Focus Group Report

Prepared for the
Foundation for Community Health
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Focus Group Report  
Foundation for Community Health

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Executive Summary

Four focus groups (two with seniors from Connecticut and New York and one each with Latino migrant workers and parents of school age children) were held during the Winter and Spring of 2004-05. The purpose of the focus groups was to learn about community members’ perceptions and experiences as consumers of health care and also about their unmet health care needs.

Both Connecticut and New York seniors identified independence and relationships with others as important aspects of health. The seniors used a combination of self-care techniques and social service programs to maintain their health. There was concern that there is no central information repository for all health and community resources.

Participants in the Latino group identified concrete obstacles to maintaining good health. Unfamiliarity with the American health care system and the English language were major obstacles in accessing care. Likewise, limited financial resources and insurance coverage coupled with a sickness stigma prevented many people in the Latino community from seeking timely care for treatable conditions. The dominant theme in this focus group was an interest in learning more about health issues and the health care system.

The parents with school age children identified affordable health insurance was a major issue. This group valued their privacy, and often sought health care across state lines to preserve their confidentiality and anonymity. They also valued a trusting and collaborative relationship with their practitioners, convenient access to care and information and diversity of thought among their health care practitioners.

Each of the groups offered program recommendations to address the problems that they identified. Overlapping ideas included greater and more organized dissemination of information and the creation of family community centers that would increase access to social, emotional and financial support while reducing the stigma associated with receiving help.
I. Methodology
Four focus groups were held from November 30, 2004 through April 6, 2005. The first focus group consisted of seniors from Connecticut and the second was composed of seniors from New York. A third group was held, in Spanish, with Latino migrant workers from New York and the fourth group targeted Connecticut parents with school age children. Recruitment strategies and available demographic data are located in Appendix A. A meal was served at each group to encourage participation and to recognize the value of participants’ contributions. No financial remuneration was offered to focus group participants. Each focus group was approximately two hours long.

The purpose of the focus groups was to learn about community members’ perceptions and experiences as consumers of health care and also about their unmet health care needs. The focus group planning committee chose to define health care broadly, including (but not limited to) physical, mental and emotional health. The focus group instrument is located in Appendix B. A survey to assess reliability was conducted at the conclusion of the three English-speaking groups. Survey results are reported in Appendix D. Although the focus groups appear to be reliable, their generalizability beyond the groups studied cannot be ascertained without further research.

This report first lays out the results from the Connecticut and New York seniors combined (section II), followed by the Latino (section III) and the parent groups (section IV), respectively. Each section concludes with a brief summary of that group’s results. A synthesis of the program recommendations follows (section V).

II. Connecticut & New York Seniors
Definitions of “Healthy”
The Connecticut and New York seniors’ definitions of healthy included several related concepts. The first theme identified in both groups was the absence of pain. Next they discussed physical and cognitive aspects of independent functioning, i.e. being able to think clearly, ability to cope with frustrations, physical independence. One participant from New York summed up physical independence as “going where I want, without help” another member from the same group referred to “not being beholden to others”.

Another dominant theme, that was slightly stronger in the Connecticut group had to do with volunteering and making a unique contribution. Contributing to the community was an integral aspect of staying healthy for the Connecticut seniors. Both groups cited contact with others as an extremely important aspect of health. The New York group tended to stress contact with family and friends (even if geographically separated) while the Connecticut group made more references to joining activity groups and (as noted above) giving back to the community through volunteer activities. A possible explanation for the difference in emphasis on the type of community connections is that the location of the New York group attracted some slightly less mobile participants. In general, both groups valued staying active (physically and mentally) and correlated high activity with good health.
Maintaining One’s Health
Participants named several programs and strategies for maintaining their health. Programs included Meals on Wheels (note: group members spoke about the social visits and token gifts, more than the meals), libraries (actual visit was preferred to a delivery service), exercise classes, and transportation services. Strategies for staying healthy included maintaining contact with family and friends, scheduling regular doctors appointments, volunteering in the community, participating in community meals (or for the New Yorkers events at the Fountains) and self-care, i.e., nutrition, “being dressed and ready to go,” having a routine – mentally and physically. A key theme for both groups was connection to individuals and community.

The participants also reported a negative cycle whereby new programs get funded but not publicized, leading to low utilization rates. In their view, the programs then get canceled because policy makers interpret the low utilization rates as evidence of an unnecessary program. Although this cycle was explained more clearly by the New York seniors, the theme emerged in Connecticut as well.

The New York group spent a great deal of time talking about the value of and need for transportation services. The New York discussion addressed the transportation difficulties inherent to a rural community. This group believed that accessing all aspects of the community is an important aspect of health and that transportation services should facilitate the maintenance of personal connections and also include access to community resources such as supermarkets, art exhibits, recreational activities and other personal interest destinations. A review of the survey results (Appendix D) shows that many participants came to the focus group with a transportation agenda. An issue related to transportation services was the participants’ concern regarding the short supply of volunteer ambulance personnel and the community’s obvious dependence on this service.

Almost as an after thought, the New York group added “access to medications and money” as necessary to maintain their current level of health.

Supports Utilized (What do you do when you are not feeling well?)

After listing the obvious resources (“go to the doctor”) the Connecticut seniors moved into a discussion of their expectations regarding healthcare. They expect qualified and personalized referrals and described themselves as sophisticated patients who “know of advanced practitioners elsewhere”. They were annoyed by “referrals of convenience,” which were described as a one-size-fits-all local referral. Several participants also spoke of doctors who became insulted when the patient indicated that she wanted a second opinion. A participant noted that doctors act like they are Gods, “big Gods and little Gods”. All participants felt that consumer self-protection was a very important aspect of receiving good medical care.

The New York seniors identified a range of self-care activities, ranging from showering and reading to utilizing medical resources at the Fountains. One member spoke of adapting hobbies and interests to stay busy, even with new limitations. Participants
longed for more intergenerational interactions and discussion groups about current issues and events.

When asked about their personal experiences in receiving care, some Connecticut participants reported they felt as though they were part of an “invisible syndrome,” that “once you turn 65 you disappear”. They described not feeling cared about by their providers, but placed most of the blame on Medicare and insurance companies. One participant captured the dynamic by saying that she felt like a “babbling brook” when talking to her physician. Other participants voiced concern about the “what do you expect at your age?” attitude to which they are often subjected. They also spoke of leaving the Sharon community, first identifying Boston and New York and then Hartford Hospital and St. Francis. Reference was made to the fact that there is no teaching hospital near by. Though not answered, one participant wondered aloud if small towns attracted physicians who want easier lives?

Finally, the group noted that continuous coverage is a problem. They talked of experiences where their doctors had been on vacation and a substitute filled in but did not have full access to the patient’s medical records. This group wanted to see more group practices and electronic record systems that would allow substitute physicians full access to their medical records when their primary care physician is not available.

**Program Ideas and Recommendations**

Connecticut seniors expressed the view that their personal health is not a community issue. When pressed about community services that could be helpful they wondered if there was a well-child clinic and if there was a need? After a little prodding the group noted that there were some resources available for hearing difficulties and that some transportation services existed, but there were long waits. Residents of Noble Horizon believed that transportation was not a problem for them, but agreed it was a general problem in rural areas. Group members finally acknowledged that they would like to see insurance paperwork simplified and advocates who could assist with the paperwork and insurance processes.

The New York group was interested in seeing an increase in medical personnel and services such as dermatologists, MRI and blood testing. They again noted the importance of publicizing existing services so that they get used and maintained. They would like to see existing services and information pooled for easy and efficient access. They believed that there is not a good process for matching community resources with individual needs. Primary information sources currently utilized include word of mouth, local paper, church/religious services and senior citizen groups. There was a sense that the non-uniform nature of these sources led to random dissemination of information. The New York seniors said they would like to get information from a community bulletin board (the post office bulletin board is too small and too high) or a centralized phone line. Resource directories can be cumbersome and hard to use.

A program idea that emerged from the New York discussion was to encourage high school students to offer delivery services for those who have difficulty leaving home.
The service should be designed to bring needed items to the seniors as well as to include social interaction.

**Mental Health Case Study: Mr. Doe (Case study is reprinted in Appendix C)**

Connecticut seniors believed that the Doe family’s biggest problem was a lack of money. They said, “This could be anyone”. They also concluded that a psychiatrist was not needed in this case and that the mental health clinic (The Northwest Center) social worker could help. They noted that although Mr. Doc did not want to reach out for help, he was disconnected and needed someone to whom he could talk. Group members stated that it is natural to be reluctant at first, but that once one gets started with a social worker it is like “talking to a normal person” and that the “key is to know what is available”. They suggested the Foundation work to publicize existing resources. Current sources of information relied on by participants consisted of the yellow pages, personal contacts and state caseworkers.

Intervention suggestions included rest and relaxation, a support group, low cost mental health treatment, couples therapy (not having sex is a couple’s problem). They also believed that the referral was a referral of convenience (as defined above), one medical provider to another rather than exploring allied health options.

As for changes in the community that could help the Doe family, this group felt that access to health care was a national problem (not a community issue) and that the remaining Doe family problems were personal and not the responsibility of the Foundation. They wondered if Mr. Doe could get a second job and noted that the employer utilized a kind and gentle approach. The only possible role for the Foundation, according to this group, was to help in the dissemination of information that could help the Doe family.

The New York seniors, on the other hand, believed that if Mr. Doe did not see a psychiatrist the family would lose everything. The common nature of the problems were noted as well as the isolation experienced by the Doe family. The psychiatrist, in the opinion of the group, needed to work with the whole family and involve other helpers such as the school psychologist and nurse. A spiritual advisor could also be helpful to the Doe family. One participant noted that Mr. Doe should receive a “good physical exam”.

The community change that could help the Doe family was a “Family Service Center” that would be a multi service, non-stigmatized community support. It would be a spiritual, recreational, information-rich center. Services would be private, coordinated and include transportation, temporary financial assistance and other services as needed. The name would be neutral and some people would use the center strictly for pleasure so the stigma associated with accessing services would be eliminated.

**Additional Comments**
The Connecticut seniors felt that considering the size and place there are remarkable resources in their community. However, only some of the people who need them know they are there. Reducing the stigma associated with getting help will be an important step
in increasing access and utilization of existing services. Some particularly stigmatized conditions, such as alcoholism and domestic violence are huge problems that need to be addressed.

**Summary**

Both Connecticut and New York seniors identified independence and relationships with others as important aspects of health. The seniors valued activity and community connections, but did not want to be "beholden to others". Significantly, volunteering in the community was an important aspect of many of the seniors’ lives. The seniors used a combination of self-care techniques and social service programs to maintain their health. There was concern that there is no central information repository for all health and community resources. The New York seniors communicated that transportation challenges impeded their ability to be fully connected to the community.

The Connecticut seniors expressed dissatisfaction with some of the relational aspects of their health care. They reported feeling "invisible" and dismissed by their health care providers. Issues related to impersonalized referrals emerged more than once. An additional concern was the lack of collaboration among practices that creates a discontinuity in care when their primary provider is unavailable. In spite of these issues, they tended to characterize their concerns, as well as the abstract issues identified in the case study, as personal and not community problems.

**Summary of Program Suggestions Made by Participants**

1. A centralized information repository, easily accessible, where one can learn of all available resources in the community. A community bulletin board, phone service and/or newsletter could accomplish this. E-mail and the web are not useful communication vehicles for most of the seniors.
2. Regular short, current and easy to read newsletter that contains health and resource updates.
3. The New York seniors, specifically, would also like to take part in community conversations about current issues and events that were open not just to seniors.
4. Transportation services that can be personalized and include destinations of personal interest.
5. Creation of group practices and/or an electronic record system that allows substitute providers to have access to a patient’s complete medical history.
6. Insurance advocates who are trained to assist seniors in completing paperwork and navigating complex systems.
7. Increase the local availability of certain medical services, i.e. dermatology, MRI, blood testing.
8. Create a volunteer program where high school seniors and others could provide delivery services and social visits to seniors.
9. Encourage seniors to unite and be involved with government and health care policy decisions.
10. Establishment of a family community center that features recreational activities as well as safety net and mental health services. A key component would be to reduce stigma associated with seeking help.
III. Latino Group

Definitions of “Healthy”

The participants in the Spanish-speaking group, like the others, reported that good health includes both physical and mental aspects. Maintaining physical health required eating well and receiving medical attention while mental health was promoted through positive relationships with work, family and community.

Obstacles to Maintaining Health

The group went on to describe obstacles in accessing medical care. They explained that accessing health care involves reading, writing and knowing how to use technology such as phone systems. They explained that people need to be familiar with the way things are done here; for example, not knowing how to make an appointment is a major obstacle to receiving health care. There are people in the Latino community that could help other community members navigate the system, but that would require the person in need of assistance to admit that s/he did not have the necessary skills. Another major obstacle is the cost of care. Sometimes there is only money for food or medical (or dental) care. Choosing one means forgoing the other.

This group also told of work and other stresses that are particular to their citizenship statuses and English language skills. For example, they described situations where their American co-workers criticize their work and give directions that differ from those given by the boss. The Spanish-speaking workers, some with limited English language understanding, do not want to complain and risk getting fired. Likewise, for undocumented workers, deportation is always a fear. People do not complain of human rights violations and exploitation. Although they believe they have the worst jobs available in the community, there is a strong feeling of having to tolerate the exploitation to survive. Finally, many of the workers feel financially responsible for their family in the States and for family members back home. These stresses make it hard to maintain a good level of health.

Supports Utilized (What do you do when you are not feeling well?)

Participants reported eating well, resting, hand washing, and covering one’s mouth when coughing as basic strategies to avoid getting sick. Health care resources utilized by the focus group participants included the clinic in Amenia, Sharon Hospital and traveling to Poughkeepsie for appointments with specialists. One participant was satisfied with her experience at Sharon Hospital using a telephone for translation. In general, participants reported going to the hospital for bigger problems, like surgery, but taking care of little things on their own. A concern was that the hospital asks for a lot of personal information raising the fear of deportation for many. This is especially true considering the current climate of fear and mistrust of immigrants. Group members noted that a lack of health insurance is a serious problem both locally and nationally. People might be able to afford primary care and a diagnosis, but not treatment. Additionally, programs for the

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1 This group was conducted in Spanish by a different facilitator than the others. While the information obtained is consistent with the project’s research goals the focus group transcript suggests there were variations made to the meeting agenda. For that reason this section of the report uses slightly different headings.
uninsured can be intimidating, complicated and inaccessible for immigrants and undocumented residents.

There was considerable discussion and confusion about the Hospital, the Foundation and Hudson River Community Health Center (HRCHC) funds. Other insurance systems were also discussed, i.e. car insurance. It was clear that the group got “warmed up” and needed information about the different financial insurance systems in the US. The group was confused over payroll deductions and workers’ compensation insurance. There were varying levels of sophistication about the different systems and the coverage provided by each.

In general, people are not getting help for treatable diseases. Reasons for lack of treatment included the obstacles noted above as well as some negative experiences at the clinic. If people felt they were treated badly they would avoid the clinic in the future and look for home made remedies. Plants and herbs were discussed as an example. Herbs used include Canela, Savila Ruda and Ajo. Likewise, community members were thought to be afraid of what the doctor might say, and avoid seeking help until very late. Denial is a major barrier to care, especially for men, who suffer from additional stigmas when sick.

Program Ideas and Recommendations
This group would like to see more health information, especially prevention information reach their community. They would like to receive information by radio, video, pamphlets or meetings. Some members recalled learning about Lyme disease at a meeting and felt good about their ability to prevent and/or identify the disease. A difficult but important topic is sexually transmitted diseases (STDs). The group members believe that a lack of knowledge and shame contribute to the spread of STDs in their community. In the latter circumstance, seeking health care through an interpreter makes the situation especially embarrassing.

Group members believed that talking about STDs in small groups could help spread valuable information. One participant spoke of health campaign strategies that were effective in Nicaragua. The campaign would focus on one health issue at a time and train community members to give out information and organize talks. It was noted that the talks are offered here too, but are usually poorly attended. This is especially true if it is a taboo topic (such as STDs)

For almost all problems discussed, dissemination of information was presented as the solution. Group members wanted information about programs and medical issues. One idea for disseminating information included the creation of a weekly program on health topics to be aired on the Spanish radio station. The participants believed that it would take time to build a listening base, but that it would be successful after the startup period. Regular meetings (monthly/weekly) would also be successful if given time to build attendance through word of mouth. Consistent with the idea regarding health campaigns, one member’s idea of health competitions (prizes given for the most significant health
improvements in a specified area, i.e. lowering blood pressure) appeared to be well received by group members.

Additional Comments
Other issues that emerged were the importance of dental care, eye care and prevention. People who are isolated were viewed as at greater risk for substance abuse problems. Again it was noted that alcoholism and addictions could be helped through public information campaigns. Personal encouragement and support are also necessary in overcoming these problems. People need to know that smoking and drinking cause damage that cannot be undone. The group believed that employers should support these campaigns to reduce worker sick time. Similarly, domestic violence was recognized as including physical, verbal and emotional abuse and was classified as a sickness. It was noted that there are organizations that can help with this problem, though language once again is barrier to benefiting from the services.

There was a strong desire to see assistance go to the most needy. This group felt that most of the time they will be able to take care of their own problems, and that help should be reserved for those who have greater needs. The group concluded with the notion that members need to work together to create a supportive environment, integrate into the community and learn to speak English. There was also a call to work with employers to create a better living-working environment.

Summary
The participants in the Spanish-speaking focus group defined health as including physical and mental components. However, participants in the Latino group identified concrete obstacles to maintaining good health. Unfamiliarity with the American health care system and the English language were major obstacles in accessing care. Stresses caused by working conditions and immigration statuses served to exasperate the situation. Likewise, limited financial resources and insurance coverage coupled with a sickness stigma prevented many people in the Latino community from seeking timely care for treatable conditions. These factors translate into a reliance on home remedies as a first line treatment. The dominant theme in the focus group was an interest in learning more about health issues and the health care system.

Summary of Program Suggestions Made by Participants
1. Package important health information into videos, pamphlets, radio advertisements and talk shows targeted to reach the Latino community.
2. Conduct health information meetings where small groups of people can learn about important health issues in person. Be patient if there is low attendance at first. Word will need to spread through the community.
3. Tackle taboo subjects such as STDs that are prevalent and preventable.
4. Initiate health campaigns that focus on a specific health issue at a time.
5. Create health competitions in the community that reward healthy behaviors.
6. Use a personal approach that encourages community members to help each other.
7. Encourage employers to invest in their workers (to reduce sick time) and promote healthy behaviors.
IV. Parents with School Age Children

Definitions of “Healthy”
After quickly defining health as “a sense of well being” that included physical, spiritual and mental health, the group went on to identify issues of community health. One member in particular appeared to have a strong public and environmental health agenda. She described a “robust healthy environment with safe food sources” and a dynamic and educationally/financially diverse community as important aspects of health. All group members agreed that connection with other people was an important aspect of health.

Important aspects of medical care included access (identified in terms of coverage hours), a trusting relationship with provider (a relationship “built on a history of healing, communication and collaboration”), affordability and diversity of thought among providers.

Maintaining One’s Health
Participants described personal exercise, sleep and eating habits as well as having time with their families as important health maintenance activities. Important tools for staying healthy included access to outdoor trails, swimming, team sports and in general “places to go and people to play with”. Likewise, a “comfortable safe home” also made the list.

There was a huge debate between two members in particular about the value of local versus chain pharmacies. Each identified the pros of their preferred pharmacy type (personal relationship with pharmacist at locally owned pharmacy versus less expensive products at the chain pharmacy).

The group identified a wide range of issues, ranging from the national crisis regarding access to health care to local on-call coverage. Even the big issues, however, related to personal experiences. For example, one participant noted that her family was too well off to receive government benefits, but not wealthy enough to purchase insurance independently. In fact, two of the four participants were not eligible for an employer sponsored health plan and reported that preventive care e.g. regular colonoscopies are absolutely cost prohibitive. On the local level participants wanted to see more cooperation among local practices to ensure more hours of coverage and shorter waits for appointments. One participant had a lengthy story where an on-call doctor refused to treat his son at Sharon Hospital, causing the son to be moved by ambulance to another facility. This, of course, proved to be quite costly for the family and a disruption in the son’s care. The group members noted that the ER becomes the default on-call system.

Supports Utilized
In general, this was a well-resourced group that knew who to call for different needs. Several issues emerged related to living in a small rural community. One member in particular explained that she preferred to use New York practitioners to protect her confidentiality and anonymity. In spite of the difficulties associated with using her health insurance across state lines, she did not want to run into her practitioners “at dinner parties”. The significance of confidentiality and anonymity was especially important in regards to mental health issues and/or marital counseling. Another member put a positive
spin on the same dynamic and stated that he enjoyed access to information and advice through informal means. Everyone agreed that access to information and quality health care was easier to obtain for their children than for themselves.

Other dialogue connected to rural health care included the limited choice of hospitals and limited referral networks. It was acknowledged, however, that healthcare is not always better in the big city... there can be long waits and other negatives.

In general, all participants, some with health insurance and others without, felt that navigating the health care system requires skill, advocacy and demanding of one's rights. Another point of agreement was that Sharon Hospital has a top-notch emergency room. Participants believe the ER to be an essential community service.

Program Ideas and Recommendations
One member noted that as of five years ago she experienced a lack of support for new parents who were also new to the community. She stated, "A healthy community will welcome its new members". Several participants agreed that there are few formal means for welcoming new people into the community. Ideas generated at this time included using a welcome wagon model, having the town social worker reach out to new members and the establishment of a family community center (much like the idea generated in the focus groups with seniors).

There was also a desire among at least some of the participants to see corrections made to land use patterns that contribute to an increase in Lyme disease and to see increased air quality monitoring.

Solutions identified by this group included:
- A nurse hot line that one can call for specific medical advice
- A call hour system where physicians are available to take calls (thereby eliminating the receptionist as a gatekeeper, increasing patient confidentiality by eliminating the receptionist's public (and often overheard) end of the conversation and reducing the amount of time between asking the question and receiving the answer.
- Increase use of nurse practitioners (providing that they are aware of their limits)

Mental Health Case Study: Mr. Doe
This group quickly empathized with Mr. Doe's plight and reluctance to seek help. They also quickly identified the double bind; in that Mr. Doe both needed help, but also needed to save his money. Group members wondered what community resources might exist (none really knew for sure). They were concerned about Mr. Doe's downward spiral and that his anger appeared to be directed toward his children.

All agreed that Mr. Doe needed medical intervention and that the employer and doctor should either locate affordable services or provide for the needed services themselves as a part of their collective social responsibility. They firmly believed that the Physician should know of available community resources and be able to make appropriate non-
medical referrals. Some group members also believed that a social worker or psychiatric nurse might be a less expensive alternative to a psychiatrist. All agreed that this was a family problem requiring a family intervention.

The group believed that there were a lot of missed opportunities for early interventions that could have prevented the current crisis. Significantly, the participant that voiced the strongest concern for “new” families believed that her prior recommendations (Welcome Wagon, contact with the town social worker) would have been helpful in averting the Doc family crisis. Although all agreed that getting help was not easy, only one participant believed the current safety net system was adequate to meet the Doc family’s needs. The group noted the particular difficulty in getting help with health care payments.

As with the other focus groups, this group identified a need for a community recreation center where parents can drop off children, meet other adults and learn about community resources. This approach would produce a stigma-free way of accessing health and support services.

Additional comments
When asked if there was anything else that should have been discussed, one participant suggested the group rate the local health care system. The group created a Likert type, one through five, scale where one was awful and five was excellent. The group wished to answer separately for adult, pediatric and emergency care.

The scores were as follows
Pediatric – Range was from 0-4. Mean was 2.81
Adult – Range was from 2.25-2.5. Mean was 2.44
ER – all participants rated the ER 4.5

Summary
This group was comprised of sophisticated health care consumers. They were environmentally aware and knowledgeable of public health issues. Their definition of health included physical, spiritual and mental health. Strategies for staying healthy included proper nutrition, exercise and connection with other people. Affordable health insurance was a major issue for this upper-middle class group who could not qualify for state benefits, nor afford to purchase insurance independently.

This group valued their privacy, and often sought health care across state lines to preserve their confidentiality and anonymity. They also valued a trusting and collaborative relationship with their practitioners, convenient access to care and information and diversity of thought among their health care practitioners. All agreed that navigating the health care system required skill and advocacy.

Summary of Program Suggestions Made by Participants
1. Creating a formal system to welcome new members to the community, i.e. Welcome Wagon, contact from the town social worker.
2. Create a family community center (almost identical to the ideas that were generated in both senior focus groups).
3. Encourage cooperation among practices to increase hours of coverage.
4. Establish a nurse hot line that one can call for specific and timely medical advice
5. Create a call hour system where physicians are available to take calls (thereby eliminating the receptionist as a gatekeeper, increasing patient confidentiality by eliminating the receptionist's public (and often overheard) end of the conversation and reducing the amount of time between asking the question and receiving the answer.
6. Increase use of nurse practitioners (providing that they are aware of their limits)

V. Synthesis of Program Suggestions

Information Distribution
Although stressed most clearly in the two senior groups and the Latino group, all groups value and desire easier access to information. There is a pervasive sense that information is distributed randomly. Information could be disseminated through newsletters, a call-in phone system, media, and in-person meetings.

Cohesive Health Care
The two senior groups and the group with parents all expressed a need for a cohesive system that ties individual practices together. All participants in these groups wanted to see an increase in coverage and more rapid responses to information requests. The parents group suggested the establishment of a nurse hot line that one can call for specific and timely medical advice, whereas the seniors focused on the ability of substitute practitioners to access the patient’s medical records.

Health Insurance Advocates
All four focus groups contained a discussion of the complexity of health insurance processes and paperwork. Trained advocates that could help individuals navigate the health care labyrinth could increase access to health care.

Social Connections
All four focus groups stressed the importance of social connections. The parents group suggested a systemized way to welcome new community members. The New York seniors expressed a need for individualized transportation services that would allow them to maintain personal contacts and interests. The use of community volunteers and delivery services could also be used to increase social connectedness.

Family Community Center
The two groups of seniors and the parents group generated virtually identical ideas for a family community center. The center would feature recreational activities as well as safety net and mental health services. The seniors also indicated a desire to take part in community conversations about current issues and events that were open to people of all ages. The “Family Community Center” would be a perfect forum for this type of
discussion group. An important aspect of the community center is its ability to reduce the stigma associated with seeking help.

**Employer Social Responsibility**
The Latino and parents groups both believed that employers have a social responsibility to contribute to the health of their workers and the community as a whole.
### Appendix A

#### Sampling Strategies and Group Demographics

<table>
<thead>
<tr>
<th>Group, Date and Location</th>
<th>Participants</th>
<th>Sampling Strategy</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td>CT Seniors 11/30/04 2:00 – 4:00 p.m.</td>
<td>6 women from Salisbury, Sharon, Canaan, Falls Village</td>
<td>Flyers at public places. Professionals identified key informants. Follow up by FCH staff.</td>
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<td>The Boathouse, Lakeville, CT</td>
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<tr>
<td>NY Seniors 12/15/04 10:30 a.m. – 12:30 p.m.</td>
<td>11 women (4 residents of the Fountains) others from Dover Plains, Wingdale,</td>
<td>Flyers at public places. Professionals identified key informants. Follow up by FCH staff.</td>
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<tr>
<td>The Fountains at Millbrook, Millbrook, NY</td>
<td>Millbrook, Union Vale</td>
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<tr>
<td>Latino 11/15/04 6:30-9:30 p.m. Amenia, NY</td>
<td>9 participants (4 men and 5 women) ranging in age from 35 to 54 yrs.</td>
<td>Professional contact approached Spanish-speaking residents of Eastern Dutchess and Columbia Counties who have used the health care system.</td>
<td></td>
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<tr>
<td>Parents of School-Age Children 4/6/05</td>
<td>4 participants (3 women and 1 man)</td>
<td>Press releases, flyers at public places. Professionals identified key informants. Follow up by FCH staff.</td>
<td>All participants had some connection to a health care discipline beyond being a consumer. This created many different “experts” during the life of the group.</td>
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<tr>
<td>6:30 – 8:00 p.m. The Interlaken Resort &amp;</td>
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<tr>
<td>Conference Center, Lakeville, CT</td>
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Appendix B
Focus Group Agenda

10 minutes  
Cushion time

5 minutes  
Setting the stage  
- Thank everyone for coming  
- Creation of Foundation (Sale of Sharon Hospital)  
- Foundation for Community Health is sponsoring this session to learn about your perception of this community’s health needs and goals.  
- Length of session (2 hours) -- brief survey at the end  
- In answering the questions asked we would like for you to think of your own personal experiences, those of your family and neighbors and even local acquaintances.  
- Informed Consent – taping

Opening Question  
5 minutes  
First name and favorite food

Introductory Question  
10 minutes  
What does “healthy” mean to you?  
- prompt – encourage broad thinking  
- interested in physical and emotional, subs abuse and MH

Transition Question  
10 minutes  
What people or services help you maintain your current level of health?  
- Community  
- Services  
- Providers

Key Questions  
15 minutes  
When you are not feeling well either physically or emotionally, what do you do?

15 minutes  
How could the community, including its healthcare system be more helpful to you when you are not feeling well?

25 minutes  
Mental Health Case Study: Mr. Doe and Family (Appendix C)

Ending Questions  
10 minutes  
Of all the issues that we discussed, which one is most important to you?”

15 minutes  
Is there anything that we should have talked about but did not?

Survey  
10 minutes
Appendix C
Mental Health Case Study

A Stressful Time

Money Matters
Mr. Doe has been under a lot of stress. He and his second wife of 12 years have been experiencing financial stress. It began with a major breakdown of their car, followed by a broken furnace. Mr. and Mrs. Doe have been arguing about money for some time.

Family Relationships
Mr. Doe has found himself becoming more and more irritable. He often yells at his children for no real reason. This makes him feel guilty and that he is a terrible father. His wife has accused him of seeing someone else because he has lost interest in sex.

Physical Symptoms
Mr. Doe acknowledges that he does not usually feel like eating and that his is not sleeping well. He lies awake at night and cannot stop thinking about his troubles.

Work
Mr. Doe is a new employee and does not yet qualify for health insurance. There have been recent personnel changes at work that add to his feelings of insecurity. Recently, Mr. Doe was called in to his supervisor’s office because of an episode of angry and foul language that took place at work. When confronted with his supervisor’s warning that his job might be at risk, Mr. Doe completely fell apart. Until this incident Mr. and Mrs. Doe believed that Mr. Doe just needed to work harder and stay focused.

Medical Intervention
At the supervisor’s request, an Employee Health Physician was called to meet with Mr. Doe. The physician found Mr. Doe in an agitated state, saying he was going to go home and put his head in the oven. The physician explained to Mr. Doe that he was suffering from a treatable condition linked to stress. Mr. Doe was not sure he could afford the cost of treatment. He also felt uncomfortable about the idea of having to see a psychiatrist.

Questions for Discussion
What stands out for you the most about Mr. Doe’s situation?
What suggestions do you have for Mr. Doe? For his family?
What changes in our community could improve the situation of the Doe family?
Appendix D
Participant Surveys

Seniors (CT & NY)

n= 13 (4 CT, 9 NY)

1. How would you like to get information about health? Check all that apply.
   
   (number of respondents who checked item)
   
   Family &/or Friends (10)        Magazines (5)
   Work (1)                        TV (7)
   Medical Provider (10)           Books (2)
   Newspaper (7)                   Web (3)
   Other (specify): ____Northwest VNA (1) ____Specific, clear, concise newsletter (1)________

2. Did you come to the focus group with a particular topic that you wanted to discuss?
   
   Six (6) respondents indicated no. The others revealed the following topics (# of responses):
   
   Transportation (6) Note: 5/6 were NY respondents.
   Programs of interest (2)
   Keeping contact w/ local community (1)
   Cross state medical info and services (1)
   
   Do you have additional comments that you wish to add? Yes (2) no (2)
   
   Does community extend beyond local to state and nation? I'm thinking of Medicaid & Medicare and the need for national insurance
   
   Yes (1 – see above) no (7)

3. Were there issues that you thought of or that were raised during the group that were not adequately addressed?

4. I actively participated in the focus group discussion.

   1 (1*) 2 3 (2) 4 (2) 5 (4)

   If not, explain. _______________ * “my issue is radical and didn’t come up” __________

5. My comments reflected my true views.

   1 2 3 4 (1) 5 (6)

   Thank you for your time.
Appendix D
Participant Surveys

Parents with School Age Children

n= 4

1. How would you like to get information about health? Check all that apply.
   (number of respondents who checked item)
   
   Family &/or Friends (3) Magazines (3)
   Work (0) TV (0)
   Medical Provider (3) Books (2)
   Newspaper (2) Web (3)
   Other (specify): __________________________

2. Did you come to the focus group with a particular topic that you wanted to discuss?
   
   Two (2) respondents indicated no. The others revealed the following topics (# of responses):
   
   Community Health Concerns (1)
   The relationship of exercise to health – exercise for all generations (1)
   
   Do you have additional comments that you wish to add? _____Forgot to mention the issue of
   undocumented aliens ______

3. Were there issues that you thought of or that were raised during the group that were not adequately
   addressed?  
   Yes (1 – see below)  no
   
   Additional comments:
   
   High cost of insurance and lack of coverage for preventive intervention (1)
   I think the public health concerns are truly worthy of greater attention (1)
   I would love to see a Rec center that offers exercise classes/athletics/childcare/information
   clearinghouse (1)
   
   Use the scale below to rank the accuracy of the following statements:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Neutral</td>
<td>Strongly Agree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. I actively participated in the focus group discussion. 1 2 3 4 (2) 5 (2)
   If not, explain. __________________________

5. My comments reflected my true views. 1 2 3 4 (1) 5 (3)

Thank you for your time.