessary or the most effective way to get the care they need?</p>	<p><u>Better access to services</u></p> <ul style="list-style-type: none"> • Minute clinics, urgent care facilities, and other off-hour care options • More doctors – people use the ER due to the long wait for a doctor’s appointment; doctors even refer them to ER due to lengthy wait times for an appointment • Specialty clinics for chronic disease management (diabetic clinics, congestive heart failure clinics) • Home visits and home care – paid by insurance, to address health crises and chronic illnesses • Nurse visits to housing projects to target low income and immigrant elders <p><u>Better communication and coordination of care</u></p> <ul style="list-style-type: none"> • Improved care coordination prevents unnecessary hospitalizations. This includes check in after ER visit or new diagnoses (right after, 6 months later), NOT an on-line or paper survey – a real person checking in. • Better and more communication – clear discharge instructions after hospital or with a new diagnosis from their doctor, written summaries of doctor’s visits – in particular regarding medication. • Culturally competent education and outreach for elders in their own language about when to go to the doctor vs. ER <p><u>Better non-healthcare services</u></p> <ul style="list-style-type: none"> • Improved transportation options for non-emergency care. Elders sometimes use ambulances to go to the ER because doing so solves the transportation issue. • Provision of home visits to ensure homes are safe for seniors (no clutter, no obstacles) <p><u>Other issues that were raised:</u> health education such as how to use online medical information and use of the nurse’s info line; better relationship building between practitioners and patients.</p>

QUESTION	SYNTHESIS OF RESPONSES
<p>6. Most elders in our community have at least 1 chronic or severe disease. What helps them manage chronic disease(s)?</p>	<p><u>Health education</u></p> <ul style="list-style-type: none"> • Education – Life Path education sessions are very helpful. Topics of interest mentioned were medication management, diabetes, cardiovascular disease and heart issues, obesity, and safer sex • Do not require participation limits on education sessions – requiring a certain number of people in order to offer educational courses in rural areas may be difficult <p><u>Health care resources</u></p> <ul style="list-style-type: none"> • Medication – helpful to manage chronic disease but understanding medication is an obstacle • Case managers • Homecare providers to assist with exercise, shopping, care • Online support - helpful but some need help learning how to use it • Regular visits to the doctors and compliance with doctor’s orders • Access to different types of care in various settings: 24 hour care; dieticians for those who require it; providers to advise on chronic illness in gyms, senior centers, etc. • Timely response to patient requests and needs <p><u>Other issues that were raised:</u> Activities that support good health such as exercise, good nutrition, socialization, religious beliefs, and church communities.</p>
<p>7. What are some of the emotional and mental health (MH) issues faced by elders in our community?</p>	<p><u>Emotional and mental health issues faced by elders in our community</u></p> <ul style="list-style-type: none"> • Loneliness and isolation came up the most often as a mental health issue • Depression related to separation from home and family • Anxiety, worry, stress • PTSD and trauma from war in home countries for some immigrants • Alzheimer’s, dementia, short term memory loss, forgetfulness • Substance use disorder– not just drugs (opioid) but also alcohol • Abuse – spousal, financial, and elder abuse and neglect <p><u>Barriers to getting treatment</u></p> <p><u>Health Care Barriers</u></p> <ul style="list-style-type: none"> • Lack of mental health providers who understand seniors • Lack of local bilingual therapists • Private insurance will not cover dispensing machines to regulate pain management prescriptions (contributor to opioid abuse) <p><u>Lack of resources</u></p> <ul style="list-style-type: none"> • Lack of transportation for mental health appointments • Lack of resources among family caregivers to properly care for elders leading to neglect <p><u>Personal barriers</u></p> <ul style="list-style-type: none"> • Fear of leaving the house • If people are living alone no one can monitor their use of medications • People self-medicate with alcohol • Elders may fear retaliation and may not discuss neglect and poor treatment • Reliance on God to address physical and mental health • Stigma among all populations; not wanting to accept mental health services; for nonwhite populations or immigrants cultural barriers to being treated for depression. <p><u>Other issues that were raised:</u> One person tied living in deplorable conditions to mental health; embarrassment due to physical limitations; for some mental health is bigger problem than physical health.</p>

QUESTION	SYNTHESIS OF RESPONSES
<p>8. How can the hospital, or community or senior center help elders who are struggling emotionally?</p>	<p><u>Socialization opportunities and assistance in participation</u></p> <ul style="list-style-type: none"> • Informal activities and support groups to help people adjust to and cope with aging; help to make sure people have a network of family, friends and neighbors • Outreach to elders who cannot or will not leave the home, and to immigrants/low income elders who may not be aware of resources • Seniors Centers help with socialization, programs and services, staff and participants know what activities are going on in the community, and keep track if someone has not showed up. • Better transportation to increase the ability to participate in programs and activities • More marketing so seniors know about the opportunities that do exist (at Senior Centers, etc.) • Help getting seniors more connected to the computer in order to converse with family & friends. <p><u>Mental health providers and services</u></p> <ul style="list-style-type: none"> • Access to mental health services, including psychiatric and therapeutic treatment, case managers • More access to mental health practitioners outside of regular appointments (in senior centers, housing projects, gym, etc.) • Bilingual mental health providers • Support groups and programs focused on mental health, such as Green River House • Home based care • More rehab and detox beds for people with alcohol problems • If people need to go to a hospital, send people to a gerontology psychiatric unit (there's one in Gardner) rather than the local hospital <p><u>Better quality of mental health care</u></p> <ul style="list-style-type: none"> • Improve mental health expertise/training of front line staff in organizations serving elders • Mental health providers who understand and want to work with seniors – older mental health counselors; knowledge of medication differences for seniors vs. younger adults, and mental health providers who stay in the community. <p><u>Other issues that were raised:</u> Have a resource manual about agencies that provide programs and services at all doctor's offices and senior centers; more support for men who are aging – men need other men to be involved in their care, not just women; and more Rainbow supports and services for LGBT elders.</p>
<p>9. What can better ensure that elders of color, those with limited English, or newer immigrants get the help and care that they need?</p>	<ul style="list-style-type: none"> • Bilingual staff in senior centers and healthcare organizations • Programs/group settings/services targeted to non-English speakers • More access to interpretation services in hospitals and other wellness settings (senior centers, nursing homes, etc.) • Improve cultural competence of practitioners to improve understanding of common immigrant characteristics: <ul style="list-style-type: none"> ○ Emphasis on close relationships and family ○ Aggressive, assertive behavior as culturally based (especially Latino) ○ Trust and comfort comes with discussion of personal issues a family–not <i>only</i> medical discussion. ○ Preference for direct, personal engagement with eye contact • White practitioners often lack a personal touch

QUESTION	SYNTHESIS OF RESPONSES
<p>10. What needs do elders have for social services? What are the barriers they face in accessing these services?</p>	<p><u>Help in the home</u></p> <ul style="list-style-type: none"> • Handyman services • Help with cooking and housecleaning • Home wellness checks • Home assessments for safety – i.e. Triad helps seniors get walkers, shower handles, etc. • Culturally competent home care and health mentoring <p><u>Addressing isolation</u></p> <ul style="list-style-type: none"> • Weekly check in visits (as needed, not just every 3 months) • Address isolation through companionship • A volunteer match-up – so seniors have a buddy <p><u>Help with benefits and programs</u></p> <ul style="list-style-type: none"> • Assistance connecting to social service programs (e.g., fuel assistance, etc.) • Financial support for those who don't qualify for subsidies but don't make enough to meet all their needs; assistance with cost of rent, utilities, and food • More money to pay for caretakers for seniors – 1:1 is what elderly need; funding for home visiting (and staff to do it) • Better and more marketing of the services that Life Path has, and more information about all the available resources <p><u>Services and resources</u></p> <ul style="list-style-type: none"> • Transportation • Translation • More senior housing <p><u>Other issues that were raised:</u> It is important that care is provided in one's own language; help managing medications</p>
<p>11. What would help elders be able to continue to live at home?</p>	<p><u>Education</u></p> <ul style="list-style-type: none"> • Information and financial support about home adaptations as you age – handicap bathrooms, ramps, adaptable repairs • Education about when it's best to not stay home • Information about available home care resources <p><u>Services and assistance</u></p> <ul style="list-style-type: none"> • Wellness checks and help for seniors to get home modifications. • Assistance at home, good homecare • Assistance with managing finances • Housing – for elderly, need first floor apartments, need affordable housing • Culturally competent home care and health mentoring <p><u>Financial support</u></p> <ul style="list-style-type: none"> • Financial support for those who want to stay in their homes longer • More marketing about the Adult Family Care program through Life Path – where family members can get a stipend for keeping their aging parent at home and taking care of them. <p><u>Other issues that were raised:</u> Advocacy for seniors' issues; disaster preparedness – educating seniors about what to do; having seniors participate in disaster preparedness exercises for the town so responders know how to deal with the senior and disabled population.</p>

Appendix: Franklin County Focus Group and Interview Quotes

- “Our unmet needs are enormous.”

Lack of Doctors

- “There is a lack of doctors in Franklin County – specifically we need gerontologists. Our needs are different than someone dealing with kids or younger adults.”
- “Lack of longevity of doctors is a problem. Seniors like to have a relationship with doctors, you just get established then in two years, they are gone...no one stays anymore.”
- “There’s a lack of [health care] service - It’s a health challenge; we live in Heath, we have 703 residents, 60% are over 60 years of age. We have one EMT, now we have two but he’s not always available.”
- “There are special health needs relative to older bodies.”

Communication and Coordination Of Care

- “Doctors [need to] have good communication with a senior, if they talk quickly or use vocabulary outside our normal vocabulary, it’s difficult. Doctors need to be able to pause a minute and make sure people understand.”
- “There’s no communication. The doctor you see in the hospital – that’s not who you’re going to see ongoing. And they don’t communicate between your general practitioner and the doctor you saw in the hospital – you have to do it for them.”
- The ER is not dealing with the emotional side of recovery... It is systematically a thing if you're on your own when you go there...
- There's no relationship building between the patient and healthcare provider... It's the worst thing to be in a hospital or health care facility and sense that the staff is frustrated. My primary reason for leaving Franklin is that the nurses are frustrated.”
- “As an elder I don't see the hospital being integrated with the local providers and that integration is critical. I go to my endocrinologist who has her own separate account for me with my patient electronic medical record. Why don't I have one in the hospital that covers the doctors in the area?”
- “We need our physicians to be clearer on the orders you get when you leave a hospital or ER. Patients need to be able to understand these. When you’re discharged from hospital you may be groggy from whatever medication you were given...No one is coordinating your care. This lack of coordination of care results in people going to the ER when they otherwise wouldn’t need to do that.”

Infrastructure

- (No broadband or cell service) “I had major heart surgery; and due to some problems, had a [pacemaker] implanted. I have to talk to doctor in NH. There’s no cell phone or broadband, my wife had to drive to Shelburne to transmit information. It was insane!”
- “Not only do we not have broadband or cell phone coverage, also our phone lines are not reliable.”

Costs and Limitations of Insurance

- “Sometimes people don’t go to the doctor because they fear insurance companies and extra costs. “You might go – ok how sick am I how much does it hurt. I might break my finger, but I could let it heal crooked because I can’t afford the co pays.”
- “In my town some seniors are afraid if they tap into services it will lessen the services they already receive.”

- “When you go for physical, a physical has no copay but if you talk about anything specific, you get charged a co pay.”

Emergency Room Is Bad

- “The ER situation is a nightmare. If you fall down and think you broke something, you can yourself thinking maybe only a bruise, wait a few hours, rather than go to the ER.”

Health Education and Communication

- “There needs to be more of a checkout system to make sure you have gotten the education, you know how to do the steps for yourself.”
- “[There should be] a follow up a month to 6 weeks after. When you’re in the thick of it, you’re dazed and glazed.”
- “Medication – the info you get with meds is not at all clear, you get this huge sheet, and the print is tiny.”
- “We need our physicians to be clearer on the orders you get when you leave a hospital or ER. Patients need to be able to understand these. When you’re discharged from hospital you may be groggy from whatever medication you were given...No one is coordinating your care. This lack of coordination of care results in people going to the ER when they otherwise wouldn’t need to do that.”
- “What’s needed is to bring gymnasiums into the hospital or send hospital personnel to exercise facilities to work with elders there. There needs to be a face of the hospital at the senior center, talking with folks. Chatting about my condition, rather than the last three tasks assigned to me by my provider. The comprehension of why I do this to improve my care and what should my expectations be.”

Mental Health and Substance Use Disorder

- “A lot of problems, including mental health, are from lack of socialization after people stop working... People are shell shocked once they leave work. It was their social life, and they didn’t even know it.”
- “It’s nice to become involved in things in the town you live in. You get this network and then you have a need and people are willing to help you. You realize you’re not alone.”
- “I have one friend who takes me [to the senior center] and back. I like it because I have conversations and there are new things to do... We give advice to each other, we talk.”
- “Here at senior center, people come in and visit and joke and laugh. And pretty soon they feel comfortable, and we find out what they really need.”
- “Many of them are strong physically but it’s mental issues that they struggle with... They don’t want to be treated for depression. I’ll say to someone that from what they’re telling me, maybe they’re depressed, and they’ll say, “No, I’m fine.”
- “If you can get someone to accept mental health services, access to services with a therapist or psychiatrist who has experience with a senior population is still a challenge. The needs are very different. And with medication [for mental health issues] – what you prescribe for a 20 year old is very different than for an 80 year old.”
- “We have support groups for diabetes, but we don’t have any support groups for elders dealing with mental health issues.”
- “A lot of focus has been on young people with opiate drugs and that sort of thing, but I know a lot of older people with addiction issues. As they get older, especially if they retire, they indulge in more and more alcohol drinking, which can lead to depression... Addiction with seniors is a hugely different story than it is with a 22-year-old in terms of how it is visualized, recognized...Addiction among elders needs to be addressed and treated.”

- “With opioid crisis, when you try to get someone a [treatment] bed when it’s “only” good old alcoholism, it’s not as easy. A lot of beds have been taken up by people suffering with opioid addiction.”

Vulnerable Groups

- Elders of color are an “invisible group” with multiple health care needs.”
- “It’s about education and outreach and cultural competence... Many of our elders come from countries where they didn’t have access to the health system, or they think it’s too expensive or not accessible, or they think that you just put up with pain and maybe it will go away.”
- “Putting a system in place, like a case manager, a companion, a visitor coming often to check in at least every 2 weeks, and then they look forward to that visit which is nice. Someone with cultural competence who respects their culture and doesn’t impose their own culture.”
- “Going to the housing projects would be good to target low income and immigrant seniors. If there’s a nurse helping with diabetes there, then people will come and they can get other information from the nurse then too.”
- “Most of them would probably benefit from going to a therapist but there are no therapists who are bilingual.”