

# What Does “Patient-Centered” Mean? Qualitative Perspectives from Older Adults and Family Caregivers

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## Abstract

This study aimed to (1) examine what patient-centeredness means for older adults and family caregivers, and (2) assess circumstances underlying their preference for geriatric care. We conducted separate focus groups with older adults and family caregivers of older adults about health care experiences and expectations and conducted a vignette-based experiment to assess preference for geriatric care. Participants expressed a need for greater skill and empathy and integration of caregivers. They preferred geriatric care to usual primary care with increasing social, health, and healthcare complexity. Distinct needs of older adults should be considered in referral practices to geriatric medicine.

## Keywords

patient-centered care, geriatrics, focus groups, patient values

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## Background

By 2050 the population of adults over 65 (older adults) is expected to reach 83.7 million in the U.S. (25% of the U.S. population) and 1.5 billion globally (Balachandran et al., 2019; Bloom et al., 2015; Ortman et al., 2014; The American Geriatrics Society, 2017; United Nations, 2019). For example in the U.S., older adults are more likely to see multiple providers to manage multiple chronic conditions (MCC) and geriatric syndromes, increasing their susceptibility to conflicting care recommendations, negative health outcomes, and higher health-care costs (Kaiser Family Foundation, 2016). Primary care physicians (PCPs) are overwhelmed with growing patient panels with increasing clinical complexity and report inadequate training to support older adults undergoing clinical, social, and economic transitions within a fragmented health system (Bennett et al., 2010; Boswell, 2012; Boulton et al., 2010; Salsberg & Grover, 2006). There is a critical need to ensure that the U.S. health system is equipped to provide high-quality care to older adults. One potential approach is through geriatric medicine.

Geriatric medicine is an individualized, team-based approach led by a fellowship trained physician with demonstrated benefits when compared to usual care in terms of diagnostic accuracy, functional status, and medication management; decreased nursing home and

hospital service use; and lower costs due to shorter length of stay (Applegate et al., 1990; Eloniemi-Sulkava et al., 2009; Grigoryan et al., 2014; Sorbero et al., 2012). However, the transition to geriatric care is less defined than other transitions such as from pediatrics to primary care, further limited by the geriatrics workforce shortage (Di Anni et al., 2016; Moreno, 2013). Patients, especially older adults and their caregivers, often feel that medical care does not closely align with their values and needs. We must better understand what patient-centeredness means to older adults and family caregivers—who may assist in medical decision-making—and further, how they consider geriatric care—in order to clarify its value, understand its alignment with needs and values of older adults, and inform optimal use of the service (Flaherty & Bartels, 2019; Tinetti, 2016).

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## Theoretical Background

Patient-centered care considers and responds to patients' needs, preferences, and values (Berwick et al., 2008; Epstein & Street, 2011; Osterman, 2017). Needs may be *assessed* or *normative*, such as through an objective screening measure indicating a gap between a person's status or function and an accepted or expected norm, and are used for identifying clinical treatments (Andersen, 2008; Beach et al., 2018; Bradshaw, 1977; Gaugler et al., 2005; Zuverink & Xiang, 2019). *Perceived needs* may overlap with *assessed needs* but are distinct in that they are expressed by patients themselves and may be specific to a service or aspect of care (Calsyn & Winter, 2001; Cohen-Mansfield & Frank, 2008; Coulton & Frost, 1982). For example, an older adult may have an assessed need for a geriatrician based on their age and clinical complexity but may express a need for fewer medications and continuation with their current physician. Preferences and values are related but distinct concepts that contribute to patient-centeredness (Epstein & Street, 2011).

"Values," expressed by patients, underlie preferences (Bastemeijer et al., 2017; Epstein & Peters, 2009). A patient may "value" a particular service or a characteristic of a provider and subsequently "prefer" one service or physician over another. For example, a patient may value care that improves quality of life rather than extending life and may subsequently prefer a new physician whose approach aligns with this value, over their current physician. Further, values may change over time—for example, an older adult may have different values later in their life based on experiences and health needs than they had as younger adults; their preferences may reflect these changing values.

There is a need to examine how older adults and family caregivers describe needs and values, and further, how different experiences and circumstances are related to the preference for geriatric care; a service that will become increasingly important with population aging (Bradley et al., 2002; Lehnert et al., 2011). The objectives of this study were to (1) examine what patient-centeredness means for older adults and family caregivers, and then to (2) assess circumstances underlying the preference for a geriatrician (Aronson, 2015; Pomey et al., 2015).

## Research Design and Methods

We conducted two types of focus groups: one, with community-dwelling older adults, and the other, with family caregivers of older adults (e.g., adult children). This approach enabled us to gain insights that were more likely to emerge via group interactions than through interviews or surveys (Carey, 1994; Kitzinger, 1995; Morgan, 1996). Then, we conducted a thematic analysis to understand older adults' and caregivers' experiences and expectations within the health care system and an

analysis of vignettes to understand their preferences for geriatric care vis a vis usual primary care.

## Participants

We recruited participants through flyers and an online health research platform that is part of the managed by a large academic medical center in the mid-western U.S. and has been recognized nationally by the Clinical and Translational Science Award network (MICHR, 2020). Older adults (age 65 or older) were eligible if they were comfortable speaking English in a group and had received healthcare in the U.S. for at least 1 year. Individuals with a diagnosis of cognitive impairment (e.g., dementia) could not view the study. Caregivers were included if they were at least age 25, actively supporting an older relative, and comfortable speaking English in a group. In order to identify caregivers who actively support an older relative such as a parent, spouse/partner, aunt/uncle, or sibling, we provided examples of different types of support a caregiver may provide (e.g., memory support, transportation, financial, health care visits) and asked that interested participants message us if they were unsure of their role as a "caregiver." Interested and eligible participants self-identified either as an "adult 65 or older," "family caregiver," or "both" for session placement. Participants who identified as "both" indicated the focus group in which they preferred to participate. In addition, we asked interested and eligible participants to report whether they were enrolled in care with a geriatrician. We recruited older adults and caregivers from different households, meaning that participants in older adult focus groups were not related to any caregivers in the caregiver focus groups.

The recruitment from September to November 2018 identified 140 individuals. We selected participants to ensure diversity in race/ethnicity, age, gender, and health status (determined by information such as the number of medical conditions listed on platform profiles). We purposively enrolled caregivers in one female-only group and one male-only group to assess whether there were any differences in emergent themes by gender. This approach to conducting separated and mixed focus groups based on gender has been suggested in literature on focus groups (Bloor et al., 2002; Morgan, 1997). Further, we wanted to assess consistency in candor. Research suggests that female caregivers are more burdened than male caregivers but that male caregivers also underreport the emotional, financial and physical burden associated with caregiving (Lopez-Anuarbe & Kohli, 2019; Swinkels et al., 2019). We wanted to ensure that participants would not feel inhibited in reporting their caregiving experiences and challenges. Groups ranged from 4 to 6 participants to allow sharing of in-depth experiences (Morgan, 1992). Most groups included one participant (or their relative) enrolled in geriatric care.

We conducted preliminary analyses following each session until achieving saturation—that is, when no new themes were emerging, and when themes emerging across focus groups for each participant type were consistent—resulting in our total of four sessions with older adults and four sessions with caregivers (Fusch & Ness, 2015).

### Setting

All focus group sessions were conducted in Southeastern Michigan and were approximately 1.5 hours in duration. Five sessions were conducted at a senior center and three at a local library at varying times of the week to accommodate work schedules.

### Procedures

Focus groups were the selected approach for this study in order to identify any insights emerging from dialog between participants. Since participants in each group were of different ages, genders, and racial/ethnic background, focus groups presented an opportunity for participants to respond to each other's experiences, perspectives, and even disagreements, enabling richer data than may have been gathered through one-on-one interviews. Focus groups were also a more efficient approach, in comparison to key informant interviews, to gathering data that captured diverse perspectives and experiences. The first author facilitated all focus groups and was accompanied by a trained observer (Krueger, 1998). Participants completed a demographics questionnaire at the end of the session. We recorded sessions upon permission from participants and used Rev for de-identified transcription. We provided refreshments and a \$25 gift card. The study was granted permission with exemption by the University of Michigan Institutional Review Board. Participants gave written informed consent at the beginning of their participation.

We used the patient-centeredness framework to guide focus group discussions, which included older adults' (or caregivers' relative's) (A) experiences with, and (B) expectations from, the healthcare system and providers. A third area assessed (C) provider preferences using vignettes (Brondani et al., 2008; Hughes & Huby, 2002).

**Experiences.** We asked participants to discuss their positive and negative experiences with the health care system with a focus on interactions with providers. Older adults discussed their healthcare experiences and caregivers discussed their own observations and experiences as described to them by their older relative. While the discussion was open-ended in order to identify the aspects of these interactions at the forefront of participants' minds, we used prompts to help participants think about how they typically communicate with their providers, their comfort and relationship with their providers, and challenges they perceived in their providers'

ability to meet their (or their relative's) needs and preferences. We used poster boards for visual brainstorming and wrote down words or phrases reflective of participant "experiences" that they could verify and clarify. Each participant in the focus group shared an initial comment followed by discussion.

**Expectations.** Next, participants discussed their expectations from the healthcare system and providers. A new "expectations" poster was positioned next to the "experiences" poster. Participants related and described experiences they had discussed earlier to expectations, and also discussed other expectations that were not necessarily related to their actual experiences but reflected aspects of healthcare that were important to them. Specifically, as a group, we reviewed the themes of experiences that were written on the "Experiences" poster and asked participants to discuss what their expectation were of the system and their providers, and how the expectations were different from or similar to the experiences they discussed previously. Each participant in the focus group shared an initial comment followed by discussion.

**Preference for geriatric care.** We developed two sets of four vignettes describing a hypothetical, female patient, for preliminary insights into how different experiences and circumstances may shape preferences (Epstein & Street, 2011). One set featured a 67-year-old patient, and the other, a 91-year-old patient in order to assess if there were any differences in preferences based on age group. Each of the four vignettes described either the 67- or 91-year old individual with different health, social, and healthcare circumstances and experiences. We gave participants 1 to 3 different vignettes, each on a separate sheet of paper with definitions for *primary care physician* and *geriatrician* (Supplemental Table 2). For every vignette, individual participants were asked: "Which type of doctor do you think [patient] should see?" and indicated either: (a) switch to a geriatrician, (b) continue care with PCP who is not a geriatrician, or (c) continue seeing PCP and also see a geriatrician.

To ensure the validity of the vignettes, we asked caregivers in one initial session to think about their older relative's health, social, and medical circumstances, consider their relative's providers, and then choose between the same three provider options. Then, each participant summarized their older relative's circumstances to others in the group and other participants made a provider selection and discussed their selection. The written vignettes were used in all subsequent focus groups.

### Analysis

We created a codebook drawing from session posters for thematic analysis, a qualitative approach to identifying patterns and themes that emerge from data (Boyatzis, 1998; Vaismoradi et al., 2013). The first author coded

**Table 1.** Demographic Characteristics of Focus Group Participants.

	Older adults	Family caregivers
Total N	18	18
Sex		
Female	11	11
Male	7	7
Race		
White	13	9
Black	2	3
Other	3	6
Age		
Mean (range)	74 (66–92)	52 (26–77)
Education		
High school or less	0	0
Some college	4	0
B.A. or higher	14	18

focus groups transcripts using MAXQDA 2018 and presented emergent themes along with representative quotes to the full study team to verify interpretation. The patient-centeredness framework guided integration of emergent themes. For example, experiences that participants mapped directly onto expectations reflected perceived needs (Parasuraman et al., 1991). Expectations described separately suggested other values or characteristics that were important to participants. We descriptively analyzed responses to vignettes, which reflected participant preferences for PCPs vis-a-vis geriatricians, by recording the frequency of responses indicating a preference for a geriatrician, PCP, or both types of specialists. In addition, we summarized demographic characteristics using Microsoft Excel.

## Results

Eighteen older adults and eighteen family caregivers participated across the eight focus groups (Supplemental Table 1). Both participant types had 11 females and 7 males. Older adults ranged from age 66 to age 92; caregivers ranged from age 26 to age 77 (Table 1). Caregivers supported a parent/parent-in-law ( $n=11$ ); spouse/partner ( $n=3$ ); aunt/uncle ( $n=2$ ); or grandparent ( $n=2$ ). We found no differences in emergent themes by caregiver gender; we report hereon the overall themes without making a distinction by caregiver gender.

### Healthcare Experiences and Expectations

Older adults and caregivers described experiences and expectations related to characteristics of (a) healthcare providers (i.e., provider skill, care coordination, issue prioritization, respect and empathy), (b) care delivery (i.e., holistic approach, integrating caregivers), and (c) the healthcare system (i.e., considering social determinants of health, trust and persistence toward older adults) (Table 2).

### Characteristics of Healthcare Providers

Older adults and caregivers both discussed the importance of providers who are skilled and trained in addressing specific clinical and social needs and circumstances of older adults, and further, who demonstrate respect and empathy for the aging experience.

**Provider skill.** Older adults tended to attribute issues (e.g., diagnostic errors) to the tremendous demands on doctors in addition to their own medical complexities despite major risks to their health. For example, one participant explained that acquiring strep throat could be extremely dangerous for him and that his symptoms varied with each infection. On a recent visit, his doctor did not diagnose him with strep or prescribe treatment because he did not present “classic symptoms.” He later ended up in the emergency department. He was forgiving—and other participants affirmed with nods—of doctors, explaining that *they too, are human*. Yet, participants then expressed the need for specialized skills and training for providers to understand that the medical needs, symptoms, and concerns of older adults may be unlike those of younger or middle-aged adults, thereby ideally improving diagnostic accuracy.

**Care coordination.** Caregivers described experiences related to care coordination and follow-up. They were frustrated that too often, their relative’s doctor was reading outdated health information or even neglecting critical information from other providers involved in their relative’s care. Some caregivers struggled to coordinate care between various electronic health record (EHR) systems (e.g., their older relative’s previous and current physicians’ separate systems) to remedy lack of coordination between the physicians themselves. They expected that providers should recognize and undergo training in effective coordination, which is critical and fundamental to the care of older adults who may (and are more likely to) receive care from multiple doctors.

**Issue prioritization.** Both types of participants discussed conflicting priorities during doctor visits subsequently requiring additional follow-up appointments—often, also, without guarantee of addressing other concerns. For example, one caregiver explained that her relative’s doctor took the entire appointment to address a flagged test result from a previous appointment even though it was already resolved. Consequently, her relative’s insomnia was left unaddressed; others expressed similar incidents.

While caregivers attributed issues with prioritization to overuse or ineffective use of the EHR, older adults explained that healthcare providers often dismissed their concerns. For example, one participant described that after explaining his symptoms, his physician simply said that the issue was because of his age—and moreover,

**Table 2.** Summary of Needs, Values, and Preferences as Related to Characteristics of Providers, Care Delivery, and the Health System as Described by Participants.

	Needs (perceived)		Values	Preferences
	Experience	Expectation		
Characteristics of providers	Doctor misdiagnoses condition	Doctor has an understanding of how older adults are distinct from younger/middle-aged adults (e.g., symptoms)	Interpersonal quality For example, doctor shows respect, listens Technical quality For example, doctor has appropriate skills and training	Choose a new doctor who addresses concerns and whose practices align with values
Characteristics of care delivery	Doctor asks patient about their mental health following retirement.	Doctor considers healthcare for older adults holistically by considering mental and physical health	Holistic care For example, consider and address both mental and physical health Integrate family caregivers For example, facilitate caregiver involvement via technology or teamwork	Stay with current doctor who provides holistically and seeks insights from family caregivers during the clinical encounter
Characteristics of health system	Doctor refers patient to several specialists in disparate locations to manage multiple conditions.	Older adult expects that they would be able to receive all care in the same facility given transportation difficulties.	Address social and environmental factors For example, consideration of transportation needs of older adults Trust and persistence For example, limit dismissal of needs and concerns of older adults; attend to distinct and equally important needs of older adults	Choose a new doctor whose practice either resembles a patient-centered medical home, or who refers to a social worker to help older patient navigate their various appointments and providers.

did not attempt to minimize the burden on quality of life caused by these symptoms.

**Respect and empathy.** Additionally, caregivers discussed a need for patient, respectful, empathetic providers who treat older adults with dignity and consider that older patients are immersed in various medical, social, economic, and psychological transitions within a complex health system. Caregivers supporting relatives with cognitive impairment recounted instances where providers or clinic staff seemed apathetic toward the experiences and behaviors of older adults. For example, one caregiver recalled:

*We went to [the clinic] and my father-in-law is naturally loud, not to mention that he lost his hearing aids. Everyone is looking at you, like 'how impolite'. I didn't feel that they understand what's going on with people with dementia who have to ask the same question ten times. . . And the nurse was really irritated and said "If I give him an amplifier would he be happier"?*

### Characteristics of Healthcare Delivery

**Holistic approach.** Participants related experiences of siloed and fragmented care to the need for a holistic approach to healthcare that considers the clinical, social and environmental circumstances of patients, and further, effectively integrates caregivers. For example, one participant thought she was experiencing depression but was told that her symptoms were more likely a side

effect of her recent stroke. Subsequently, her mental health concerns were left unaddressed and she was not pointed to resources (e.g., a psychologist). Older adults desired more explicit attention to mental health, for example, for depression resulting from the “chronic bereavement” following the loss of multiple friends, in addition to greater consideration of functional impairments, mobility, medication management, and preventing cognitive impairment, thereby supporting their independence and quality of life. They desired proactive and holistic care delivery.

Similarly, caregivers discussed a need for holistic care and early detection, especially for their relatives' mental and cognitive health, and options for non-allopathic pain management such as acupuncture or massage. One older adult recalled her positive experience as a caregiver:

*When my mom came over to visit we took [her] to see the geriatrician. . . my dad had just passed away about a year and a half earlier. He actually asked my mom "Do you ever have suicidal thoughts in your life?" And my mom says, "Yes." I was shocked. . . he noticed my mom had depression which is something that we didn't know. Yeah, my dad passed away so she's kind of sad, but in reality, she's in depression.*

**Caregiver integration.** Caregivers also expressed wanting to be integrated into the health system and care delivery. Even though they were sometimes troubled that they had to arbitrarily “step up” to perform tasks they felt

unqualified to carry out (e.g., navigating Medicare), they saw themselves as advocates for their older relatives. Yet, they were frustrated that providers ignored their insights and comments, often redirecting questions to the patient. Caregivers were enthusiastic about the possibility of formal integration into care teams, and likened potential eldercare integrated models to pediatric models where a parent/guardian is included in information sharing and decision-making. In one focus group, caregivers discussed their ideal role within the healthcare team:

*Participant 1: Well that's not a bad idea. But I think it would be difficult if I was the person at the center giving the information to my husband, I don't know that I would want four different people calling me and saying. . . we discovered this and then 20 minutes later I get another call from somebody else. . . I don't know anything about the medical profession. . . I relay information to my husband all the time now, but it'd be nice if you were a part of that team.*

*Participant 2: I think it would be hard for the caregiver to be the main person to pass on information to the patient. The expectation of your role is different even though you are actively participating in all of the coordination and being an advocate. I think it still has to come from a health professional. But . . . there could be a team meeting where you can participate. . .*

### Characteristics of the Healthcare System

**Social determinants of health.** Older adults discussed that the healthcare system needs to consider and address social determinants of health. They also shared a profound desire for a system that trusts them, and one that is persistent in its efforts to improve health and wellbeing of older adults.

Many older adults discussed transportation challenges with getting to doctor appointments, for example, if they could no longer drive due to poor eyesight. Others discussed concerns with scheduling procedures requiring a companion to take them home following anesthesia. Several described these instances as a pivotal moment in their realization that they were isolated. For example, one older adult participant explained:

*I live alone, and one thing that I'm running into quite regularly now is that particularly if I have a procedure, they won't perform it, unless I have a companion or someone accompany me. Over the last few years, it has become more and more difficult to find someone because the people that I associated with during my life and work, they've either died, or they're in retirement homes, or they have moved down south, or like me they can't drive anymore.*

In another group, a participant explained that although her doctor recommended going to a support group following her stroke, she has not been cleared to

drive and local shuttles are typically late or do not travel far enough. Participants expected providers to be aware of their social circumstances and further, the healthcare system and social policies to address barriers to accessing care and support. Noting the high demand on doctors, they suggested that the system could utilize the skills of social workers and other healthcare professionals to identify and address some of these other circumstances.

**Trust and persistence.** Older adults also discussed a need for a system that trusts them and persists in helping them. Multiple participants discussed the opioid epidemic, which had become more prominent of a topic in the news during these focus groups, as signaling system mistrust in older patients. For example, one older adult described:

*The reason they gave me for not being able to prescribe me narcotics is the opioid crisis. Well, I don't have a history of opioid abuse. I'm in pain. I have a punctured eardrum. . . I don't want to hear about the opioid crisis when I'm in pain. . . The [provider] told me, "Well, the only thing I can tell you is to suck it up." . . Whatever somebody else has done, that causes the system to get to be this way, I shouldn't have to suffer for it. Especially when I haven't abused anything.*

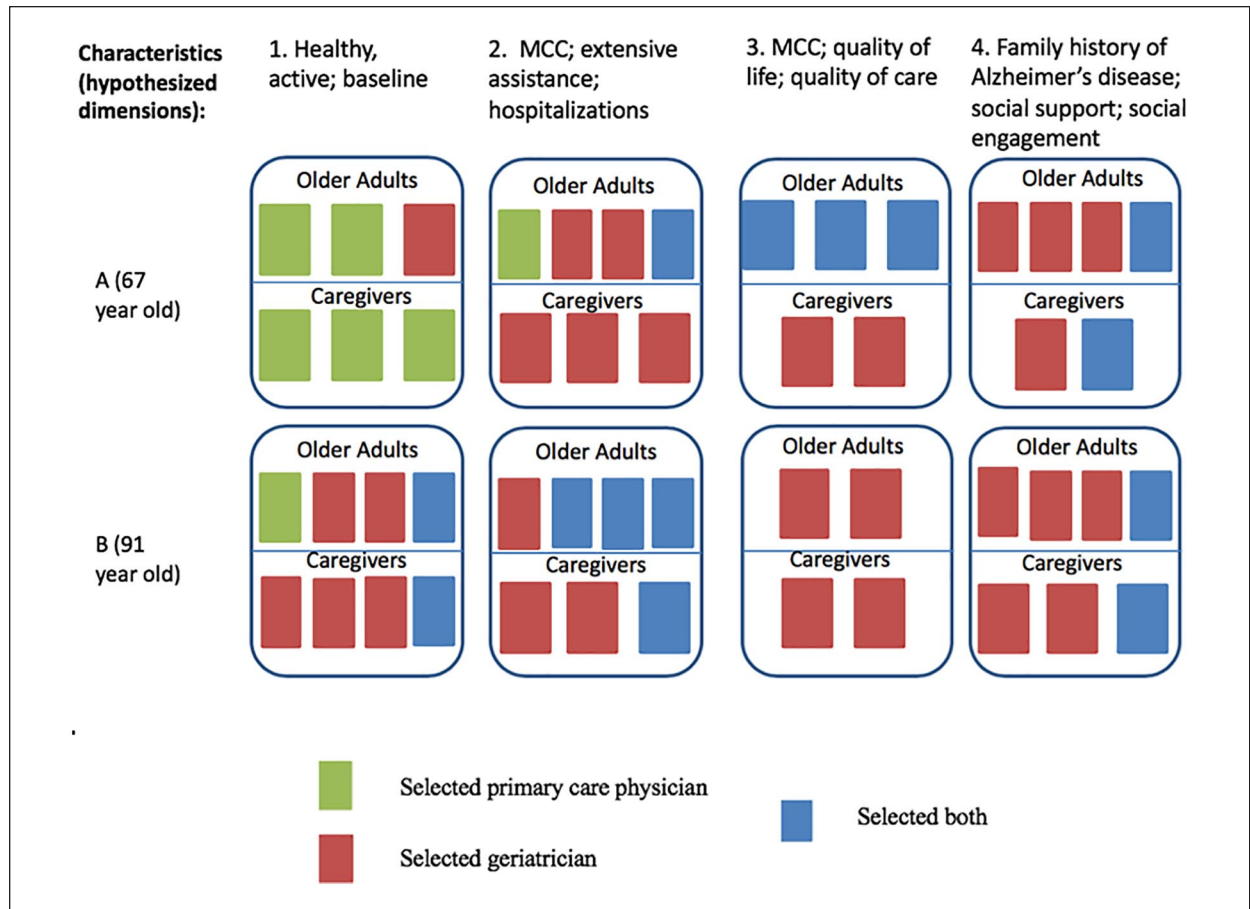
Some participants offered that older adults should be allowed and more involved as standardized patients in order to build a system that recognizes the distinct needs of older adults without risk of ageism that may lead to systemic mistrust or dismissal.

Caregivers also described the idea of trust and persistence—that is, that the system should persist in its efforts to promote older adults' health maintenance (even if not improvement) and thereby preserve their dignity. They often became advocates for their relatives, for example in navigating health insurance coverage for resources that were deemed unnecessary from payors, but were critical for quality of life.

### Preference for Geriatrics

Vignettes were analyzed to assess how participants made independent decisions about providers based on information about a hypothetical older adult. The "real life" scenarios that were used in the focus group with caregivers to verify vignettes suggested that the circumstances presented in the vignettes were reflective of considerations when making a decision about providers. As one caregiver from that group described:

*"If you're an old person who has one disease, then you go to that "one thing" doctor. But if a geriatrician is anything like a pediatrician they are supposed to be able to be more cognizant not only of the disease that they're presenting but also. . . both psychological and physical challenges that go along with a specific period in a person's life."*



**Figure 1.** Illustration of participants' preferences for providers based on vignettes.  
 Note. Each box represents one participant.

In responses to vignettes, caregivers favored switching to geriatric care while older adults preferred enrolling in care with both—possibly to maintain continuity of care with their PCP and also benefit from geriatric care. For the 67-year-old patient, most older adults and caregivers selected PCP at the healthy baseline. Caregivers primarily selected a geriatrician for all subsequent stages of complexity while half of older adults selected geriatrician and the other half selected both geriatrician and PCP at increasing levels of social and clinical complexity. In contrast, for the 91-year-old patient, all caregivers selected PCP or both even at healthy baseline and most older adults selected PCP or both at baseline as well. Some participants wrote that the patient may recover faster with support from both types of physicians; others who recommended *both* additionally wrote “*in one person*” meaning that the PCP should have training in geriatrics. A summary of participants' preferences is illustrated in Figure 1.

## Discussion and Implications

In this study, we explored how older adults and family caregivers who often support older relatives in medical

decisions, expressed and related their experiences to characteristics that were important to them in their healthcare. Then, we examined how older adults and caregivers expressed their preferences for geriatric care drawing on characteristics of a hypothetical older patient. Through insights into experiences and expectations (needs and values) and preference for geriatric care, we identified characteristics of health care that older adults and caregivers would consider patient-centered—that is, reflective of their needs, values, and preferences.

Focus groups suggest that, to older adults and family caregivers, patient-centered care involves having providers with technical and interpersonal skills (Fung et al., 2005); it is a holistic approach to medicine that considers the various circumstances within which older adults are immersed and addresses their physical and mental health as a standard of care rather than requiring initiative by older adults or advocacy by caregivers. At the system level, patient-centeredness requires a healthcare system that considers and addresses the social determinants of health and is persistent in its efforts to support older adults. Older adults and caregivers both indicated that trust from the system and its providers is essential for ensuring that

they receive appropriate care, but also, for fostering shared decision-making, strengthening partnerships, and improving quality of care as defined in multiple ways (Grob et al., 2019). Similarities in themes emerging from the two types of focus groups suggest a need for greater exploration of caregivers' role in health-care decisions for or with their older relatives (Dalton, 2003; Rabow et al., 2004; Reinhard et al., 2008; Rodakowski et al., 2017). Given that nearly 40% of older adults are accompanied by a caregiver to health care visits, there is a need to better understand the nature of caregiver responsibilities in these visits which may include decision-making and advocacy (Wolff et al., 2020; Wolff & Roter, 2011).

The use of vignettes provided some exploratory insight into, first, whether older adults and caregivers will select geriatric care at all, and second, some of the circumstances under which they may do so. A limitation of this approach is that it is unclear whether the discussion influenced provider preferences or whether participants selected the provider type based exclusively on the circumstances presented in the scenarios. However, given that vignettes were presented at the end of the session it is possible that participants' preferences reflect some of the experiences and characteristics they discussed during the earlier phase of the session. Findings suggest that older adults and caregivers may see value in geriatric care even with a basic definition of the services they provide and may express a preference for a geriatrician given increasing clinical complexity as well as social circumstances.

Findings from this study may inform several areas for future research. There is a need to better understand how needs, values, and different types of patient circumstances that underlie patient-centeredness relate to subsequent decision-making, perceived value, and use of health services such as geriatric care. Such research would be more robust by including and comparing perspectives of older adults and family caregivers. Here, we conducted separate focus groups by participant type to minimize discomfort, but future research may consider dyadic approaches to better understand how older adults and caregivers express experiences and needs, and subsequently make decisions both separately and together about different types of healthcare services.

Practitioners may consider avenues for integrating caregivers whether through the EHR or through in-person communication during healthcare encounters as this may guide optimal referral practices and clinical decisions. Integrating caregivers—who act as advocates and support provider recommendations—may be necessary for patient-centered care. Their integration may also support provider decisions when prioritizing multiple patient concerns. Further, providers may have an important role in helping older patients navigate challenges with social determinants of health (e.g., transportation) and may consider approaches to

building and demonstrating trust and persistence in patients—especially since they may reflect the broader system in their practices. Continuing to understand what patient-centeredness means is essential for developing medical training curricula and for fostering alignment between practice and patient values. For providers supporting older adults, this may involve training in diagnostics, or perhaps, in discussing aging-related concerns. Further, given the perceived value of geriatric care among older adults and caregivers, there is a need to ensure an adequate workforce to support the needs and preferences of this population. This may require (a) further study on specialty selection, (b) curricular modifications to encourage interest in the specialty, and (c) institutional reframing of the value of geriatric care driven both by clinical perspectives as well as by the preference for care from specialists as expressed by patients and caregivers (Brummel-Smith, 2015; Flaherty & Bartels, 2019; Raj et al., 2020).

There are some limitations of this study. Participants' interest in the study may have also been influenced by particularly positive or negative healthcare experiences, which could have also influenced their comments during the discussion. All participants were able to attend sessions possibly signaling a certain health status; however, that these participants also mentioned the need for greater support for maintaining functioning, cognition, and mobility, suggests that it is a salient concern even among relatively healthy older adults and may be understated. Finally, participating in the study as a "caregiver" required first identifying as a caregiver; perspectives of individuals who do not self-identify as "caregivers" but still support older relatives require further study. Our inclusion criteria of caregivers age 25 and older may have also restricted the perspectives garnered from this study. Nevertheless, there are opportunities for future research to build on this study in order to better understand the perspectives of older adults and family caregivers as they interact with the healthcare system.

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## IRB

The study was granted permission with exemption by the University of Michigan Institutional Review Board (protocol HUM00142286).

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## Supplemental Material

Supplemental material for this article is available online.

## References

- Andersen, R. M. (2008). National health surveys and the behavioral model of health services use. *Medical Care, 46*(7), 647–653.
- Applegate, W. B., Miller, S. T., & Graney, M. J. (1990). A randomized, controlled trial of a geriatric assessment unit in a community rehabilitation hospital. *New England Journal of Medicine, 322*, 1572–1578. <https://doi.org/10.1056/NEJM199005313222205>
- Aronson, L. (2015). Necessary steps: How health care fails older patients, and how it can be done better. *Health Affairs, 34*(3), 528–532. <https://doi.org/10.1377/hlthaff.2014.1238>
- Balachandran, A., de Beer, J., James, K. S., van Wissen, L., & Janssen, F. (2019). Comparison of population aging in Europe and Asia using a time-consistent and comparative aging measure. *Journal of Aging and Health, 32*(5–6), 340–351.
- Bastemeijer, C. M., Voogt, L., van Ewijk, J. P., & Hazelzet, J. A. (2017). What do patient values and preferences mean? A taxonomy based on a systematic review of qualitative papers. *Patient Education and Counseling, 100*, 871–881. <https://doi.org/10.1016/j.pec.2016.12.019>
- Beach, S. R., Schulz, R., Friedman, E. M., Rodakowski, J., Martsolf, R. G., & James, A. E. (2018). Adverse consequences of unmet needs for care in high-need/high-cost older adults. *The Journals of Gerontology: Series B, gby021*. <https://doi.org/10.1093/geronb/gby021>
- Bennett, K. L., Phillips, J. P., & Barr, M. S. (2010). Finding, recruiting, and sustaining the future primary care physician workforce: A new theoretical model of specialty choice process. *Academic Medicine, 85*(10), S81–S88. <https://doi.org/10.1097/ACM.0b013e3181ed4bae>
- Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: Care, health, and cost. *Health Affairs, 27*(3), 759–769. <https://doi.org/10.1377/hlthaff.27.3.759>
- Bloom, D. E., Canning, D., & Lubet, A. (2015). Global population aging: Facts, challenges, solutions & perspectives. *Daedalus, 144*(2), 80–92.
- Bloor, M., Frankland, J., Thomas, M., & Robson, K. (2002). *Focus groups in social research*. SAGE Publications.
- Boswell, S. S. (2012). “Old people are cranky”: Helping professional trainees’ knowledge, Attitudes, aging anxiety, and interest in working with older adults. *Journal of Educational Gerontology, 38*(7), 465–472. <https://doi.org/10.1080/03601277.2011.559864>
- Boult, C., Counsell, S. R., Leipzig, R. M., & Berenson, R. A. (2010). The urgency of preparing primary care physicians to care for older people with chronic illnesses. *Health Affairs, 29*(5), 811–818. <https://doi.org/10.1377/hlthaff.2010.0095>
- Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Sage.
- Bradley, E. H., McGraw, S. A., Curry, L., Buckser, A., King, K. L., Kasl, S. V., & Andersen, R. M. (2002). Expanding the Andersen model: The role of psychosocial factors in long-term care use. *Health Services Research, 37*(5), 1221–1242. <https://doi.org/10.1111/1475-6773.01053>
- Bradshaw, J. (1977). The concept of social need. In N. Gilbert & H. Specht (Eds.), *Planning for social welfare, issues, models and tasks* (pp. 290–296). Prentice Hall.
- Brondani, M. A., MacEntee, M. I., Bryant, S. R., & O’Neill, B. (2008). Using written vignettes in focus groups among older adults to discuss oral health as a sensitive topic. *Qualitative Health Research, 18*(8), 1145–1153. <https://doi.org/10.1177/1049732308320114>
- Brummel-Smith, K. (2015). Family physician geriatricians do mostly geriatric care: Is this a problem for our specialty? *Journal of the American Board of Family Medicine, 28*(3), 311–313.
- Calsyn, R. J., & Winter, J. P. (2001). Predicting four types of service needs in older adults. *Evaluation and Program Planning, 24*, 157–166. [https://doi.org/10.1016/S0149-7189\(01\)00006-4](https://doi.org/10.1016/S0149-7189(01)00006-4)
- Carey, M. A. (1994). The group effect in focus groups: Planning, implementing and interpreting focus group research. In J. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 225–241). Sage.
- Cohen-Mansfield, J., & Frank, J. (2008). Relationship between perceived needs and assessed needs for services in community-dwelling older persons. *The Gerontologist, 48*(4), 505–516. <https://doi.org/10.1093/geront/48.4.505>
- Coulton, C., & Frost, A. K. (1982). Use of social and health services by the elderly. *Journal of Health and Social Behavior, 23*, 330–339. <https://doi.org/10.2307/2136491>
- Dalton, J. M. (2003). Development and testing of the theory of collaborative decision-making in nursing practice for triads. *Journal of Advanced Nursing, 41*, 22–23. <https://doi.org/10.1046/j.1365-2648.2003.02502.x>
- Di Anni, B., Eng, L., & Islam, I. (2016). An operational standard for transitioning pediatric patients to adult medicine. *NEJM Catalyst, 2*(5), 1–2.
- Eloniemi-Sulkava, U., Saarenheimo, M., & Laakonen, M. L. (2009). Family care as collaboration: Effectiveness of a multicomponent support program for elderly couples with dementia. Randomized controlled intervention study. *Journal of the American Geriatrics Society, 57*(12), 2200–2208. <https://doi.org/10.1111/j.1532-5415.2009.02564.x>
- Epstein, R. M., & Peters, E. (2009). Beyond information: Exploring patients’ preferences. *JAMA, 302*(2), 195–197. <https://doi.org/10.1001/jama.2009.984>
- Epstein, R. M., & Street, R. L. (2011). The values and value of patient-centered care. *The Annals of Family Medicine, 9*, 100–103. <https://doi.org/10.1370/afm.1239>
- Flaherty, E., & Bartels, S. J. (2019). Addressing the community-based geriatric healthcare workforce shortage by leveraging the potential of interprofessional teams. *Journal of the American Geriatrics Society, 67*(S2), S400–S408. <https://doi.org/10.1111/jgs.15924>
- Fung, C. H., Elliott, M. N., Hays, R. D., Kahn, K. L., Kanouse, D. E., McGlynn, E. A., Spranca, M. D., & Shekelle, P.

- G. (2005). Patients' preferences for technical versus interpersonal quality when selecting a primary care physician. *Health Services Research, 40*(4), 957–977. <https://doi.org/10.1111/j.1475-6773.2005.00395.x>
- Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *The Qualitative Report, 20*(9), 1408–1416.
- Gaugler, J. E., Kane, R. L., Kane, R. A., & Newcomer, R. (2005). Unmet care needs and key outcomes in dementia. *Journal of the American Geriatrics Society, 53*, 2098–2105. <https://doi.org/10.1111/j.1532-5415.2005.00495.x>
- Grigoryan, K. V., Javedan, H., & Rudolph, J. L. (2014). Ortho-geriatric care models and outcomes in hip fracture patients: A systematic review and meta-analysis. *Journal of Orthopaedic Trauma, 28*(3), e49–e55. <https://doi.org/10.1097/BOT.0b013e3182a5a045>
- Grob, R., Darien, G., & Meyers, D. (2019). Why physicians should trust in patients. *JAMA, 321*(14), 1347–1348. <https://doi.org/10.1001/jama.2019.1500>
- Hughes, R., & Huby, M. (2002). The application of vignettes in social and nursing research. *Journal of Advanced Nursing, 37*, 382–386. <https://doi.org/10.1046/j.1365-2648.2002.02100.x>
- Kaiser Family Foundation. (2016). *Health insurance coverage of the total population*.
- Kitzinger, J. (1995). Qualitative research. Introducing focus groups. *BMJ, 311*(7000), 299–302.
- Krueger, R. A. (1998). *Moderating focus groups*. SAGE Publications.
- Lehnert, T., Heider, D., Leicht, H., Heinrich, S., Corrieri, S., Lupp, M., Riedel-Heller, S., & König, H.-H. (2011). Health care utilization and costs of elderly persons with multiple chronic conditions. *Medical Care Research and Review, 68*(4), 387–420. <https://doi.org/10.1177/1077558711399580>
- Lopez-Anuarbe, M., & Kohli, P. (2019). Understanding male caregivers' emotional, financial, and physical burden in the United States. *Healthcare, 7*(2), 72.
- MICHR. (2020). *Leveraging UMHealthResearch.org to connect COVID-19 study participants with research teams*. Michigan Institute for Clinical and Health Research. <https://michr.umich.edu/news/2020/4/30/leveraging-umhealthresearchorg-to-connect-covid-19-study-participants-with-research-teams>
- Moreno, M. A. (2013). Transition of care from pediatric to adult clinics. *JAMA Pediatrics, 167*(7), 684. <https://doi.org/10.1001/jamapediatrics.2013.2657>
- Morgan, D. L. (1992). Designing focus group research. In I. M. Stewart, F. Tudiver, M. Bass, E. Dunn, & P. Norton (Eds.), *Tools for primary care research* (pp. 177–193). Sage.
- Morgan, D. L. (1996). Focus groups. *Annual Review of Sociology, 22*, 129–152.
- Morgan, D. L. (1997). *Focus groups as qualitative research* (2nd ed.). SAGE Publications.
- Ortman, J. M., Velkoff, V. A., & Hogan, H. (2014). *An aging nation: The older population in the United States* (Current population reports). U.S. Census Bureau.
- Osterman, P. (2017). *Who will care for us? Long-term care and the long-term workforce*. Russell Sage Foundation.
- Parasuraman, A., Berry, L. L., & Zeithaml, V. A. (1991). Understanding customer expectations of service. *Sloan Management Review, 32*(3), 39–48.
- Pomey, M.-P., Ghadiri, D. P., Karazivan, P., Fernandez, N., & Clavel, N. (2015). Patients as partners: A qualitative study of patients' engagement in their health care. *PLoS One, 10*(4), e0122499. <https://doi.org/10.1371/journal.pone.0122499>
- Rabow, M. W., Hauser, J. M., & Adams, J. (2004). Supporting family caregivers at the end of life: "They don't know what they don't know." *JAMA, 291*, 483–491. <https://doi.org/10.1001/jama.291.4.483>
- Raj, M., Platt, J. E., Anthony, D. L., Fitzgerald, J. T., & Lee, S.-Y. D. (2020). Exploring how personal, social, and institutional characteristics contribute to geriatric medicine subspecialty decisions: A qualitative study of trainees' perceptions. *Academic Medicine, 96*(3): 425–432. <https://doi.org/10.1097/ACM.0000000000003784>
- Reinhard, S. C., Given, B., Petlick, N. H., & Bemis, A. (2008). Supporting family caregivers in providing care (chapter 14). In R. G. Hughes (Ed.), *Patient safety and quality: An evidence-based handbook for nurses*. Agency for Healthcare Research and Quality.
- Rodakowski, J., Rocco, P. B., Ortiz, M., Folb, B., Schulz, R., Morton, S. C., Leathers, S. C., Hu, L., & James, A. E. (2017). Caregiver integration during discharge planning for older adults to reduce resource use: A metaanalysis. *Journal of the American Geriatrics Society, 65*(8), 1748–1755. <https://doi.org/10.1111/jgs.14873>
- Salsberg, E., & Grover, A. (2006). Physician workforce shortages: Implications and issues for academic health centers and policymakers. *Academic Medicine, 81*(9), 782–787. <https://doi.org/10.1097/00001888-200609000-00003>
- Sorbero, M. E., Saul, M. I., Liu, H., & Resnick, N. M. (2012). Are geriatricians more efficient than other physicians at managing inpatient care for elderly patients? *Journal of the American Geriatrics Association, 60*(5), 869–876. <https://doi.org/10.1111/j.1532-5415.2012.03934.x>
- Swinkels, J., Tilburg, T., Verbakel, E., & van Groenou, M. B. (2019). Explaining the gender gap in the caregiving burden of partner caregivers. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 74*(2), 309–317.
- The American Geriatrics Society. (2017). *Projected future need for geriatricians*. [https://www.americangeriatrics.org/sites/default/files/inline-files/Projected-Future-Need-for-Geriatricians\\_1.pdf](https://www.americangeriatrics.org/sites/default/files/inline-files/Projected-Future-Need-for-Geriatricians_1.pdf)
- Tinetti, M. (2016). Mainstream or extinction: Can defining who we are save geriatrics? *Journal of the American Geriatrics Society, 64*, 1400–1404. <https://doi.org/10.1111/jgs.14181>
- United Nations. (2019). *World population ageing 2019*. <https://www.un.org/en/development/desa/population/publications/pdf/ageing/WorldPopulationAgeing2019-Highlights.pdf>
- Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing and Health Sciences, 15*(3), 398–405. <https://doi.org/10.1111/nhs.12048>
- Wolff, J. L., Freedman, V. A., Mulcahy, J. F., & Kasper, J. D. (2020). Family caregivers' experiences with health care workers in the care of older adults with activity limitations. *JAMA Network Open, 3*(1), e1919866.
- Wolff, J. L., & Roter, D. L. (2011). Family presence in routine medical visits: A meta-analytical review. *Social Science & Medicine, 72*(6), 823–831.
- Zuverink, A., & Xiang, X. (2019). Anxiety and unmet needs for assistance with daily activities among older adults. *Journal of Aging and Health, 32*(5–6), 491–500. <https://doi.org/10.1177/0898264319830805>