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GEORGIACARES COMMUNITY OUTREACH EVENTS: AN EVALUATION

by

ERIN FISHER

Under the Direction of Candace Kemp

ABSTRACT

Medicare is vital to the health and well-being of many American seniors. However, due to its complexity, beneficiaries often need assistance navigating the federal health insurance system. GeorgiaCares, Georgia's State Health Insurance Assistance Program (SHIP), provides free and unbiased Medicare information and counseling. The aims of this thesis were to evaluate GeorgiaCares outreach events to discern the social and demographic characteristics of participants and decipher how to best market the events. Participants of nine GeorgiaCares outreach events (n=81) completed anonymous surveys; mixed-methods data analysis revealed the typical participant to be a 71-year-old African American female. Findings suggest an effective way to assist beneficiaries in Medicare-related decisions is through the formation of community partnerships. Suggestions to market outreach events include partnering with churches and grocery stores to disseminate information and enlisting the support of community leaders to overcome barriers of distrust.

INDEX WORDS: Gerontology, Minorities, Medicare, Seniors, Insurance, SHIP, GeorgiaCares, Community outreach, Program evaluation, Senior citizens, Older adults

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by

ERIN FISHER

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

in the College of Arts and Sciences

Georgia State University

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Dedication

"A long life makes me feel nearer truth, yet it won't go into words, so how can I convey it? I can't, and I want to. I want to tell people approaching and perhaps fearing age that it is a time of discovery. If they say – 'Of what?' I can only answer, 'We must find out for ourselves, otherwise it won't be discovery.'" (Scott-Maxwell, 1968, p. 142)

To those who embrace discovery, both old and young.

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List of Abbreviations

AAA	Area Agencies on Aging
AIMS	Aging Information Management System
AoA	U.S. Administration on Aging
ARC	Atlanta Regional Commission
CMS	Centers for Medicare and Medicaid Services
DHR	Department of Human Resources
HICARE	Health Insurance Counseling, Assistance and Referral for the Elderly
HMO	Health Maintenance Organization Plan
IRB	Institutional Review Board
LIS	Low-Income Subsidy
MA plans	Medicare Advantage Plans
MSP	Medicare Savings Programs
OBRA	Omnibus Budget Reconciliation Act
PPO	Provider Organization Plan
QDWI	Qualified Disabled and Working Individuals Program
QI	Qualified Individual Program
QMB	Qualified Medicare Beneficiary Program
RCMAR	Resource Centers on Minority Aging Research
SHIP	State Health Insurance Assistance Programs
SLMB	Specified Low-Income Medicare Beneficiary Program
UCHSC	University of Colorado Health Sciences Center
USCF	University of Southern California, San Francisco

Chapter 1

Introduction

Statement of the Problem

The data regarding older adults in the United States attests to a rapidly aging population. According to a 2011 U.S. Census Bureau report, between 2000 and 2010, the population 65 years and older increased at a faster rate than the total U.S. population (Werner, 2011). The state of Georgia is expected to exceed the national growth in the older adult population for several decades into the future (Georgia Council on Aging, 2010). Not only is the population of older adults skyrocketing, but the number of ethnic minorities is growing as well. According to Greene, Cohen, Galambos, and Kropf (2007), more than 25% of the population of older adults will be non-White by 2025 (p. 38). Within this population of aging adults, regardless of ethnicity, race, or background, a common thread uniting almost every older American is the need for health insurance. For most, this need is met in Medicare, the federal health insurance program for those over 65, those under 65 with certain disabilities, and every person with end-stage renal disease (Centers for Medicare & Medicaid Services, 2012a). Unfortunately, Medicare often is a complicated and expensive program and many beneficiaries lack the understanding to effectively navigate the system. Creating and fostering partnerships within the community enables the dissemination of Medicare information to minority beneficiaries who are likely to face barriers to accessing not only information about Medicare, but health-related information in general.

It is important to recognize that understanding Medicare is crucial to all beneficiaries, and maybe even more so for minority populations. A seemingly endless array of research suggests that minorities in America have endured health disparities since the inception of healthcare. Brian Smedley of the Health Policy Institute stated that "healthcare disparities are not new – they

are a persistent relic of segregation and inadequate healthcare for communities of color" (2009, p. 2). Continuing through history, Gunnar Myrdal, a Swedish social theorist in 1944 conferred that "area for area, class for class, Blacks cannot get the same advantages in the way of prevention and care of disease that Whites can" (Hosseini, 2010, p. 113). Four decades later, a report for the Department of Health and Human Services from the Secretary's Task Force on Black and Minority Health found that:

> …despite the unprecedented explosion of scientific knowledge and phenomenal capacity of medicine to diagnose, Black, Hispanics, Native American and those of Asian/Pacific Islander heritage have not benefited totally or equally from the fruits of science or from the systems responsible for translating and rising health technology (Hosseini, 2012, p. 27).

Unsurprisingly, these disparities last throughout the lifespan and affect elderly minority beneficiaries as well. Dilworth-Anderson and colleagues (2012) state:

> Older minority Americans have consistently been shown to have worse health than Whites of the same age group across measures of disease, disability, and self-assessed health. When compared to Whites, elderly Latinos have higher rates of diabetes and disabilities, and older African Americans have more chronic conditions (p. 26).

Research demonstrates that many Medicare beneficiaries struggle with the complexities of Medicare; additionally, thousands of dollars are lost to those who are eligible for low-income subsidies but are unaware of the subsidies existence (Harris-Kojetin et al., 2007; Lipton, Lai, Cutler, Smith, & Stebbins, 2010; Morgan et al., 2008; Piette & Heisler, 2006). Lack of Medicare knowledge also has healthcare-related ramifications. According to a 2008 study, Medicare beneficiaries who "reported being unfamiliar with Medicare were less likely than those who

were familiar to report their overall health as excellent or very good and more likely to report their health as poor or very poor" (Morgan et al., p. 2055). Additionally, those less familiar with Medicare were less likely to have any physician visits, use prescription medication, and have self-reported poor access to general medical care (Morgan et al., 2008). While it is clear that promotion of Medicare knowledge is vital to the financial and physical health of beneficiaries, it is less clear how to best disseminate this information, and specifically, how to disseminate this information to minority populations.

Established by the Centers for Medicare and Medicaid Services (CMS), State Health Insurance Assistance Programs (SHIP) provide "free, unbiased and factual information and assistance to Medicare beneficiaries and their caregivers" ("GeorgiaCares," 2012). Each state receives a grant from CMS to maintain the state SHIP, plus the District of Columbia, Puerto Rico, and the Virgin Islands (Rehnquist, 2003). The SHIPs are locally operated programs, located within either the State Departments of Aging or the State Departments of Insurance (Rehnquist, 2003). Although there is one SHIP for each state, the grant monies may be divided into different regions within the state; for example, Georgia's SHIP is named GeorgiaCares and there are 12 individual SHIP regions within the Georgia state network coinciding with the 12 Area Agencies on Aging in Georgia. GeorgiaCares is a portal to the community in which Medicare beneficiaries may receive Medicare information and assistance in making important Medicare and health insurance related decisions. While GeorgiaCares is primarily a phone based service, CMS dictates that GeorgiaCares reach constituents through various community events. These events allow participants face-to-face interactions with GeorgiaCares employees and volunteers and potentially greater exposure to GeorgiaCares than the current system comprised primarily of telephone communication. While community events are an important component of

GeorgiaCares outreach, they are potentially more effective when paired with community collaborations. Existing research elucidates that partnerships are beneficial in facilitating and espousing health promotions within communities (Kaplan et al., 2009; Parrill & Kennedy, 2011; Tumiel-Berhalter, Kahn, Watkins, Goehle, & Meyer, 2011).

It is vital to understand and make the needs of minority elders a priority. However, due to historical prejudice and discrimination, stigmatization, and economic barriers, it is often difficult to reach minority populations. For this reason, it is essential that organizations collaborate; together they may have the capacity to engage vulnerable groups. Through partnership, organizations have the ability to provide added value, change attitudes and improve knowledge in communities, and foster long-term and sustainable programs. The literature reveals several themes within the creation of successful community partnerships, including the concept of trust (Radermacher, Karunarathna, Grace, & Feldman, 2011), the use of the African American church as a platform for healthcare discussion (Parrill & Kennedy, 2011), the importance of community input and ownership (Beck, Young, Ahmed, & Wolff, 2007; Tumiel-Berhalter et al., 2011) and the use of influential community leaders (Gona, Xiong, Muhit, Newton, & Hartley, 2010). While these topics are merely a fraction of the entire concept of community partnerships, they comprise a solid foundation on which to begin building.

Research Aims

The purpose of this study was to evaluate the effectiveness of GeorgiaCares community outreach events. My research aims were as follows:

Aim 1: To understand the current GeorgiaCares community outreach event participants; and

Aim 2: To discover how to best market current GeorgiaCares community outreach events to the community.

I expect that through this research, GeorgiaCares will better understand the participants who currently attend community outreach events and how these participants desire to receive the Medicare information that GeorgiaCares provides. My hope is that this research will advance the development of a strategic plan to educate Medicare beneficiaries about GeorgiaCares and eventually increase Medicare knowledge within the Atlanta community.

Chapter 2

Literature Review

In this section, I review the current research regarding Medicare and State Health Insurance Assistance Programs (SHIP) and consider community partnerships. I first discuss the demographic climate in Atlanta, then describe the intricacies of Medicare and the rationale behind the need for Medicare education, as well as detail the purpose and structure of GeorgiaCares. Finally, I discuss the research behind community collaborations and how GeorgiaCares might benefit from such partnerships. I close with my purpose of research and research aims.

Minority Populations

Currently, the minority population within the U.S. is approximately 30% of its total population (Hosseini, 2012, p. 26). Projections suggest that by 2050, 20% of adults in the United States aged 65 and older will be of minority descent (Yang & Levkoff, 2005), and by 2080, the U.S. Census Bureau suggests that the minority population will reach over 50% of the total population (Hosseini, 2012, p. 26). Within the state of Georgia, the American Indian, Asian, multiracial, and Hispanic races almost doubled in population in the past decade (Aka, 2012).

Between 2000 and 2008, diversity trends for the 20-county Atlanta metropolitan area saw a 40% increase in the African American population, 91% increase in the Hispanic population, and 62% increase in the Asian population (Aka, 2012). Minorities have long faced socioeconomic status disadvantages, lower life expectancy, and poorer health compared to their White counterparts (Dilworth-Anderson et al., 2012; Villa, Wallace, Bagdasaryan, & Aranda, 2012). In addition to a lifetime of accumulated disadvantage, minorities are often harder to reach with traditional and conventional methods (Flanagan & Hancock, 2010). Those who wish to

educate the Atlanta minority population about Medicare should realize that traditional marketing methods of attending health fairs and visiting senior centers may not be effective. The literature shows that foraging relationships within the community is one way to bridge the disparity (Leiyu Shi, Michel E. Samuels, Thomas E. Brown, & Brian C. Martin, 1996).

Medicare

Enacted in 1965 under Title 18 of the Social Security Act, Medicare is comprised of four parts. Part A is hospital insurance and is generally paid through payroll taxes (Friedland, 2005). Part B is medical insurance and covers doctor visits and outpatient care. Most individuals pay a monthly premium for Part B. Medicare Advantage Plans, or Part C, is a voluntary health plan that takes the place of original Medicare (Centers for Medicare & Medicaid Services, 2012b). These plans, also known as MA plans, are offered by private companies approved by Medicare and act more like a Preferred Provider Organization plan (PPO) or a health maintenance organization plan (HMO). The fourth component of Medicare is Part D, also known as prescription drug coverage. Part D is the most recent addition to Medicare, originating in 2006, and it acts as prescription drug insurance, provided by private insurance companies. In addition, there are several Medicare Savings Programs (MSP) available to assist low-income beneficiaries pay for premiums, deductibles, coinsurance, and co-payments (Centers for Medicare & Medicaid Services, 2012c). These programs include the Qualified Medicare Beneficiary Program (QMB), the Specified Low-Income Medicare Beneficiary Program (SLMB), the Qualified Individual Program (QI), and the Qualified Disabled and Working Individuals Program (QDWI) (Centers for Medicare & Medicaid Services, 2012c). Another vital source of assistance for those who meet certain income and resource limits is Extra Help and the Low-Income Subsidy (LIS). Those who qualify under Extra Help pay only a fraction of their prescription drug costs and also may

receive a reduced rate on their Medicare drug plan premiums and deductibles (Centers for Medicare & Medicaid Services, 2012c).

Medicare is a lifeline for many older adults who have experienced limited access to healthcare throughout their life. Health insurance can often be prohibitively expensive in the United States and enrollment into Medicare may be the first time that many adults, especially those with limited income, have been able to afford adequate health insurance. In 2011, there were over 47 million Medicare beneficiaries; 1.2 million of those lived in Georgia (Centers for Medicare & Medicaid Services, 2010).

While it is obvious that those who utilize Medicare make up a large proportion of the U.S. population, the extensive and complicated Medicare system is less clear for many of the beneficiaries to navigate. A 2011 survey by the National Council of Aging found that 54% of seniors state that they do not understand Medicare and 55% of boomers feel unprepared to help loved ones with Medicare decisions (National Council on Aging, 2011). Morgan and colleagues (2008) surveyed almost 3,000 White, Black, and Hispanic community-residing Medicare beneficiaries in six metropolitan areas. They found that “Medicare beneficiaries face a number of difficulties in acquiring and using information about their Medicare benefits and most find choosing a health plan to be a hard or very hard decision (Morgan et al., 2008, p. 2053). Similarly, Piette and Heisler (2006) state that many older adults have “only a minimal understating of their health insurance benefits” (p. 91). At the conclusion of their nationwide internet survey study of 3,119 older adults, Piette and Heisler (2006) suggest that it is critical to educate older adults about Medicare as a significant number of their respondents had a “gap in knowledge” regarding their medication costs and coverage limits (p. 92).

In addition to the dearth of knowledge many seniors face about the complexities of Medicare, many seniors are not familiar with the assistance programs provided by Medicare to help low-income beneficiaries (National Council on Aging, 2012). This lack of knowledge regarding assistance programs translates into missed opportunities to save substantial amounts on prescription drugs and medical services. Fuller-Thomson and colleagues (2009) found that:

> Whether covered by Medicare or private insurance, for example, lower-income individuals, including a disproportionate number of Blacks, are less likely to be able to afford the cost of deductibles, coinsurance, and uncovered services and frequently forgo procedures that could improve their functional status (p. 689).

A 2010 study by the Kaiser Family Foundation found that "the average value of the subsidy amount applied to the Part D benefit, premium and cost-sharing for those enrolled in the Low Income Subsidy (LIS) program will be approximately $4,000" (Summer, Hoadley, & Hargrave, 2010, p. 2). Cutler and associates (2011) state that although 9.6 million Medicare beneficiaries received LIS in 2009, an additional 2.3 million were not receiving the subsidy, although they were likely eligible (p. 343). Lipton and colleagues (2010) hypothesize that the number of those eligible but not receiving LIS to be even higher; they estimate that almost 3.3 million "of those representing the most vulnerable Medicare beneficiaries" who qualify for LIS are not receiving the subsidy (p. 2).

In sum, research suggests that the gauntlet of Medicare can be overwhelming for adults of any age to navigate. In addition, many eligible seniors who are unaware and eligible for the low-income Medicare subsidies that help pay for doctor visits and prescription drugs may potentially spend thousands of unnecessary dollars on their healthcare every year. For those who do not have the resources to spend thousands of dollars on health care, the most common

response is to do without needed medications and check-ups, creating a lower quality-of-life for the patient and higher future medical bills. In an effort to combat these problems, it is suggested within the literature that Medicare education should be taken into the community to better reach low-income and minority populations (Cutler et al., 2011). However, it is large task for one organization to undertake, so it is advised that organizations collaborate within the community to maximize the effectiveness of an educational program.

Highlighting the importance of medical insurance affordability is especially relevant to low-income and minority Medicare beneficiaries; as evidenced by the discrimination portrayed in feminist theory, African Americans are more likely to have poorer health as a result of the inability to afford medical treatment (Eichner & Vladeck, 2005; Fuller-Thomson et al., 2009). Moreover, certain minorities are found to be even more vulnerable than their minority counterparts. Feminist theory engenders the idea of intersectionality, a theory framed by Kimberle Williams-Crenshaw in 1989 which suggests that socially constructed categories like race, socioeconomic status, class, and gender interact on multiple levels and intersect, creating more inequity and disparity (Crenshaw, 1989) . For example, while it is well known that older African Americans are more disadvantaged than their White counterparts, those in the Southeast may be more so:

> Due to slavery's legacy, the issues of disparity and discrimination bear special relevance to the Southeastern United States. Forty-one percent of U.S. African American population resides in the Southeast, and this region has the highest proportion of African Americans living in poverty (Halanych et al., 2011, p. 223).

Similarly, while older Hispanics are more than twice as likely to be poor as older Whites, female older Hispanics fare even worse than elderly male Hispanics (Greenberg & Fowles, 2011).

GeorgiaCares

Program Description

GeorgiaCares is the State Health Insurance Assistance Program (SHIP) that provides "free, unbiased and factual information and assistance to Medicare beneficiaries and their caregivers" (GeorgiaCares, 2012). Assistance includes information about Medicare, Medicaid, fraud, abuse, long-term care insurance, and financial assistance programs (GeorgiaCares, 2012). GeorgiaCares provides services throughout the state through the 12 Area Agencies on Aging (AAA). The main Atlanta site, which serves 10 counties, is located at the Atlanta Regional Commission in downtown Atlanta. GeorgiaCares is predominately a phone-based service; three full-time staff counselors, a certified coordinator, and volunteer counselors provide phone counseling. In addition to the phone counseling available Monday through Friday (8:30 am - 5 pm), the federal grant mandates that GeorgiaCares staff or volunteers attend at least five community education events per month. These outreach events may be held at any number of locations, including senior centers, health fairs, retirement communities or churches. The purpose of attending outreach events is to provide the same information and counseling available over the phone, but within the community so that they are locally accessible to all beneficiaries, including low-income and minority populations. These community education events were the focus of the evaluative aspect of this research project.

Formation

State Health Insurance Assistance Programs (SHIP) were created under the 1990 Omnibus Budget Reconciliation Act (OBRA) and there are 54 SHIP programs (50 states, plus Washington D.C., Puerto Rico, Guam, and the Virgin Islands). OBRA authorized CMS to make grants to states for health advisory services programs for people with Medicare (The National

SHIP Resource Center, 2012). GeorgiaCares, Georgia's state SHIP, began in 1992 and was originally known as HICARE (Health Insurance Counseling, Assistance and Referral for the Elderly) and operated in six locations across the state (GeorgiaCares, 2006). In 2002, the program expanded and became known as GeorgiaCares. The Georgia Department of Human Resources Division of Aging Services operates the statewide toll-free GeorgiaCares hotline and contracts with the 12 AAAs for each local GeorgiaCares.

Funding

Each SHIP receives funds through grants from CMS, the U.S. Administration on Aging (AoA) and state funds appropriated by the General Assembly. The majority of the funds come from noncompetitive continuing CMS grants; in 2010, SHIP funding was $45 million, averaging about $9 for each person served, but "because of the significant contribution of unpaid volunteers who assist beneficiaries, the program's effective resources are higher" (O'Shaughnessy, 2010, p. 3). Each state receives $75,000 for a basic program award, plus an:

> additional amount based on a formula that considers the percentage of all Medicare beneficiaries nationwide who reside in the state, the percentage of the state's Medicare beneficiaries to the state's total population, and the percentage of the state's Medicare beneficiaries who reside in rural areas (O'Shaughnessy, 2010, p. 3).

Information Delivery Channels

The basic premise of GeorgiaCares is as follows: a Medicare beneficiary or caregiver calls GeorgiaCares' toll-free phone number to request one-on-one counseling about Medicare. There are also local telephone numbers for each of the 12 local GeorgiaCares sites located through the state. Both telephone counseling and on-site outreach counseling may include information about Medicare, low-cost prescription assistance programs, managed care, long-term

care insurance, Medigap, Medicare savings programs, and Medicaid. The GeorgiaCares staff member or volunteer assists beneficiaries in applying for various Medicare programs and evaluating health insurance and managed care plans. A plethora of educational materials produced by The Centers for Medicare and Medicaid Services (CMS) are also available in a multitude of languages at a reading level accessible to most individuals with a tenth grade or equivalent education. While most of the educational materials are brief brochures and pamphlets, some of the material is large and comprehensive. One such example is the Medicare & You handbook, which is sent to Medicare beneficiaries in the mail and also available from GeorgiaCares.

Changes

There have been no major changes to the purpose or target population of the GeorgiaCares program since its inception. As with most organizations, the depressed economy has affected finances and fewer funds are now available. SHIP funding was at an all-time high in 2008, at $54.3 million; 2009 saw a decrease of around $2 million, but funding for 2010 decreased by over $7 million dollars (O'Shaughnessy, 2010). While the core target population that GeorgiaCares hopes to reach will remain Medicare beneficiaries, each year, CMS establishes expectations within the grant programs that emphasize outreach to certain low-income beneficiaries. This year, SHIPS are focused on "those who may be eligible for, but are not receiving LIS to help them pay for prescription drugs" and those beneficiaries with disabilities (O'Shaughnessy, 2010, p. 3).

Organizational & Political Environment

The entire Division of Aging Services is located within the Atlanta Regional Commission (ARC) in downtown Atlanta. The ARC also acts as the Atlanta region AAA. There appears to be

cooperation and coordination between GeorgiaCares and the other aging services. As GeorgiaCares is funded by a grant specific to SHIPs, there is not competition for funds by other aging agencies within the ARC; this encourages cooperation between the agencies instead of antagonism. Many of the other programs located within the DHR Division of Aging Services, like the Community Care Services Provider, Adult Protective Services, and Home & Community Based Services Program use a computerized database called the Aging Information Management System (AIMS). This database is used by all the aging programs within the Division of Aging Services and acts as a referral facilitator between GeorgiaCares and the other programs.

Stage of Development

GeorgiaCares is an established, stable program. The delivery system requires that beneficiaries are active and engaged enough to make a phone call to GeorgiaCares or go to a community outreach event to receive counseling and Medicare information. This may not be the best delivery system for low-income clients if they do not have access to a phone to call GeorgiaCares for phone counseling or transportation to go to one of GeorgiaCares' outreach events.

Target Population

GeorgiaCares target population is those who are current Medicare beneficiaries and their caregivers. There are 12 individual regions within the GeorgiaCares state network; the Atlanta metro area GeorgiaCares serves 10 counties: Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry, and Rockdale. As shown in Table 2.1, there are approximately 348,460 seniors over the age of 65 in these counties according to 2010 census data.

Table 2.1 Atlanta GeorgiaCares population

County	Population	Population Aged 65+	
		n	%
Cherokee	214,346	19,720	9.2%
Clayton	259,424	17,122	6.6%
Cobb	688,078	59,863	8.7%
DeKalb	691,893	62,270	9%
Douglas	132,403	11,254	8.5%
Fayette	106,567	13,534	12.7%
Fulton	920,581	83,773	9.1%
Gwinnett	805,321	54,762	6.8%
Henry	203,922	17,129	8.4%
Rockdale	85,215	9,033	10.6%
Total	**4,107,750**	**348,460**	**9% (Mean)**

Theoretical Foundations

Two theoretical approaches were used to discuss the implications of the historical lower healthcare literacy of minorities. One theoretical framework to discuss the implications of minority and vulnerable populations is feminist gerontology. While the feminist perspective certainly details the historical marginalization of women in society, the same framework can be used to express how vulnerable populations have been systematically oppressed due to ethnicity, race, culture, sexual orientation, religion, and age. Both women and minorities are often dependent on those who hold economic power, whether it is the state through the redistribution of economic resources, or other economically active persons or entities (Calasanti, Slevin, & King, 2006). Carroll Estes, pioneer of the political economy theory which forms the basis of feminist gerontology, espouses the feminist idea of dependency on the welfare state, affecting both gender and race relations (Calasanti et al., 2006; Estes, 2001). Within feminist theory is the concept of intersectionality, which exposes how the intersections of race, gender, socioeconomic

status, class, and other constructs, create layers of inequality (Crenshaw, 1989). The feminist gerontology perspective will help elucidate why minorities and vulnerable populations may not receive many community services and also explain why it is so vital for partnerships to focus on positively impacting these communities.

Feminist gerontology situates individuals within wider social contexts and systems. Similarly, the Ecological Model, constructed by Urie Bronfenbrenner, provides a way to view health literacy through the many layers of environmental and individual health determinants (Bronfenbrenner, 1977). As Figure 2.1 illustrates, there are five environmental systems that interact with a person, the microsystem, mesosystem, exosystem, macrosystem, and chronosystem (Bronfenbrenner, 1977).

> The microsystem is the relationship between the individual and his or her immediate environment. The mesosystem is the interconnection of microsystems, or the interrelations among major settings in which the person lives. The mesosystems examined consisted of the relationship between the elder and his or her family as well as how the family aids in the elder's understanding of his or her present circumstances. The exosystem is an extension of the mesosystem which includes both formal and informal institutions such as the community in which the elder resides and the healthcare system that he or she utilizes. The macrosystem represents overarching institutional patterns of the culture (Wangmo, 2011, p. 332).

Finally, the Chronosystem consists of consistency or change (e.g., historical or life events) in the individual and the environment over the life course (Hong, Kral, Espelage, & Allen-Meares, 2012, p. 447)

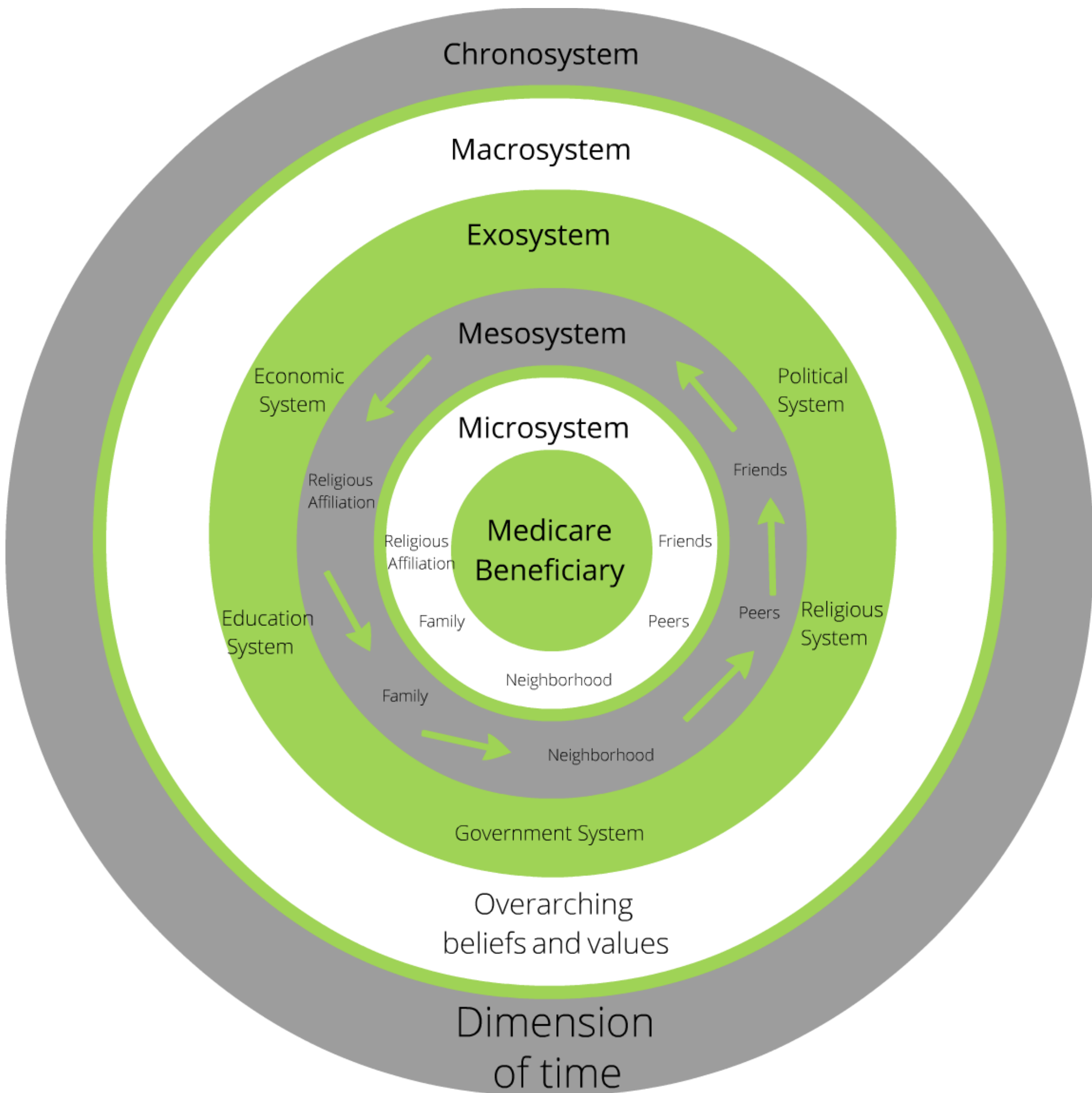

Figure 2.1 Bronfenbrenner's Ecological Theory

Williams and Kumanyika (2002) view this model as a reciprocal relationship, where "the environment affects health-related behaviors, and people can, through their actions, affect the environment" (p. 23). Further analysis of the ecological model expresses the physical, social, and cultural dimensions of the environment in addition to a "variety of personal attributes, including genetic heritage, psychologic dispositions, and behavioral patterns" that can affect a multitude of

health outcomes (Stokols, 1996 p. 4). The ecological model is salient in the study of minority knowledge about Medicare because it portrays healthcare literacy and actions as a conglomeration of both environment and personal action. "The same environmental conditions (e.g., population density, change of residence, or economic recession) may affect people's health differently, depending on their personality, perceptions of environmental controllability, health practices, and financial resources" (Stokols, 1996, p. 286). The amalgamation of feminist theory and the ecological model formed a conceptual framework which guided this research. Feminist theory and the ecological model illuminate the complexity of the intersecting and layering of socially-constructed concepts; it was easier to visualize how social, historic, and racial factors affected the behaviors and backgrounds of the participants in this study through these frameworks. As many Atlanta minority Medicare beneficiaries have been marginalized, oppressed, and discriminated, I was better able to analyze the survey responses through the lenses of these conceptual frameworks.

Community Partnerships

To better detail the significance of collaborating partnerships to reach minority populations with Medicare education, community partnerships must first be defined. Roussos and Fawcett (2000) state that collaborative partnerships "attempt to improve conditions and outcomes related to the health and well-being of entire communities" (p. 369). Whether the partnership is between an influential and trusted individual in the community, religious entity or local organization, research shows that collaborative partnerships allow for a common message to be broadcast to those who may not otherwise receive it. In fact, many researchers espouse that "an adequate response to health related issues cannot be reached by any one individual or group working alone" (Radermacher et al., 2011, p. 550). Community partnerships are important for

"gaining access to funds, for better meeting client needs, a means to maximize limited resources, and a viable way of achieving organizational aims more effectively" (Radermacher et al., 2011, p. 553). In an economic environment devoid of excess funding, the ability to maximize resources is incredibly important to any organization, especially those similar to health literacy organizations which rely heavily on grants and private donations.

Trust

The overarching theme throughout the literature about successfully impacting minority and underserved communities is that of trust. There has been an enduring distrust of the government for African Americans, Hispanics, and Native Americans for decades and this lack of trust is often mentioned as a significant barrier (Choi & Smith, 2004). Minorities have been abused and mistreated by researchers and the government in the past, creating a resilient and endemic distrust of healthcare related organizations, the medical community, and the government (Brave Heart, Chase, Elkins, & Altschul, 2011; Davis, Green, & Katz, 2012; Ojanuga, 1993).

Historical examples abound of Africans Americans being used as human experiments and exploited by researchers and medical professionals. Dr. Marian Sims, the father of gynecology, used unwilling female slaves to create his technique for the cure of vesico-vaginal fistula (Ojanuga, 1993). The infamous Tuskegee Syphilis Study "exploited hundreds of Black sharecroppers from Macon County, Alabama who were infected with syphilis by following and studying those subjects, virtually untreated, until their deaths" (Davis et al., 2012, p. 59). Native Americans are consistently ranked as being of poorest health among Americans and much of this can be attributed to the way they have been treated by the government over the years (Henderson, 2010). For example, the U.S. government created compulsory Indian boarding

schools that generated a "cumulative generational impact which negatively influence[d] the quality of parental interaction with children, and contribute[d] to unresolved or prolonged grief, depression, substance abuse, and other behavioral health issues" (Brave Heart et al., 2011, p. 284). Penned as "historical trauma," it is clear within the research that "Indigenous Peoples have experienced pervasive and cataclysmic collective, intergenerational massive group trauma and compounding discrimination, racism, and oppression" (Brave Heart et al., 2011, p. 282). In 1942, after the bombing of Pearl Harbor placed a pallor and fear over the American people, Japanese Americans were evacuated and incarcerated in sixteen "assembly centers" by order of the U.S. government (Mizuno, 2003, p. 850). Those incarcerated lost their civil liberties, freedom, and even use of their native Japanese tongue during internment (Mizuno, 2003). These historical examples represent only several of the abuses towards minorities over the decades by the hands of those in the medical field and the United States government. While many laws, rules, and regulations now stand to help prevent the reoccurrence of any such travesties again, there appears to be an endemic distrust by minorities towards the government and researchers, specifically medical researchers.

Due to the prevalent environment of mistrust within minority populations, it is critical that trust is established to foster community relationships. According to Parrill and Kennedy (2011), "African Americans are more likely than the majority population to believe that health research holds personal risk and that full disclosure is not afforded minority populations" (p. 153). They continue by saying that "a majority of researchers identify open and honest communication as a means to build trust when partnering with African American communities" (Parrill & Kennedy, 2011, p. 153). Researchers of national and state policy collaboration with community organizations promote the importance of trust as well, stating that the fundamental

component to a successful partnership is trust and that a lack of trust undermines the partnership (Radermacher et al., 2011). Gilbert and colleagues (2011) addressed health disparities among urban African American neighborhoods through an inter-organizational network and found that in order to create the right environment for their Healthy Black Family Project, trust and credibility had to be established between the community and partners. One study of the literature found that "linking with community-based organizations can facilitate access to the health care system and more trust in the system itself" (Dancy & Ralston, 2002, p. 233). While the methods vary, it is accepted within the literature that fostering a community partnership to build trust within minority populations is key to overcoming the barriers of fear and distrust. One entity within the community, especially the African American community, that acts as a source of social stability and tradition is the church. Researchers and health literacy advocates often have used the African American church as a platform in which to gain trust and establish relationships within the community.

Although the research suggests that partnering with the church works well to garner trust within the African American community, little research is found to show that religious institutions work as well within other racial and ethnic groups. However, other methods to gain the trust of minority populations have been discussed within the literature. For example, the importance of face-to-face contact between the researcher and her participant to gain trust is highlighted in multiple journal articles (Arean, Alvidrez, Nery, Estes, & Linkins, 2003; Gilliss et al., 2001; Gonzalez, Gardner, & Murasko, 2007; Greaney, Lees, Nigg, Saunders, & Clark, 2006; McHenry et al., 2012).

A 2004 study by Moreno-John and colleagues of trust-building activities by the Resource Centers on Minority Aging Research (RCMAR) found that the RCMAR is successful in

"recruiting and retaining ethnic minority older adults in clinical research studies and health promotion projects" (p. 93S). RCMAR has developed four recommendations to enhance research participation among African American, Latino and American Indian elders. These strategies are, to "build faith with community members and community-based organizations; use a participatory approach to research; target the special circumstances of ethnic minority older adults; and study and disseminate information on conducting research with ethnic elders" (Moreno-John et al., 2004, p. 112S).

The University of Colorado Health Sciences Center (UCHSC) was chosen as a location for a RCMAR to encourage Native Americans to participate in research. The researchers used the strategy of special circumstances to offer Native elders not just monetary compensation for participating, but the culturally appropriate idea of gifts in the form of a "give-away ceremony, as gift-giving practices are an important part of many Indian and Native cultures. The gift-giving ceremony enhanced trust because they showed respect for traditional cultural practices and they communicated the researcher's concern for the practical needs of elders." (Moreno-John et al., 2004, p. 109S).

The University of California, San Francisco (UCSF), was chosen as a location for another RCMAR, this one to encourage Latinos to participate in research. This RCMAR took particular note of community-based organizations to create trust within the Latino community and it maintained trust with community members by sharing research results with the community. The program is described as such:

> Two symposia were organized to announce the results of the UCSF study on attitudes of African Americans and Latinos on research. Time was allotted for a dialogue and opportunity to interact was important to community members and researchers alike.

> As a result of the trust built between the UCSF and the community, there was an increase in participation by minority older adults in several research projects (Moreno-John et al., 2004, p. 110S).

Researchers Harala and colleagues (2005) echoed the idea of sharing research results with the community during their study of research and Native Americans. They state that the "findings of research should be shared with the community leadership so that they can take the next step in resolving issues identified during the research process" (p. 75). The literature regarding building trust within minority populations focuses on African Americans and as there is a strong positive correlation in the literature between African Americans and the church, I focused on this link as a basis to form trust within this particular community.

African American Churches

The research literature recognizes the African American church as an integral component of the African American community (Beck et al., 2007; Kaplan et al., 2009). The church forms the basis of strong social networks within the community and plays a role in many facets of daily life (Parrill & Kennedy, 2011; Williamson & Kautz, 2009). Given that "churches have been deeply rooted in African American communities and represent a trusted social institution second in importance only to the family," the church can be a tool to disseminate Medicare information throughout the community (Beck et al., 2007, p. 29). Partnering with churches to educate minorities about health-related topics or to conduct research is a common practice and "many public health and health education initiatives have been implemented through collaborations with faith-based institutions" (Kaplan et al., 2009, p. 1113).

Because the church is "recognized as a strong institution in reference to its prevalence, independence, and outreach" within the African American community, partnership with the

church may create value for Medicare education within the community (Parrill & Kennedy, 2011, p. 151). Kaplan and colleagues' (2009) qualitative study to identify the benefits and challenges of using a faith-based initiative to address health disparities found that using the resources and influence of churches could "change the knowledge, attitudes, and behavior of community members concerning health promotion, disease self-management, and navigation of the health care system" (p. 1113).

While partnering with a church may provide a bridge into the community and the catalyst to establish trust, the partnership is likely to be ineffective if the church plays only a minor role. To more fully involve and establish a successful and abiding partnership with a church, it is essential that ongoing support is provided and church attendees participate, are involved, and integrated into the program. Williamson and Kautz (2009) established a health promotion program in a local church aimed at educating African Americans about stroke and cardiovascular disease. They found that the idea of "church ownership" was linked to the success of the program and that members were more likely to stay involved with the program if they were given some control and ownership (Williamson & Kautz, 2009. p. 104). Indeed, several studies, as evidenced in the following section, have shown that providing leadership opportunities and ownership of a program to the community partner is an effective way to maintain a successful program.

Community Input & Ownership

While those working in conjunction with a community partnership to educate beneficiaries about Medicare may appreciate and support the cause, often, if they only play a minimal role instead of a leadership role in the program, the partnership tends to falter and eventually fail. Researchers consistently recommend that those within the partnership help

formulate the plan to reach those in need. In fact, the "process used to develop a partnership's vision and mission may be as important as the product" (Roussos & Fawcett, 2000, p. 384). To best develop and sustain the partnership, representation of the collaborating party, both in terms of influential leaders and Medicare beneficiaries, is necessary (Roussos & Fawcett, 2000). Beck and colleagues' 2007 study of a community-based cancer education curriculum emphasizes the importance of the community partner's involvement of the curriculum development, saying that it "would have more lasting value to the community than one-time presenters by experts" (p. 33).

Equally as important as including the input of the community partner in the planning process of a Medicare education is the eventual transfer of ownership to the partner. The "Good for the Neighborhood" community program was developed to improve the health of two African American communities, one Latino, and one American Indian community in the Buffalo, New York region (Tumiel-Berhalter et al., 2011). The program's "overwhelmingly positive impact on the communities" was attributed to the original plan to "gradually transfer ownership and leadership to the community partner as the program progressed" (Tumiel-Berhalter et al., 2011, p. 670). If inclusion of the community partner is vital to the success of a program, then the lack of ownership by the partner is a reason for failure. A 2006 study of a six-month, church-based exercise intervention for African American women in Baltimore, Maryland, failed because the researchers believed that they had neglected to "elicit a sense of community ownership of the program by the church and its congregants (Young & Stewart, 2006, p. 112).

Influential Leaders

Without the credibility and trust lent to an organization by an influential community leader, a collaborative partnership is likely to struggle. Choi and Smith's 2004 study of successful elderly nutrition programs found that it "is important to gain the trust of the respected

community leaders whose connection with the programs will act as a stamp of approval" (p. 100). In a report concerning the state government's community relations approach to a mental health program development in South Beach, Florida, the role of community leaders to act as advocates ranked as one of the three most important principals of the successful development of the program (Byalin & Harawitz, 1988). The authors found that once the community leaders trusted the organization, they were able to "exercise influence on behalf of their constituents and to effectively shape the direction of program development" as their credibility and endorsement was accepted by the community (Byalin & Harawitz, 1988, p. 202). Reaching out to both community dwellers and influential neighborhood leaders can be thought of as horizontal and vertical outreach (Darrow, Montanea, & Sánchez-Braña, 2010). "Horizontal outreach" to residents, and "vertical outreach" with neighborhood gatekeepers, was the plan for a 2010 community health intervention strategy for HIV prevention with a goal of "pursuing outreach strategies uniquely suited to the ethnic community" (Darrow et al., 2010, p. 870). Neighborhood gatekeepers, or leaders, may play several roles within the community.

In a 2009 study to investigate different approaches to identify people with disabilities, researchers categorized three types of community leaders: economic dominants who "occupy major economic roles in the community," "prescribed influentials", who "hold positions formally designed to sanction and facilitate influence in the community," and "attributed influentials", who are "perceived by others as being influential in community decision making" (Gona et al., 2010, p. 80). The study found that these leaders could be "empowered to reduce social stigma, increase awareness and improve health-seeking behavior of community members" (Gona et al., 2010, p. 83). Within the Atlanta metro region, local African American pastors often play the role of both attributed influentials and even prescribed influentials (e.g., Martin Luther King, Jr.).

The central role that the African American church plays within the community is highlighted by the individual influence of the pastor. Pastors have been noted in numerous journal articles as serving as “catalysts for health-related behavioral and social change” (Chatters, Levin, & Ellison, 1998, p. 693; Markens, Fox, Taub, & Gilbert, 2002). Pastors have a unique and trusted role within the community and are often able to connect a health related message to a spiritual lesson (Kaplan et al., 2009). In fact, if the pastor trusts the organization who wants to partner with the church, then the congregants are more likely to endorse the program and participate (Parrill & Kennedy, 2011).

Summary

The population of Americans 65 and older has increased during the twentieth century and continues to grow. The 2010 census found the older population at its highest level at 40.3 million; among minorities, the number of those over the age of 65 is growing more rapidly than those of their White counterparts (Green & Adderley-Kelly, 2002; Werner, 2011). For those with Medicare, the national health insurance program, guidance through the complicated program is incredibly beneficial and often enables beneficiaries to save money and receive better health care. While organizations exist that provide Medicare counseling and education, they are limited in scope and ability and often have trouble reaching beneficiaries. However, the formation of a community partnership allows for a way to engage both people and organizations in the “common purpose of addressing community-determined issues of health and well-being” (Roussos & Fawcett, 2000, p. 394).

Creating a successful and enduring community partnership to educate minority beneficiaries about Medicare takes time. It also takes time to build trust, develop relationships, and encourage meaningful participation (Kaplan et al., 2009). It also takes time to identify

community leaders who will lend credence and give support to the partnership. Sometimes it is a pastor within an African American church who is willing to be the messenger and figurative cheerleader for the community to embrace a program. Whatever the case, effective, long-lasting community partnerships do not take root overnight and success depends on the hard work and dedication of both the community partner and the education provider. “Because of the dynamic health care market Medicare consumers face, their limited understanding of their options, the limitations of human information processing and health literacy, it is critical that we find effective ways to help consumers make more informed Medicare choices” (Harris-Kojetin et al., 2007, p. 153). The research suggests that one effective way to help consumers make more informed Medicare choices is through community partnerships.

Purpose of Research

The research clearly suggests that the majority of Medicare beneficiaries are confused and overwhelmed by the gauntlet of Medicare (Piette & Heisler, 2006; Morgan et al., 2008). Unfortunately, this lack of knowledge and understanding of Medicare can be detrimental to beneficiaries’ health and financial stability (Summer et al., 2010). GeorgiaCares aims to bridge the gap of Medicare knowledge that exists and thereby stem the financial hardship and healthcare strain experienced by many Medicare beneficiaries. One of GeorgiaCares’ methods to reach elders about Medicare is through community events.

Understanding the formation and significance of collaborative partnerships to foster Medicare education within minority communities in Atlanta is beneficial for both beneficiaries who deserve to understand the complicated Medicare system and those who want to partner to help facilitate the dissemination of the information. Minorities have long suffered disproportionately from health-related issues and faced barriers to receiving health literacy

education, including Medicare education. Paring with organizations vested in the community is helpful to understanding the cultural perceptions and attitudes behind the minority populations they seek to serve. A successful partnership with an organization to educate minority beneficiaries about Medicare potentially has the distal outcome of improving the financial stability of beneficiaries. A recent study found that when vulnerable Medicare beneficiaries receive assistance from community partners, they were likely to enroll in the lowest-cost plans, reduce out-of-pocket expenses, and be identified as eligible for the low-income-subsidy benefit (Cutler et al., 2011, p. 347). The organizations that collaborate as community partners play a vital role in increasing the knowledge and improving the access and quality of care.

Research Aims

The purpose of this study was to evaluate the effectiveness of GeorgiaCares community outreach events. My research aims were as follows:

Aim 1: To understand the current GeorgiaCares community outreach event participants;

a) What is the demographic make-up of current GeorgiaCares participants?

b) How do participants hear about GeorgiaCares?

c) How knowledgeable are participants of Medicare?

Aim 2: To discover how to best market current GeorgiaCares community outreach events to the community.

a) How do participants prefer to receive information about Medicare from GeorgiaCares?

b) What suggestions do participants have about how to better market GeorgiaCares within the community?

c) How do participants suggest that GeorgiaCares improve its services?

Chapter 3

Methods

I will describe the methods used for my research in this chapter. I gathered my own data using an IRB-approved instrument to measure the characteristics of GeorgiaCares outreach event participants. I will discuss the methods of recruitment, site selection, data collection process, data analysis procedures, IRB approval, consent procedures, and measures used to protect confidentiality and anonymity of participants in this chapter.

Research Design

I used a non-experimental design for this evaluation of GeorgiaCares community outreach event. It was not possible for me to survey every Medicare beneficiary in the 10-county GeorgiaCares region, so my design did not include random assignment. Instead, it was a convenience sample of the attendees of the outreach events; 81 attendees completed a survey. The design was a one-group, posttest-only design.

Methods of Recruitment

Participants were recruited at GeorgiaCares community outreach events. These events took place in various locations throughout DeKalb, Fayette, Fulton, Clayton, and Gwinnett counties. Outreach event locations included senior centers, churches, and senior living communities. Eighty-one participants were recruited to participate in the study and participants were not offered compensation. The events chosen to act as recruitment sites were selected by the scheduled events pre-determined by GeorgiaCares. Table 3.1 details the community outreach events attended.

Table 3.1 Community outreach events

Date	Type of Event	Name	Location	City	Zip	County	Surveys Collected
9/25	Presentation	Fayette Senior Services	203 McIntosh Trail	Peachtree City	30214	Fayette	5
9/27	Health Fair	Briarcliff Oaks	2982 Briarcliff Rd	Atlanta	30329	DeKalb	10
10/1	Presentation	Lithonia Senior Center	2484 Bruce St	Lithonia	30058	DeKalb	6
10/3	Health Fair	Lou Walker Senior Center	2538 Panola Road	Lithonia	30058	DeKalb	23
10/3	Presentation	Antioch Manor Estates	1861 S Harriston Rd	Stone Mnt	30088	DeKalb	13
10/4	Presentation	Fayette Senior Services	203 McIntosh Trail	Peachtree City	30214	Fayette	3
10/5	Health Fair	Radcliff Presbyterian Church	286 Hamilton E Holmes Dr	Atlanta	30318	Fulton	15
10/13	Health Fair	Pleasant Hill Baptist Church	797 Moon Road	Lawrenceville	30046	Gwinnett	4
10/12	Health Fair	J. Charley Griswell Senior Center	2300 Hwy 138 SE	Jonesboro	30236	Clayton	2
						Total	**81**

Participants were given an IRB approved informed consent form stapled on top of the anonymous questionnaire. The form specified the nature of the study and highlighted participant rights, including the right to skip questions or quit at any time. Participants were not required to sign the informed consent form in order to keep the study anonymous.

The survey was handed out at community outreach events to interested attendees. Participants were briefed on the content and purpose of the survey and then instructed to read the consent form. I answered any questions that the participant had about the survey and purpose of the study and then requested that the participant fill out the survey.

Data Instrument

The survey was four pages, 25 questions, and took approximately 15 minutes to complete (see Appendix A). Table 3.2 illustrates the questions, the characteristic measured within the

question (demographic, information channel, Medicare knowledge, trust, behavioral, and opinion) and the type of question (close-ended, open-ended, partial open-ended, and scaled).

Table 3.2 Survey questions

Question	What characteristic is measured	Type of question
Sex	Demographic	Closed-ended
Age	Demographic	Open-ended
Zip Code	Demographic	Open-ended
Partnership Status	Demographic	Closed-ended
Education	Demographic	Closed-ended
Ethnicity	Demographic	Closed-ended
Race	Demographic	Partial Open-ended
Income	Demographic	Closed-ended
Transportation	Demographic	Partial Open-ended
Do you have Medicare?	Background Info	Closed-ended
Do you have Medicare Part D coverage?	Background Info	Closed-ended
Are you a caregiver for a Medicare beneficiary?	Background Info	Closed-ended
How did you hear about GeorgiaCares?	Information Channel	Partial Open-ended
Member of a group who would like to have a presentation by GeorgiaCares?	Information Channel	Closed-ended
How would you like to receive GeorgiaCares information?	Information Channel	Partial Open-ended
Where do you go on a monthly basis?	Behavioral	Partial Open-ended
Did you know about GeorgiaCares before today?	Medicare Knowledge	Closed-ended
Have you heard of Extra Help?	Medicare Knowledge	Closed-ended
Have you heard of Medicare Savings Plans?	Medicare Knowledge	Closed-ended
How much do you understand Medicare?	Medicare Knowledge	Scaled
Have you been a victim of Medicare fraud?	Trust	Closed-ended
Have you been a victim of identity theft	Trust	Closed-ended
If you have been a victim of Medicare fraud or identity theft, has it changed your opinion of people?	Trust	Closed-ended
How can GeorgiaCares help you better understand Medicare?	Opinion	Open-ended
How can GeorgiaCares help you solve your Medicare questions or problems?	Opinion	Open-ended
How can GeorgiaCares improve its services?	Opinion	Open-ended

The survey questions probed for demographic, behavioral, and attitudinal information. Questions types included open ended, partial-open ended, close ended, and scaled. Questions were created to gather basic demographic information from the participant, gauge current Medicare knowledge, measure the participants' general trust and gather recommendations to better the GeorgiaCares program. Both the consent form (see Appendix B) and the survey were written at the eighth grade reading level.

Demographic information included questions about participants' sex, age, partnership status, education, ethnicity, race, and income. All of the demographic questions were either closed-ended or open-ended, except for the question to probe the participants' race, which was partially open-ended. The question regarding race allowed participants to choose from six races or write in their preferred racial identification. Participants were asked how they heard about GeorgiaCares (friend or family, GeorgiaCares brochure, newspaper, Medicare/Medicaid representative, Medicare brochure, GeorgiaCares presentation, senior center, health fair, or other), how they wanted to receive information about Medicare from GeorgiaCares (over-the-phone, face-to-face at a senior center, face-to-face at an off-site location, from email, from a presentation or other), and if they wanted GeorgiaCares to give a presentation at a social function. These partial open-ended and closed-ended questions probed how participants received and would like to receive Medicare information in the future. Participants were also questioned about their current Medicare knowledge. These knowledge-related questions asked if the participants had heard of Extra Help, Medicare Savings Programs, GeorgiaCares and questioned the extent to which participants understood Medicare. By asking if participants had been victims of Medicare fraud and identity theft, I hoped to gauge their general trust level. Questions about trust correlated with the literature suggesting that minority populations have generally less trust

of healthcare and the government (Moreno-John et al., 2004). These questions were an attempt to gauge the general trust level of GeorgiaCares outreach event participants. The final three questions were open-ended and asked participants how GeorgiaCares can help them better understand Medicare, how GeorgiaCares could solve their Medicare questions and problems, and how GeorgiaCares could improve its services. These qualitative questions allowed participants to suggest or comment on topics or ideas that I may not have covered in the rest of the survey.

IRB Approval

"The primary function or role of the IRB [Intuitional Review Board] is to safeguard human subjects by training researchers in research ethics and best practices and reviewing research proposals" (Enfield & Truwit, 2008, p. 1333). IRB approval was granted for the survey on July 5th, 2012.

Confidentiality & Anonymity

No identifiable private information on participants, such as home address, date of birth, or social security number, was collected. After the participant completed the survey, he or she returned the survey to me. Although the survey is anonymous and could not be traced back to the participant, all precautions were taken to safeguard the surveys.

Data Analyses

As the survey instrument was composed of open-ended, partial-open ended, closed-ended and scaled questions, a combination of quantitative and qualitative analysis methods was used. The statistical program SPSS 19.0 was used to analyze simple descriptive statistics and cross tabular analysis to answer research questions about the demographic make-up of participants, how they learned about GeorgiaCares, and their levels of Medicare knowledge. In order to analyze the open-ended, qualitative responses, I coded the data using "inductive analysis" which

"involves discovering patterns, themes, and categories in one's data" (Patton, 2002, p. 453). Put otherwise, I examined the content of participants' responses and grouped them according to similarity of ideas or topics.

Chapter 4

Results

I will describe the results of the survey in this chapter. As mixed-methods research was used for this study, I will divide this chapter into the quantitative analysis and qualitative analysis. Within the quantitative analysis section, I will discuss the outreach events attended and the social and demographic information gathered, including age, education, partnership status, ethnicity, income, and transportation. I will discuss participants' initial introduction to GeorgiaCares, their Medicare knowledge, their preferences in receiving Medicare information, their trust level, and finally the type of trips they take monthly. Within the qualitative analysis section, I will discuss the three themes that emerged: information preference, assistance, and the desire to receive simple and understandable information.

Quantitative Analysis

Descriptive quantitative analyses were used to address my first research aim, which was *to understand the current GeorgiaCares community outreach participants*. This aim included discovering the participants' social and demographic make-up, how they learn about GeorgiaCares, and their knowledge of Medicare. I originally anticipated collecting 100 surveys, however, due to the cancellation of four scheduled outreach events, I collected 81 surveys from nine outreach events throughout the metro Atlanta area.

Outreach Events

Between September 25th and October 13th, I attended nine community outreach events with GeorgiaCares (see Table 3.1). Locations include senior centers, senior living communities, and churches. GeorgiaCares outreach events were held in Fayette, DeKalb, Fulton, Clayton, and Gwinnett counties (see Figure 4.1).

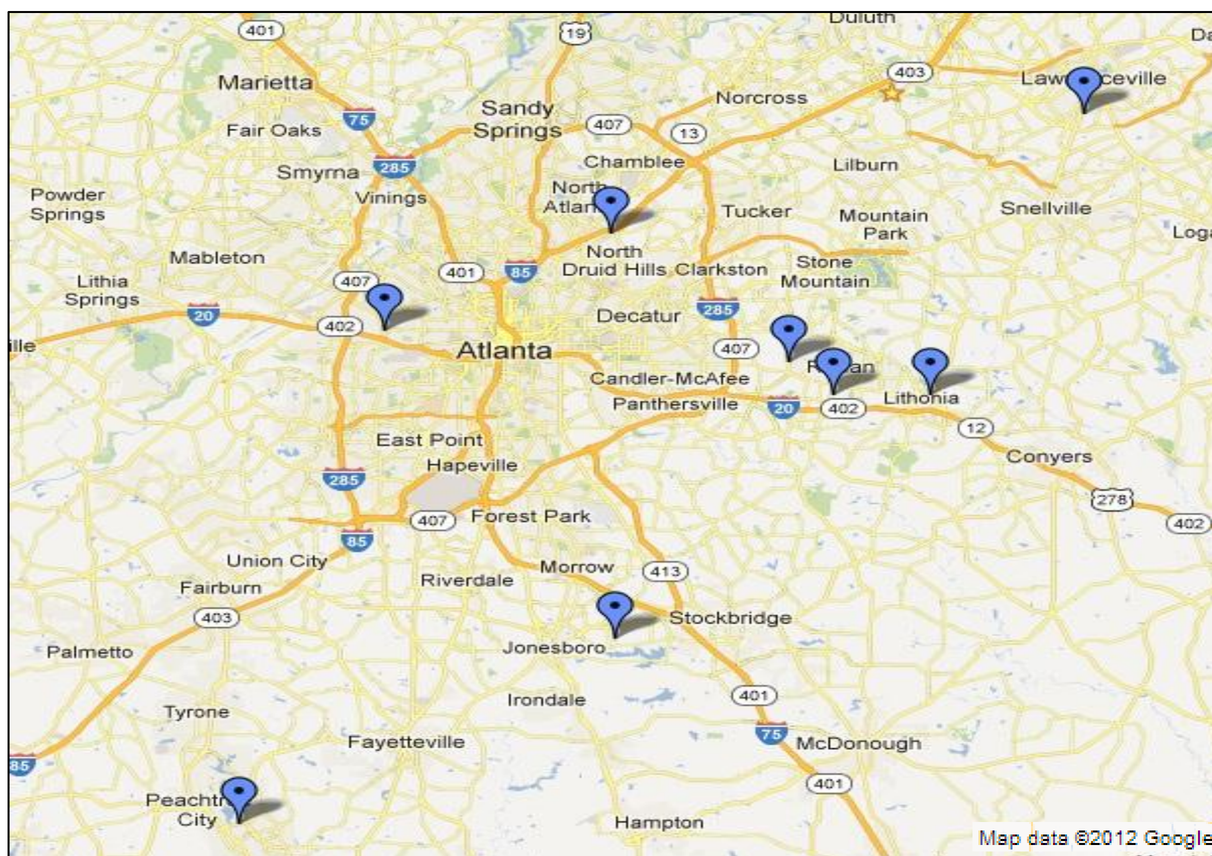

Figure 4.1 Outreach event locations

Fayette Senior Services operates a senior center in Peachtree City called The Gathering Place for adults 50 and older. Lithonia Senior Center and Lou Walker Senior Center, both located in Lithonia, were also presentation sites. Pleasant Hill Baptist Church in Lawrenceville held a health fair and GeorgiaCares hosted a table at the event. The remaining events were held in conjunction with SPARC (Sickness Prevention Achieved through Regional Collaboration) clinics and included health screenings, vaccinations, nutritional counseling, and vision exams. These clinics are administered through a partnership between the Atlanta Regional Commission and participating county offices of aging. Briarcliff Oaks, a 125-apartment senior high-rise in Atlanta, Antioch Manor Estates, a 120-apartment, low-income, senior living community in Stone Mountain, Radcliff Presbyterian Church in Atlanta, and J. Charley Griswell Senior Center in

Jonesboro all hosted SPARC events in September and October. GeorgiaCares attended these events and I collected data at the GeorgiaCares sponsored table (see Appendix C for zip code information).

Surveys were distributed across the events based on the number of attendees who were able and willing to take the survey. Two events were held at the Fayette Senior Services; one data collection event produced five completed surveys and the second event produced three completed surveys. The event at Briarcliff Oaks yielded 10 surveys; Lithonia Senior Center, six surveys; Lou Walker Senior Center, 23 surveys; Antioch Manor Estates, 13 surveys; Radcliff Presbyterian Church, 15 surveys; Pleasant Hill Baptist Church, four surveys; and J. Charley Griswell Senior Center, two surveys. A total of 81surveys were collected from these nine sites.

The response rate of each event differed considerably. The first event held at Fayette Senior Services was attended by 10 adults; six of these attendees completed the survey, for a response rate of 60%. The other event held at this same location in Fayette county had a response rate of 100%, as both attendees completed the survey. These were the only two events where the response rate was specifically calculated; it was not possible to calculate the response rate for the other events because attendees came in and out of the event space too often to feasibly count participants accurately, so the following response rates are estimations based on my perceptions. The majority of adults who visited the GeorgiaCares table at the events held at Briarcliff Oaks and Lou Walker Senior Center were agreeable to completing the survey. The Lou Walker Senior Center SPARC event drew a very large crowd of older adults. I would estimate two hundred seniors attended this event. Approximately half of the Radcliff Presbyterian Church SPARC event participants finished the survey. Inversely, only a small percentage of the 20 or 25 adults at

the Lithonia Senior Center presentation agreed to complete the survey. Similarly, few of the approximately 30 attendees of the Pleasant Hill Baptist health fair were interested in the survey.

It is difficult to speculate why each event's perceived response rate varied so dramatically. A well-known and trusted GeorgiaCares employee introduced me to attendees at the Fayette Senior Services presentations, which could have accounted for the particularly high response rates at these two events. However, a well-known and trusted GeorgiaCares volunteer introduced me to attendees at the Lithonia Senior Center and this event yielded a low response rate. I cannot neglect to mention that I may not have been persuasive enough when eliciting volunteers to complete the survey; my own timidity may have impeded my ability to attract participants. It is also possible that those with higher education levels were more likely to respond to the survey. At the two Fayette events, over 60% of the respondents had a 4-year college degree or higher, whereas at the Lithonia Senior Center, where the response rate was poor, only 16.7% of the attendees had a 4-year college degree or higher. Similarly, the majority of the Lou Walker participants were well educated and many respondents agreed to complete the survey at that location.

Social & Demographic Information

The majority of survey respondents were female (84%) and African American (74%). The average participant age was 71 and almost 40% of the participants were widowed. Approximately 30% of the participants completed some college and 25% had completed high school or obtained a Generational Education Diploma (GED). Fifty percent of the sample had an annual household income of $25,000 or less and almost half of the participants drove themselves to the outreach event. The demographic information is separated into variables and Table 4.1a and Table 4.1b illustrate each demographic variable within the outreach event locations.

Social & Demographic Information: Age

The average event participant age was 70.7 years old and the median age was 71 years. The youngest participant was 48 years old and the oldest was 90 years old. Interestingly, the mode age was 64, which happens to be the year before most people are Medicare eligible. The fact that 10 survey participants were 64 years old is important to GeorgiaCares and this surprising finding will be discussed in greater detail in the following chapter. See Figure 4.2 for a graph of participants' ages.

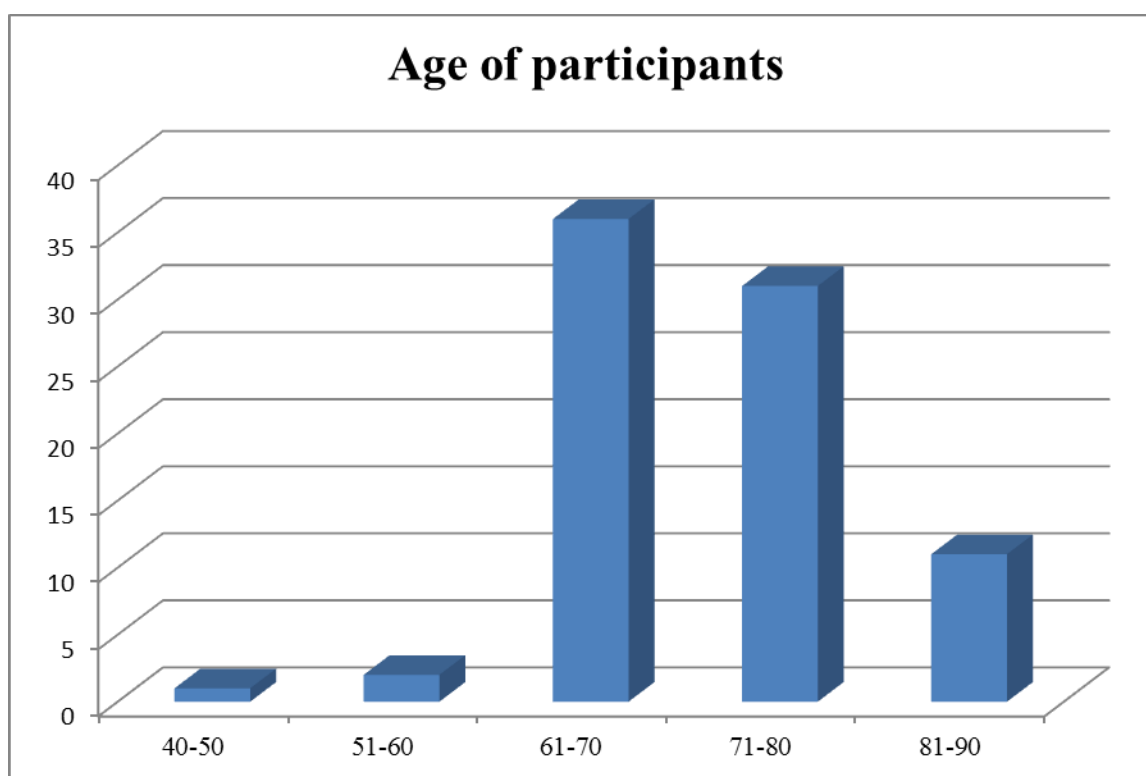

Figure 4.2 Age of participants

Social & Demographic Information: Education

Participants were asked to disclose the highest level of education completed (Figure 4.3). Many of the participants (29.6%) had completed “some college.” The second most common answer was “high school/GED” (24.7%), followed closely by “4 year college degree” (22.2%). The remaining answers in descending order were “less than high school” (6.2%), “2 year college degree” (3.7%) and “doctoral degree” (2.5%). According to 2009 Census data, 27.5% of Georgians have a bachelor’s degree or higher; my sample was slightly less educated than the average Georgia resident (U.S. Census Bureau, 2012, p. 11).

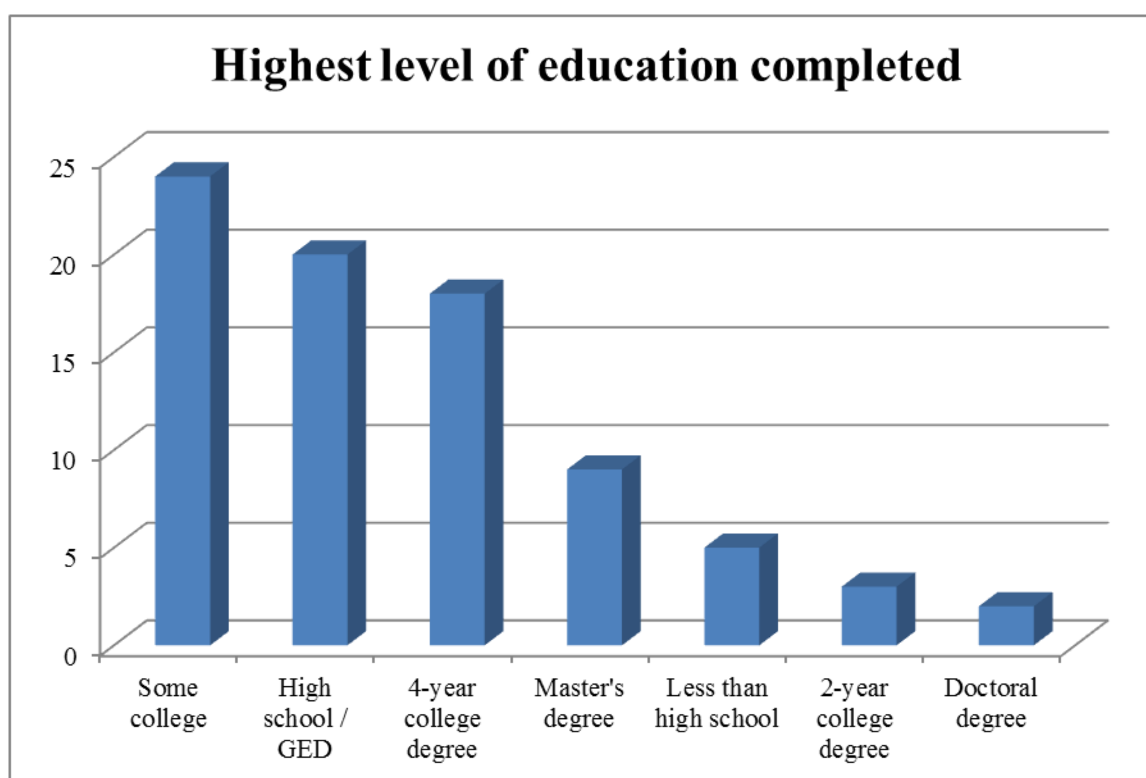

Figure 4.3 Highest level of education completed

Social & Demographic Information: Partnership Status

Thirty-two participants were widowed, meaning the most common partnership status of the sample (39.5%) was widowed (Figure 4.4). While only 14.3% of persons 18 and older in the United States are widowed, this number increases dramatically by age and gender (U.S. Census Bureau, 2011, p. 52). For adults 65 years old and over, 28.1% of Americans are widowed and 39.9% of women 65 and older are widows (U.S. Census Bureau, 2011, p. 39). As my sample is predominately female (84%), it is not surprising that it closely resembles national data. The second most common partnership status in the sample was married (28.4%), followed by divorced (18.5%), single (11.1%), and separated (2.5%).

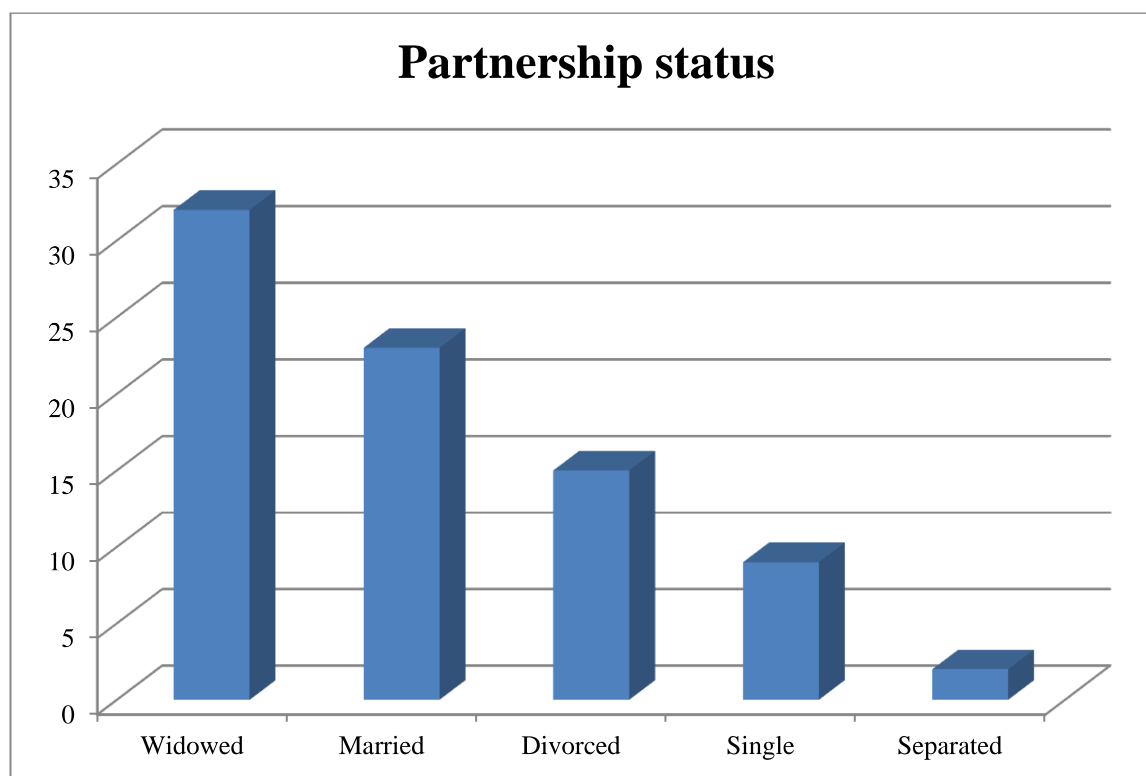

Figure 4.4 Partnership status

Social & Demographic Information: Ethnicity and Race

Ethnicity and racial background were addressed in two separate questions. The majority of participants (69.2%) self-identified as non-Hispanic and 2.5% of the sample identified as Hispanic/Latin American. A large percentage of participants (28.4%) either did not answer the question or chose the option of "I do not wish to answer." The vast majority of the sample self-identified as "Black or African-American" (74.1%). The remaining 17.3% of the sample selected "White" as their racial background and 8.6% self-identified as "Asian" or "Other" or did not answer the question. See Figure 4.5 for a graph of the participants' race. According to 2010 Georgia census data, 65% of residents in DeKalb county and 52% of Fulton county residents are African American. As most of the sample participants live in these two counties, this gives perspective to the county data versus the sample data.

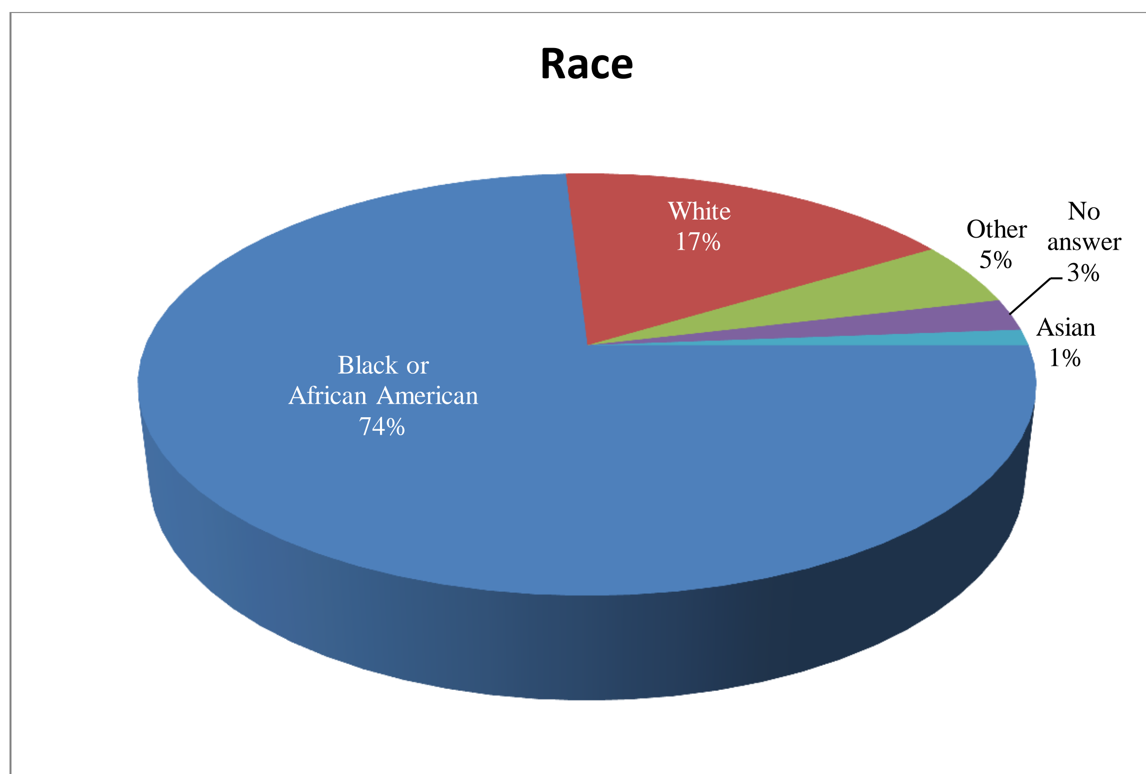

Figure 4.5 Race

Social & Demographic Information: Income

Fifty percent of the sample selected an annual household income of $25,000 or less (27.2% reported an income of $10,000 or less and 33.3% reported an income of $10,000 to $25,000). Sixteen percent indicated an income between $25,000 and $50,000, 11.1% indicated an income between $50,000 and $100,000 and 1.2% (n=1) indicated an income of over $100,000. The remaining 11.1% did not respond to the question. See Figure 4.6 for a graph of the participants' annual household income.

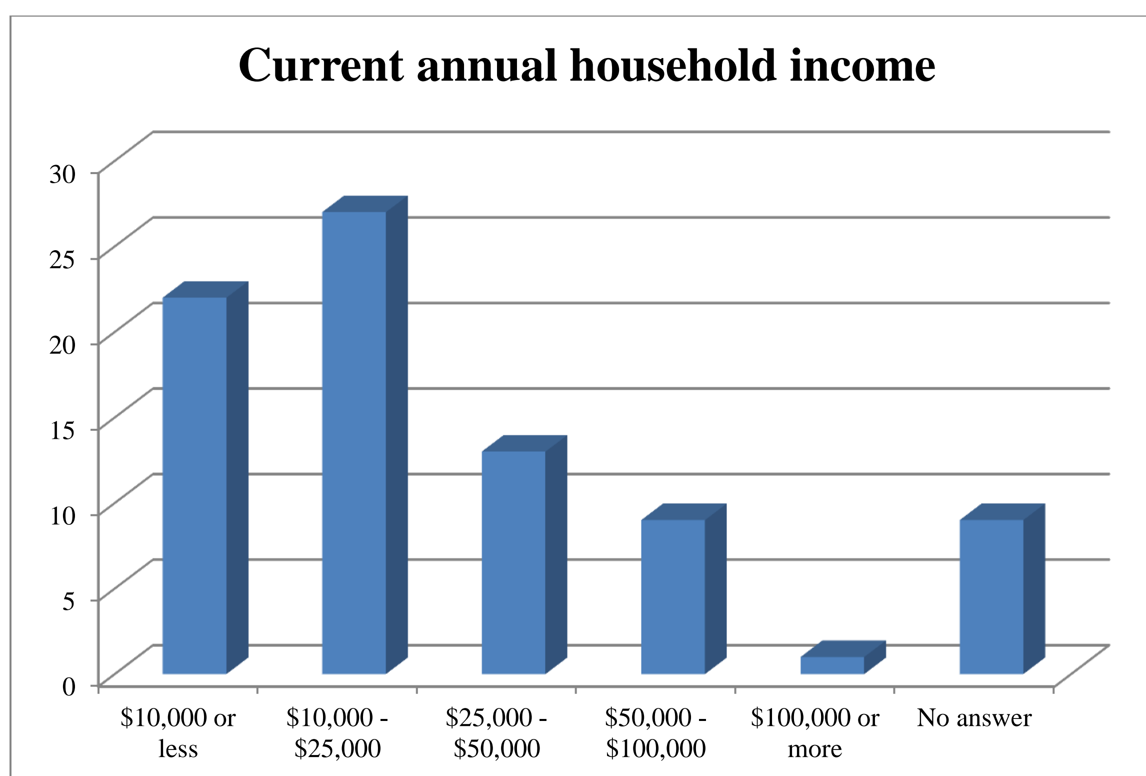

Figure 4.6 Annual household income

Social & Demographic Information: Transportation

While transportation is not considered a social or demographic variable, it is germane to this research (see Figure 4.7). According to an Atlanta Regional Commission report, “transportation has been and continues to be a challenge for older adults in the Atlanta region” (Lawler, 2007, p. 12). Almost half (44.4%) of the participants drove themselves to the outreach event. Six percent of the sample was driven by a family member (other than spouse) and an additional six percent took MARTA public transportation. Ten percent took a van for seniors; in this sample, the van’s only purpose was to take seniors to and from a senior center and is thus distinguished from a MARTA bus. Almost eight percent were driven by a spouse or friend. The 23.5% who chose “other” were residents of Briarcliff Oaks and Antioch Manor Estates, the two senior residence locations within the sample, and they walked to the health fair or presentation.

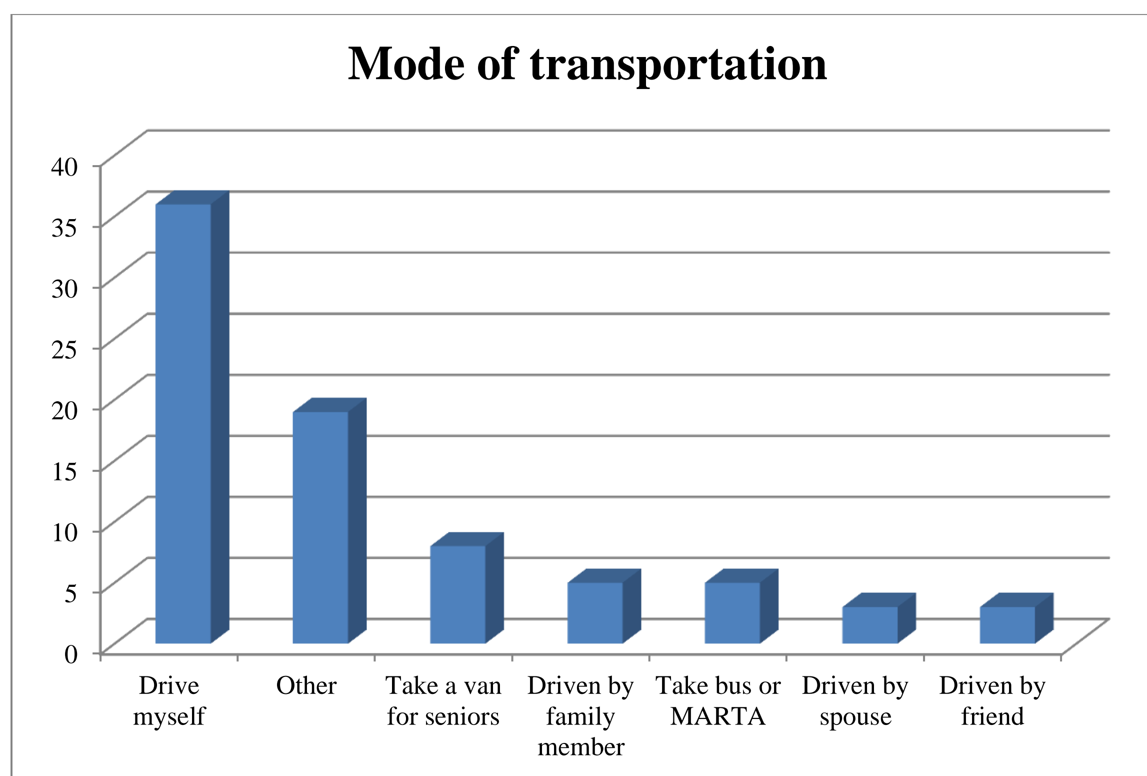

Figure 4.7 Mode of transportation to event

Table 4.1a Participant social & demographic characteristics by location

Characteristics	Fayette Senior Services n=8		Briarcliff Oaks n=10		Lithonia Senior Center n=6		Lou Walker Senior Center n=23		Antioch Manor Estates n=13		Radcliff Presbyterian Church n=15		Pleasant Hill Baptist Church n=4		J. Charley Griswell Senior Center n=2		Total n=81	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Gender																		
Male	4	50%	1	10%	0	0%	2	8.7%	2	15.4%	2	13.3%	2	50%	0	0%	13	16%
Female	4	50%	9	90%	6	100%	21	91.3%	11	84.6%	13	86.7%	2	50%	2	100%	68	84%
Age (Years)																		
40-50	0	0%	0	0%	0	0%	0	0%	0	0%	1	6.7%	0	0%	0	0%	1	1.2%
51-60	1	12.5%	0	0%	0	0%	0	0%	0	0%	0	0%	1	25%	0	0%	2	2.5%
61-70	2	25%	4	40%	2	33.3%	13	56.5	6	46.2%	4	26.7%	3	75%	2	100%	36	44.2%
71-80	1	12.5%	3	30%	4	66.7%	10	43.5%	5	38.4%	8	56.3%	0	0%	0	0%	31	38.1%
81-90	4	50%	3	30%	0	0%	0	0%	2	15.4%	2	13.3%	0	0%	0	0%	11	13.6%
Education (Highest level)																		
Less than high school	0	0%	1	10%	0	0%	0	0%	0	0%	4	26.7%	0	0%	0	0%	5	6.2%
High School/GED	3	37.5%	3	30%	1	16.7%	3	13%	4	30.8%	5	33.1%	1	25%	0	0%	20	24.7%
Some college	0	0%	3	30%	2	33.3%	9	39.1%	4	30.8%	3	20.1%	2	50%	1	50%	24	29.6%
2 Year college degree	0	0%	0	0%	2	33.3%	0	0%	1	7.7%	0	0%	0	0%	0	0%	3	3.7%
4 Year college degree	4	50%	2	20%	1	16.7%	3	13%	3	23.1%	3	20.1%	1	25%	1	50%	18	22.2%
Master's Degree	1	12.5%	0	0%	0	0%	7	30.4%	1	7.7%	0	0%	0	0%	0	0%	9	11.1%
Doctoral Degree	0	0%	1	10%	0	0%	1	4.3%	0	0%	0	0%	0	0%	0	0%	2	2.5%
Partnership Status																		
Married	7	87.5%	0	0%	0	0%	9	39.1%	2	15.4%	2	13.3%	3	75%	0	0%	23	28.4%
Separated	0	0%	0	0%	0	0%	1	4.3%	0	0%	1	6.7%	0	0%	0	0%	2	2.5%
Divorced	0	0%	3	30%	2	33.3%	2	8.7%	6	46.2%	1	6.7%	0	0%	1	50%	15	18.5%
Widowed	1	12.5%	6	60%	2	33.3%	8	34.8%	4	30.8%	10	66.7%	1	25%	0	0%	32	39.5%
Single	0	0%	1	10%	2	33.3%	3	13%	1	7.7%	1	6.7%	0	0%	1	50%	9	11.1%

Table 4.1b Additional participant social & demographic characteristics by location

Characteristics	Fayette Senior Services n=8		Briarcliff Oaks n=10		Lithonia Senior Center n=6		Lou Walker Senior Center n=23		Antioch Manor Estates n=13		Radcliff Presbyterian Church n=15		Pleasant Hill Baptist Church n=4		J. Charley Griswell Senior Center n=2		Total n=81	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Ethnicity																		
Hispanic/Latin American	0	0%	1	10%	0	0%	0	0%	1	7.7%	0	0%	0	0%	0	0%	2	2.5%
Not Hispanic	8	100%	7	70%	3	50%	13	57%	9	69.2%	13	86.7%	1	25%	2	100%	56	69.1%
No answer	0	0%	2	20%	3	50%	10	43%	3	23.1%	2	13.3%	3	75%	0	0%	23	28.4%
Race																		
Black or African American	0	0%	2	20%	6	100%	18	78.3%	13	100%	15	100%	4	100%	2	100%	60	74.1%
White	8	100%	6	60%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	14	17.3%
Asian	0	0%	1	10%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	1	1.2%
Other	0	0%	1	10%	0	0%	2	8.7%	0	0%	0	0%	0	0%	0	0%	4	4.9%
No answer	0	0%	0	0%	0	0%	3	13%	0	0%	0	0%	0	0%	0	0%	2	2.5%
Income																		
$10,000 or less	0	0%	7	70%	1	16.7%	5	21.7%	1	7.7%	8	53.3%	0	0%	0	0%	22	27.2%
$10,000 - $25,000	1	12.5%	3	30%	5	83.3%	6	26.1%	8	61.5%	4	26.7%	0	0%	0	0%	27	33.3%
$25,000 - $50,000	2	25%	0	0%	0	0%	3	13%	2	15.4%	1	6.7%	3	75%	2	100%	13	16%
$50,000 - $100,000	2	25%	0	0%	0	0%	4	17.4%	0	0%	2	13.3%	1	25%	0	0%	9	11.1%
$100,000 or more	1	12.5%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	1	1.2%
No answer	1	12.5%	0	0%	0	0%	5	21.5%	2	15.4%	0	0%	0	0%	0	0%	9	11.1%
Transportation																		
Drive myself	6	75%	0	0%	4	66.7%	13	56.5%	1	7.7%	6	40%	4	100%	2	100%	36	44.4%
Driven by spouse	2	25%	0	0%	2	33.3%	1	4.3%	0	0%	0	0%	0	0%	0	0%	3	3.7%
Driven by family member	0	0%	0	0%	0	0%	4	17.4%	1	7.7%	0	0%	0	0%	0	0%	5	6.2%
Driven by friend	0	0%	0	0%	0	0%	3	13%	0	0%	0	0%	0	0%	0	0%	3	3.7%
Take bus or MARTA	0	0%	0	0%	0	0%	1	4.3%	0	0%	4	26.7%	0	0%	0	0%	5	6.2%
Take a van for seniors	0	0%	0	0%	0	0%	1	4.3%	0	0%	5	33.3%	0	0%	0	0%	8	9.9%
Other	0	0%	10	100%	0	0%	0	0%	9	69.2%	0	0%	0	0%	0	0%	19	23.5%

Initial Introduction to GeorgiaCares

Participants were asked how they heard about GeorgiaCares for the first time (see Figure 4.8). Options included hearing about GeorgiaCares from a friend or family member, from a GeorgiaCares brochure, a newspaper, a Medicare or Medicaid representative, a Medicare brochure, a GeorgiaCares presentation, a senior center, a health fair, or from another source. The last four options also included a space for participants to fill in where they heard the GeorgiaCares presentation or from which senior center or health fair they initially heard about GeorgiaCares. The "other" option also had room for participants to write in a response, if desired.

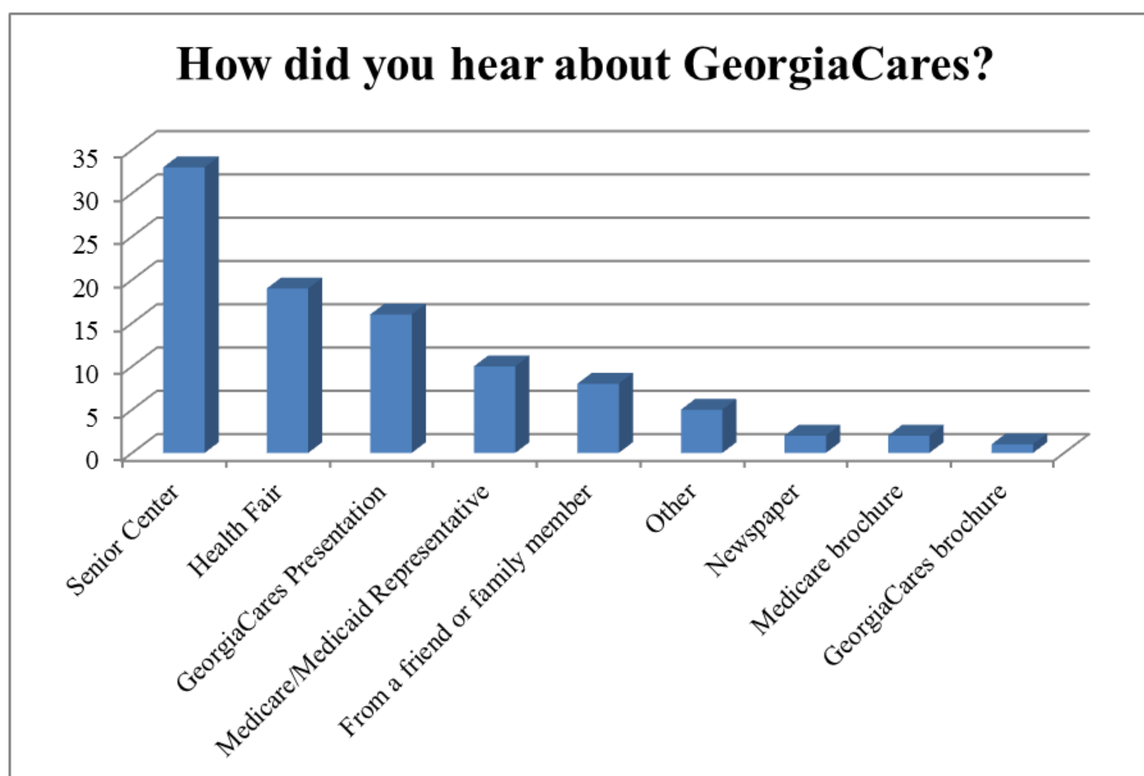

Figure 4.8 First GeorgiaCares encounter

Most of the participants noted that they initially heard of GeorgiaCares at a senior center (41%). This outcome is not surprising as nearly half of the sample (n=39) completed the survey

at a senior center. Nineteen participants stated that they heard about GeorgiaCares from a health fair. The next most common responses included learning from a GeorgiaCares presentation (n=16), a Medicare or Medicaid representative (n=10), or from a friend or family member (n=8). Five participants marked “other” as their response and wrote in the following responses: TV, RSPV, church, and Piedmont Hospital (n=2). The least common responses were from the newspaper (n=2), a Medicare brochure (n=2), or from a GeorgiaCares brochure (n=1). Participants who indicated that they initially heard about GeorgiaCares from a senior center, a health fair, or a presentation, also wrote in the name of the senior center or the facility that hosted the event. Most participants who included this information wrote the name of the senior center or facility where the survey information was being collected. For example, Participant 4 initially heard of GeorgiaCares from Fayette Senior Services and this information was collected at a presentation outreach event at Fayette Senior Services. The one event where this was not the case was at the SPARC health fair event held at the Radcliff Presbyterian Church. Several of the participants had heard of GeorgiaCares from a presentation at the Auburn Neighborhood Senior Center. This scenario is not surprising as many of the health fair attendees at that event were bused to the event from the Auburn Senior Center.

Medicare Knowledge

Several questions were posed to discern the type of attendee and their level of Medicare knowledge. To determine background information, participants were asked if they currently had Medicare and/or Medicare Part D Prescription Drug Coverage. They also were asked if they were caring for a Medicare beneficiary (to determine caregiver status), if they had heard of Extra Help or Medicare Savings Programs, and if they had heard of GeorgiaCares before the event they were attending (see Table 4.2).

Table 4.2 Medicare background & knowledge

Question	Response							
	Yes		No		I don't know		No answer	
	n	%	n	%	n	%	n	%
Do you currently have Medicare?	63	77.8%	16	19.8%	0	0%	2	2.5%
Do you currently have Part D?	43	53.1%	28	34.6%	7	8.6%	3	3.7%
Are you caring for a Medicare beneficiary?	13	16%	64	79%	N/A		4	4.9%
Have you heard of Extra Help?	34	42%	44	54.3%	N/A		3	3.7%
Have you heard of Medicare Savings Plans?	24	29.6%	53	65.4%	N/A		4	4.9%
Did you know about GeorgiaCares before today?	32	39.5%	45	55.6%	N/A		4	4.9%

The majority of respondents (77.8%) answered affirmatively to the question about having Medicare. Approximately 53% of respondents (n= 43) stated that they did have Part D and 8.6% of respondents (n=7) said they did not know if they had Part D. About 56% of respondents had not heard of GeorgiaCares before and 39.5% had heard of GeorgiaCares.

Participants' level of Medicare knowledge was gauged by two dichotomous questions: "Have you heard of Extra Help?," "Have you heard of Medicare Savings Programs?," and the self-assessment, ordinal question, "I understand Medicare," with four responses ranging from "strongly agree" to "strongly disagree." Forty-two percent of participants (n=34) had heard of Extra Help, but the majority, 54.3% (n=44) had not. An even larger percentage of participants had not heard of Medicare Savings Programs (MSP); sixty-five percent of participants (n=53) had not heard of MSP, while almost 30% (n=32) knew of the low-income subsidy programs.

Contrary to the literature that suggests a majority of Medicare beneficiaries and their caregivers do not understand Medicare (Morgan et al., 2008; National Council on Aging, 2011; Piette & Heisler, 2006), the majority (63%) of this sample either strongly agreed or agreed that they understand Medicare (n=51). Figure 4.9 shows a graphic representation of participants' self-assessed Medicare understanding.

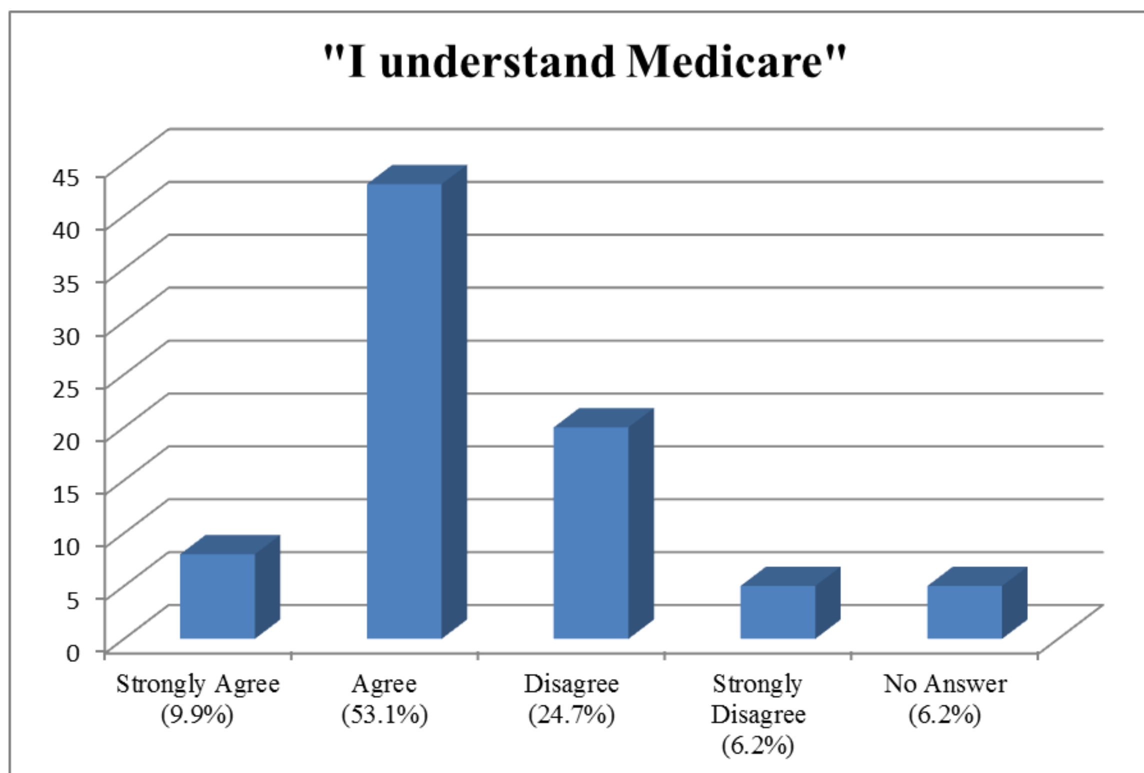

Figure 4.9 Self-assessed Medicare understanding

An analysis using the phi coefficient, which is a correlation coefficient used with nominal data, was performed to determine if there was any significant relationship between knowledge of Extra Help and MSP and a self-assessed understanding of Medicare for those with annual household incomes of $25,000 or less (n=46). This parameter was chosen as both Extra Help and MSP are low-income subsidies that those with incomes over $25,000 would not receive. It is most relevant to this research to determine if those who could potentially qualify for LIS understand Extra Help and MSP and also understand Medicare (see Tables 4.3 and 4.4).

For those with incomes of $25,000 and below, analysis revealed that the phi coefficient for hearing of Extra Help and understanding Medicare was .107 (φ=0.107) with a significance (*p*) of .467, revealing no significance between one's knowledge of Extra Help and understanding of Medicare in this sample. The same analysis was run to determine if there was any significant

relationship between hearing of MSP and understanding Medicare for those with incomes of $25,000 and below. The analysis resulted in a phi coefficient of .313 (φ=0.313) with a significance (*p*) of .034, revealing a significant positive relation between one's knowledge of MSP and understanding of Medicare.

Table 4.3 Heard of Extra Help & understand Medicare

		Understand Medicare		Total
		Strongly Agree & Agree	Strongly Disagree	
Heard of Extra Help	Yes	18	7	25
	No	13	8	21
Total		31	15	46

Phi	Value	Significance
	0.107	0.467

Table 4.4 Heard of Medicare Savings Plans (MSP) & understand Medicare

		Understand Medicare		Total
		Strongly Agree & Agree	Strongly Disagree	
Heard of MSP	Yes	14	2	2
	No	17	13	30
Total		31	15	46

Phi	Value	Significance
	0.313	0.034

Information Preference

Participants were asked how they wished to receive Medicare information from GeorgiaCares (see Figure 4.10). Participants chose the option of "face-to-face at a senior center" most often with 40% (n=32) of the sample reporting this preference. Receiving the information "over the phone" (n=19) and "from a presentation" (n=18) were both close to the second choice of the participants at 23% and 22% respectively. The remaining participants wanted to receive Medicare information "face-to-face at an off-site location" (n=14) or from e-mail (n=11). Seven participants (8.6%) wanted to receive GeorgiaCares Medicare information in the mail.

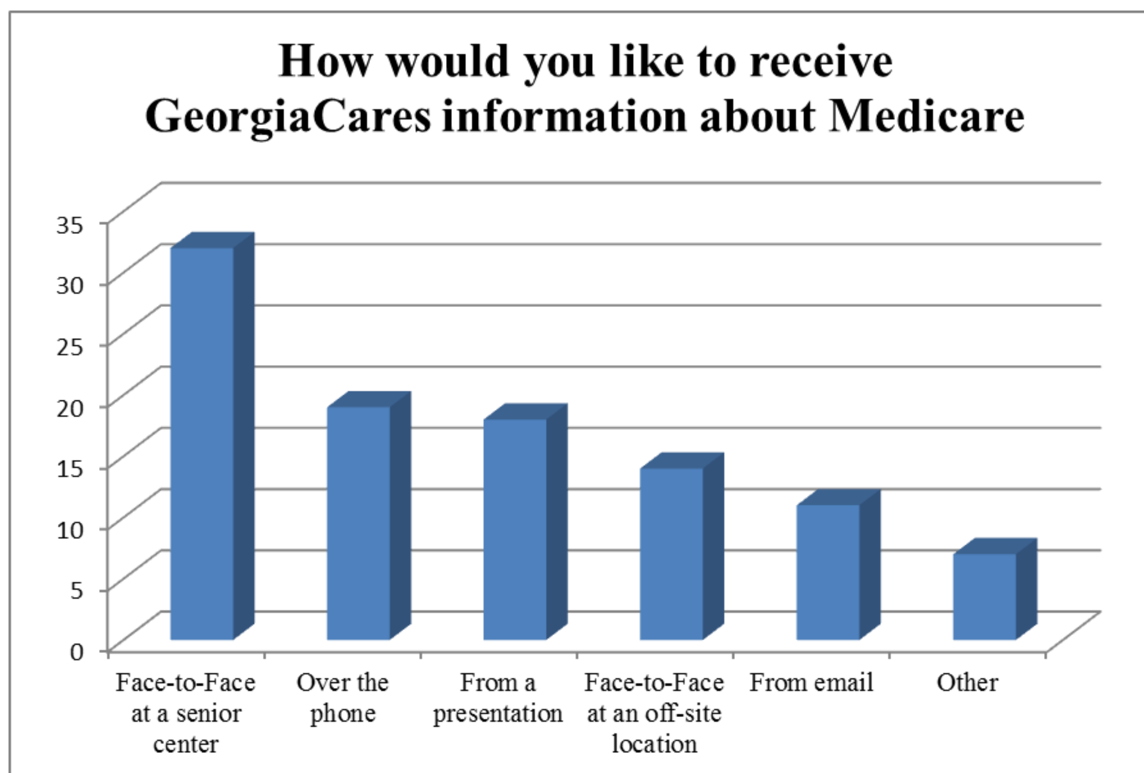

Figure 4.10 GeorgiaCares Medicare information preference

Trust Level

Three questions in the survey attempted to measure participants' trust: "Have you ever been a victim of Medicare fraud?," "Have you ever been a victim of identity theft?," and "If you have been a victim of Medicare fraud or identity theft, has it changed your opinion of people?" See Table 4.5 for a description of these trust-related questions. The majority of respondents had not been victims of Medicare fraud (87.7%) or identity theft (70.4%). After gathering the data, I determined that the third trust question was confusing for the respondents, and consequently, a high percentage of people did not answer the question at all (45.7%). As the question was poorly crafted, it makes it impossible to analyze the data for participants' trust level.

Table 4.5 Participant trust level

Question	Response							
	Yes		No		I don't know		No answer	
	n	%	n	%	n	%	n	%
Victim of Medicare fraud	2	2.5%	71	87.7%	5	6.2%	3	3.7%
Victim of identity theft	19	23.5%	57	70.4%	3	3.7%	2	2.5%
Changed opinion	7	8.6%	29	35.8%	8	9.9%	37	45.7%

Monthly Trips

Participants were asked to check all applicable options of where they go on a monthly basis (see Figure 4.10). Options included: grocery store (n=71), religious service (n=54), pharmacy (n=52), senior center (n=50), restaurant (n=38), gas station (n=37), barber/beauty shop (n=36), doctor's office (n=35), library (n=23), other (n=13), and the laundromat (n=9).

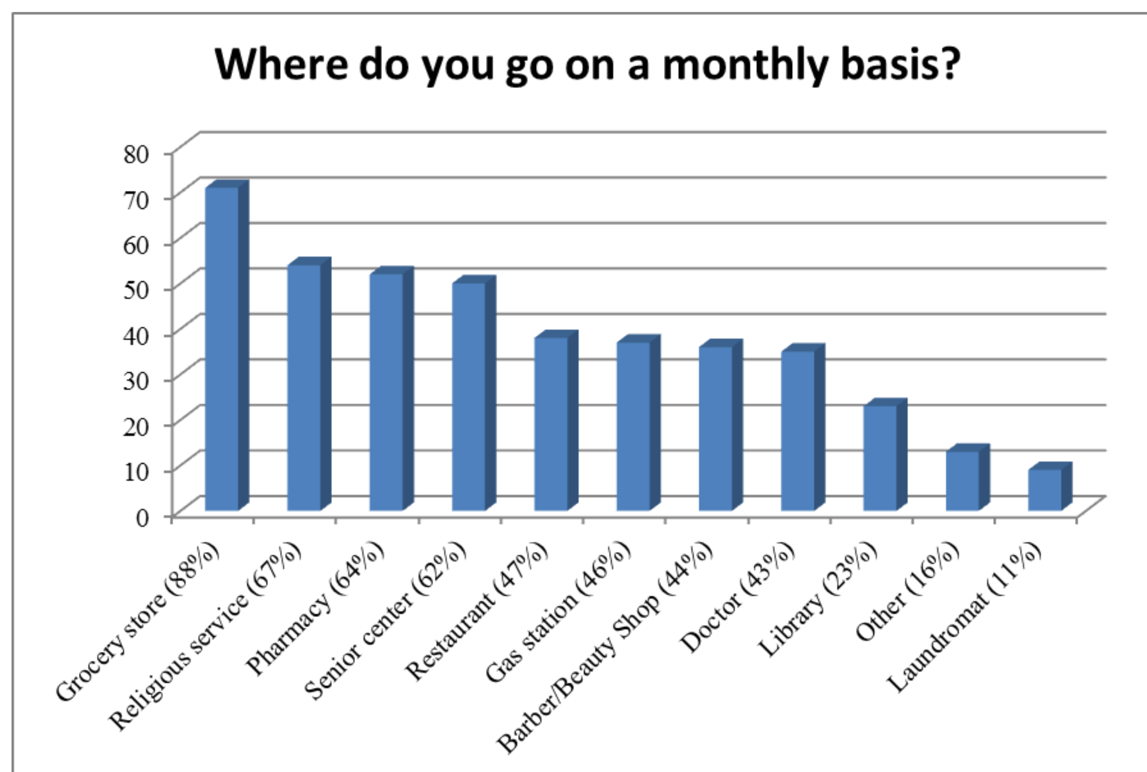

Figure 4.11 Locations frequented

The “other” option included a space for participants to write in a location. These responses included visiting children and grandchildren, trips to Wal-Mart (n=2), Target, thrift stores, the movie theatre (n=2), the bank, the post office, and dialysis.

Qualitative Analysis

The second aim of this research was: *to discover how to best market current GeorgiaCares community outreach events to the community*, which involved understanding how event participants want to receive Medicare information and learning about their suggestions for improving and disseminating Medicare information. Three qualitative questions on the survey were asked to address this second aim. Due to the qualitative nature of the questions, coding through inductive thematic analysis was used. The questions, “How can GeorgiaCares help you better understand Medicare?” “How can GeorgiaCares help you solve your Medicare questions or problems?” and “How can GeorgiaCares improve its services?” were analyzed for major themes and ideas. Thirty people responded to the question of how GeorgiaCares can help people better understand Medicare (37% response rate). Sixteen people responded to the question of how GeorgiaCares can help people solve their Medicare questions or problems (20% response rate) and 10 people responded to the final question asking how GeorgiaCares can improve its services (12% response rate). Three themes emerged throughout the questions: how people want to receive Medicare information, what people need help with or information about, and the idea that the information should be simple and understandable.

Information Preference

Although question 21 of the survey explicitly asked how participants would like to receive GeorgiaCares information about Medicare, many people used the qualitative questions to discuss their information preference. The word “presentations” was written most often, with

eight respondents discussing a desire for more presentations. Participant 75 requested “face to face presentations to a group” and Participant 35 suggested that GeorgiaCares could better help them understand Medicare “by having monthly meetings and presentations at senior centers and local churches.” Several respondents suggested Lou Walker Senior Center as a specific location for a presentation; for example, Participant 33 said, “continue to do presentations at the Lou Walker Senior Center” and Participant 34 echoed the sentiment with “by coming to the Lou Walker Center with presentations.”

Respondents also frequently suggested that senior centers, face-to-face interactions, and the telephone would be beneficial to understanding Medicare. Participant 15 simply stated “talk face to face” when asked how GeorgiaCares could help him/her solve Medicare questions or problems. Participant 32 stated, “I would benefit from a one-on-one interview to make sure I have all I need” and Participant 50 said, “explain to me face to face – one on one.” Participants also wanted answers over the phone; two respondents even requested that GeorgiaCares call them and Participant 14 suggested that a phone line could be available 24 hours a day. Other suggestions included health fairs, sending information in the mail, and using the radio, TV, internet, and workshops to help disseminate Medicare information.

Assistance

Some respondents listed specific topics that GeorgiaCares could help them understand. Several respondents asked for help with different Medicare plans, “drug Rx programs,” “income limits for extra help” and Participant 13 requested “help me with the Obama Health Plan.” Participant 63 said GeorgiaCares should “get the elderly to know what plan they are on.” Also common was a more general plea to “answer my questions” or “explain Medicare.” One suggestion unrelated to Medicare information assistance came from Participant 35. This

participant suggested that GeorgiaCares assist beneficiaries by providing food or snacks at senior centers for those participants who are low-income and may not have enough to eat. While this is a legitimate suggestion, it is unlikely that GeorgiaCares' budget would allow for such an expenditure.

Simple & Understandable

One final theme that appeared within the qualitative data was that of making Medicare simple and understandable through clear explanations. Participant 9 stated that GeorgiaCares could help him/her understand Medicare with a "good explanation" and Participant 14 said to "make more simple and easy to understand." Similarly, Participant 17 requested that GeorgiaCares volunteers and staff "speak in a manner that is understandable."

Several respondents believed that GeorgiaCares was already doing a good job of explaining Medicare and should continue what they have been doing in the past. Participant 4 said that GeorgiaCares should "keep talking and helping," and Participant 50 said that they should "continue to educate people, especially seniors and disabled people." Participant 44 said that GeorgiaCares has "already helped," Participant 9 thought that GeorgiaCares' services already were "very good," and Participant 33 said "I am satisfied now!"

Chapter 5

Discussion & Conclusion

This program evaluation of GeorgiaCares' community outreach events was conducted to determine who attends GeorgiaCares outreach event and how participants want GeorgiaCares to propagate Medicare information. The data can be used to identify and create sustainable community partnerships that will assist GeorgiaCares in disseminating Medicare information throughout the 10-county region. This is the first and only study to focus on who attends GeorgiaCares outreach events; ideally, the quantitative and qualitative nature of this survey offered a comprehensive view of the GeorgiaCares event participant and allowed GeorgiaCares to discover ways to enhance the program. In the following section, I discuss the findings, how they relate to existing research, and their implications for practice and future research.

Aim One

The first aim of this research was to understand the current GeorgiaCares community outreach event participant. This was achieved because event attendees participated in a survey that probed for demographic information, Medicare knowledge, and asked how attendees first heard about GeorgiaCares.

Social & Demographic Characteristics

While the demographic composition of event participants varied significantly based on the event location, the typical participant in this sample was a 71-one year-old, non-Hispanic, African American female. She was likely widowed, obtained a high school degree and attended some college, but did not graduate from college. Her annual household income was likely below $25,000 and she probably drove herself to the event. Although this participant may have been

"typical" for the majority of GeorgiaCares events in this sample, she was not typical at every event, as most of the events were highly segregated.

Participants of five of the nine events in this sample were 100% African American (see Table 4.2 and Figure 4.5). Participants at two of the events were 100% White and the remaining two events were only slightly less racially homogeneous, with approximately 75% of the attendees in this sample identified as African American. In order to determine if this racial stratification is unique to this sample, a brief literature search was conducted to review senior center racial diversity in other research. There is a surprising dearth of research regarding this topic, but a recent 2012 survey looked to find the racial and ethnic diversity of 56 randomly selected senior centers in five New York City boroughs. Centers were considered diverse if at least 60% of the "participant population were identified as having no predominant racial/ethnic group" (Giunta et al., 2012, p. 473). Within this sample, there were 11 racially/ethnically diverse senior centers and 45 non-diverse centers (Giunta et al., 2012, p. 473). A study of three senior centers in Pittsburgh found that 76% of the centers were comprised predominantly of African Americans (Tang, Heo, & Weissman, 2011, p. 116). Taylor-Harris and Zhan focused on a senior center in Atlanta (not a senior center in the present sample) to examine African American seniors' participation in senior centers; the facility was 99% African American (2011, p. 357). Exposing the implications of racial segregation at these events is intriguing and germane to GeorgiaCares, but out of the realm of this particular research aims. Future research should determine the racial and ethnic diversity in Atlanta area senior centers and how this diversity (or lack of) affects GeorgiaCares outreach events.

While it is unfortunate that the survey questions aimed at measuring trust lacked validity and therefore resulted in a very low response rate, it should be noted that the idea of trust, and

distrust, is still very pertinent to this study. As my trust variable failed to measure the level of trust scientifically, I can only suggest anecdotal evidence regarding trust. Several event attendees, including some attendees who did not complete my survey, asked facetiously if Georgia really cared. This was, of course, a play on GeorgiaCares' name. Although these comments were made in good humor, there was certainly an element of truth to the participants' incredulous belief that Georgia might actually care. Do those participants who question whether the state of Georgia cares about their future have less trust? One would assume so, but it is a question to be answered scientifically, not through assumptions. In the future, questions related to trust should be reconfigured to better gauge the participants' actual trust level.

First Encounter

Slightly over 40% of participants stated that their first encounter with GeorgiaCares was at a senior center and 23% of respondents responded that they were first exposed to GeorgiaCares at a health fair. While over 60% of participants indicated that they were introduced to GeorgiaCares at a senior center or health fair, it should be noted that approximately 84% of the surveys were completed at senior centers, health fairs, or a combination of both. A telling indication is that 55% of respondents had not heard of GeorgiaCares before the day of the event. Many participants likely heard of GeorgiaCares the day of the GeorgiaCares outreach event in the sample. For the 32 participants who had heard of GeorgiaCares previously, anecdotal evidence suggests that they learned of GeorgiaCares through a presentation at the senior center they frequent.

Medicare Knowledge

Research suggests that many beneficiaries and their caregivers feel that they do not understand Medicare (Bernstein & Stevens, 1999; Blendon, 1995; Morgan et al., 2008; National

Council on Aging, 2011; Piette & Heisler, 2006). Contrary to the literature, the majority of the respondents in this survey felt confident that they understood Medicare. In fact, over 60% of respondents in this sample either strongly agreed (9.9%) or agreed (53.1%) that they understood Medicare. An analysis of the data showed that of the 32 participants who had heard of GeorgiaCares before the event, 72% of these individuals stated that they understood Medicare. This result suggests that those who have been exposed to GeorgiaCares are more confident in their Medicare knowledge. This is an encouraging finding for GeorgiaCares as it does appear that GeorgiaCares is positively affecting people's understanding of Medicare.

One contradiction, however, appears to be that while the majority of respondents agreed that they understand Medicare, over half had not heard of Extra Help (54%) or Medicare Savings Plans (65%). As Extra Help and Medicare Savings Plans (MSP) are part of the low income subsidies offered by the Centers for Medicare and Medicaid Services (CMS), it is vital that seniors who qualify for these subsidies understand low-income subsidies (LIS) so they are able to make informed Medicare decisions. It is possible that the 27% of seniors in this study with incomes less than $10,000 already receive or at least qualify for LIS. The data show that within this sample, low-income seniors were slightly more knowledgeable about LIS than the average participant. Forty-two percent of all respondents had heard of Extra Help and 30% of respondents had heard of MSP; within the low-income population of this sample, 64% of the respondents had heard of Extra Help and 36% had heard of MSP. It is possible that the participants knew of these programs, but did not know the programs by their formal names. It is important for GeorgiaCares to determine if these potentially LIS-eligible beneficiaries know of the programs but are not aware of their names, or if they lack knowledge of their existence, as they are the very population that should be educated about LIS.

Aim Two

The second aim of this research was: *to discover how to best market current GeorgiaCares community outreach events to the community*, which involved learning how event participants want to receive Medicare information and identifying their suggestions for improving and disseminating Medicare information.

Information Preferences

Participants overwhelmingly (40%) prefer to receive GeorgiaCares' Medicare information face-to-face at a senior center. As stated earlier, this finding could be related to the fact that almost half of the sample received the survey at a senior center. The next two most preferred ways to receive information were over the phone and from a presentation. Anecdotal evidence suggests that participants of these events liked being able to speak with a representative one-on-one about specific Medicare-related questions. At both of the events held at senior residences, participants brought paperwork to the GeorgiaCares representative to gain guidance or information. These participants particularly enjoyed the ability to speak with a representative in person.

Twenty percent of the sample wanted to receive Medicare information via email or mail. Almost all of the Medicare literature that GeorgiaCares provides to interested parties is written and distributed by CMS; several research articles have explored the effectiveness of CMS Medicare informational materials. One such study found that the "longer and more detailed [Medicare & You] handbook was not viewed as being more useful than the shorter bulletin" (McCormack, Garfinkel, Hibbard, Kilpatrick, & Kalsbeek, 2001, p. 45). The authors concluded that "beneficiaries are simply being saturated with information, and that more information has been not necessarily better (McCormack et al., 2001, p. 45). A similar study in Kansas City

found that “Medicare information materials had a positive effect on beneficiary knowledge” but that “absolute gain in knowledge, even for the most detailed materials, appears to be modest” (McCormack et al., 2002, p. 60). GeorgiaCares should be aware that while distributing the CMS Medicare materials may be helpful to some beneficiaries, it is also important to continue to supplement the written information with other sources of information. McCormack and colleagues (2001) concur, stating “the more exposure beneficiaries had to other sources of information, the more useful they found the [Medicare] materials (p. 43). Other sources of information (for example: face-to-face consultations and presentations) are especially vital for those beneficiaries with lower education attainment and reading skills. McCormack and colleagues (2002) state:

> Vulnerable populations – including low-income persons, non-Whites, women, and those without supplemental insurance – who, compared with the less vulnerable, did not gain as much from the new information. Simplifications to the handbook [Medicare & You] and/or alternative transmission strategies to reach these populations should be considered to address this limitation (p. 61).

A 2005 article echoes this sentiment, saying “people whose habits do not include frequent reading, other ways of disseminating information may be more effective. Such possibilities could include a variety of oral communication methods such as broadcasts, workshops, or one-on-one tutorial sessions” (Bayen, McCormack, & Bann, 2005, p. 677).

Marketing Suggestions

The open-ended questions at the end of the survey probed for participant suggestions on how GeorgiaCares could best market its services within the community. It is clear that many people still are unaware of GeorgiaCares’ existence; even 55% of this sample had not heard of

GeorgiaCares previously. Indeed, SHIPs are still widely unknown. McCormack and colleagues (2001) state that:

> The majority of beneficiaries were not aware of State-and federally-funded health insurance counseling services, known collectively as State Health Insurance Assistance Programs, that provide free and unbiased information and counseling about Medicare to beneficiaries and their families. However, about 60 percent of beneficiaries said they would use this type of service if it existed. This supports earlier research indicating that these programs are underutilized, need to perform more outreach, and require additional funding (p. 40).

Hensley's 2011 study of the roles of community partners in helping mentally ill, dual-eligible beneficiaries understand Part D plans found that none of the persons in her study had ever heard of their state SHIP or received any information from the SHIP.

Unfortunately, there were very few responses from survey participants suggesting ways that GeorgiaCares can market itself. Participant 35 suggested that GeorgiaCares provide food at some of the presentation events at senior centers as both a way to draw in more interested beneficiaries and to benefit low-income seniors. Participant 21 proposed that GeorgiaCares advertise on TV. While this suggestion may be cost prohibitive for GeorgiaCares, it is an intriguing one as adults over the age of 65 watch three times as much TV as younger adults (Depp, Schkade, Thompson, & Jeste, 2010). Not only do older adults watch more TV, according to Brown and colleagues, 75% of older adults state that television is their top source of information (Brown, Prisuta, Jacobs, & Campbell, 2004, p. 88).

An intriguing finding from the data was that while the median age of the survey participants was 71 years old, the most common age was 64 years. This is both interesting and

pertinent information for GeorgiaCares as the eligibility age for Medicare at 65; those who are 64 years old are likely considering their future Medicare options and need information regarding their imminent health care insurance changes. GeorgiaCares attempts to reach older adults with Medicare information before they make Medicare choices that could affect them negatively in the future. For example, a beneficiary could opt not to enroll in Medicare Part B, but, if the beneficiary chooses to enroll in Part B at a later date, she is penalized 10% of the premium for each year that she could have been enrolled in Part B and was not. This penalty endures for the life of the beneficiary. GeorgiaCares should consider holding an informational session or presentation for older adults who are about to turn 65; the survey data in this study suggests that many adults of this age are already attending presentations. An outreach event tailored to the specific needs of adults who are about to be Medicare eligible could be very beneficial to this particular population.

Service Improvement

Only 12% of the survey participants responded to the final open-ended question which asked what GeorgiaCares could do to improve its services. Some of these responses were mentioned earlier, like using the TV to disperse Medicare information and supplying food at senior centers. A few of the responses were encouragements to continue the outreach that GeorgiaCares already engages in; Participant 4 said for GeorgiaCares to "keep talking to people" and Participant 50 said to "continue to educate people." Further suggestions for marketing and service improvement will be discussed in conjunction with community partnerships.

GeorgiaCares & Community Partnerships

The literature reviewed in the introductory chapters suggests that community partnership creates a way to engage both people and organizations in the "common purpose of addressing

community-determined issues of health and well-being" (Roussos & Fawcett, 2000, p. 394). Creating community partnerships is appropriate for GeorgiaCares as studies have shown that when Medicare beneficiaries receive assistance from community partners, they are likely to enroll in the lowest-cost plans, reduce out-of-pocket expenses, and be identified as eligible for the low-income-subsidy benefit (Cutler et al., 2011). If partnerships are important for GeorgiaCares to reach more Medicare beneficiaries, what are some practical suggestions from the literature reflective of this research sample?

As discussed previously, lack of trust is a major barrier for health-related and government organizations and GeorgiaCares is not impervious to this obstacle. The idea that building relationships in the community in turn builds trust and this is a common theme in the literature (Moreno-John et al., 2004). The fact that GeorgiaCares has been in existence since 1992 is a testament to its commitment to the Atlanta metro area. However, SHIPs are still relatively unknown, as evidenced by both this sample and other research (McCormack et al., 2001). GeorgiaCares must focus on building trust within the community to continue to forage through barriers of suspicion and distrust. This practice emulates the findings of existing research (Arean et al., 2003; Gilliss et al., 2001; Gonzalez et al., 2007; Greaney et al., 2006; McHenry et al., 2012) which suggests that community outreach events facilitate face-to-face interaction and are an effective way to gain trust. Many GeorgiaCares outreach event participants indicated that they preferred receiving Medicare information through face-to-face interactions and not only will these events continue to educate the participants, they seemingly will continue to build the trust necessary to maintain and attract more beneficiaries to the program.

The literature also suggests that forming a partnership with a church may also be a beneficial way to form trust within the community (Kaplan et al., 2009; Parrill & Kennedy,

2011).Fifty-four participants, or approximately 67% of the sample population, stated that they go to a religious service at least on a monthly basis. GeorgiaCares is already utilizing churches as a platform to disseminate Medicare information; this is evidenced by the fact that two of the nine outreach events in this survey were held in a church. GeorgiaCares should continue to hold outreach events in metro area churches to reach Medicare beneficiaries. Samuels (2011) encouraged the African American church to continue to serve as a conduit of health education, saying, "until the time comes that the underserved aged can obviate the need for assistance, the African American church must play a vital role in providing health services" (p. 131). Unfortunately, holding periodic health fairs and presentations at a church is unlikely to be enough to maintain community relationships. Just as building trust takes time, creating long-lasting relationships with churches will likely take more time and effort than just a single interaction. Creating a relationship with churches can start in two ways: with the church leaders and with the church members. Vertical outreach to church leaders, especially pastors, lends instant credibility and GeorgiaCares should pursue relationships with pastors to gain access to church attendees (Chatters et al., 1998, p. 693; Markens et al., 2002). Horizontal outreach to willing church members also plays an important part in expressing GeorgiaCares' mission of educating beneficiaries. One question on the survey asked if the participant was a member of a group that would potentially be interested in receiving a presentation from GeorgiaCares. Twenty-five percent of respondents said that they would like GeorgiaCares to give a Medicare presentation to their group. Since the majority of this sample attends church on a regular basis, then it is likely that church attendees would be agreeable to a presentation at a church function or group activity. Whether through the pastor or the congregants, forming a relationship with

churches is an effective and achievable way for GeorgiaCares to reach more beneficiaries about Medicare.

The Centers for Medicare and Medicaid Services fund much of GeorgiaCares and therefore dictates the scope of GeorgiaCares' activities. While CMS restrictions may limit the amount that partners can be involved in the planning process of GeorgiaCares events, the research suggests that it is still important for the partners to be part of the plan (Roussos & Fawcett, 2000). Including partners in GeorgiaCares' outreach event planning and decision-making process allows the partners to be more intimately involved than they would be by just hosting the events. Currently, GeorgiaCares presentations are created by volunteers and staff members. Community partners could work with GeorgiaCares to create a more comprehensive education curriculum, based on the needs and background of the population, including a workshop series which would be more involved than single presentations. Beck and colleagues suggest that community-based curriculum emphasizes the importance of the community partner's involvement of the curriculum development, and creates a "more lasting value to the community than one-time presenters by experts" (2007, p.33).

Influential community leaders instill credibility into organizations and GeorgiaCares must find leaders with whom to partner. Research suggests that gaining the trust of respected community leaders "acts as a stamp of approval" (Choi & Smith, 2004, p. 100) and is an important component in the success of a program (Byalin & Harawitz, 1988). As mentioned earlier, pastors can play this role for GeorgiaCares, but volunteers are also capable of acting in this capacity. One GeorgiaCares' volunteer is a social worker who travels to different senior centers. In addition to her paid duties as a social worker, she also gives Medicare presentations to participants at the senior centers she visits. Two survey respondents specifically identified this

social worker as a trusted source of information and suggested that she continue to present Medicare information at senior centers. It is clear that she is a trusted, influential leader for some of the senior center participants and her continued support and work with GeorgiaCares is important. Other volunteers may have the same influence and it is in GeorgiaCares' best interest to maintain and nurture relationships with these volunteers.

Recommendations

There are several specific community partnerships recommendations for GeorgiaCares based on the respondents' monthly visit survey results. Grocery stores were the number one location participants frequented on a monthly basis. Several chain grocery stores offer senior discounts: Kroger provides a 10% discount, Publix offers a 5% discount, and Food Lion offers a 6% discount (Smidt, 2011). Atlanta is also home to several discount grocery stores, like Sav-A-Lot and ALDI, which do not offer additional senior discounts, but may be frequented by limited-income seniors. GeorgiaCares should consider a partnership with grocery stores and set-up an information table staffed by a volunteer. The volunteer would be available on a specific day every week (possibly on the senior discount day for those stores that offer it) and would provide Medicare counseling and provide information. Price Chopper supermarkets, located in New York, partnered with Senior Services of Albany to provide discounts and programs to senior citizens in the area. The grocery chain promoted a "senior night" at one of its local stores and offered program information, health screenings, and product giveaways and almost 1,000 people attended the event (Angrisani, 2004). The Price Chopper/Senior Services of Albany partnership is a perfect example of how GeorgiaCares could effectively reach a large group of Medicare beneficiaries by partnering with a grocery store.

After grocery stores and religious services, pharmacies were the third most frequently visited location by participants and partnering with pharmacies could be a very effective way to reach Medicare beneficiaries. Ninety-one percent of adults 57 to 85 years of age regularly take at least one medication and 41% of seniors reported taking five or more medications (Qato et al., 2008, p. 2872; Wilson et al., 2007, p. 6). Not only do many Medicare beneficiaries have regular contact with pharmacies, pharmacists are ranked "among the most ethical, honest, and trusted professionals and remain the most accessible to the public" (Rosenfeld, Etkind, Grasso, Adams, & Rothholz, 2011, p. 440). In addition to pharmacists' seemingly inherent ability to break through the barriers of distrust, pharmacists may also be able to assist beneficiaries by educating them about LIS. A 2011 study aimed at reducing prescription drug costs found that "when vulnerable Medicare beneficiaries receive assistance from pharmacists and trained pharmacy students, they are likely to enroll in the lowest-cost plans reduce expected [out of pocket] costs, and can be identified as eligible for the LIS benefit" (Cutler et al., 2011, p. 347).

Partnering with pharmacies is possible in two ways: the first is to contact pharmacies, especially those located within areas with a high density of seniors, and create a relationship with the pharmacists and pharmacy technicians. When seniors have questions about Medicare and part D plans, the pharmacy staff will encourage the beneficiaries to contact GeorgiaCares for assistance. The second way GeorgiaCares could partner with pharmacies is to train pharmacists and pharmacy technicians as volunteers so they are properly educated about Medicare. Instead of only referring customers to GeorgiaCares, these trained volunteers would council beneficiaries directly. According to research by Melissa Hensley (2011), pharmacists are already frequently helping beneficiaries with plan selection and enrollment processes. One participant expressed to

Hensley that “a pharmacy employee had gone out of her way to assist him to enroll in the state pharmaceutical assistance program” (2011, p. 264).

Strengths & Limitations

This research adds to the understanding of Medicare beneficiaries GeorgiaCares’ target population in the Atlanta metro area. Before this study, the characteristics and preferences of GeorgiaCares outreach event participants were unknown. The information gathered from the survey expands the knowledge of Atlanta metro-area GeorgiaCares outreach event participants and is an important step in creating a meaningful portrait of Medicare beneficiaries and how to best reach them with accurate and appropriate Medicare information.

Despite the study’s strengths, there were several limitations; it should not be expected that this evaluation can be generalized to other GeorgiaCares SHIPs within the state or national SHIPs. Due to the monetary and time constraints on my GeorgiaCares community outreach events study, I used a non-experimental design. It was not possible for me to survey every GeorgiaCares community outreach event participant at every outreach event in the 10-county GeorgiaCares region, so my design did not include random assignment. For this reason, it is likely that my convenience sample suffered from biases, as convenience samples can create an underrepresentation or overrepresentation of particular groups of people within the sample. Additionally, the small sample size (n=81) of this research in relation to the number of Medicare eligible residents in the ten-county region, could easily misrepresent the “typical” GeorgiaCares event participant and his/her Medicare information preferences. It is also important to recognize that the study sample was comprised of older adults who agreed to participate in the study and may therefore be healthier and more educated than the average Medicare beneficiary.

Future Directions

This research represents the first study of GeorgiaCares clients and outreach event participants. While this was a small study, it could be the beginning of much more exhaustive research to uncover how different types of people best understand Medicare information. Community outreach events, especially in conjunction with strategic community alliances, can be particularly effective in reaching beneficiaries, but only with a deeper understanding of GeorgiaCares' client base will GeorgiaCares be able to break through some of the demographic and social barriers.

The other 12 GeorgiaCares SHIPs throughout the state should also take the initiative to learn their client base as there is certainly regional differences that will affect participant preferences. On an even grander scope, a national evaluation of SHIPs and Medicare beneficiaries would allow for changes on a macro level that could have large ramifications in the quality of service provided by SHIP programs. It has been suggested that informed beneficiaries make better Medicare decisions (Summer et al., 2010). Why not create national partnerships to reach even more older adults and create a well-informed, healthier group of Medicare beneficiaries? The need for a more educated Medicare beneficiary is evident, but only additional research, on a larger state and national level, will truly tell what beneficiaries and their caregivers need to be informed.

Conclusion

GeorgiaCares is a reliable resource and provider of free, unbiased Medicare information in an environment where such information is often tied to a sales pitch or a political scare tactic. Challenges to understanding Medicare abound, not least of which is a fundamentally complex and ever-evolving Medicare system that necessitates GeorgiaCares' staff and volunteers to

remain vigilant in maintaining and refreshing their Medicare knowledge. Yet, despite the challenges, GeorgiaCares remains a resource of clear and impartial Medicare information. Given the strained economic resources, charged political environment, and continuously evolving insurance regulations that permeate this current time, GeorgiaCares faces an enormous challenge to effectively educate a rapidly aging population about the complexities of Medicare. Outreach events are a practical and effective way to continue reaching the Atlanta-metro population and even greater number of beneficiaries could be educated about Medicare through community partnerships forged with GeorgiaCares.

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Appendices

Appendix A: GeorgiaCares Questionnaire

GeorgiaCares Questionnaire

1. **Sex** (*circle*): Male Female

2. **Age**: ______________

3. **Home Zip Code:** ______________

4. **Partnership Status** (*check* ***one***):

☐ Married
☐ Separated
☐ Divorced
☐ Widowed
☐ Single
☐ Co-habitating (living with a partner)

5. **Highest level of education you have completed** (*check* ***one***):

☐ Less than high school
☐ High school/GED
☐ Some college
☐ 2 Year college degree
☐ 4 Year college degree
☐ Master's degree
☐ Doctoral degree
☐ Professional degree

6. **Category that best describes your ethnicity or ethnic origin** (*check* ***one***):

☐ Hispanic or Latin American
☐ Not Hispanic
☐ I do not wish to answer

7. **Category that best describes your racial background** (*check* ***all that apply***):

☐ Black or African American
☐ White
☐ American Indian
☐ I do not wish to answer
☐ Native Hawaiian
☐ Asian
☐ Other: _________________

7. Current household income level ($/year)? (*circle **one***):

10,000 or less	10,000 to 25,000	25,000 to 50,000	50,000 to 100,000	100,000 or more

8. How did you get here today? (*check **all that apply***):

- ☐ Drive myself
- ☐ Driven by spouse
- ☐ Driven by family member
- ☐ Driven by friend
- ☐ Take the bus and/or MARTA
- ☐ Take a transportation van for seniors
- ☐ Take a taxicab
- ☐ Other (please specify): ________________

9. How did you hear about GeorgiaCares? (*check **all that apply***):

- ☐ From a friend or family member
- ☐ GeorgiaCares brochure
- ☐ Newspaper
- ☐ Medicare/Medicaid Representative
- ☐ Medicare brochure
- ☐ Other *Where?*___________________
- ☐ GeorgiaCares Presentation *Where?* ___________________________
- ☐ Senior center *Where?* ___________________________
- ☐ Health fair *Where?* ___________________________

10. Do you currently have Medicare? (*circle **one***):

Yes No I don't know

11. Do you currently have Medicare Part D Prescription Drug Coverage? (*circle **one***):

Yes No I don't know

12. Are you caring for someone who receives Medicare benefits? (*circle **one***):

Yes No

13. Have you heard of Extra Help? (*circle **one***):

Yes No

14. Have you heard of Medicare Savings Programs? (*circle **one***):
Yes No

15. Did you know about GeorgiaCares before today? (*circle **one***):
Yes No

16. Have you ever been a victim of Medicare fraud? (*circle **one***):
Yes No I don't know

17. Have you ever been a victim of identity theft? (*circle **one***):
Yes No I don't know

18. If you have been a victim of Medicare fraud or identity theft, has it changed your opinion of people? (*check **one**):*
Yes No I don't know

19. How much to you agree or disagree with the following statement (*check **one**):*

"I understand Medicare."

Strongly Agree	Agree	Disagree	Strongly Disagree
☐	☐	☐	☐

20. Do you belong to a group who would like to have GeorgiaCares give a presentation and answer questions about Medicare? (*circle **one***):
Yes No

If Yes, please take a card and include your contact information so GeorgiaCares can contact you about scheduling a presentation time.

21. If available, how would you like to receive GeorgiaCares information about Medicare?
(*check* ***<u>all that apply</u>***):

☐ Over the phone
☐ Face-to-Face at a Senior Center
☐ Face-to-Face at an off-site location
☐ From e-mail
☐ From a presentation
☐ Other
How? ____________________

22. Where do you go on a monthly basis? (*check* ***<u>all that apply</u>***):

☐ Grocery Store
☐ Convenience Store/Gas Station
☐ Religious Service
☐ Senior Center
☐ Laundromat
☐ Other
Where? ____________________
☐ Doctor
☐ Library
☐ Restaurant
☐ Pharmacy
☐ Barber Shop/Beauty Shop/Hair Salon

23. How can GeorgiaCares help you better understand Medicare?

____

____

____

____

____

24. How can GeorgiaCares help you solve your Medicare questions or problems?

____

____

____

____

____

25. How can GeorgiaCares improve its services?

____

____

____

____

____

Thank you for taking part in this study. Please give the questionnaire to the GeorgiaCares representative.

Appendix B: Waiver of Documentation of Consent

Georgia State University
Gerontology Institute
WAIVER OF DOCUMENTATION OF CONSENT

Title: GeorgiaCares Community Outreach Events: An Evaluation
Principal Investigator: Dr. Candace Kemp
Student Investigator: Erin Fisher

I. Purpose:

You are invited to take part in a research study. This study will look at whether GeorgiaCares does a good job explaining Medicare at community events. The purpose of the study is to try to find out how people know about GeorgiaCares. We also want to know how GeorgiaCares can make it easier to tell people about Medicare. We will collect some basic facts about you and ask some questions about how you feel about Medicare and GeorgiaCares. You are invited to take this survey because you get Medicare benefits or because you are a caregiver. A total of 100 people will be asked to take this study. This study will take about fifteen minutes of your time.

II. Procedures:

If you decide to take part, you will be asked to fill out one survey. This survey can be filled out at your own speed. It will take about fifteen minutes to fill out. Once you finish the survey, you can give it to the GeorgiaCares person who gave you the form or place it in the box labeled "GSU study."

III. Risks:

In this study, you will not have any more risks than you would in a normal day of life.

IV. Benefits:

Participation in this study may not benefit you personally. We hope learn how GeorgiaCares can do a better job telling people about Medicare.

V. Voluntary Participation and Withdrawal:

Participation in this research is voluntary. You do not have to be in this study. If you decide to be in the study and change your mind, you can quit. You can skip questions or quit at any time.

VI. Confidentiality:

This is an anonymous survey. Your name will not be on any of the forms. Erin Fisher and her thesis committee will have access to the information you provide. That information may also be shared with those who make sure the study is done correctly (GSU Institutional Review Board, the Office for Human Research Protection). Your name will not be identified with your survey. The information you provide will be stored in a locked cabinet in a locked office. No facts that

might point to you will not appear when we present this study or publish its results. The findings will be summarized and reported in group form.

VII. Contact Persons:

If you have questions about this study, you may contact Dr. Candace Kemp at (404) 413-5216 / ckemp@gsu.edu or Erin Fisher at (404) 413-5214 / efisher6@student.gsu.edu.
If you have questions or concerns about your rights as a participant in this study, you may contact Susan Vogtner in the Office of Research Integrity at (404)413-3513 / svogtner1@gsu.edu.

VIII. Copy of Consent Form to Subject:

You may keep this consent form.

If you agree to join in this research, please continue with the survey.

Appendix C: Participant Home Zip Codes

Participant Home Zip Codes

Zip Code	Frequency	County
30017	1	Gwinnett
30032	1	DeKalb
30034	1	DeKalb
30035	1	DeKalb
30038	1	DeKalb
30039	1	Gwinnett
30043	1	Gwinnett
30045	1	Gwinnett
30058	11	DeKalb
30083	1	DeKalb
30087	1	DeKalb
30088	18	DeKalb
30094	1	Rockdale
30215	2	Fayette
30236	1	Clayton
30238	1	Clayton
30269	6	Fayette
30294	1	Henry
30308	2	Fulton
30311	2	Fulton
30312	6	Fulton
30313	1	Fulton
30314	2	Fulton
30315	1	Fulton
30318	1	Fulton
30329	10	DeKalb
30331	1	Fulton
30519	1	Gwinnett
45417	1	Montgomery, OH