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HCFA MARKET RESEARCH FOR BENEFICIARIES

SECOND INVENTORY REPORT

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EXECUTIVE SUMMARY

As part of its strategic plan, the Health Care Financing Administration (HCFA) has undertaken an Agency-wide initiative to adapt its operations and communication strategies to better serve its customers and partners. A goal of this initiative is for HCFA to improve communications with Medicare beneficiaries, as well as with provider partners. By providing information about Medicare in formats that are easily understandable by beneficiaries, HCFA can assist them in making appropriate choices among healthcare delivery systems, providers, and treatment options, and in using the Medicare program effectively. Because HCFA is responsible for assuring healthcare security for all customer groups, it must tailor information on Medicare to the needs of beneficiaries. To that end, HCFA has identified a diverse set of subpopulations that it believes may have special information needs regarding the Medicare program.

The aim of this Second Inventory Report is to identify the specific information about Medicare that "hard to reach" and other groups of beneficiaries want and need, and the best communication strategies to use with each of the groups. The First Inventory Report provides evidence of the information needs of the general Medicare population, whereas this Second Inventory Report builds on the previous report and provides an in-depth look at the needs of five groups of Medicare beneficiaries. Subsequent reports will cover the needs of other groups. The five groups discussed in this report include:

- African Americans,
- Hispanic Americans,
- Dual eligibles (Medicare and Medicaid),
- Beneficiaries living in rural locations, and
- Those about to enroll in Medicare.

It is beyond the scope of this work to fully cover all that is known about these groups, however, this report examines the variations in socioeconomic status, health status, and family networks that interact with age to produce varying needs for information from HCFA about Medicare. The following two questions are the focus of the market research:

- **What information do beneficiaries want and need from HCFA?**
- **How can that information be most effectively made available?**

The market research project will provide HCFA with an understanding of the needs of different groups of Medicare beneficiaries by synthesizing data from three sources: (1) an inventory of perceived information needs and effective communication strategies from a variety of organizations, (2) focus groups with Medicare beneficiaries, and (3) surveys of the Medicare population. The data collection strategies are complementary, and will provide HCFA with a more thorough understanding of how to communicate more effectively with various beneficiary groups.

Inventory Component

The inventory component is important in that it provides HCFA with a global picture of current and emerging methods and strategies for both determining information needs and disseminating material on both the Medicare program and health, in general, to beneficiaries. There are two major components of the inventory: a review of current research literature, and a series of interviews with key individuals in organizations that have experience with understanding Medicare beneficiaries' information needs, as well as implementing a variety of communication strategies.

We interviewed more than 45 individuals and/or organizations to learn about the information needs of Medicare beneficiaries from the various subpopulations. We also queried respondents on the characteristics of both effective and ineffective communication strategies they had used to reach each group. We interviewed multiple individuals at two large Federal agencies to identify communication strategies that might be directly relevant to HCFA. Finally, we interviewed community organizations, including local Medicare advocacy programs, social service agencies, multipurpose senior centers, a local housing authority with social service staff onsite, Medicare carriers and managed care plans. Interviews were conducted in and around Washington DC and in targeted cities, chosen because of their differing geographic regions and large ethnic minority or rural Medicare populations, including Los Angeles, San Diego, Memphis, Miami, and New York.

In the First Inventory Report, we found that Medicare beneficiaries want information that is ***timely, relevant***, and presented in a way that is ***easily comprehended*** and within the context of individuals' personal circumstances.

Following is a synthesis of our findings on beneficiary information needs, the processes used by organizations to discover them, and "best practices" for communicating information on Medicare and staying healthy to "hard to reach" groups of elderly. Some of the second inventory findings apply to all of the groups considered in this report, whereas other findings are particularly relevant to specific groups.

Cross-Cutting Inventory Findings

In this section we present findings that relate to four of the five groups, followed by our findings on the information needs of the about-to-enroll beneficiary. African Americans, Hispanic Americans, dual eligibles (Medicare and Medicaid), and beneficiaries living in rural locations are similar in at least five important ways:

- Each group has traditionally experienced barriers to the healthcare system and are generally considered to be "vulnerable" and/or "underserved";
- Members of these groups are more likely to be uninsured than members of the majority population;
- A disproportionately high number of individuals within each of these groups has little or no formal education or low literacy;

- A disproportionate number of these groups are among the lowest socioeconomic stratum; and
- Each group has a unique profile of chronic conditions that are more prevalent in the subgroup than in the majority population of Medicare beneficiaries.

Three major issues emerged as being important across the four groups.

- In general, we found that for the vulnerable groups of beneficiaries considered in this report, ethnic minority and other groups did not so much need different information on Medicare than the general population, but they needed it to be **presented differently** from the way it is presented to majority group beneficiaries. For example, low levels of literacy preclude many of these individuals from being able to read HCFA materials, such as *Your Medicare Handbook.* Communication delivery methods in addition to mailed written materials will be important with these groups, especially targeted media (such as cable television programming) and interpersonal delivery through community-based organizations. The implications for HCFA of this finding are:
  - Information should be delivered in innovative ways, through multiple channels simultaneously, and in places that seniors typically frequent, such as through information kiosks placed in pharmacies and banks, through beauty parlors, or through individuals seniors see regularly, such as the "Avon lady".
  - Printed information should be clear, concise, and illustrated with pictures wherever possible. One provider puts pictures of the sun on medications her patients are to take in the morning, and the moon on the ones to be taken at night because her patients cannot read.
  - Materials written in Spanish should be written in "textbook Spanish" and should avoid idiomatic expressions and "street Spanish," which can be culture-specific. Direct translations from English to Spanish often do not make sense. For example, the translation of the Cuban phrase for "he died" into English is "he stretched out his leg."
  - Use concrete examples to illustrate abstract points. For example, to explain the "deductible," a rural provider tells patients: "First, you pay $100 out of your pocket before Medicare pays anything, then after that, you pay $20 and Medicare pays $80 of every $100."

- A second theme that we heard across groups and in each geographic area is that healthcare is embedded among a myriad of other social services, and that often beneficiaries consider these other services to be more important than Medicare (for example, housing). In many communities, there exist well developed networks of state, local, and community organizations providing different services to seniors. This finding has two implications for HCFA:
  - In order to raise public awareness of HCFA as a resource, subgroup beneficiaries with questions about Medicare might be provided with additional types of information on social services or programs, or specific information on how to obtain the answers to their peripheral questions;

- ◊ HCFA might consider providing information on Medicare not only through its healthcare partners, but also through partnerships with non-healthcare oriented organizations, such as state welfare offices, county and community-level social service workers (in programs such as Meals-on-Wheels, congregate meal programs, senior centers or onsite in subsidized housing), and private social service programs (such as those provided by the United Way).

- ♦ A third theme is that many ethnic minority individuals do not trust government, either because they emigrated from a country where government was totalitarian and oppressive, or because they have a history of facing racism and being disappointed by government programs that either fail, or are cut, or do not meet their needs. Because of this mistrust, it will be important for HCFA to partner with community leaders and organizations respected by the particular group, supplying partners with the resources to educate and train individuals within the community about HCFA's message. Informants identified the following seven critical elements for building effective outreach programs through partnerships:

- ♦ **Identify the audience:** gather information on the cultural background, religious beliefs, financial situation and family support of the audience. At this time, it is important to determine what information or services beneficiaries in the community need. These "reconnaissance activities" might require HCFA to collect detailed data on ethnicity from Medicare beneficiaries at time of enrollment.
- ♦ **Develop the message:** design a message that is culturally relevant and sensitive, with words, phrases and concepts understandable to the audience. Pretest the message.
- ♦ **Build and maintain community partnerships:** identify and recruit community partners. Clearly define each partner's role and HCFA's expectations.
- ♦ **Build community infrastructure:** develop community support for your activities by forming coalitions of community leaders and members of the identified audience.
- ♦ **Promote the program and recruit participants:** use a variety of channels (i.e. cultural, civic, and religious events) to communicate your message. Involve family members.
- ♦ **Develop and establish partnerships with healthcare providers:** provide information about diagnostic, follow-up, tracking and treatment services to healthcare professionals in the area.
- ♦ **Monitor and evaluate program:** maintain an ongoing evaluation to refine the program.

The Centers for Disease Control and Prevention (CDC), for example, uses a system of locally-based field personnel to perform outreach into "hard to reach" communities. These individuals were described in interviews as "great ground troops" in that they are knowledgeable about grassroots efforts, culturally competent, and highly trained to carry out a coordinated outreach program. We observed in our First Inventory Report that the current generation of Medicare beneficiary tends to respond well to receiving complex information in a one-on-one and in-person format, in which his or her specific concerns can be addressed and questions can be answered. We found in the second inventory that this format is especially important with ethnic minority, dual eligible, and rural beneficiaries.

Many of the findings from the First Inventory Report can also be applied to the development of communication strategies for underserved beneficiaries. Below, in Table 1, we summarize the various communication channels that second inventory informants reported using, some of which were also reported in the first inventory, and the advantages of each.

Table 1. Advantages & Disadvantages of Various Communication Channels

	Advantages	*Disadvantages*
Mass Media ♦ Public service announcements in radio, TV, news-papers, and magazines ♦ Stories in community newspapers	♦ can reach many people quickly ♦ can raise public awareness ♦ can provide information ♦ can help change and reinforce attitudes ♦ can demonstrate the desired action	♦ are less personal and intimate ♦ are less trusted by some people ♦ do not permit interaction ♦ offer limited time and space ♦ offer limited opportunities to communicate complex or controversial information ♦ can be costly
Community Channels ♦ schools, employers, churches and religious institutions, community organizations	♦ may be familiar, trusted, and influential ♦ may be more likely than media alone to motivate or support behavior change ♦ can reach large groups of people at once ♦ can offer shared experiences	♦ can be time consuming ♦ can sometimes be costly ♦ may not provide personalized attention ♦ organization may have its own agenda
Interpersonal Channels ♦ social workers, counselors, healthcare providers, clergy, lay helpers, educators	♦ are often seen as very credible ♦ can permit two-way interaction ♦ can be motivational, influential, supportive ♦ can permit a long term or ongoing engagement	♦ can be expensive ♦ can be time consuming ♦ can have limited target audience reach ♦ quality is dependent upon the interpersonal skills of the individual providing the information

Unique Inventory Findings for Each Group

Following are unique findings regarding information needs or optimal communication strategies for each of the groups, and the implications for HCFA of the findings.

African Americans

Managed care is a particularly confusing issue for African American seniors. Many plans do not offer services in predominantly African American neighborhoods and do not provide relevant, detailed information on either the provider network or the exact nature of the coverage. According to those interviewed, many African American seniors feel more comfortable with an African American physician. In many managed care settings, however, seniors do not have the

option of selecting an African American specialist, or even a primary care physician. There are a disproportionately low number of African American physicians in managed care plan networks as compared to the number in the general population.

In areas where community organizations have significant influence on the views and the level of trust of members of the African American community, HCFA may not only face suspicion from seniors but may also have to overcome a negative legacy from previous "failed" government programs. Social workers, case workers, leaders and healthcare providers who work and live in underserved communities have had to "fight the system" to procure even basic health resources and to secure access to adequate and appropriate care, so may not be entirely receptive to HCFA's efforts.

Hispanic Americans

There are three unique findings regarding the information needs of Hispanic Americans and the "best practices" for creating an effective communication strategy to reach them. The first finding is that newly enrolled Hispanics may not have had previous experience with health insurance, therefore these beneficiaries will need general information about insurance, in addition to information about Medicare. For example, beneficiaries will need to learn the meaning of a whole new set of basic terms relating to insurance, many of which will be completely unfamiliar to them. The lack of insurance among Hispanics is most prevalent among women of Puerto Rican and Mexican descent between the ages of 50 and 64, and only about 83 percent of Hispanic elderly currently receive Medicare benefits (compared to 96 percent of the general population).

Among minority elderly groups, Hispanics have the least amount of education. Only 27 percent of Hispanics, as compared to 60 percent of the total elderly population, have completed high school (National Center for Education Statistics, 1995). Individuals of Mexican and Puerto Rican descent are the most educationally deprived within the elderly population. Some estimate that as many as 16 percent of Hispanic elderly have had no formal education, so illiteracy is frequently a barrier to effective communication, especially through printed materials, as these beneficiaries can neither read English nor Spanish.

Providing health information to Hispanic seniors can be challenging because of language and cultural barriers, and low educational attainment, as well as their lack of access to healthcare providers as sources of health information. On the other hand, targeting the elderly Hispanic population is relatively easy--nearly three-quarters of elderly Hispanics live in just four States: California; Texas; Florida; and New York.

Dual eligible Beneficiaries

Medicare beneficiaries who receive benefits through their state Medicaid program are known as dual eligibles. Dual eligibles receive both their Medicare benefits, as well as additional services provided by state Medicaid programs, which vary by state. The primary issue concerning dual eligibles that is of particular concern and relates to their information needs about Medicare is their having to navigate two separate entitlement systems, which seem fragmented in that certain services may be covered by one or the other but related services are not covered by either. The

implication for HCFA of this finding is that DHS offices and Medicaid caseworkers can serve as a conduit for information on Medicare, as dual eligibles are already known to them. Also information aimed at helping these beneficiaries understand the interaction between programs and how to obtain information will greatly help this group of beneficiaries.

Rural Beneficiaries

Healthcare providers are considered to be the most trusted source of information in rural communities. We found that in rural communities, beneficiaries' relationships with providers were often long term and somewhat more stable than the relationships we observed in urban settings. Additionally, providers told us that one-on-one interpersonal channels were most effective with rural beneficiaries, because they were able to use local idiom and metaphors to illustrate their points. The implication for HCFA is to strengthen its communication with rural providers.

Summary of Information Needs and Communication Strategies by Group

While many of the information needs are similar across groups, there are important differences in the sources and information delivery vehicles that were reported by respondents in the second inventory. Additionally, HCFA is currently engaged in multiple initiatives, tailored to the individual group, and we heard about many different efforts. Table 2 below summarizes our findings regarding African Americans, Hispanic Americans, dual eligibles, and beneficiaries living in rural locations.

Table 2. Summary of Information Needs and HCFA Communication Efforts by Group

	African Americans	Hispanic Americans	Dual Eligible Beneficiaries	Rural Beneficiaries
Information Needed				
♦ basic insurance concepts		X		
♦ covered benefits	X	X	X	X
♦ eligibility		X	X	
♦ EOMBs	X	X		X
♦ interface of Medicare with other public programs	X		X	
♦ QMB/SLMB	X	X		X
♦ managed care	X	X	X	X
♦ supplemental policies	X	X		X
♦ fraud and abuse	X	X		X
♦ service availability				X
♦ transportation			X	X
♦ providers	X	X	X	X
♦ quality of care				

Table 2, continued

Summary of Information Needs and HCFA Communication Efforts by Group

	African Americans	Hispanic Americans	Dual Eligible Beneficiaries	Rural Beneficiaries
Trusted Sources of Information				
♦ family and friends	X	X	X	X
♦ church	X			
♦ community leaders	X	X		
♦ health care providers		X		X
♦ SSA case workers			X	
Examples of Current HCFA Media Initiatives	♦ *Dr. Deas Radio Show*--NY radio health show ♦ *Ethnic Minority Outreach*--targets ethnic news publications - SF RO ♦ *New York Region Medicare Print Media Outreach*--Press releases on Medicare to over 30 local newspapers in NJ, NY	♦ *Spanish Television Interview on Flu Shots*--interviewer visits flu shot site - Dallas RO ♦ *TV PSAs* on HICAP program - SF RO ♦ *QMB/SLMB PSAs* on TV, radio, cable TV - Dallas RO ♦ *Medicare Radio Outreach to Latino Community* reaches 250,000 listeners - NY RO ♦ *Ethnically Diverse Speakers Bureau* recruits volunteers to serve as speakers in designated ethnic communities-SF RO	♦ *Migrant Farm Worker Resource Directory* lists services in Denver area - Denver RO ♦ *Newsletter for State Surveyors* ("On the Old West Trail") features articles on rural health - Denver RO ♦ *Screening Mammography Campaign* carrier pilot project - Philadelphia RO	♦ Training guide issued in 1993 to state Medicaid workers on QMB ♦ *Medipass* explains managed care plan for Medicaid enrollees in English and Spanish - Florida Medicaid office

Inventory Findings for the About to Enroll

Beneficiaries who are about-to-enroll in Medicare as a group differ from the ethnic minority, dual eligible, or rural beneficiary in that they need a specific kind of information presented at a specific time, namely how to enroll in the program and how to think about all the choices they will soon be making. Additionally, there is a small group of beneficiaries who age into Medicare and are unknown to HCFA, who need to be identified before they can be reached.

Most about-to-enroll individuals need an introduction to Medicare, they need to know how to decline Part B if they choose not to enroll in it, and they need to know that there are various options for service delivery (i.e., fee-for-service or managed care). Side-by-side comparisons of their different options are helpful, because this presentation format reduces the information to a set of dimensions on which the beneficiary can make choices. Presenting information in a layered fashion, in which simpler concepts are presented first, with more complex information following has also been shown to be effective. Also, announcing the mailing of materials with a postcard to alert the audience that an important piece is coming is a good way to prepare individuals who are not in the habit of receiving information from Medicare.

Below, we summarized our inventory findings in terms of the beneficiary question and the strategy or strategies most frequently recommended by informants. It is important to note that HCFA is currently providing vehicles to answer targeted questions. In many cases, the most important strategy for the Agency is to refine these vehicles and improve the reach of their distribution.

Table 3
Information Needs of the About-to-Enroll Beneficiary

Information Need	Recommended Communication Strategy
Do I qualify for Medicare?	Current enrollment package includes a questionnaire to help individuals decide whether or not they qualify. These questions should be clear, concise and provide a logical sequence of action steps tailored to each scenario (e.g., already receives Social Security, government employee, spouse still works, etc.). The action steps should directly follow each defining question and list deadlines for each action.
Medicare Overview	Explain Part A and Part B and introduce terms such as "assignment," "deductible," "co-insurance" as well as managed care terms such as "network" and "PCP." These definitions will familiarize beneficiary with terms they will encounter in the *Handbook* and other Medicare related documents and forms. BCBS of CA developed a packet of this type of information.
Fee-for-Service or Managed Care?	By far, respondents said the best strategy is the comparison chart which clearly states similarities and differences among available options. The Oregon ICA produces a *Consumer's Guide* which covers both supplemental plans and HMOs.
Supplemental Insurance	Region specific comparison chart - HCFA produces this through various ICAs. Some respondents said that beneficiaries find it confusing. A possible remedy is to simplify it.

Information Need	Recommended Communication Strategy
Choice of managed care plans	Region specific comparison chart - Because beneficiaries are confused by marketing materials from the plans, respondents said they would like to receive more information from HCFA. The HCFA *Medicare Managed Care Resource Information Directory* might be one solution.
Long Term Care	Region specific comparison chart -description of services not covered by Medicare - Idaho ICA produces a *Guide to Long Term Care Insurance* that is periodically updated.
Where to go with questions	Medicare wallet card with important telephone numbers - BCBS of AZ provides pocket or wallet-sized calling cards.

Another key inventory finding is that many of the about-to-enroll individuals serve as caretakers for elderly parents and are already seeing some Medicare information through the materials their parents receive. Targeting information specifically to the caretaker through corporations or businesses where they are employed or religious communities, for example, might personalize the information, and enhance the possibility that it will be read in detail. The next generation of beneficiaries (individuals now aged 55-60) are different from the current generation in that they are more comfortable with technology and familiar with having health insurance and making choices regarding their coverage. Many of these individuals will also know about managed care, having been enrolled in a managed care plan while they were employed. Managed care is an area that current beneficiaries, especially ethnic minority and rural beneficiaries, find especially confusing.

Building on Current HCFA Activities

The Health Care Financing Administration is already involved in initiatives and ongoing media activities that address many of the issues and strategies identified in this Second Inventory Report, including establishing in-house workgroups to address the needs of these groups. Many of these efforts are creating a positive impact, and could be built upon to extend their reach. By using media specifically directed to the about-to-enroll that are unknown to HCFA, these individuals might be provided with the information to contact their Social Security Office at the very least. Though by no means exhaustive, we include below a sample of current HCFA activities:

- *Let's Talk About Medicare*--Televised series of twenty programs produced by a division of Medicare's Puerto Rico Field Office which features a discussion of Medicare issues. Several community-based respondents in Miami told us that their seniors would like to see a program about Medicare, especially if it was in Spanish.
- *Spanish Medicare Video/PSAs*--Video produced by the New York Regional Office featuring a general discussion of Medicare Part B in Spanish, with close captions for hearing impaired viewers. This video has been well-received and could be distributed more widely, especially to reach the about-to-enroll.
- *Spanish Radio in Los Angeles*--Produced by a carrier, Transamerica Occidental Life Insurance Company, this is a local effort to disseminate information to the Spanish speaking community. Also available are Spanish brochures and a Spanish speaker as needed.

- *Tell Your Medicare Parents about the Flu Shot*--Four rotating messages regarding flu shots both in English and Spanish run on an electronic message board onboard the Dallas Area Rapid Transit system by the Dallas Regional Office.

The many ongoing and planned HCFA activities, complemented by findings of the market research, all contribute significantly to HCFA's strategic vision of improving service to "hard to reach" segments of the beneficiary population.

This research provides a concise yet detailed snapshot of the information needs of five groups of Medicare beneficiaries who have special needs, and the best ways to communicate information to them. The work is applicable across HCFA initiatives, for effective communication lies at the heart of customer-oriented service provision.

INTRODUCTION

The Health Care Financing Administration (HCFA) is responsible for assuring healthcare security for all customer groups. As part of this responsibility, HCFA needs to provide access to information on Medicare to all beneficiaries. When discussing the information needs of Medicare beneficiaries, there is a tendency, however, to speak of the elderly as if they are a monolithic and homogenous entity. Volumes 1 and 2 of the First Market Research for Beneficiaries Inventory Report present findings from a review of the literature and interviews conducted with approximately seventy organizations regarding the information needs and the "best practices" for communicating complex material to the general Medicare beneficiary population. We found considerable diversity among different racial and/or ethnic minority subgroups, but focused the report on the commonalties among them. We found overall, that Medicare beneficiaries want information that is ***timely, relevant***, and presented in a way that is ***easily comprehended*** and within the context of individuals' personal circumstances.

HCFA plans to conduct market research on a number of subpopulations within the Medicare population which may have special needs. The aim of this Second Inventory Report is to identify the specific information about Medicare that beneficiaries who are from certain subpopulations need, and the best ways to provide it to them.

This Inventory Report provides evidence from our research on the information needs of five subpopulations of Medicare beneficiaries:

- African Americans,
- Hispanic Americans,
- Dual eligibles (Medicare and Medicaid),
- Rural beneficiaries, and
- Those about-to-enroll in Medicare.

It is beyond the scope of this report to fully cover all that is known about these groups, however, this report examines the variations in socioeconomic status, health status, and family networks that interact with age to produce varying needs for information from HCFA about Medicare.

It is well documented that the older population is more heterogeneous than any other age group. Although similarities exist among different subpopulations, such as in family structure, language, or information-seeking behavior, it is their unique needs that present HCFA with the greatest challenge in effectively providing them with information. Furthermore, each individual group is highly stratified and differences in immigration patterns, birthrates, geographic region, social class, and acculturation level may make some members more difficult to reach than others. For example, Hispanic beneficiaries of Cuban descent differ markedly from those of Mexican or Puerto Rican descent in a number of ways, including levels of education and income. Since education and income level have been shown to be highly correlated with information-seeking behavior, these differences will matter to HCFA in the development of an integrated communication strategy.

The purpose of this report is to examine if and how inter-group and intra-group differences in information needs may differ from the needs of the general population, and how these might require HCFA to vary its communication strategies to meet the needs of these groups. The data sources for this inventory include: interviews with approximately 45 individuals and organizations who work with elderly members of these groups on a regular basis, and a review of the research literature. A third Inventory Report will be released later in 1997 and will contain a synthesis of what we found to be useful strategies for communicating with visually and/or hearing impaired beneficiaries, and beneficiaries with low levels of education.

Overview of Market Research for Beneficiaries

The Market Research for Beneficiaries initiative is dedicated to helping HCFA understand the information flow between itself and beneficiaries. The following two questions are the focus of the market research:

- What information do beneficiaries want and need from HCFA?
- How can that information be most effectively made available?

The specific goal of this project is to provide HCFA with an understanding of the information needs of subgroups of Medicare beneficiaries and effective communication strategies through a series of data collection activities and analyses. The three main activities for the market research include: (1) constructing an inventory of the perceived information needs and effective communication strategies used by a wide variety of organizations; (2) conducting focus groups with Medicare beneficiaries; and (3) directly surveying the Medicare population through an expanded version of the Medicare Current Beneficiary Survey (MCBS). While complementary, each approach to data collection has particular strengths that contribute to a thorough understanding of the research questions. For example, the surveys of Medicare beneficiaries help ensure that the information gathered is representative of the population as a whole, while the focus groups provide more in-depth information than can be obtained from large-scale surveys.

The inventory component, to which this report contributes, is central to the project's success as it serves to guide the design of focus group protocols and survey questions. The inventory provides HCFA with a blueprint of current and emerging methods of determining information needs and disseminating Medicare program details and general health information in formats that are tailored to subpopulations of beneficiaries. Organizations that have provided input for the second inventory include HCFA Regional Offices; social service organizations; organizations representing or advocating for ethnic minority or other special population groups; federal agencies administering benefit programs to large numbers of participants (Social Security Administration and Centers for Disease Control and Prevention); Medicare and Medicaid carriers, intermediaries and healthcare providers. The inventory also provides the best available information from both published research and the practical experience of organizations and individuals engaged in communications on a day-to-day basis with these groups.

The second major component of the market research is a set of focus groups conducted with Medicare beneficiaries from each of the various groups. Focus groups provide the opportunity to gather in-depth information and to probe for clarification of seemingly contradictory information

gathered in the inventory. The method can also be tailored to accommodate particular groups of the population that are of special interest.

The third major component of the market research is information that is being collected from supplemental questions which were added to Round 18 (the current 1997 administration) of the Medicare Current Beneficiary Survey (MCBS). The survey data are designed to yield nationally representative, statistically reliable estimates of individuals' knowledge of the Medicare program, sources of program information, requirements for Medicare and health-related information, and preferences on ways in which different beneficiary subgroups would like to receive information. Survey data will provide HCFA with the population estimates necessary to prioritize activities within the Agency's overall communication strategy. Because of the size of the survey sample, this data will also permit statistical analysis of the special needs of the subgroups of the Medicare population.

In order for HCFA to respond to the varying needs of a diverse Medicare population, the Market Research for Beneficiaries project is being conducted in several phases. The focus of the initial phase was the general Medicare population, with an inventory of communication strategies used by organizations to understand the needs of Medicare beneficiaries as a whole and provide them with the requisite information (see the First Inventory Report.) The initial phase also included reports based on findings from the focus groups and will include survey data analysis of the general Medicare population. Subsequent phases of the project will provide similar types of information for select groups of Medicare beneficiaries, such as those who have impairments in vision or hearing. The current report focuses on five beneficiary groups: African Americans, Hispanic Americans, dual eligibles, rural beneficiaries, and those about-to-enroll in Medicare. Future reports will cover other high priority populations.

Basic Research Questions and Categories for Analysis

Research has shown that while knowledge about some aspects of health insurance coverage among the general elderly population can be substantial, it is usually lower than in the population younger than age 65. Among privately insured individuals, most understand that they have coverage for hospital care and physician visits, but they tend to underestimate their coverage for mental health or substance abuse treatment and overestimate their coverage for long term care (Garnick et al., 1993). Even early literature suggests that correct knowledge of coverage of particular services tends to be associated with current experience with health problems and one's expected use of these health services (Cafferata, 1984). Additionally, older people tend to make decisions differently than younger people, as their increased risk of illness and changing financial status due to retirement can make them more risk averse (Wells, 1993). Studies have also found that older people may be overwhelmed by both the volume and the complexity of the information regarding healthcare that comes their way, further complicating the decision process (Sofaer et al., 1990).

This Second Inventory Report provides insight into the two basic research questions of the Market Research: "What information does each subgroup of beneficiaries need/want about the Medicare program?" and "What are the best ways to communicate that information to them?" In

order to provide useful operational information to HCFA, we queried informants about two aspects of their information gathering:

- What are the specific information needs/wants of beneficiaries with respect to the Medicare program?
- What are the most effective strategies you use for understanding the information needs of beneficiaries?

An issue we considered is that there may be a difference in the type of information that each special group of beneficiaries wants about the Medicare program. For information needs/wants, we queried informants about their perceptions of beneficiaries' need for information in four general areas: (1) information about the Medicare program, (2) information about managed care and supplemental insurance, (3) information about the cost and quality of care, and (4) information about Medicare coverage of preventive health services.

To describe the strategies that organizations use to understand the information needs of different subgroups of customers, we interviewed two groups: informants from two large Federal agencies (the Centers for Disease Control and Prevention (CDC) and the Social Security Administration (SSA)) and informants from smaller local organizations of various types. In general, we found that large organizations tended to use formal strategies for identifying the information needs of their constituents (such as focus groups and surveys) and monitoring constituent needs (such as computerized tracking methods). On the other hand, local or community-based organizations tended to rely on their day to day interactions with beneficiaries to identify and meet their needs, and informal methods of integrating the information into operations. Additionally, large agencies often partnered with community-based or local organizations to gather more in-depth information about the target population. Organizations varied in the extent to which they periodically reassessed information needs to account for changes and growth in programmatic understanding.

The inventory revealed a range of both traditional and innovative communication techniques, with a particular emphasis on how these techniques fit with the specific cultural needs and preferences of specific groups of the Medicare-eligible population. Among the strategies we found were: (1) use of specialized printed materials in the group's own language, (2) interpersonal and one-on-one communication techniques in provider offices, local senior centers or by telephone, (3) small group discussions or presentations, and (4) mass media, either radio or television.

In our First Inventory Report covering the general beneficiary population, we found that it is critical to understand that the information needs of beneficiaries change over time, depending upon a variety of factors. Through our interviews in this second inventory, we found that there are two types of factors that contribute to this evolution: factors specific to the group, as well as factors in the larger social environment. Individual group factors include the influence of language, average age, health status, and time in the U.S. or familiarity with American organizational systems.

Environmental factors, which are also changing over time, include the group's access to the healthcare system as it can be a major information conduit. The level of the group's access to care will be a significant determinant of the kind and level of information that individuals will need. Additionally, some cultures have very clearly identified disease entities that they do not describe using standard biomedical terms, which will require some sort of crosswalk or translation. Additionally, certain information is specifically relevant to the beneficiary being introduced to Medicare (such as "What is Medicare?" and "What services are covered?"), whereas other navigational information is more relevant to the tenured beneficiary's ongoing use of the Medicare program (such as "How do I find a doctor that speaks my language or accepts Medicaid?" and "How do I file an appeal?"). Finally, information needs will vary depending upon the healthcare choices that are available in the county in which the beneficiary lives (such as whether there are very many HMOs in the area). In mature managed care markets, consumers who are experienced with having health insurance are generally somewhat knowledgeable about the features of an HMO, so the information they will want will tend to be more specific than the general information needs of a consumer who knows little about managed care. Additionally, a consumer who has never had health insurance before Medicare will need additional basic information on insurance and how it works.

Structure of the Second Inventory Report

The purpose of the Second Inventory Report is to be an operational summary of the special and unique needs, as well as the "best practices" for communicating with five groups of Medicare beneficiaries: African Americans, Hispanic Americans, beneficiaries who are eligible for both Medicare and Medicaid (dual eligibles), beneficiaries living in rural locations, and individuals about-to-enroll in Medicare. This detailed description of the varied information needs of the groups will help HCFA and its Regional Offices be responsive to the unique features and nuances of presenting information to the group. This report presents our analysis and the implications for HCFA's design and implementation of an integrated communication strategy.

This report begins with a listing of the organizations interviewed as part of the inventory. Next, the report summarizes some of the common themes we encountered as we collected information from the groups. The report then presents findings for each of the specific groups examined. For each group, we review the available research literature and synthesize the results of our interviews.

Organizations Interviewed

Interviews conducted for this inventory provide a mechanism for drawing on multiple sources about the health information needs of various groups of the elderly, methods for identifying each group's information needs, effective strategies for communication of needed information, and methods of outreach and education to encourage information-seeking behavior. The interviews "update" and expand upon the findings from the literature review. While the research is fairly recent, the 1990s have been a time of rapid change, both in the structure of the healthcare market and in communication technologies. The interviews also offer the opportunity to obtain the opinions and insights from experts in health communication who work regularly with seniors and have grappled with the various barriers to effective communication with them. Informants provide critical insights into the day-to-day reality and concerns of the Medicare population. Our

interviews also include multiple informants at two federal agencies and how they approach communication with various groups, as this information will be directly relevant to HCFA. Finally, selected results of an analysis by group of the public relations MCBS questions from 1995 provides a generalizable look at how well each of the specific groups understand aspects of Medicare.

The goal of contacts with these entities was to learn both about the characteristics of effective and ineffective communication strategies with Medicare beneficiaries from racial and/or ethnic minority and other groups, as well as about additional organizations in the local area who we could potentially interview. We worked closely with both HCFA staff and the Technical Advisory Panel for the project to identify individuals and organizations that could offer relevant information on developing effective communication strategies with each of the groups. Additionally, organizations were identified through the literature review. Our preliminary list included local Medicare advocacy programs, social service agencies, Medicare carriers and managed care plans. Interviews were conducted in and around Washington DC and in targeted cities, chosen to represent different geographic regions with large ethnic minority or rural Medicare populations, including Los Angeles, San Diego, Memphis, Miami, and New York. By including many different types of organizations through this two-stage effort, we were able to obtain multiple perspectives on information needs and communication strategies. Table 1 below contains a list of organizations and their geographic location interviewed for the inventory organized by type.

Table 1. Organizations and Individuals Interviewed for Second HCFA Market Research Inventory

Organization	Location
Federal Agencies	
Centers for Disease Control and Prevention	Atlanta, GA
Social Security Administration	Washington, DC
State/Local Agencies	
Arthur Ashe Institute for Urban Health	New York, NY
Center for Healthcare Rights	Los Angeles, CA
Department of Human Services-Tipton County	Covington, TN
Health Insurance Counseling and Advocacy Program (New York)	New York, NY
Health Insurance Counseling and Advocacy Program (San Diego)	San Diego, CA
Hialeah Housing Authority	Hialeah, FL
Mid-South Foundation for Medical Care	Memphis, TN
Office of Rural Health and Health Access	Nashville, TN
Social Security Administration	Miami, FL
Social Security Administration	Hollysprings, MS
Tennessee Association of Legal Services	Nashville, TN
Senior Organizations	
Breast Cancer Awareness Group	Memphis, TN
De Hostos Senior Center	Miami, FL
Organization	**Location**

Goddard Riverside Senior Center	New York, NY
Harlem Consumer Education Council	New York, NY
Institute for Puerto Rican and Hispanic Elderly	New York, NY
James E. Scott Community Association	Miami, FL
Little Havana Activities and Nutrition Center	Miami, FL
Ministerial Interfaith Alliance	New York, NY
Neighborhood House	San Diego, CA
New Family Services	Miami, FL
South Miami Plaza Senior Center	Miami, FL
S.T.A.R. Senior Center	New York, NY
Summit Health Coalition	New York, NY
Health Clinics/Providers	
Bells Medical Center	Bells, TN
Church Health Center	Memphis, TN
Methodist Family Medical Center	Oakland, TN
United Homecare Services	Miami, FL
UT Medical Group- ESRD Program	Memphis, TN
Watts Health Foundation	Los Angeles, CA
Women's Advisory Program, North General Hospital	New York, NY
Medicare Carriers	
Blue Cross and Blue Shield of Florida	Miami, FL
Transamerica Occidental Life	Los Angeles, CA
Medicare Insurers and Risk Contractors	
United Health Plan	Inglewood, CA

Cross-Cutting Inventory Findings

This Second Inventory Report includes the information needs of five populations of beneficiaries: African Americans, Hispanic Americans, dual eligibles (Medicare and Medicaid), beneficiaries living in rural locations, and those about-to-enroll in Medicare. The first four of these groups are similar in several important ways:

- Each group has traditionally experienced barriers to being able to access the healthcare system and are generally considered to be "vulnerable" and/or "underserved,"
- Members of ethnic minority and rural groups are more likely to be uninsured than members of the majority population,
- Disproportionate numbers among each of these groups are among the lowest socioeconomic stratum, and
- Each group has a unique profile of chronic conditions that are more prevalent in the group than in the majority population of Medicare beneficiaries.

It is generally accepted that much of the health disparity in the U.S. is a direct outgrowth of poverty (Gold, 1994). Numerous studies of the relationship between health and socioeconomic status have indicated that poor health, low levels of health knowledge and literacy, and little use

of preventive health services tend to occur in the lowest socioeconomic strata. (Mechanic, 1989; Winkleby et al., 1990). Because health communication efforts that are designed to reach those individuals with the highest risk of disease-related mortality or morbidity are often unsuccessful, these vulnerable groups have been called "hard-to-reach," or "disadvantaged," or "nonresponsive." Additionally, the "hard-to-reach" typically do not trust dominant group institutions, such as Federal or local government agencies. Efforts on the part of these organizations are often met with considerable resistance, especially when individuals have emigrated from countries with totalitarian or oppressive governments.

Understanding cultural preferences in both developing health-related messages and conveying them is critical. Beneficiaries in rural or racial and ethnic minority groups are exposed to many of the same health messages as the rest of the population. However, the effect of these messages on the different groups is likely to be minimal unless reinforced by more specific messages that are perceived to be more personally "relevant."

Two major themes were repeated throughout our interviews and across the various groups. In general, we found that ethnic minority and other groups did not so much need different information on Medicare than the general population, but they needed it to be **presented differently.** For example, low levels of literacy preclude many of these individuals from being able to read HCFA materials, such as *Your Medicare Handbook*. Communication delivery methods in addition to mailed written materials will be important with these groups, especially targeted media (such as cable television programming) and interpersonal delivery through community-based organizations.

For example, the Centers for Disease Control and Prevention (CDC) field personnel were described in interviews as "great ground troops" in that they are locally based (so they are knowledgeable about grassroots efforts), culturally competent, and highly trained to carry out a coordinated outreach program. We observed that the current generation of Medicare beneficiary tends to respond well to receiving complex information in a one-on-one and in-person format, in which his or her specific concerns can be addressed and questions can be answered. There are four implications for HCFA of this finding:

- In order to provide more opportunities for seniors to experience a one-on-one interaction with a knowledgeable human being, expand the Insurance Counseling and Assistance programs;
- In order to disseminate information in a culturally competent way, enlist the help of organizations within the various racial and ethnic minority or other communities, supplying the resources to educate and train individuals within the community to provide outreach and information dissemination;
- Information needs to be delivered in innovative ways, through multiple channels simultaneously, and in places that seniors typically frequent, such as pharmacies, banks, and beauty parlors, or through individuals seniors see regularly, such as the "Avon lady"; and
- Segment subpopulation audiences on relevant factors, such as education level, language spoken at home, style of decisionmaking, or time in the U.S. Conduct audience research before designing messages in order to match message content to the particular audience

segment. For example, CDC segments its audiences on a variety of factors in order to tailor its messages. This type of effort, however, will require HCFA to collect this data from Medicare beneficiaries at time of enrollment.

A second finding for the groups considered in this Inventory Report is that healthcare is embedded among a myriad of other social services, many of which beneficiaries consider more important than Medicare. In many communities, well developed networks of state, local, and community organizations exist which provide different services to seniors. For example, in Miami, we visited the Hialeah Housing Authority, a complex of subsidized apartments for low income elderly. The social workers at Hialeah coordinate the delivery of many social services and handle all of their residents' needs regarding government entitlement programs. The social workers serve as intermediaries between the resident and the outside world, turning away aggressive salespeople, answering residents' questions about Medicare and interpreting government correspondence (such as the EOMBs) for them. Due to recent federal immigration legislation, many of the Hialeah clients needed to formally file their papers for naturalization as U.S. citizens, so this was the issue that took center stage in early 1997 in many ethnic minority communities. There are two implications for HCFA of this finding:

- In order to raise public awareness of HCFA as a resource, subgroup beneficiaries with questions about Medicare might need to be provided with additional types of information on social services or programs, or provided with specific information about how to obtain the answers to their peripheral questions; and
- HCFA needs to consider providing information not only through its healthcare partners, but also through partnerships with non-healthcare oriented organizations, such as state welfare offices, county and community-level social service workers (such as Meals-on-Wheels), and private programs (such as those provided by the United Way).

The following chapters contain our findings for each of the identified beneficiary groups: African Americans, Hispanic Americans, dual eligibles (Medicare and Medicaid), beneficiaries living in rural locations, and those about-to-enroll in Medicare.

AFRICAN AMERICAN BENEFICIARIES

Understanding cultural preferences in how health-related messages are written and presented is critical as HCFA attempts to provide new information to "hard-to-reach" populations. Minority communities are exposed to many of the same health messages as the general population. However, the effect of generic health messages on minority populations is likely to be minimal unless messages are reinforced by more specific ones perceived to be more personally "relevant" to minority Americans (Nickens, 1990). Understanding a minority culture's uniqueness is therefore a prerequisite to being able to produce an effective educational message.

This section reviews the literature on the communication strategies that have been targeted to African Americans, describing their relative success. It is followed by a section in which findings from our interviews are presented and summarized.

Literature Review

Understanding the racial and ethnic correlates of health outcomes is an active area within current health services research. National public health goals and targets are now specified for African American and other minority populations, and community-based health education approaches are recommended to reduce widely noted disparities in health (Montes et al, 1995; IOM, 1988). A disproportionate share of African Americans, however, are poor, lack health insurance, and so have reduced access to healthcare and preventive services, such as health education. Markedly higher rates of heart disease and cancer than in the general population are seen in the African American community, and are often attributable to socio-economic disadvantage, health behaviors related to poverty, and reduced access to healthcare services. African Americans also have higher rates of some chronic conditions attributable to genetic components, such as diabetes and hypertension. Finally, certain health outcomes, such as low birth weights, seem to persist, even when controlling for socioeconomic status.

African Americans experience higher death rates at birth and during their young adult life than the general population. Consequently, many fewer African Americans survive into old age. The life expectancy at birth (the average number of years a person would live given current age-specific mortality rates) for African Americans is substantially lower than for whites (among men, 65 versus 73; among women, 73 versus 80). African American men do not, on average, live to an age where they can benefit from the Medicare program. Even so, from 1990 to 2050, as the baby boom generation ages, the number of elderly African Americans will triple and their proportion of the total elderly population will increase from 8 to 10 percent (Hobbs and Damon, 1996).

Because health education programs that have been directed at African American and other minority populations have often been unsuccessful in changing risky health behaviors or reducing rates of death and illness, this population has been labeled "hard-to-reach." The literature suggests that factors other than race be used in the design of communication programs. Rather than using demographic characteristics to segment the market, distinct attitudes and lifestyles of audience members might be used to target groups more effectively. Using a "psychographic" approach, the National Cancer Institute defined six distinct groups (e.g., naïve

optimists), each with different health-related outlooks. (Freimuth and Mettger, 1990). Race alone can be an imprecise tool for designing health education programs to reach different groups. For example, a poor inner city resident of Washington DC, a rural farmer in the South, a wealthy businessman in Chicago, and a recent immigrant from Senegal may all be African American, but have remarkably different communication needs and preferences. One implication for HCFA is that some additional occupational or other data might be collected from beneficiaries on enrollment and used to further segment ethnic or racial groups.

From a strictly communications point of view, African Americans are likely 'hard to reach' because of their relatively high rates of poverty and low levels of educational attainment. Poverty rates are three times higher for elderly African Americans than for whites (33 *versus* 11 percent lived in poverty in 1992). The African American elderly are much less likely than the general elderly population to have at least a high school education (33 versus 60 percent). The presence of functional limitations may also impede efforts to outreach to elderly African Americans. Elderly African Americans are more likely than others to need assistance with activities of daily living (ADLs) such as personal care and home management tasks (25 *versus* 17 percent). Providing information about Medicare to the elderly at worksites may be an effective strategy for African American women, but would not be as effective in reaching men, as elderly African American women are over represented in the workforce. Targeting the African American community by location is relatively easy--over one-half of elderly African Americans live in the South, and 70 percent live in 13 states, mostly in the South and Northeast.

Much of what is known about health-related communication among the elderly has been learned from evaluations of health promotion campaigns. African American's use of preventive services has sometimes been hampered by knowledge deficits, such as their lack of belief in their susceptibility to disease, or in allopathic medicine's ability to successfully treat it; a fatalistic perception that individuals have no control over their chances of contracting cancer; and attitudinal barriers such as fear and embarrassment.

In a study sponsored by the National Cancer Institute, African Americans had significantly less knowledge about cancer even when education, sex, and age were controlled for in the analyses (Dignan, M., et al, 1991). The study indicated that African Americans may lack cancer knowledge relative to whites because they tend to obtain information on cancer from television and radio rather than from printed materials; often lack education, and may be unmotivated because of their reduced access to medical care.

Common Health Beliefs Regarding Cancer Among African Americans

- "Cancer won't happen to me."
- "Doctors can't do anything for people with cancer."
- "There is nothing I can do about my health - it is all up to chance."
- "Health is a personal thing - it's nobody's business but mine."
- "Doctors can't be trusted."

Information on a minority population's family composition, friendship networks, churches, schools, clinics, community centers, workplaces and other social units can be used to tailor messages. Some studies of African American elders suggest that health promotion campaigns tackling common risky behaviors and conditions (e.g., obesity, smoking) are more effective if communicated through individuals and community institutions important to the social networks of black elders. These individuals can be family members (e.g., spouses, children, and grandchildren), or institutions like the church, employers, and civic or social/fraternal clubs (e.g., the NAACP). Because of the importance of religion in the lives of black elders, churches may be an effective source of health information (Eng et al, 1985; Yee and Weaver, 1994).

Community-based Health Communication Efforts

Community-wide health promotion intervention typically casts a wide net around a town or city and uses a specific health problem to create a coalition of organizations, neighborhoods, families, and friends. The goal of the intervention is to change the life-styles and social ecological conditions that place residents at risk. Longitudinal community-wide intervention trials have documented three levels of effects (Eng and Parker, 1994):

- Effects related to the knowledge, attitudes, and behaviors of individual residents;
- Effects related to social support, contacts with resources, and referrals to services provided through social networks; and
- Effects upon the availability and accessibility of services through organizational policies.

A method widely used in social marketing and an essential starting point for communicating with any group is to conduct a community assessment to learn about the unique needs of the potential audience. Some useful steps in conducting a community assessment include (Randall-David, 1989):

- Participating as an observer in meetings, clinics, religious events, and other community gatherings. The best first step is to look and listen before asking or acting.
- Making a list of all of the institutions the target population utilizes (social services agencies, key businesses);
- Listing community leaders (e.g., clergy, local minority legislators, sports figures, leaders of community groups);
- Conducting in-depth interviews with community leaders or case studies of specific programs; and
- Developing working relationships with community-based organizations.

Learning as much as possible about the targeted community will help ensure that the planned intervention is appropriate, available, affordable, accessible, and acceptable to the target population. Other social marketing methods that can be used include using a variety of communication channels to disseminate information in order to help ensure that the target population is reached. Examples include some community-based cardiovascular risk reduction programs targeted to African Americans that have relied on a wide ranging set of communication channels including insurance agents, the Salvation Army, churches, barbers, local fire departments, cooperative extension services, and local chapters of the American Heart Association (Magnus, 1991). While there is no clear evidence regarding the channel that is most effective, experience suggests that the above factors are essential to the success of these efforts.

Social Marketing Methods

- widespread community participation (e.g., actively involve indigenous leaders in the community);
- local needs assessment (e.g., assess local knowledge and beliefs);
- appropriate pretesting of messages (messages need to be culturally sensitive);
- message simplification; and
- adopting specific approaches for specific subgroups.

The literature details the key elements in the development of culturally relevant educational materials for African Americans. These elements include: minority leadership, use of the target audience as primary evaluators of the proposed materials, development of the topic around a central theme, and inclusion of linguistic patterns unique to the minority group. This process was used to develop an educational brochure for African Americans to raise their awareness of the risks associated with having high blood pressure (Parks, 1988).

Some states have responded to the health promotion and disease prevention objectives outlined in the Healthy People 2000 report (Ward et al, 1993). In one case, regional task forces were formed to develop health promotion objectives and make recommendations for the states' minority populations. Each regional task force prioritized health topics (e.g., cancer, violent and abusive behavior) and assumed a leadership-partnership role in promoting health. The implementation process included the following five steps:

- Raising awareness about the extent of the problems identified and preventive strategies that are available to address the problems (e.g., form a speakers bureau to address communities, organizations, and foundations);
- Assisting communities in defining and identifying their health promotion concerns;
- Developing coalitions to address the issues;
- Mobilizing for action aimed at implementing the recommendations (e.g., assist in the development of proposals for funding of community-based interventions); and
- Developing training and orientation to the task force agenda.

The Henry J. Kaiser Family Foundation and Carnegie Corporation have funded the Health Promotion Resource Center at Morehouse School of Medicine in Atlanta to provide technical

assistance in community-based health promotion for minority and poor communities. The Health Promotion Resource Center uses community development as the vehicle and community-based health promotion intervention as the change model. This approach relies on a decision-making community coalition board to identify its health promotion priorities, inventory resources, build coalitions with the public and private sectors, access other resources, address policy, and manage resources in support of health interventions (Braithwaite and Lythcott, 1989).

Using a model from international development efforts, volunteer health cadres have been formed in many communities as units of health education, healthcare, or as community health committees. The cadres may include respected community members, and members of local volunteer organizations such as the NAACP, urban league, churches, and sororities and fraternities (e.g., *Chi Eta Phi*, an African American nursing sorority), and representatives of organizations such as the American Red Cross and Heart Association.

Interventions Organized Through Churches

Several community-based public health interventions have been launched within the African American community through churches. More than one-half of all Americans regularly attend church or are church members. Studies of racial differences in church participation generally find that African Americans participate at a greater rate than whites, although church attendance is relatively low in urban areas, especially in the central cities of the North (Loury and Loury, 1997).

In one rural North Florida community, a church-based community planning and self-help approach was used to promote health among the elderly in rural African American communities (Cowart, 1995). The implementation of the Centers for Disease Control and Prevention (CDC) Planned Approach to Community Health (P.A.T.C.H.) program resulted in weight reduction, lowered blood pressure, and improved self-perceived health status among participants. More importantly, the project contributed to the development of a local community structure for determining, monitoring, and improving the health status of older African American residents using a church-based health promotion program.

The church-based P.A.T.C.H. model described above and developed at the CDC, involves grassroots participation in four steps: data collection and analysis, problem identification and priority setting, intervention planning and implementation, and evaluation. Communication channels used within the program included a monthly newsletter, church bulletins, black radio stations, and local gathering places (e.g., beauty or barber shops).

Coronary heart disease screening and nutrition classes have been shown to be effective in lowering blood cholesterol levels in the African American community. The classes are conducted in African American churches by trained volunteers from the congregation. As part of one program, church members were invited to attend a 6-week nutrition education class and received information in the mail specifically about cholesterol. Six months after the initial screening, participants were found to have decreased their mean cholesterol level by 10 percent, an amount sufficient to have a sizable impact on heart disease risk reduction (Wiist and Flack, 1990).

Over ten years ago in Lansing, Michigan, a health committee focused on the control of high blood pressure through local churches (Davis, 1986). Another project. "Fitness Through Churches" which was funded by the American Heart Association, was organized to combat cardiovascular disease through 14 inner-city congregations in Durham, North Carolina. Members of the congregations were taught to be health advocates. The advocates organized exercise programs, offered information on nutrition, weight control, smoking cessation, and stress management (Hatch et al, 1986).

Churches have also been the host sites for cancer screening programs. Twenty midwestern African American community churches took part in one colorectal cancer prevention and screening program. Volunteer nurses from the States Black Nurses' Association presented educational programs and provided home screening tests to church members. Of the nearly 1,500 church members who brought home the free screening kit, 18 percent returned the kit. Low compliance was traced to the time involved and dietary restrictions required for the test (e.g., abstaining from meat 48 hours prior to the test) (Mitchell-Beren et al., 1989). Those exposed to the educational program did report an increased awareness of cancer, and behavioral changes in their lifestyles to lower their risk of cancer. Screening programs are also available through churches in other locations. The Oakland Cancer Program, for example, offers mail-in tests for occult blood through local churches (Olson, 1989).

Specific Communication Approaches

Much has been done in the African American community to tailor messages about health to specific audiences. After a brief description of some general findings, we present examples from the literature of health interventions for African American women and for African American men.

Culturally sensitive educational campaigns can be very successful. While there is considerable skepticism and mistrust of the medical community arising from a history of experimentation and exploitation of African Americans, successful approaches have been able to mitigate this mistrust by demonstrating the benefit of the promoted information or behaviors through featuring "experts" of color. Some research suggests that the use of positive images of people of color may increase receptivity and attendance to the message because they reinforce ethnic identity and pride in ethnic group membership. Although African Americans were observed to be the least likely to use the Cancer Information Services hotline, their use tripled following the airing of targeted public service announcements featuring a recognizable African American cultural figure, singer Aretha Franklin (Yancey and Walden, 1994).

Health communication programs targeted to African Americans should accommodate their preferred sources of information, and should be oriented toward increasing perceptions of the benefits of taking such action as well as reducing the barriers to taking action related to prevention and early detection (Michielutte and Diseker, 1982). One particularly useful approach with underserved elderly populations is the use of peer or nonprofessional counselors, health intervenors, or promoters. The Arthritis Self-Management Program, for example, is a 6-week course offered at senior centers, churches, and shopping malls by pairs of trained peer leaders. Improvements in depression, pain, and disability have been reported among large numbers of participants who have completed the program over the last 12 years (Marin et al., 1995). Strategies to enhance the success of communication programs within minority communities include involving minority individuals in program planning and operation, and personalized outreach through trusted individuals in the community or social service agencies (National Eldercare Institute on Health Promotion, 1992; Dorfman, 1993).

Characteristics of Successful Campaigns

- Minority involvement in campaign planning and operation;
- Information dissemination through ethnically oriented media and through minority organizations;
- Personalized outreach through trusted persons or local social services agencies that can help identify high-risk elderly;
- Use of community-based volunteers and bilingual/bicultural staff who are client-oriented; and
- Formation of community-based planning and steering committees.

A 'Good Health Calendar' and radio spots were successfully used by an urban hospital to air preventive healthcare issues, publicize free and low-cost services, and to provide outreach to the predominantly African American community it served. The 'Good Health Calendar' included health tips and highlighted key community information, such as school registration deadlines, area church bazaars, coupons for neighborhood stores and businesses and premiums promoting hospital provided services, such as diabetes screenings and stop-smoking clinics. Radio spots featured African American physicians and were aired on stations popular with African Americans. The calendar and radio spots were very successful in bringing community members into the hospital for preventive services (Bathurst, 1992).

Programs Targeted to African American Women

African American women ages 50 and older have been a difficult group to reach by conventional breast cancer intervention programs. Many African American women do not visit physicians regularly and when they do, they are not referred for mammograms as frequently as white women are referred. In one study of mammography and Pap test use by elderly poor African American women, the main reason women cited for not being tested was that their doctor had not recommended the test (Mandelblatt, 1992). Other barriers to preventive health use include not having a telephone and not being able to pay for tests (Weinrich et al, 1995).

Cultural differences in perceived susceptibility and affectual barriers, such as fear and embarrassment, also contribute to the under-use of mammograms and breast self-examination among African American women over age 50. In a study of the attitudes of African American women toward cancer and prevention, the American Cancer Society found that fear, pessimism

about cure, concern about the inconvenience of obtaining medical care at free clinics, and suspicion of experimental treatment may keep a woman from seeking medical attention even when she recognizes a potential cancer warning sign. Even when offered at no cost, many low-income African American women do not take advantage of mammography or cervical cancer tests. Urban African American women tend to be much less knowledgeable than urban white women about cancer warning signals and less apt to see a doctor if they experience symptoms.

A variety of interventions have been used to overcome these barriers. Many are based on the premise that the most effective educational efforts are those that involve existing community leaders, organizations, and resources in the targeted neighborhoods. One example of a successful partnership was the collaboration between the Chicago Chapter of the National Black Nursing Association and the Illinois Cancer Council. The goal of their intervention was to increase black women's use of breast self examination and other screening practices by having nurses provide education within Chicago hospitals (Willis et al., 1989). While mass media has generally been found to be ineffective in recruiting African Americans for cancer screenings, some research suggests that the strategy's effectiveness is dependent upon the individuals' readiness to hear the message. Mass media is usually used to increase awareness of a product or service, and may be successful in recruiting individuals who already are considering obtaining a screening, whereas individuals who have not even considered obtaining a screening may need the personal contact and education that community-based outreach provides (Vellozzi, et al., 1996).

Another recent and successful project described in the literature was designed to increase breast cancer screening awareness by providing a referral or free breast screening, or both, through beauty salons. The National Cancer Institute developed culturally sensitive educational pamphlets and a video to promote mammography, clinical breast examinations, and breast self-examinations and distributed them through local beauty salons (Forte, 1995). Vouchers for free mammograms at a local clinic were provided, along with a listing of low or no-cost services. In addition, a mobile mammography unit visited the salons each month.

Recognizing that elderly African American women have lower rates of participation in cervical cancer screening, a recent study reported a health intervention that offered women living in a senior-citizen high-rise apartment building information about screening and on-site testing. There were two groups of participants: an intervention group in one building, and a control group in another. Information about the screening program was slipped under the intervention group residents' door, they were invited to a lecture and showing of a video-tape featuring a popular black actress, and community speakers discussed cancer screening in the dining hall and at a tenant meeting. Cervical cancer screening was offered onsite at the apartment building. Women in the intervention building were much more likely than residents of the control building to be screened for cervical cancer (either on-site or by their own doctor) following this intervention (69 *versus* 52 percent) even though there were no differences in their perceptions of personal cervical cancer risk (White et al., 1993).

Using social marketing strategies, the National Cancer Institute launched a community-based health education project in Forsyth County, North Carolina to increase cervical cancer screenings among black women. This community was chosen because death rates among non-white women

were 4 to 6 times higher than among white women. The population was segmented to target church attendees, patients in waiting rooms of public and selected health providers, female students at local colleges, shoppers, viewers of radio and television, newspaper readers, and business owners and managers. Television and radio media messages were found to be more effective than newspaper coverage in increasing awareness of the program (Dignan et al, 1991).

A church-based intervention to promote cervical cancer screening among African American and Hispanic women was very successful in encouraging test use among unscreened women. Lay health leaders were identified within the churches and trained to serve as health advisers and site coordinators. Screening tests were offered at the church at no cost. The fact that the test was free may have discouraged some African American women from having the test. During a subsequent question and answer session, women tended to characterize the free offering of the Pap test as a "favor to the poor." The women objected to being seen as poor, despite their inability to afford the cost of regular medical attention. Women also intimated that "free" services often result in "substandard" services in black communities. There was some speculation that imposing a token fee may have resulted in greater participation among the targeted African American women (Davis et al., 1994).

Programs Targeted to African American Men

An example of a health campaign designed to reach inner-city African American men is a culturally targeted video that provided information about sexually transmitted disease (STD). The video sought to educate the men about STDs, and encouraged them to return to the health clinic for a follow-up test-of-cure. This communication method was successful in both informing participants and promoting follow-up care. Men randomly assigned to a control clinic received written materials instead of the video and scored significantly lower on a knowledge test. Control group scores depended upon the men's educational attainment. Patients who saw the video, however, acquired an equivalent high level of factual knowledge, regardless of educational background (Solomon and DeJong, 1988).

Communication Approaches Currently Used by HCFA

Several communication products specifically targeted to African Americans are available through HCFA's central and Regional Offices and are briefly described below.

Selected HCFA Products Targeted to the African American Audience

Radio Projects

Dr. Deas Radio Show--NY radio health show with large African American audience discusses Medicare issues (Division of Medicare's Customer Relations Branch)

Print Media

Ethnic Minority Outreach--Target of ethnically diverse news publications and radio and television stations to reach Asian, Hispanic and African American senior population.(San Francisco Regional Office)

New York Region Medicare Print Media Outreach--Includes press releases on Medicare to over 30 local newspapers in New Jersey, New York (including Spanish and Chinese language newspapers and African American weekly), Puerto Rico and the Virgin Islands (Division of Medicare's Customer Relations Branch)

Source: Project Customer: A listing of HCFA Customer Service Activities, September 1995

Interviews: Findings and Implications

We conducted interviews with organizations and groups representing and working with African American Medicare beneficiaries throughout New York, Florida, California and Tennessee. These interviews revealed a variety of important issues for HCFA to understand and take into account as the Agency continues its transition to becoming a "beneficiary centered" purchaser.

HCFA's 1996 study on the effects of race and income on mortality and use of services among Medicare beneficiaries documented fewer physician visits, lower immunization rates and greater incidence of radical surgical procedures among African American beneficiaries than among other groups (Gornick, et al., 1996). The disparity that exists in access to healthcare and insurance coverage has contributed to shorter life spans and an overall lower health status for African American beneficiaries. This study further emphasizes the need for an Agency-wide effort to develop a comprehensive communication and education strategy to reach the entire population and attempt to equalize the health status differences which exist across beneficiary subgroups.

In the interviews conducted for this inventory, we collected information on the "best practices" of community groups and direct service organizations located in underserved areas. These groups, for the most part, have developed effective outreach efforts to deliver medical care and health information. In particular, we spoke with groups experienced in serving elderly who face more debilitating health conditions and can easily become isolated. Discussions with these groups and organizations revealed that elderly African Americans have the same overall healthcare concerns as the general population, but may respond differently to mass communication strategies and may require assurances that they can trust the information and services they are receiving.

Information Wants and Needs of African American Beneficiaries

The information needs of African American Medicare beneficiaries generally reflect those of the overall beneficiary population. We heard concern over fraud and abuse, uncertainty over choosing fee-for-service or managed care, and general questions about Medicare coverage and entitlements. Most do not know what "HCFA" is, and are not particularly interested in knowing. Their main concern is that they receive medically appropriate and personalized care that is delivered in a respectful and sensitive manner.

General Entitlement/Coverage Questions

African American seniors have the same concerns and questions regarding their Medicare coverage as any other ethnic group or the general Medicare population. In particular, these questions focus on either decisions surrounding Part B coverage as well as understanding of the Explanation of Medicare Benefits (EOMB) forms. However, beneficiaries are most looking for information relevant to their lives and in venues familiar to them. Government documents can be somewhat impersonal and, in some attempts to be "reader-friendly," can be construed as being condescending. When materials are written either too technically or too simplistically, beneficiaries often feel that the Agency does not understand them. It is difficult for beneficiaries who have always provided for themselves or relied on spousal support to think of themselves as being dependent upon Medicare and/or Medicaid for health insurance. Informants emphasized the fact that seniors are not looking for a "handout" and are generally only interested in services they are entitled to receive. We also heard that often when a beneficiary's income qualifies them for Medicaid or even QMB and SLMB, he or she may be too proud to apply.

Managed Care

Managed care is a particularly confusing issue for African American seniors and represents an area in which there are significant information needs. Many plans do not offer services in predominantly African American neighborhoods and do not provide relevant, detailed information on either the provider network or the exact nature of the coverage, which seem to be the two areas of greatest need. As with all consumers, African American seniors are looking for the "best" plan, do not always recognize that each plan can service their needs differently, and that their choice should directly reflect their priorities and meet their needs. The promotional information received from managed care organizations, along with the general Medicare information from HCFA, makes this decision process overwhelming. Seniors then turn to their family and community for advice sorting through the materials and identifying the information that will be useful to them. The Summit Health Coalition in New York provides a consumer question checklist to help seniors prioritize their health needs and determine if a particular managed care plan can meet their needs. This checklist is similar to others provided through Health Insurance Counseling and Advocacy Programs (HICAPs) and community organizations, but tailors questions to ensure that cultural and social concerns important to African American seniors are addressed. The following are some examples of questions from this checklist.

Does this plan hire African Americans who:

- Get people to sign up for the plan?
- Answer questions about the plan?
- Handle office duties?
- Manage other employees?
- Run departments or the plan itself?

Can I get a list of African American doctors and other health specialists who are in this plan?

African American seniors have been exposed to various forms of racism and classism exhibited by individuals or organizations in the healthcare system. Many of the organizations interviewed reported incidents of racist behavior against African Americans by foreign-born physicians who either refused to treat or demonstrated little concern for their African American patients. This situation not only creates a hostile and inappropriate environment for beneficiaries, but reduces their access to care since seniors do not utilize facilities where they know these instances have occurred. Counselors from the Goddard Riverside Senior Center, who primarily work with Hispanic and African American seniors, reported that access to quality care was the largest beneficiary concern in both the managed care and fee-for-service environment. In fee-for-service, because some physicians do not accept Medicare assignment, and because they cannot afford to pay the full fee, minority beneficiaries can be left with a smaller pool of physicians and specialists to choose from. When looking for specialists, the limited number that either accept Medicare assignment or accept Medicaid forces the beneficiary to undertake a tedious search and usually results in the beneficiary "settling" for the first doctor they find. According to both recent research and those we interviewed, many African American seniors feel more comfortable with an African American physician. Congruence between provider and patient has been shown to be associated with increased patient satisfaction with care (Castro, 1997). In a managed care setting, however, seniors may not have the choice of selecting an African American specialist or even a primary care physician. There are a disproportionately low number of African American physicians in managed care plan networks as compared to the general population. In Baltimore, MD, for example, only seven to eight percent of physicians are black while the city's population is almost 65 percent black. In addition, there have been reports of managed care plans rejecting or dropping black patients because they tend to have a lower income and suffer from more chronic conditions than other enrollees (Sugg, 1995). This indirectly causes a barrier to access for black beneficiaries who may want to join a managed care plan, or who feel they must join for financial reasons, but do not feel comfortable doing so fearing that their care will be substandard or inappropriate. Minority owned managed care plans, though few in number, are often the only types of plans that offer services to meet both the medical and cultural needs of their populations.

Strategies for Understanding Information Needs

Strategies that are appropriate for HCFA versus those used by community-based organizations will differ due to the level of direct interaction each has with Medicare beneficiaries. HCFA must rely on formal mechanisms such as surveys, focus groups and HCFA Regional Office feedback to develop a sense of information needs, which will be primarily in the aggregate. Local healthcare

providers and community-based organizations are able to determine these needs informally, through their day-to-day interactions with beneficiaries. National organizations often have local chapters or offices which are responsible for identifying the health information needs within their respective geographic locations.

The Arthur Ashe Institute for Urban Health, a national organization located in New York, is able to develop effective communication strategies because the Institute actually becomes "part of the community" which it serves, knowing, living and understanding the needs of the individual community. While the Institute's directives and education agenda are set at the national level (health intervention and education topics are chosen from among those conditions and diseases with a disproportionately high incidence in underserved populations), the actual strategy is implemented at a local level where community nuances can be integrated. Many information needs are a result of misconceptions and myths, so it is important to find out what the predominating beliefs are before trying to develop messages. For example, organ donation and transplants are viewed negatively in the African American community because the donor views him/herself as a sacrifice.

In their work in Harlem, the Institute reaches out to African American senior women through beauty salons. Salons provide a "safe" and social forum for discussing family histories and current events, as well as such private matters as breast health. Beauticians are often opinion leaders in the local community. These discussions provide the Institute with the level of detail and the requisite information to evaluate and understand seniors' perceptions and beliefs regarding their health and healthcare. Health is a very private matter to many African American seniors, and they do not feel comfortable discussing their perceptions. Respondents suggested that many seniors are afraid they will look stupid or be criticized for not knowing certain things, especially technical medical issues. Through these informal discussions, the Institute is able to design an educational campaign to effectively reshape specific misperceptions regarding mammography.

While some community based organizations develop specific programs, such as the beauty salon project, all rely on informal feedback gathered through their day-to-day interaction or personal experience as a member of the serviced population. Often organizations comprise members who are trusted by the community and who can accurately represent its sentiments. It is impossible for HCFA, as a large government agency, to interact with neighborhoods and communities in such an intimate way. HCFA Regional Offices often experience a closer interaction, but they often have responsibility for several states and do not have the resources or geographic presence for effective intra-community involvement. Minority communities, in particular, are wary of government efforts and view HCFA as "just another government agency." This perception can potentially interfere with the collection of accurate information. Partnering to achieve local information gathering (discussed in the next section) is crucial for HCFA in order to effectively reach and understand all of the populations it serves.

Communication Strategies

Many communication vehicles have universal appeal and can provide cursory information to an entire population. Mass mailings and advertisements in major newspapers can reach a large audience, but often do not attract the attention of non-majority groups, because they contain

messages that primarily relate to "majority" issues. The context of a message is crucial, as it can create a barrier to effective communication if it is not culturally correct. Radio talk shows are better vehicles for closely targeting audiences, and there are numerous examples of talk shows that are oriented to the issues important to African Americans.

When developing communication strategies, one important issue for HCFA is to present information within the audience's frame of reference, and in a culturally competent way. Because culture and language are extremely significant factors in communication, effective messages are tailored to their audience. Beneficiaries in racial and/or ethnic minority and rural groups are exposed to many of the same health messages as the rest of the population. However, the effect of these messages on these groups is likely to be minimal unless reinforced by more specific messages that are perceived to be more personally "relevant." For example, a 30-minute film produced by the Revlon/University of California at Los Angeles Cancer Research Program is co-hosted by Jane Pauley and Phylicia Rashad, and features other well-known celebrities. This film is an example of how including an ethnically relevant African American celebrity as a co-host improved its reception in minority communities.

Culture is defined as a "set of beliefs and customs that cuts across specific ethnicities and exerts a powerful influence on behavior" (LaVizzo-Mourey, 1997). Cultural competence is "the knowledge and interpersonal skills that allow organizations and individuals to understand, appreciate, communicate, and work with people from cultures other than their own" (HCFA, 1997). For example, in the African American community, physicians are considered to be like "gods" and patients do not generally question their doctors. This consideration will exert significant influence over how the subject of fraud and abuse is presented. Beneficiaries may not be receptive to literature which suggests that they speak up against their doctor, or behave in a manner which they feel may counter their upbringing.

There are four basic elements to cultural competence. An understanding of each of these elements has been shown to significantly enhance intercultural communication. These elements are: (1) an understanding of racism, even in its more subtle forms; (2) an understanding of the culture of poverty and the daily activities and preferences of individuals who are poor; (3) an understanding of cultural health beliefs, such as the patterns of caregiving that characterize the group; and (4) an understanding of the language, such as the predominant reading levels, the slang expressions, and how meanings of the same word can vary across cultures.

As HCFA develops tailored communication strategies to meet the needs of minority populations, it is important to recognize how government agencies are generally perceived within the community, and any previous experiences the particular community might have had with government-sponsored programs. The community's underlying perspective on issues such as the role of the healthcare provider must be fully integrated into the communication effort. Our interviews revealed three major issues that can affect communication between HCFA and most African American beneficiaries. These issues are:

♦ Perception of health and the health information "messenger" among African American beneficiaries,

- Identification and understanding of community infrastructure and key leaders, and
- Creation of a well-targeted communication strategy.

Perception of Health and Health Information "Messenger' among African American Beneficiaries. In areas where community organizations have significant influence on the views and the level of trust of community members, HCFA may not only face suspicion from seniors but may also have to overcome a negative legacy from previous "failed" government programs. Social workers, case workers, leaders and healthcare providers who work and live in underserved communities might have had to "fight the system" to procure even basic health resources and to secure access to adequate and appropriate care. Government employees are often regarded as "pencil pushers" who lack the insight needed to develop policies and programs that fully consider the "human factor".

> "Seniors are not stupid and do not want sympathy--they want truth, love and caring"
>
> - Bishop, New York

When the broadcasted message involves healthcare, African American seniors often feel vulnerable and exposed, because one's health is "a very private and scary matter." Many of the direct service providers we interviewed acknowledged that some beneficiaries would rather not find out that they are sick, and specifically avoid going to the doctor. These beneficiaries traditionally do not engage in preventive health behaviors, such as regular doctor visits, immunizations, or cancer screenings. African American elderly communities are also plagued by misinformation about disease and treatment--many community education groups have had to build their health prevention strategies through dispelling myths and teaching basic concepts about health. For example, both the Arthur Ashe Institute for Urban Health and the Women's Health Program at North General Hospital in Harlem develop their programs around the theme of the empowerment of the individual, teaching about health from within the safe and comforting surroundings of the audience's neighborhood. The focus of those programs is to promote involvement in one's own healthcare by asking questions. The commitment and credibility of the educator has also been a crucial factor in the success of these programs. While the director of the Women's Health Program is increasingly busy with the growth of her outreach programs, she always attends or leads weekly workshops. She says the attendees see her as their daughter or granddaughter and expect her to be there. When she does community outreach, it is often the reputation she has earned as a committed, caring individual that helps her get the message across on a wide variety of issues.

> "I never miss my Tuesday workshop, they expect me and I can't let them down. When they see me, they see their own daughters and granddaughters."
>
> - Director, Women's Health Program

Identification and Understanding of Community Infrastructure and Key Leaders. Many African American communities have developed extensive support networks, at both the national and local levels. Despite underrepresentation in various levels of government, some African Americans have committed themselves at the grassroots level to creating policies that can represent and further the needs of their individual communities. These existing networks comprise a number of prominent and active individuals who have the interests of the community in mind, and who best

understand its needs. HCFA does not need to recreate these networks in an effort to provide outreach to the African American community. In some cases, attempts to do so may exacerbate fragile relationships which may exist between an African American community and "the government." According to some groups interviewed, HCFA should focus its efforts on working within the community through established networks of community leaders, and using the community infrastructure. If a neighborhood relies on the church for guidance, HCFA is best served by working within the structure of that church and under the direction of the pastor or community minister, for example.

There are a number of organizations that can provide the Agency with important information about the local infrastructure. The 1993 national healthcare debate raised concern among many African American healthcare providers that the proposed reforms and policy changes might not adequately incorporate the needs of their communities, and that policy makers might not accurately assess the impact of reforms on future generations. Groups like the Summit Health Coalition in New York were organized to ensure a voice for the African American community in the healthcare debate. Congressman Louis Stokes (D-Ohio), who took an active role in the 1993 debate, has lead the 1,500 member Congressional Black Caucus Health Braintrust since 1977, monitoring and assessing the impact of health legislation on various minority communities over the years. In 1994, the Health Braintrust convened a Legislative Working Forum to analyze the repercussions of the Clinton Administration's Health Security Act and subsequent healthcare reform proposals submitted to Congress. Stokes and fellow Congressional Black Caucus leaders chaired Forum working groups comprised of over 40 prominent African American healthcare organizations and interest groups. The goal of the Forum was to reach a consensus on the healthcare needs of the African American community in order to present a unified front throughout the healthcare reform process. Representatives from national organizations such as the National Black Nurses' Association, National Association of Community Health Centers, and the Coalition of Black Hospitals attended the sessions, many of whom were key players in the enactment of the Disadvantaged Minority Health Improvement Act of 1990 (Blount, 1994). Social and equity issues, such as increasing the number of African American healthcare providers, and ensuring equal access and equal quality care to underserved areas were at the forefront of the Forum agenda. Thus, African American health professionals and legislators have already formed a national leadership coalition to whom HCFA can turn for policy and program advice. Currently, local chapters of these organizations, such as the Summit Health Coalition, already provide consultations to HCFA Regional Offices. For example, the New York City Chapter is working with the Region V HCFA office to design and implement a "Medicare Store", already in place in Philadelphia, PA, in a location convenient to all communities and neighborhoods in the five borough area. The implication for HCFA is that these groups, among others, can provide the Agency with important information and introductions to the community "players," and that Agency efforts that are well coordinated between central office and the Regional Offices can be very successful.

> "Who knows best about who we are, how we think, and what we need, than us?"
>
> - Louis Stokes, Congressman (D-Ohio)

Although the national network is helpful in providing insight into overall policy formulation and strategy, it is at the local level where the most pressing concerns of an individual community can be identified. An implication of this for HCFA is to solicit input and guidance from the local organizations who are already familiar with the residents and individual community infrastructure. Because of some previous government projects that may not have fulfilled community expectations, HCFA may have to "prove" its credibility and commitment. Too often community groups have invested time and resources into projects which have never seen fruition. Local groups are often inundated with information from organizations that is to be disseminated, and this needs to be recognized as well.

HCFA has already begun many such efforts at the community level, however, at this time some of them are somewhat narrow in their scope. The Horizons Pilot project, an example of these efforts, was initiated in 1996. The Horizons project works to foster community level partnerships among HCFA and HCFA-funded Quality Improvement Organizations, and Historically Black Colleges and Universities to achieve an increase in immunization and mammography rates among African Americans in the southeastern United States. Tennessee's Peer Review Organization, the Mid-South Foundation for Medical Care, is working with the Horizons Project, in collaboration with the region's Historically Black Universities and Colleges. As a result of this project, HCFA's partners and target population are becoming familiar with "HCFA," but only within the context of immunizations and mammographies. HCFA's name is not yet associated with Medicare in general, therefore the Agency may not be able to leverage name recognition as the agent providing health and Medicare information on a larger scale.

The New Family Services in Miami engages in community-level partnering to match agencies and organizations to the needs of its member seniors. One of its most effective services is a "one-stop" referral resource. Staff is committed to seeing through a problem or question to resolution, even when it is beyond the scope of their expertise. After an appropriate referral has been made, staff members are trained to follow up to make sure the senior has been taken care of. For minority beneficiaries, who may not feel comfortable accessing information from institutional and unfamiliar resources, community organizations and groups have become a lifeline of information to these communities. Many African American seniors, (as well as many seniors in general) do not venture beyond their own neighborhoods and often see no need to do so. This isolation creates a barrier which can be overcome only by supportive and invested family members, or proactive community leaders and groups.

> "No one expects HCFA to do everything. But HCFA needs to define exactly what it can and cannot do. Every organization must understand the limits of its resources and deliver what they promise."
>
> - Director, Manhattan Senior Center

It is clear from our various interviews, that HCFA recognizes the differing needs of minority populations. For example, the Minority Beneficiary Workgroup has provided recommendations for HCFA's central infrastructure in order to ensure that the needs of underserved and minority beneficiaries are an integral component of policy. A pilot project underway through the San

Francisco Regional Office is examining partnering opportunities with local groups and community service organizations as a means of systematically outreaching to minority communities. The results of this project will help HCFA understand both its capabilities and its constraints when working with minority populations. It is important to note that partnering with local organizations is very important to constructing an effective outreach program for an agency as large as HCFA. However, a preliminary step to partnering is developing an understanding of the community and the neighborhood so that the most appropriate community partners can be identified. Community partners should have a history in the community, should be organizations that are trusted within the community, and should be organizations that have the broadest community representation possible. Additionally, the mission of the organization should be congruent with the Agency's mission.

The Health Insurance Couseling and Assistance Project (HICAP), which is operated through the State Department on Aging, has limited resources and restricts its programs and services to the community at large. While there is the intent to reach each neighborhood, the HICAPs must find very central locations and use conventional methods to advertise and provide services. As a result, in some cities, several minority communities do not have access to or are not aware of HICAP services. In an effort to provide more comprehensive service, many HICAPs have actively recruited socially and culturally competent volunteers to extend the scope of their programs into historically African American, Latino and Asian communities. For the New York City HICAP, which serves a diverse population, work within communities through community leaders has helped advertise their services. Seniors are more likely to approach local leaders at the neighborhood level for help. The New York City HICAP has initiated a "train the trainer" strategy to develop a network of intra-community volunteers who are familiar with and trusted by the local neighborhoods.

Creation of a Well-Targeted Communication Strategy. One reason cited by respondents for the failure of many traditional mass media strategies for communicating with minority individuals is the obvious appeal of many campaigns to majority population interests and groups. Majority interests are often perceived to be different from those of minority populations, because they are based upon a culture having a different historical context. Cultural incongruence can be seen in all phases of message development, including the way the message is framed, use of stereotypical imagery, and erroneous assumptions about the audience. An example from one informant is the instance in which advertisements featuring African American families always depict a single-parent household. As communication strategies take into account the differences between the younger and older beneficiary generations, so should they incorporate differences across ethnicities. This not only includes cultural nuances, but the vehicles for and placement of messages. For example, relying on the American Association for Retired Persons (AARP) to reach African American retirees is not going to be maximally effective as AARP's black membership is fairly low. Instead, information should be disseminated through churches, pastoral organizations, local health providers and community health advocacy or education groups. Public locations in which materials are placed must also be carefully selected. Banks are often a good site for distributing information to seniors, as they come at minimum to deposit their social security checks. However, to reach African American beneficiaries, one must consider which banks are most accessible in predominantly black neighborhoods. In Harlem, for example, residents may be more likely to use and feel comfortable using Carver bank, a black owned neighborhood bank, than a Citibank or Chemical bank.

The following represent some additional "best practices" used by community groups serving African American seniors. These practices represent some of the specific suggestions from respondents to our interviews for communicating with beneficiaries in African American communities.

- Identifiable images - Community groups serving African American beneficiaries emphasize the need to attract the attention of seniors through materials that feature black seniors, national black leaders and celebrities, or traditional graphic designs such as those found in kente cloth.
- Placement of promotional materials - Use locales known to be frequented by African American seniors. Make no assumptions that a store purporting to cater to the African American community actually does so, or that the store has a large African American clientele.
- Choice of media - Use of neighborhood newspapers and local radio or television advertising, run during gospel or bible radio shows, for example. Several of the workers at senior centers we visited noted that television advertisements geared toward their senior clients should be run prior to 8 p.m., as their clients tended to retire early. One group of social service workers at a multipurpose senior center suggested running television advertisements during the airing of "Jeopardy," since the majority of their clients always watched the show.

In summary, non-traditional communication and information gathering strategies are crucial for HCFA to effectively disseminate information on Medicare to beneficiaries in African American communities. Furthermore, it will be important for HCFA to show a substantive and sustained commitment when partnering with local groups, and be sufficiently flexible to address the concerns of these communities in the Agency's messages.

HISPANIC AMERICAN BENEFICIARIES

While there is limited literature regarding health-related communications within the Hispanic community, there is a considerable body of research in health services that points to several important differences between individuals of Hispanic descent and other groups of Medicare beneficiaries. These differences have been shown to affect Hispanic beneficiaries' information needs regarding the Medicare program. As a result, communication strategies used with this diverse subgroup need to be tailored to accommodate some of these factors. For example, while only 4 percent of Hispanics are currently elderly (due to shorter life expectancy and high fertility), the group has experienced the greatest increase in median age between 1960 and 1990 of all ethnic minority groups, suggesting that the percentage of Hispanic elderly may rise steeply in the future as younger cohorts age into Medicare.

In this section, we present an overview of the Hispanic American group of beneficiaries, using information from the Literature Review, the Inventory Interviews, and an analysis of MCBS data from 1995 concerning public relations. We conducted interviews with multipurpose organizations serving Hispanic elderly in Los Angeles, Memphis, Miami, and New York, most of which provide a full range of social services to their clients, including help with their questions on Medicare.

Literature Review

Hispanic Americans represent the second largest ethnic minority group in the Medicare population, following African Americans, and also the fastest growing. It is widely speculated that Hispanics will outnumber the latter by the year 2000 (Frank-Stromberg, 1991). During the last decade, the elderly Hispanic population (age 65+) grew by 75 percent, from 709,000 persons in 1980 to 1,124,000 persons in 1991 (Census Bureau, 1993). Nearly three-quarters (73 percent) of elderly Hispanics live in just four States: California (27 percent); Texas (20 percent); Florida (15 percent); and New York (11 percent) (Hobbs and Damon, 1996).

The Hispanic American population is extremely diverse, and represents individuals from many places, among others, Mexico and Puerto Rico (the two largest groups), Cuba, El Salvador, Nicaragua, and Colombia, with each group having a unique cultural heritage and dialect (Hooyman and Kiyak, 1993). Although they share a common language, these groups differ substantially in their cultural traditions, levels of income and education, and geographic concentration. For example, Mexican Americans are the largest and poorest group (representing 64 percent of the Hispanic population in the U.S.) and are concentrated in five southwestern states. Cubans are the wealthiest and most highly educated, and have the largest proportion of foreign-born elderly among Hispanic groups. The largest populations of individuals of Cuban descent are located in New York, Florida, and New Jersey, while California and Texas are the two states with the largest overall Hispanic population. This diversity has led some to suggest that market-by-market analyses be performed in order to better understand the communication preferences of each group within the Hispanic community (Johnson and Delgado, 1989).

Cultural diversity within a group does not necessarily mean that entirely different communication strategies are required, however. A recent study found that showing English and Spanish videos

in clinic waiting areas was effective in increasing cancer screening rates among low-income Hispanic women both in New York City and in Los Angeles. The two clinics drew women of different cultural backgrounds. In New York City, the population served was largely Puerto Rican and Caribbean, while women at the Los Angeles clinic tended to be from Mexico and Central America. The video used interviews with members of the target population to explore beliefs, fears, misconceptions, and feelings about cancer risk and screening. Narrators and experts featured on the video were Hispanic. The videos appeared to be just as effective in the two different Hispanic groups suggesting that different approaches may not be necessary for conveying some health-related information in Hispanic sub-populations (Yancey et al., 1995; Yancey and Walden, 1994). Two keys to successful media communication across Hispanic sub-populations are: (1) to use it for conveying information on topics which evoke similar reactions from the different groups, and (2) to use Hispanic actors or announcers.

Because of recent growth in the Hispanic American segment of the U.S. population, there has been a great deal of interest in marketing consumer products to this group. To tap into this potentially lucrative pool of consumers, U.S. industries have engaged in extensive research on buying habits, behaviors, and preferences. Companies have been very successful in increasing their sales to Hispanics by conducting extensive market research, selecting audience segments, designing campaigns that are language-, culture-, and image-sensitive, and carefully tracking consumer response. From a strictly commercial perspective, the Hispanic community is no longer considered "hard-to-reach." However, the delivery of healthcare information and health education are considerably more complex than the delivery of most consumer products. For both formal and informal services, families and even the community profoundly influence the beneficiary's decisions. In addition, health education involves overcoming fears and misconceptions before being able to provide information or influence behavior.

Barriers to Communication with Hispanic Beneficiaries:

- a lower level of education than other groups,
- a high rate of poverty,
- lack of health insurance,
- generally poor health status, and
- the existence of language barriers.

It is estimated that over half of Hispanic elderly are not proficient in English, which presents a major barrier to education, employment, and utilization of health services. (Cuellar, 1990). It is also estimated that 22 percent of the older Hispanic population live below the poverty level, whereas less than 10 percent of older whites, for example, live below poverty. Poverty is one determinant of generally poor health status among Hispanic elderly, with 85 percent reporting at least one chronic condition. Because many Hispanic individuals entered the U.S. illegally, they have been unable to apply for Social Security, Medicare, and Medicaid, further isolating them from the healthcare system. Estimates of the number of individuals who are undocumented range from 3 million to over 10 million (Shirley, 1995).

Low Education

Of minority elderly groups, Hispanics have the least amount of education. Only 27 percent of Hispanics, as compared to 60 percent of the total elderly population, have completed high school (National Center for Education Statistics, 1995). Mexican Americans and Puerto Ricans are the most educationally deprived groups of the elderly population. Some estimate that as many as 16 percent of Hispanic elderly have had no formal education, so illiteracy is frequently a barrier to effective communication, especially through printed materials (Caring Magazine, 1991).

The proportion of Hispanics who have had formal education, however, does vary according to geographic region or across subgroups within the population. For example, one recent breast cancer awareness study among different subgroup populations found that less than half as many older Hispanic women had completed high school compared with older non-Hispanic white women (Saint Germain and Longman, 1993). Many Mexican and Central American Hispanics emigrated from very rural areas of their countries, have had no formal education, and are illiterate in either English or Spanish. One implication for HCFA in developing a communication strategy for use with Hispanic beneficiaries is to reduce dependence upon written materials, with increased use of media, person-to-person exchanges (for example, use of lay educators) and pictorial presentations.

High Poverty Rate

Poverty has widespread and major negative consequences, for both an individual's health status and his or her access to medical care. Hispanic Americans are disproportionately represented among the poor. The median personal income of an older Hispanic male (age 65 and over) is approximately 65 percent of older white males, and Hispanic females earn 68 percent of the income of white women (U.S. Senate Special Committee on Aging, 1992). The culture of poverty exerts a profound influence on daily activities (such as dietary choices, choices about leisure activities, and dependence upon public transportation) and priorities of individuals. Being able to pay rent and afford adequate food are more important to many than obtaining a mammogram, for example. Two obvious results of the impact of poverty on Hispanic beneficiaries' use of healthcare are delays in initially seeking treatment and difficulty obtaining and affording medications and diagnostic tests. There are two implications for HCFA: (1) the need to educate Hispanic beneficiaries about the importance of the regular practice of preventive behaviors and obtaining needed healthcare, both in terms of their value to one's health and availability under Medicare; (2) the need to provide additional information on enabling services, such as child care, transportation, and the other logistical factors that can present barriers to seeking care for an individual who is poor.

Lack of Health Insurance

Over the last ten years, the number of Hispanics without health insurance has increased five times more than the number of uninsured non-Hispanic whites (Trevino, et al., 1991). In California and Texas, for example, Hispanics account for a major proportion of the uninsured. Despite their high levels of employment, Hispanics do not tend to work for large firms that offer health insurance as a fringe benefit, concentrating in small firms in the low-wage sectors of the

economy. Without health insurance, Hispanics receive only half as much needed medical care as better insured groups (U.S. GAO, 1992).

Hispanics that are foreign born have less access than U.S.-born Hispanics to health insurance (41 versus 25 percent have no health insurance). Many elderly Hispanics lack insurance coverage, even through Medicare, although this varies by nativity status. Among elderly Hispanics, 7 percent of U.S.-born Hispanics have no Medicare coverage as compared to 18 percent of foreign-born Hispanics. Not surprisingly, access to health insurance improves with length of residence in the United States (Thamer et al., 1997).

There are several implications of this lack of insurance for the information needs of Hispanic beneficiaries and HCFA's efforts to communicate with them about Medicare. First, newly enrolled Hispanics may not have had previous experience with health insurance, and these beneficiaries will therefore need general information about insurance, in addition to information about Medicare. For example, beneficiaries will need to learn the meaning of a whole new set of basic terms relating to insurance, many of which will be completely unfamiliar to them. Studies have shown that the lack of insurance among Hispanics is most prevalent among women of Puerto Rican and Mexican descent between the ages of 50 and 64 (de la Torre et al., 1996). Since a smaller proportion of Hispanic elderly currently receive Medicare benefits (compared to 96 percent of the general population), information about the availability of Medicare itself is immediately relevant to a large segment of the Hispanic beneficiary population (Kasper, 1988).

Certain segments of the Hispanic population are particularly vulnerable because they lack health insurance and access to important sources of health information (such as healthcare providers). Nearly one half of uninsured Hispanics have no regular source of medical care, and most research evidence suggests that the uninsured tend to be less healthy and require more intensive care than individuals who have insurance (The National Coalition of Hispanic Health and Human Services Organizations, 1992). Thus, uninsured Hispanic individuals will need information on available treatment options, as well as information on the options that are covered by Medicare. For example, while a chronically ill beneficiary who needs to take medication on a daily basis might be better served by being enrolled in a plan that offers a prescription benefit, such as an HMO, he or she may not even know what an HMO is.

Poor Health Status

One's race and ethnicity have been shown to be powerful correlates of morbidity and mortality. It is estimated that the prevalence of diabetes, for example, among elderly of Mexican and Puerto Rican descent is 100 percent higher than among non-Hispanic whites (Garcia and Wallace, 1994). The importance of diabetes to HCFA and other payers is the disease's chronicity and the need for ongoing monitoring and treatment. Additionally, access to healthcare, patient education, and the quality of long term care can dramatically affect the course and outcome of treatment. There is considerable research evidence that healthcare costs, nearly four times as high for diabetic individuals as they are for nondiabetics, are responsive to disease management efforts.

Breast and cervical cancer survival rates for Hispanic women are lower than for white non-Hispanic women. Although mortality rate differences between populations are multidetermined,

there is some evidence that these differences can be attributed, in part, to differential rates of screening. For example, Hispanic women tend to have lower rates of mammography screenings and Pap smears than either African American women or whites (Brownstein et al., 1992). Low rates of screening have been associated with a variety of factors, such as age and stage of reproductive life, infrequent physician recommendations, cultural beliefs, education level, and logistical constraints (Celentano, 1988). Therefore, communication and outreach efforts need to be specifically tailored to a Hispanic female audience in order to overcome unique attitudinal barriers and increase access to care of this nature.

Language Barriers

According to the 1990 Census, as many as 40 percent of elderly Hispanics either do not speak English, or do not speak it well (1990 Census of Population and Housing, One Percent Public Use Microdata File). There are no national dialects of Spanish, although there are regional variations in the use of specific words and in the accent of the spoken language. A form of standardized Spanish or "Broadcast Spanish" is commonly used by television and radio networks to reach all Hispanics regardless of their country of origin because it is free of regional lilts and parochial vocabulary (Marin, G., et al, 1990). Several informants suggested that grammatically correct Spanish without any "street" terms is usually understood by most groups.

Research evidence of the extent to which the lack of English language fluency is a barrier to access is mixed. There are studies which indicate that English language fluency correlates with increased exposure to media-based health information, which in turn can help predict the use of some preventive screening tests (Ruiz, et al., 1992). Other research suggests that speaking Spanish, in and of itself, is not a barrier to obtaining some preventive health tests (Schur, et al., 1995; Richardson, et al., 1987). Controlling for language, socioeconomic characteristics, and enabling factors (such as income and health insurance status) Hispanics were found to be just as likely as others to have received an influenza vaccine (Mark and Paramore, 1996). Some authors link spoken language to health behavior as a proxy for attitudinal influences, such as mistrust or reverence for healthcare providers (Molina et al., 1994).

Interviews: Findings and Implications

We interviewed a variety of organizations who specialize in outreach to Hispanic and Latino communities. These included community service organizations, carriers, local government agencies and health service delivery organizations located in Miami, New York, Los Angeles and San Diego. Many of our findings regarding the information needs of and communication strategies for the Hispanic community were similar to the findings in the literature. The following paragraphs outline these findings, how they relate to the literature, and their implications for HCFA.

Information Wants and Needs of Hispanic Beneficiaries

As with other groups, the information Hispanic Americans want and need about Medicare centers both on specific questions about the benefits covered by the program (especially evident in the many descriptions we heard of how confusing beneficiaries find the EOMB to be) and more general questions about the program, especially about managed care. We were able to

observe several groups of primarily Hispanic seniors at senior centers in Miami as they were told about various aspects of Medicare. In one instance, a representative from the PRO was giving a brief talk on recognizing situations involving fraud. In another instance, one of the social workers was giving an explanation of managed care to the group. In both cases, we saw a wide range of levels of understanding, and considerable confusion. Two successful techniques were used by the social worker: first, she alternated between English and Spanish in her presentation, and second, she showed the clients a Medicare card as an illustration and had them take out their insurance cards. Although most seniors recognize the "red, white and blue" Medicare card, many carried several cards from different plans, including HMOs. The common misperception was that if they joined an HMO, they would "lose" their Medicare, so some refused to give up their Medicare card when they enrolled. Others had joined multiple supplemental plans, either not realizing that the plans overlap or being afraid they might not be covered without multiple plans.

Other specific needs identified in our interviews include eligibility information, and information on fraud and abuse. Many Hispanic seniors do not understand the abstract concepts of "fraud and abuse" and do not see that giving out their Medicare number for money represents abuse of their Medicare benefits, especially in Miami. Fraudulent activities are prevalent among the newly immigrated groups, and HCFA recently implemented an initiative called Operation Restore Trust to educate groups of beneficiaries about the importance of avoiding these activities and reporting suspected fraud.

Using market analysis to identify groups with special information needs within the general Medicare beneficiary population is vital. The results of such analyses can be used to target tailored messages to beneficiaries who do not understand the Medicare program, have especially great needs for particular Medicare-related information, or who have been frustrated in their attempts to get answers to their Medicare-related questions.

Subgroups of the Medicare beneficiary population with exceptional information needs were identified using data from a 1995 Medicare Current Beneficiary Survey (MCBS). The MCBS is a longitudinal, multipurpose survey of a nationally representative sample of approximately 14,500 aged and disabled persons eligible for Medicare. In 1995, a series of communication-related questions were asked as part of the survey in the public relations module. This module was administered to nearly 14,000 community-dwelling beneficiaries.

Preliminary bivariate analyses were conducted to identify any sociodemographic characteristics of Medicare beneficiaries associated with Medicare-related communication and informational needs. Three sets of analyses are presented. Beneficiary sociodemographic characteristics were examined to determine the best predictors of:

- Understanding the Medicare program, and
- Finding needed information or getting answers to questions.

Twelve sociodemographic variables were available for analysis: age, sex, marital status, educational attainment, income, urban/rural residence (metro/non metro), region of residence (census region), Hispanic ancestry, race, dual eligibility (Medicaid coverage), Medicare

eligibility status (under age 65 and disabled), and self-reported health status. These analyses are limited, however, and are presented for illustration of points earlier in the discussion about the implications for HCFA of the sociodemographic correlates of informational needs.

Predictors of Self-Reported Understanding of Medicare

As many as 70 percent of the general population of Medicare beneficiaries report that the Medicare program is understandable when asked "In general, do you think the Medicare program is understandable?" Among Hispanic beneficiaries, only 57 percent report understanding the program. Cross-tabulations with the sociodemographic characteristics shown to be prevalent among Hispanic beneficiaries suggest that these characteristics do impede understanding of the Medicare program:

- Beneficiaries with low educational attainment are less likely to understand (58 percent of those with less than 8 years of education report understanding the program),
- Beneficiaries who are residents of Puerto Rico are less likely to understand (60 percent report understanding the program),
- Beneficiaries with low incomes are less likely to understand (64 percent of those with incomes less than $9,000 in the previous year report understanding the program), and
- Beneficiaries with poor/fair self-reported health status are less likely to understand (65 percent report understanding the program) than the general population.

Predictors of Unmet Informational Needs

Among Medicare beneficiaries with a need for at least some Medicare-related information, more than one-third (36 percent) either did not find the needed information or found information that did not answer their questions or meet their needs. Cross-tabulations with available sociodemographic characteristics suggest that the following are associated with informational needs:

- Beneficiaries with lower educational attainment (42 percent of those with 8 or fewer years of education) have unmet needs;
- Beneficiaries in fair/poor health (42 percent of those in fair or poor health) had unmet needs; and
- Beneficiaries residing in the Southern Census region had higher levels of unmet needs (41 percent).

These above demographic correlates of self-reported understanding of the Medicare program and unmet information needs support assertions in the health services literature that the needs of this diverse beneficiary group differ from the needs of the general beneficiary population and from many of the needs of other groups.

Strategies for Understanding Information Needs

Informants we interviewed who work closely with Hispanic seniors generally rely on their daily contact with clients to uncover their information needs. Informal mechanisms are most often used, such as conversations with seniors or their families. Additionally, especially in Miami, representatives from all of the social service organizations belong to formal networking groups and sit on state and area advisory councils along with members of other groups. We found that organizational networks involving all or most of the "players" in the area (such as the ICA, local AARP chapter, HCFA Regional Office, carriers and managed care plans, in addition to local service providers such as multipurpose senior centers and community-based services) generally have a very good sense of all that is going on in the community. The implication for HCFA is to partner with a number of organizations in a community through the local area agencies on aging in order to access strong and powerful networks of organizations that have an accurate picture of local constituent need.

In both this inventory, as well as the previous one, we found that the most effective organizations regularly assessed customer need and systematically tracked customer inquiry and feedback, incorporating it into their operations in order to improve processes. In our interviews with Federal agencies, we also saw considerable evidence of efforts to use customer feedback to improve their processes. Many organizations are able to tailor their interactions with the Hispanic community through using printed materials written in Spanish and bilingual field staff.

CDC collects data through many avenues and processes such as disease surveillance, academic research, laboratory analysis, health surveys, environmental data, public opinions, social and behavioral science research, health insurance claims, vital statistics, census, and other healthcare data. This information is collected via passive and/or active surveillance. An example of passive surveillance is the CDC's National Electronic Telecommunication System for Surveillance (NETSS) which collects disease information from all states and territories, and then provides weekly transmission of over 40 conditions to state and local health departments. On the other hand, the CDC's National Immunization Program (NIP) conducts an active surveillance by providing leadership for the planning, coordination, and conduct of immunization activities nationwide. This Program currently assists health departments in developing vaccine information management systems that can facilitate the identification of children who need vaccination, and help parents and providers ensure that vaccination schedules are kept for all children in the area.

The Social Security Administration (SSA) uses computer matching programs to compare its records about an individual's income, living arrangements, and resources with records of other federal, state, or local government agencies. This information is used to determine whether a person initially qualifies for SSI benefits and to re-determine their eligibility over time. SSA data files are also critical for the determination of other benefits, such as Medicaid and Medicare.

The implication for HCFA is that it might be extremely useful for the Agency to collect detailed information from beneficiaries at the time of their enrollment in Medicare. Having detailed data would allow systematic tracking and analyses by subgroup, and would help identify key trends affecting the health of minority beneficiaries. Some attention should be paid initially to details such as using identifiers consistent with those used by the U.S. Census Bureau. Because race, as

a concept, has evolved over time from a biological one to a social one (Lee, 1993), it is difficult to measure. For example, the Census Bureau has changed procedures often in the course of taking 21 US censuses, and recommendations have recently been released for changes in the Decennial Census. The construct has been used in health services research as a proxy for other unmeasurable variables, such as socioeconomic status, cultural practices, and unspecified biological differences among groups (Williams, 1992). The way in which race is conceptualized will eventually influence policy development, so the variable should be carefully specified at the outset (LaVeist, 1994).

Communication Strategies

The literature contains many examples of communication campaigns aimed at the Hispanic community, and our interviews revealed a wealth of "best practices" being currently used by informants to convey health information. Many mass media campaigns rely on celebrities to promote their message. Some suggest that there are relatively few Hispanic celebrities of national standing, but that there are many sports figures, musicians, and others with a strong enough regional following to allow for a local market approach to communication.

Providing communication to elderly Hispanics through family members is a strategy that often works effectively, as Hispanics tend to live with extended families and are less likely than African American or white elderly persons to live alone (Hobbs and Damon, 1996). One possibly effective strategy to reach elderly Hispanics is through their children and grandchildren. Programs built around an intergenerational strategy are particularly effective among Hispanics, given the extensive family networks and the importance of these networks within this community. For example, a school-based intervention, although not directed at the elderly, reported success in recruiting Mexican-American families to participate in weekly seminars on nutrition and health (Nader et al., 1986). We visited a clinic run by a nurse practitioner in rural Tennessee which has a sizable population of mostly transient Hispanic farm workers. Because many of the patients did not speak much English, she decided to contract with a Spanish-speaking physician to see patients every Wednesday. Notices written in both Spanish and English were distributed at the local schools for students to take home. Within a very short time, news of the new physician had traveled throughout the community, and very soon the Hispanic patients began to visit the clinic mostly on Wednesdays.

Very early research found that the most common source of health information among the Mexican American community was the doctor, followed by television, newspapers, magazines, family, and radio. Nurses, pharmacists, and friends were the least cited sources. Additionally, language preference (Spanish or English) seemed to be a significant predictor of media preference. Those more comfortable with Spanish preferred television, radio, and newspapers, while those interviewed in English were more likely to report that they received health information from magazines (Gombeski et al., 1982).

Workers at the James E. Scott Community Association (JESCA) in Dade County told us that the best time to air public service announcements on television to reach their Hispanic senior clients was in the evening, before 8 p.m., preferably on Spanish television networks.

> Providing health information to Hispanic seniors can be challenging because of language and cultural barriers, their lack of access to healthcare providers as sources of health information, and their generally low educational attainment. On the other hand, targeting the elderly Hispanic population is relatively easy--nearly three-quarters of elderly Hispanics live in just four States: California; Texas; Florida; and New York.

We were told by social service workers in both Miami and Los Angeles that Hispanic seniors tended to revere physicians, and preferred doctors as their source of health information. Later research found consistent results across other minority communities as well, where the physician was sought most frequently in healthcare decisionmaking (Sofaer and Schweitzer, 1994). Other informants at multipurpose senior centers in Miami spoke of reaching Hispanic elderly through local Spanish radio, saying that in their countries of origin they had always listened to the radio. One informant who ministers to the Cuban community in Miami has a weekly call-in radio show, where he answers listener's questions on Social Security, Medicare, Medicaid, and other government programs. In all cases, communication was most successful when multiple channels were used.

Our interviews confirmed findings from the literature review that Hispanic individuals respond well to mass media combined with interpersonal communication. For example, in Miami, we interviewed a man who works for the SSA and who hosts a weekly Spanish radio talk show. The show generally covers issues regarding Medicare and Social Security, and callers can phone in and ask their questions. The show combines information dissemination with the personal attention given to callers that has been shown to be most effective. The following example from our literature review is another powerful illustration of this finding. In this case, communication efforts with Medicare beneficiaries are designed to not only convey information, but also to produce a behavioral change. In an effort to counter the effects of tobacco advertisement aimed at Hispanics, a mass media health promotion program encouraging smoking prevention and cessation was launched in southwest Texas (called A Su Salud or To Your Health). The A Su Salud project (funded by the National Cancer Institute) was a partially randomized, longitudinal study with a quasi-experimental design involving adult residents (18 to 64 years old) from about 1,200 households in two communities along the Texas/Mexico border. One community served as a control. In the experimental community an extensive mass media campaign was implemented in Spanish and English for television, newspaper, and radio. Residents within the experimental community were randomly assigned to one of two groups. In the first, a network of 400 volunteers distributed materials and a self-help booklet in the form of an illustrated novel. A second group within the experimental community received a more intensive program with a referral service and direct counseling for smoking cessation. Panels of moderate to heavy smokers were followed to compare smoking cessation rates in the control and experimental communities. Over a five-year study period, virtually no one in the control community stopped smoking (smoking status was verified using breath samples) and 8 percent of those within the experimental community had quit smoking. Somewhat surprisingly, within the experimental community, no differences in quit rates were seen among those exposed to the community

volunteer program and to personal counseling. The community based program appears to have had a modest impact and more intensive interventions did not yield higher smoking cessation rates (Ramiriz and McAlister, 1988; McAlister et al., 1992).

Community-based Health Communication Efforts

Given the geographic concentration of Hispanics, it is feasible to develop efficient local communication strategies to reach many individuals in the targeted areas. Approaches in the past have relied on institutions, schools, churches, and social services institutions to reach audiences. Relatively little attention has been paid to point-of-purchase, direct mail, street intercept and other innovations. One inexpensive and creative example of marketing social programs to Hispanics is to provide printed information about English language classes on customer receipts in supermarkets in Hispanic neighborhoods (Johnson and Delgado, 1989).

Our interviews revealed a wide variety of efforts in which local senior organizations provided innovative outreach to Hispanic neighborhoods and communities, in conjunction with the more traditional social services. In Miami, for example, the "Little Havana" Senior Center conducts annual Nutritional Risk Assessments of their clients. The most recent assessment found that 65 percent of their elderly clients were at moderate to high nutritional risk. Little Havana has a daily lunch program which provides about one-third of daily nutritional requirements, but for many local seniors, it is their only meal of the day. As a result, the center serves as a focal point in many clients' lives, and staff are able to see and talk with them on a daily basis on a variety of topics. The De Hostos Senior Center, also in Miami, serves about 120 seniors, largely of Puerto Rican descent, and has been in the community for over 20 years. De Hostos provides nutritional breakfast and lunch from Monday to Friday, a schedule of activities (such as dance classes, games, and field trips) and transportation to and from the center. Although lack of staff prevents formal outreach programs, word-of-mouth is a very efficient communication channel within the community. With some additional support, workers told us the program could be broadened and formalized.

The A Su Salud model, discussed above, was also successfully used to promote cancer screening among Mexican-American women in Corpus Christi, Texas. The use of positive role models in the media and positive social reinforcement by community volunteers led to a 57 percent increase in mammography use two years following the campaign, although there was no improvement in Pap smear testing (Suarez et al., 1993).

A Texas County Health Department used a multifaceted health promotion campaign in an effort to reduce the consequences of high rates of chronic disease in low-income Mexican American neighborhoods. With the assistance of a local university, a mass-media campaign was conducted, 50 volunteer community leaders were recruited and trained, and they in turn were asked to reach out to 10 others. This group of 50 volunteers extended support to approximately 500 individuals attempting to make life-style changes in order to reduce their risk of chronic illness (Tiernan, 1988).

In another National Cancer Institute funded project aimed at smoking cessation, a media campaign was targeted to Hispanics in San Francisco. The media messages were tailored to the

specific smoking related concerns of Hispanics and were not just "translations" of a program that had been developed for a different ethnic group. Research indicated that Hispanic smokers differ from non-Hispanic, white smokers in how they perceive of smoking (e.g., it is more of a social event) and its risks (e.g., Hispanics show more concern for short-term effects of cigarette smoking such as bad breath and are more concerned about being a bad role model for their children). Over a 7-month period, informational and motivational messages were delivered through a variety of media (television, radio, pamphlets, fliers, posters, billboards, bus cards, newspaper articles, and bumper stickers), through community group meetings and activities, and personally or by telephone by program staff. Free cessation clinics and a Spanish-language, culturally appropriate self-help manual for quitting cigarette smoking were offered. According to surveys conducted before and 7 months after the media campaign began, awareness and information about the effects of cigarette smoking and about cessation services improved, especially among the less acculturated groups (Marin et al., 1990).

In summary, Hispanic beneficiaries represent a population which has special information needs regarding the Medicare program. Furthermore, because of language and other barriers, special communication strategies are required in order that beneficiaries can understand their Medicare benefits and make the best choices concerning their healthcare. In many communities, there are extensive networks of organizations serving Hispanic elderly, and for the most part, healthcare is embedded among a myriad of social services, such as housing, transportation, and community programs. Information needs and suggested communication strategies from the interviews are summarized below.

Barrier to Communication with Hispanic Beneficiaries	Information Need	Recommended Communication Strategy
Diversity in country of origin	Broad range of information needed by different groups	Sensitivity to intergroup dynamics, rivalries, and special colloquialisms
Many non-English speakers	Materials presented in Spanish language	Use standard textbook Spanish and avoid slang or "street Spanish"
High poverty rate	Availability of special programs and services (e.g., QMB, SLMB)	Educate beneficiaries on the importance of health and prevention
Low education	Range of information	Reduced dependence upon written materials in favor of media and pictorial approaches
Lack of health insurance	General information on insurance as well as specific information about benefits	Present information using a layered approach and using multiple channels

Current HCFA Communication Initiatives for Hispanic Beneficiaries

HCFA's central and Regional Offices have developed many communication products specifically targeted to Hispanic beneficiaries. The Internet will increasingly become a useful vehicle for

disseminating culturally sensitive educational materials as individuals who are computer-savvy age into Medicare. For example, a new website addressing how language and culture affect the delivery of health services will soon be available through Resources for Cross Cultural Healthcare and the National Conference of State Legislatures. The site will include information on model programs, best practices, and training courses (Cross Currents, 1996). A variety of communication products specifically targeted to Hispanics that are available through HCFA's central and Regional Offices are briefly described below.

Selected HCFA Products Targeted to the Hispanic Audience

Television Projects

Spanish Television Interview on Flu Shots--Featured Spanish speaking interviewer visiting a local junior college where flu injections were being given to senior citizens.(Dallas Regional Office).

Public Service Announcements for TV advertising HICAP services--Five 30 second TV PSAs developed with one being in Spanish. Issues included Medicare (San Francisco Regional Office).

Let's Talk About Medicare--Discussion of Medicare issues (Division of Medicare's Puerto Rico Field Office).

QMB and ICA Public Service Announcements--Two 30-second PSAs distributed to 154 TV stations, 59 cable TV stations and 100 radio stations. Spanish captioning added to the videotapes in certain demographic areas (Dallas Regional Office).

Radio Projects

Medicare Radio Outreach to Latino Community--Radio program "El Medico de Usted" (Your Doctor) reaching a Latino audience of over 250,000 in New York. Discussions include Medicare (New York Regional Office).

Puerto Rico Radio Initiatives--Ten 30-second PSAs developed in English and Spanish distributed to 80 radio stations in Puerto Rico and the Virgin Islands. Medical director hosts radio show on health and Medicare issues (New York Regional Office).

Let's Talk About Medicare--Series of twenty programs broadcasted island-wide on Puerto Rico. A daily radio broadcast of "Let's Talk About Medicare" will air. Also includes P.R. Medicaid Program (Division of Medicare's Puerto Rico Field Office).

Spanish Radio in Los Angeles--Focus on efforts to disseminate information to the Spanish speaking community. Available are Spanish literature and Spanish speaker as needed (Transamerica Occidental Life Insurance Company).

Spanish PSA Mammography - Do Something for Yourself--Plea for Hispanic women to take care of themselves. It encourages mammography screening.(Dallas Regional Office).

Video Tape Projects

Spanish Medicare Video/PSAs--Video featuring a general Medicare Part B in Spanish. Close captions for hearing impaired. (New York Regional Office).

Print Media

Print Media Outreach to Latino Communities--PSAs in "El Diario," a Spanish language newspaper distributed in Puerto Rico and the eastern seaboard. Also negotiating with Puerto Rico newspapers regarding running a column on Medicare issues (New York Regional Office).

New York Region Medicare Print Media Outreach--Includes press releases on Medicare to over 30 local newspapers in New Jersey, New York (including Spanish and Chinese language newspapers and African American weekly), Puerto Rico and the Virgin Islands (Division of Medicare's Customer Relations Branch).

Print Media Outreach to Latino Communities--PSAs run in "El Diario," a Spanish language newspaper distributed in Puerto Rico and the eastern seaboard. Negotiation with three Puerto Rico newspapers in regard to running a column on Medicare issues (New York Regional Office).

Other Media Projects

Ethnically Diverse Speakers Bureau--Recruiting ethnically diverse volunteers as outreach speakers in designated ethnic communities. HICAP translated previously publicity materials (brochures) and presentation scripts in Mandarin Chinese, Vietnamese, and Spanish under ICA grant (San Francisco Regional Office).

Ethnic Minority Outreach--Target of ethnically diverse news publications and radio and television stations to reach Asian, Hispanic and African American senior population.(San Francisco Regional Office).

"Medipass"--Explanation of the managed care plan for Medicaid enrollees available in English and Spanish.(Florida Medicaid Agency).

Tell Your Medicare Parents about the Flu Shot--Four rotating messages regarding flu shots both in English and Spanish run on an electronic message board onboard the Dallas Area Rapid Transit system (Dallas Regional Office).

It's Your Life...Know Your Number-A Patient Guide to Two Important Measures That Show How Well Your Hemodialysis is Working--Brochure developed to educate patients on the adequacy of dialysis and to increase their participation in their own care. Brochure will be available in English and Spanish.

Spanish translation of ARU for use by Spanish speaking beneficiaries--(Dallas Regional Office).

Spanish EOMB--Beneficiaries throughout Florida will receive their EOMB's in Spanish upon request (BPO).

Spanish Translations--HCFA letters are translated into Spanish. BPO responds in Spanish, as well as translates help forms in Spanish.(BPO).

Audio Version of 95 Medicare Handbook--Audio version of the 95 Medicare Handbook to be translated into Spanish. Copies will be made available at no charge to hearing-impaired beneficiaries (Chicago Regional Office).

Comprehensive Outreach Package(COP)--This *Comprehensive Outreach Package* was published by the California Dept. of Aging. Package includes twelve fact sheets in English and Spanish (San Francisco Regional Office).

Spanish HICAP Poster--Duplication of the HICAP English Poster being completed in Spanish by a marketing firm (San Francisco Regional Office).

Other Media Projects, continued

Spanish translation of flyer on Medicare fraud--Flyer describes various practices being used in Florida to bilk the Medicare program (Atlanta Regional Office).

Source: Project Customer: A listing of HCFA Customer Service Activities, September 1995

DUALLY ELIGIBLE BENEFICIARIES

Medicare beneficiaries who receive benefits through their state Medicaid program are known as dual eligibles. Dual eligible beneficiaries can be over age 65, or can be younger with disabilities, cognitive or mental health problems, or AIDS. HCFA is particularly concerned about the information needs of this group of beneficiaries for several reasons. Although Medicare is considered to be the primary payer for those individuals enrolled in both programs, there are concerns about dual eligibles' access to healthcare. The current healthcare delivery system is not well suited to meeting the needs of dual eligibles. Recent evidence suggests that dual eligibles are less likely than other beneficiaries to receive certain preventive and follow-up care (PPRC, 1995). Dual eligible beneficiaries are considerably more likely to be members of an ethnic minority group than the general beneficiary population and research evidence suggests that minority groups are not effectively served in existing delivery systems. Finally, dual eligible beneficiaries seem to have greater healthcare needs and present challenges that differ from those presented by the general Medicare beneficiary population (Merrell et al., 1997). While only 16 percent of Medicare beneficiaries receive some assistance from the Medicaid program, dual eligibles represent 30 percent of Medicare expenditures. Similarly, while dual eligibles are approximately 17 percent of the Medicaid population, they represent 35 percent of total expenditures.

A high proportion of dual eligibles reside in long term care institutions. While only ten percent of all individuals on Medicare are institutionalized, 90 percent of the institutionalized population are Medicare beneficiaries. Additionally, Medicaid is the major payor for institutionalized care, covering up to 50 percent of healthcare costs for the institutionalized. Although this Inventory Report primarily pertains to the information needs of community dwelling beneficiaries, tailoring communication for dually eligible beneficiaries will involve some discussion of institutional and long term care coverage and options.

There are two ways a beneficiary can receive assistance from the Medicaid program. First, a beneficiary can qualify for Medicaid, either by being categorically eligible or medically needy. Categorical eligibility is based upon qualifying for income assistance programs, such as Supplemental Security Income (SSI) or Aid to Families with Dependent Children (AFDC). Medicaid eligibility is also extended to individuals who are considered medically needy. Medically needy recipients exceed the income and resource requirements of the categorically needy, however due to high healthcare bills, these recipients have net incomes at or below poverty level. Because eligibility categories vary from state to state, and are either based on income and resources, or functional and medical need, the dually eligible population is extremely heterogeneous.

The second way in which a beneficiary who does not otherwise qualify for Medicaid can receive assistance from the program is by having his or her Medicare premiums and cost sharing expenses (deductibles and co-payments) paid. Two low income groups of beneficiaries are eligible: (1) qualified Medicare beneficiaries (QMBs) - those whose income is below the poverty level and whose assets do not exceed 200 percent of those allowed under the SSI program; and (2) specified low-income beneficiaries (SLMBs) - those whose income is 120 percent of the

poverty level and whose assets do not exceed 200 percent of those allowed under the SSI program. QMBs receive both Part B premium and cost sharing support from Medicaid, while SLMBs only receive their Part B premium.

The findings of this inventory suggest that dual eligible beneficiaries need three types of information:

- Beneficiaries not otherwise eligible for Medicaid need better outreach about the QMB and SLMB programs and the benefits they are entitled to receive;
- Beneficiaries receiving full Medicaid benefits need information on how to coordinate their care between programs; and
- Dual eligible beneficiaries need information on managed care, due to recent changes in state policy toward implementing mandatory managed care in their Medicaid programs.

Literature Review

In 1995, about 6 million individuals were dually enrolled in Medicare and Medicaid (Hegner, 1997). Over 70 percent of the dual eligible population were elderly, including 17 percent who were over 85 years old. Two segments of the dual eligible population are expected to grow rapidly: non-elderly disabled individuals and individuals over 85 years old. In 1991, non-elderly disabled individuals comprised 10 percent of the Medicare population and this percentage is expected to increase to 17 percent by 2010. Beneficiaries over age 85 represented approximately 8 percent of the Medicare population in 1991, increasing to about 11 percent in 2010 (HCFA, 1997).

Dual eligibles are of particular concern to states and the federal government because they account for a disproportionate share of Medicare and Medicaid spending and exhibit such a diverse range of healthcare needs. Although significant cost shifting between programs occurs, in 1995, approximately $106 billion was spent on dual eligibles, split almost evenly between Medicare and Medicaid (Hegner, 1997). Medicaid spending has been concentrated on services related to long term healthcare, skilled nursing facilities, and prescription drugs. In 1995, Medicaid spent $9,293 per elderly recipient. Seventy five percent of Medicaid healthcare spending can be attributed to long term healthcare and acute care expenses (Kaiser Commission on the Future of Medicaid, 1995). On average, annual per eligible spending for dual eligibles is nearly twice that of non-dual eligible beneficiaries. Per eligible annual spending on Part A was $3,628 vs. $1,842 for non-dual eligible in 1995. That same year, spending on Part B was $2,065 for dual eligibles vs. $1,072 for non dual eligibles. These figures are expected to increase over time since segments of the Medicare population, such as the non-elderly disabled, and individuals over age 85 (who have higher healthcare utilization) are among the fastest growing. Beneficiaries over age 85 had healthcare expenditures that were 11 percent higher than younger beneficiaries (those between 64 to 84 years old) in 1995 (HCFA, 1997).

There are three primary issues concerning the information needs of dual eligibles that are of particular concern to HCFA: 1) beneficiaries' navigation through two separate entitlement systems which seem fragmented in that certain services are covered while related services are

not; 2) dual eligibles' generally high levels of healthcare spending; and, 3) rapid increases in the enrollment of dual eligibles in managed care as states move toward mandatory Medicaid managed care.

Health services researchers have generally used the Medicare Current Beneficiary Survey (MCBS) to identify the characteristics of dual eligibles such as their demographics, self reported health status, and access to and utilization of healthcare services (Neumann et al., 1995). It is the only HCFA data system that contains nationally representative information on beneficiaries' health status and functioning linked to data on the use and cost of health services. Characteristics of dual eligibles that are of concern to HCFA because they influence the types of information beneficiaries need include:

Demographic Characteristics.

Partially due to Medicaid's eligibility requirements, the demographic characteristics of dual eligibles reflect the program's public policy focus, and differ significantly from beneficiaries without Medicaid coverage. The dual eligible population is comprised of disabled non-elderly Medicare beneficiaries, frail elderly, as well as low income elderly who may or may not be frail. Dual eligibles tend to be among the most vulnerable, tend to have low levels of education and income, and are more likely to be among the oldest-old and to live alone. Less than 25 percent of dual eligibles are married, compared to over 60 percent of non-dual eligibles.

An analysis by the Physician Payment Review Commission (PPRC) of the 1995 MCBS found that dual eligibles are more likely to be female (64 percent versus 56 percent of non-dual eligibles). In addition, a higher proportion of dual eligibles were found to belong to racial minority groups (29 percent versus 8 percent of non-dual eligibles) and tend to be among the oldest old (15 percent were 85 years or older compared to 10 percent of non-dual eligibles). Approximately 17 percent of dual eligibles were found to live in an institutional setting compared to 4 percent of non-dual eligibles (PPRC, 1997). An earlier analysis of the 1992 MCBS also found that dual eligibles were more likely to live alone (34 percent compared to 24 percent of non-dual eligibles). Furthermore, according to the 1994 MCBS, the educational level of dual eligibles averaged 6.9 years of education, compared to 11.3 years of education for non-dual eligibles (Hegner, 1997).

Health Status

Dual eligibles were more than twice as likely to report being in poor health than non-dual eligibles (19 percent versus 8 percent for non-dual eligibles) (PPRC, 1997). A similar analysis of the 1993 MCBS by Merrell, Colby and Hogan (1997) found that dual eligibles were more likely to report a greater number of limitations associated with activities of daily living than non-Medicaid beneficiaries. An earlier study also found that about 75 percent of dual eligibles reported some disability, compared with about 13 percent of beneficiaries aged 65 to 74 in the general population and 25 percent of beneficiaries aged 75 to 84 (McBride, 1989).

Access to Care and Utilization of Health Services. Two types of measures have been used to assess dual eligible beneficiaries' access to care. The first type of measure is self-reported, and studies have shown that dual eligibles were more likely to have delayed seeking care because of

high healthcare costs, less likely to be satisfied with the quality of healthcare provided to them, and less satisfied with the availability of healthcare than their non-Medicaid counterparts. The second measure, developed by RAND for the Physician Payment Review Commission, consists of clinical indicators of access to care among Medicare beneficiaries. Dual eligibles were less likely than non-dual eligibles to obtain preventive treatment, follow-up care, or screening. Between 1992-1993, while 40 percent of female Medicare beneficiaries received mammography screenings every two years, only 25 percent of female dual eligibles received them (Merrell et al., 1997). Dual eligibles were almost twice as likely as non-dual eligibles to use the emergency room in 1995 (HCFA, 1997).

In addition to their Medicare benefits, approximately 91 percent of Medicare beneficiaries are covered by additional health insurance. Beneficiaries may also have employer-sponsored retiree health coverage or may purchase private Medicare supplemental coverage. For dual eligibles, their acute care services are provided through the Medicare program, however the Medicaid program covers their long-term care needs, and other health services such as prescription drugs and transportation.

Due to the lack of coordination between the federal and state programs and the resulting fragmentation of healthcare delivery, recipients face overlapping though not identical health benefits, separate eligibility requirements, different billing procedures, and often, a plethora of claims forms. For the dual eligible patient, this creates confusion and frustration, and becomes a barrier to accessing healthcare. For example, a dual eligible beneficiary with severe mental illness who needs home health benefits (which would likely prevent or reduce readmissions) and who attends a rehabilitative day treatment program covered by Medicaid does not qualify for the Medicare home health benefit because of the requirement to be homebound.

Only a small percentage of dual eligibles are enrolled in managed care. In 1994, for example, dual eligibles comprised 7 percent of overall enrollment in Medicare HMOs (Hegner, 1997). There may several explanations for the low enrollment of dual eligibles in managed care. Facing a new delivery system, both dual eligibles and the general beneficiary population may be hesitant to change their existing healthcare providers, especially their family doctor. In addition, there may be some disincentives for managed care organizations to enroll dual eligibles. Dual eligibles are often considered to be more expensive due to their poorer health status and higher levels of healthcare utilization. Furthermore, while managed care capitation rates are slightly higher for serving dual eligibles, this payment differential may not provide enough of an incentive to managed care organizations for enrolling this population.

In 1995, a series of communication-related questions were asked as part of the public relations module of the Medicare Current Beneficiary Survey (MCBS). This module was administered to nearly 14,000 community-dwelling beneficiaries. The following information focuses on the communication and information needs of dual eligibles. For this analysis, beneficiaries who reported having Medicaid coverage (for either all or part of the year) are defined as "dual-eligible."[1] Information is also provided on Medicare beneficiaries reporting health insurance coverage through the Veterans Administration, private insurance (either group or individual), and other sources.

In general, dual eligibles appear to be less likely than privately insured beneficiaries to understand the Medicare Program. When asked, "do you think the Medicare program is understandable?" the proportion saying "yes" varied from 64 percent for dual eligibles to 74 percent for the privately insured beneficiary population. Intergroup differences in the level of understanding are reduced somewhat when comparisons are made within education and income groups.

Dual eligibles tend to have similar informational needs as beneficiaries in general, but have a somewhat higher need for information regarding the availability of a doctor that accepts Medicare assignment. Dual eligibles are as likely as non-dual eligibles (17 versus 18 percent) to have needed information in the last year on at least one of the topics listed below:

- New Medicare benefits or changes to the Medicare program (7 versus 6 percent),
- How to find a doctor accepting Medicare assignment (7 versus 4 percent),
- Medicare coverage (9 versus 7 percent),
- Supplemental insurance coverage (6 versus 8 percent), and
- Payment for a particular medical service (5 versus 4 percent).

Dual eligibles appear to have similar experiences as the general beneficiary population in not being able to find general Medicare-related information (27 versus 25 percent report not finding at least some needed information). When compared to beneficiaries in general, dual eligibles, however, have even less success in finding specific information on new benefits or changes in the Medicare program (35 versus 27 percent in the general population do not find information) and on the level of payment for a particular service (25 versus 21 percent do not find information).

It is difficult to pinpoint why information is not found. As part of the survey, respondents are asked if they needed information in the past year, and if so, where they found the information. If the respondent reports that they did not find needed information, it is not clear whether it is because they did not seek information, or because they sought information and could not understand or find it.

Sources of Information

For the population as a whole, preferred sources of Medicare-related information include the media, such as TV, newspaper, radio, and magazines (45 percent), doctor's offices (41 percent), Medicare publications (37 percent), supplemental insurance companies (33 percent), Social Security or local Medicare office (32 percent), and family and friends (31 percent). Table 1 summarizes some findings from the MCBS survey regarding differences between the preferred sources of information among dual eligibles than among beneficiaries who are not dual eligible.

Table 1. Sources of Medicare Information among Dual eligible Beneficiaries

Information Source	Dual Eligibles	Non Dual Eligibles

Doctors' Offices	56%	41%
Family and Friends	46%	31%
Social Security Offices	42%	32%
Local Hospitals	26%	18%
Insurance Companies Processing Medicare Claims	14%	25%
Medicare Publications	28%	37%
Senior Citizen Groups	8%	14%

Roughly 10 to 20 percent of beneficiaries who report having a source of Medicare information also find that the available information does not meet their needs or answer their questions. If not finding information is combined with not having questions answered, dual eligibles in need of information fare as well as the general beneficiary population--just over one-third are left with unmet needs.

Differences have been observed in the extent to which dual eligible beneficiaries make use of printed Medicare materials and find them to be useful.

Table 2. Beneficiary Ratings of HCFA Materials

Medicare Printed Information	Dual Eligibles	Non Dual Eligibles
Report receipt of an EOMB statement	64%	82%
Find EOMBs "easy to understand"	68%	77%
Use the *Medicare Handbook*	18%	27%
Rate the *Medicare Handbook* as "very useful"	36%	30%
Use of the *Guide to Health Insurance for People with Medicare*	4%	5%
Rate the *Guide to Health Insurance for People with Medicare* as "very useful"	42%	37%
Rate the *Guide to Health Insurance for People with Medicare* as "not at all useful"	14%	7%

Over half of Medicare beneficiaries (59 percent) report being interested in watching a weekly Medicare television program, and interest is even higher among dual eligibles (64 percent). When asked whether the availability of a toll free telephone for questions about Medicare would be useful, over half of beneficiaries (53 percent) responded "yes," with nearly the same level of interest among dual eligible beneficiaries (51 percent).

Information is increasingly being made available by telephone through auto-attendant systems with pre-recorded messages. These systems usually require the use of a touch-tone telephone, which 77 percent of beneficiaries own. These telephones are somewhat less accessible to dual eligibles (70 percent of beneficiaries own one). While 51 percent of beneficiaries think an auto-attendant telephone information system would be "very easy," or "easy to use", dual eligibles are a little less likely (47 percent) than the population in general to judge these systems as "easy to use".

Dual-eligible beneficiaries are just as likely as the general population (20 percent among both) to feel that the mailed HCFA materials could be improved.

Participation in QMB and SLMB Programs to Assist Low-Income Medicare Beneficiaries

The two programs, the Qualified Medicare Beneficiary (QMB) program and the Specified Low-Income Medicare Beneficiaries (SLMB) program were authorized in 1988 under the Medicare Catastrophic Coverage Act of 1988. The QMB program is intended assist low-income Medicare beneficiaries with the program's out-of-pocket costs. Individuals who qualify for the QMB program have incomes up to 100 percent of poverty and resources below 200 percent of the limit for the SSI program.

The QMB program covers the following:

- *Deductibles*: Medicare's hospital deductible of $760 in 1997, and the $100 annual Part B deductible.
- *Coinsurance*: The daily coinsurance charges for extended stays in hospital and skilled nursing facilities, and the 20-percent coinsurance for services covered by Medicare Part B.
- *Premium*: Medicare Part B premiums of $43.80 per month in 1997.
- Coinsurance and deductibles charged by HMOs.

In general, the QMB program covers two types of Medicare beneficiaries: (1) those beneficiaries who receive the full range of benefits covered under Medicaid due to their eligibility status; and, (2) those beneficiaries that are eligible only for payment of Medicare's cost-sharing requirements.

Individuals who qualify for the SLMB program meet similar resource eligibility requirements for QMBs, however SLMB incomes fall between 100 and 120 percent of poverty. State Medicaid programs pay only Medicare Part B premiums, which is $43.80 per month in 1997.

Table 3 below shows the interaction between Medicare, Medicaid, and the two programs designed to assist low-income beneficiaries. The first row contains the baseline case of beneficiaries who only have Medicare and because they cannot afford the cost-sharing requirements, are not able to fully use their Medicare benefit.

Table 3. Coverage Options

Medicare	Medicaid	Supplemental Policy	QMB/ SLMB	Coverage
√				Some lower income beneficiaries have reduced access because they cannot afford to pay Medicare co-payments and deductibles.
√		√		Covered for Medicare co-payment and deductibles. Other coverage varies, both in terms of covered services and level of cost-sharing, depending on the particular supplemental plan purchased.
√	√			State pays for Medicare deductibles and co-payments. Depending on the state, Medicaid covers services not generally offered by Medicare.
√			√	State pays for Medicare deductibles and co-payments for QMBs, but depending on the state, prescription drugs and/or transportation may not be covered. For SLMBs, state pays Part B premiums.

Since the implementation of these programs to aid low-income Medicare beneficiaries, there have been several efforts to quantify the number of individual who participate in them. Studies have generally found low levels of participation in the programs, especially the SLMB program. For example, a study conducted by Families USA reported that 58 percent of eligible seniors were enrolled in the QMB program, as of January 1993. This report also found that less than one percent of eligible seniors participated in the SLMB program (Families USA, 1993). The second study conducted by Neumann et al. estimated that only 41 percent of nearly 4.7 million eligible beneficiaries have enrolled in the QMB program (Neumann et al., 1995). The most recent analyses of QMB and SLMB participation rates was conducted by the Urban Institute, using the Current Population Survey estimates of potential QMB and SLMB eligibles and data from HCFA on the actual number of participants. Moon, Kuntz, and Pounder (1996) estimated that the QMB program had a 63 percent participation rate and the SLMB program had a 10 percent participation rate in 1995. Thus, about 2.0 million potential QMB eligibles and about 1.7 million SLMB eligibles still did not receive support from Medicaid (Moon et al., 1996).

The reasons for non-participation in these programs are varied. Neumann et al. identified the barriers to participation in the QMB program. Using the 1992 Income and Assets Supplement to the Medicare Current Beneficiary Survey, the researchers identified beneficiaries who met the eligibility requirements for the QMB program. One-third of respondents reported that they did not need the program. Other responses included that beneficiaries did not think they qualified (27 percent) and that they did not know about the program (16 percent) (Neumann et al., 1995).

Since the Medicaid program is a combined federal and state program, some states view QMB and SLMB programs as unfunded mandates, and thus have been hesitant to promote these

programs. The Physician Payment Review Commission reported tremendous interstate variation in the percentage of Medicare beneficiaries covered by Medicaid buy-in arrangements. For example, in eight states less than 7 percent of Medicare beneficiaries are covered by Medicaid, while in two other states over 20 percent are covered (Hegner, 1997).

Another reason for a lack of participation in these programs is the stigma of being on Medicaid or receiving welfare. For Medicare beneficiaries who also receive SSI benefits, the stigma of applying in the welfare office is alleviated since these determinations can be made by local Social Security Offices. However, for other beneficiaries, the point of contact into the Medicaid system remains the local welfare office. While there have been discussions regarding eligibility screenings for QMB and SLMB at local Social Security Offices, the Social Security Administration has been reluctant to provide this service due to lack of resources.

Communication Initiatives for QMB/SLMB Programs

Since the beginning of the QMB program, HCFA, as well as the states and advocacy groups have undertaken a considerable number of outreach activities in an effort to enroll beneficiaries eligible for QMB benefits. HCFA utilized both general and targeted communication efforts to publicize the QMB program. When the program was first implemented, HCFA mailed notices to announce the QMB program to 14 million beneficiaries who could potentially meet the program's eligibility requirements. The packet included information describing the program, income and resource requirements, and appropriate contacts for further assistance. Another subsequent mailing was conducted in January 1992 by SSA. Information regarding the QMB program was included in the SSA notice describing cost-of-living increases. The notice included information on the income eligibility requirements and program benefits. Beneficiaries were encouraged to contact their local Medicaid office. In addition, HCFA has placed targeted announcements regarding the program in magazines and newspapers whose primary audience is elderly individuals. Public service announcements have also been used to promote the QMB program. The following table compiled by the General Accounting Office details HCFA's efforts to promote the QMB Program:

Table 4. HCFA Efforts to Publicize Qualified Medicare Beneficiary Program

Efforts in 1989

- Mailed a notice in summer 1989 about the QMB program to 14 million Medicare beneficiaries.

Efforts in 1990

- Included a section on the QMB program in the *Medicare Handbook* which was sent to more than 33 million Medicare beneficiaries.

Efforts in 1991

- Prepared a camera-ready story about the QMB program, in June 1991 for distribution to major newspapers and senior citizen organizations' information offices.
- Distributed copies of *Medicare 1991 Highlights*, in September 1991, which included information about the QMB benefit, for display in 7,200 supermarkets across the nation.

Table 4. HCFA Efforts to Publicize Qualified Medicare Beneficiary Program

- Sent a letter in October 1991 to states that require QMBs to enroll in Part A during Medicare's general enrollment period asking them to reconsider their decision not to become Medicare buy-in states and to their Medicaid rolls to identify individuals who are eligible for buy-ins and to enroll these individuals in the QMB program. At the same time, letters were also sent to 19 buy-in states that had enrolled fewer than 65 percent of such individuals asking them to identify these individuals and add them to the states' Part A rolls.

Efforts in 1992

- Included a flier about the QMB benefit in the January 1992 cost-of-living-allowance increase notice that SSA sent to every Social Security recipient.
- Provided each member of Congress, in March 1992, with a package of information about the QMB program that was suitable for constituent newsletters.
- Provided an information package about QMB benefits, including radio and television announcements, to news media nationwide during summer of 1992.

Efforts in 1993

- Distributed a booklet in January 1993 with state-specific information about QMB benefits to the HCFA's Regional Offices for redistribution in target areas.
- Developed a pamphlet describing the QMB benefit and the steps for applying for it and sent it to all state Medicaid agencies in February 1993.
- Identified and directly contacted about 250,000 people, in February 1993, who may be eligible for QMB. The letter included a form for the applicant to send directly to SSA to enroll in Part A and advised the individual to contact a Medicaid office to request QMB determination.
- Worked with advocacy groups to develop and issue a training guide in March 1993 that state Medicaid workers and private organizations can use to increase public awareness of the QMB benefit.
- Distributed a worksheet and computer program in September 1993 to advocacy groups, states, and senior centers to facilitate QMB screening.
- Provided grants totaling $20 million (during fiscal year 1993 and 1994) to implement state health insurance assistance, information and counseling program to advise seniors on health insurance issues, including the QMB program.

Source: General Accounting Office (January 1994).

States have also undertaken efforts to publicize the availability of QMB program benefits. State outreach efforts typically use traditional media, such as advertisements in local and community newspapers, as well as public service announcements on local television and radio channels. Print media is also used to publicize the QMB program, as well as brochures, fliers and factsheets placed in public locations. In addition, toll-free numbers were advertised so that potential eligibles would be able to contact a central location to receive information regarding the program's eligibility requirements and enrollment process.

An analysis conducted by GAO concluded that there was little correlation between the outreach efforts and increased QMB program participation. As shown in Table 5, seven states' outreach efforts were compared to the percentage increase of individuals enrolling in the QMB program. For example, Delaware and Michigan who used nearly identical outreach efforts did not achieve similar increases in QMB enrollment. Enrollment in Delaware increased by 12.5 percent but 27 percent enrolled in Michigan, nearly double the increase in Delaware (GAO, 1994). States that included public service announcements (PSAs) in their campaigns seemed to achieve a substantially higher response than states that did not use PSAs.

Table 5. Selected States Outreach Efforts and Increase in QMB Enrollment

State	Outreach Activities	Increase in Enrollment (%)
California	Press releases; toll-free line; and brochures, fliers and factsheets	4.8
Delaware	Toll-free line; public service announcements; and brochures, fliers and factsheets	12.5
Georgia	Press releases; toll-free line; and brochures, fliers and factsheets	2.0
Michigan	Press releases; public service announcements; posters; and brochures, fliers and factsheets	27.1
Oklahoma	Press releases; and public service announcements	21.8
Texas	Press releases; toll-free line; posters; and brochures, fliers and factsheets	2.8
Washington	Toll-free line	4.1

Source: General Accounting Office (January 1994).

One of the limitations of this analysis is the narrow focus taken in the types of outreach activities assessed. The activities analyzed by GAO are limited to traditional media and print advertisements. Also, there is no mention of other types of outreach activities that focused on educating individuals, such as through social workers or healthcare professionals, who work directly with potential participants. Thus, each state's increase in QMB enrollment may not necessarily be fully explained by their print and media advertising, other undocumented outreach activities may have influenced these results.

Interview Findings and Implications

Our interviews revealed not only the specific information needs of dual eligibles with regard to Medicare, but also some examples of the barriers that prevent dual eligibles from either seeking information regarding Medicare or accessing healthcare. We found that dual eligible beneficiaries experience four different impediments to understanding the Medicare program or seeking information:

- Dual eligible beneficiaries usually have more pressing problems to address than their need for Medicare information, so do not seek information about health insurance unless in a crisis;
- Dual eligible beneficiaries find the lack of systematic coordination between the two programs to be very confusing;
- Many beneficiaries have a negative perception of the Medicaid program which has to be overcome in order for them to consider themselves to be eligible for QMB or SLMB benefits; and
- Many beneficiaries are uncomfortable discussing sensitive family financial information with government workers.

Barriers to Obtaining Information

Dual eligibles are among the most vulnerable of the elderly population, often having complex health and social needs. The beneficiary's immediate focus is usually on more pressing needs (such as adequate housing and nutrition). This was cited as a major barrier to health information-seeking among dual eligibles, as health information may not be a priority. Since a disproportionate number of dual eligibles belong to racial minority groups, many of whom have recently immigrated to the U.S. (especially those of Hispanic descent), our interviews also revealed the fear and uncertainty associated with recent welfare reform legislation. We saw a great deal of anxiety, especially among the Hispanic community, regarding their being able to secure U.S. citizen status. Last year, for example, social workers employed at Hialeah Housing Authority anticipated the legislation and began offering citizenship classes to their clients. These social workers were able to secure citizenship for nearly all their elderly and non-elderly residents well in advance of the legislation because the issue assumed "center stage".

A second barrier for dual eligibles is the existence of multiple and different requirements and entry points to the healthcare system when accessing the two programs. The Medicare benefit covers acute care, while Medicaid primarily covers long-term care and the copayments for Medicare. Beneficiaries find this extremely confusing. One of the problems we encountered fairly often was that administrative processes were poorly coordinated between agencies. For example, dual eligibles who are enrolled in a Medicare HMO may be erroneously charged for healthcare services that are covered by Medicaid. At the point of service, computer records may show that the individual belongs to a Medicare HMO but these records may not include the individual's enrollment in Medicaid. This results in the dual eligible beneficiary being charged for services not covered by the HMO plan, or for copayments, because the records were not updated or did not indicate the Medicaid enrollment. A second example is the working aged beneficiary who becomes disabled may become eligible for Medicaid during the two year waiting period prior to Medicare eligibility. Under Medicaid, the beneficiary is able to obtain equipment and services that may not then be covered once he or she is on Medicare.

The perceived stigma of receiving welfare resonates within the beneficiary population. Staff from various organizations we interviewed expressed the view that elderly individuals who qualify for Medicaid due to spend-down might not apply for coverage because of pride and unwillingness to take a "hand-out" from the government. Medicaid suffers from existing stereotypes, and it is critical that more positive information regarding the program be disseminated to Medicare beneficiaries, especially those who may not consider themselves to be eligible for Medicaid, which they see as "welfare".

One state-level legal aid organization that conducted outreach efforts to increase participation in the QMB/SLMB program found through focus groups that beneficiaries were hesitant to discuss their financial situation with "strangers". For example, the process of screening beneficiaries to determine their eligibility for QMB/SLMB includes some potentially sensitive financial information, including an individual's monthly income and an estimate of their financial resources (i.e., cash, checking and savings account, stocks, bonds, etc.). Beneficiaries are often hesitant to share this information with individuals outside of their immediate family.

Information Needs of Dual Eligibles

The diversity found within the dual eligible population accounts for their widely varying information needs regarding the Medicare and Medicaid programs. This section focuses on the needs of two distinct groups: (1) dual eligibles that have full-Medicaid benefits; and (2) dual eligibles who are eligible for payment of only Medicare's cost-sharing requirements (hereafter known as QMB-only beneficiaries). We found that dual eligible beneficiaries primarily need three types of information:

- For those who may be eligible for Medicaid, information on "spend down" and the annual eligibility determination is important;
- For those who may qualify for QMB or SLMB, information on the availability of the benefit is important; and
- Many dual eligible beneficiaries have little or no prior experience with managed care and need to be introduced to the concept of the "gatekeeper" or case manager.

For those dual eligibles who receive full-Medicaid benefits, information needs center around eligibility requirements for Medicaid. Our interviews indicated that dual eligibles needed repeated explanations of the concept of "spend-down". Department of Human Services case workers in a rural Tennessee office commented that they spent many hours explaining the concept of spend-down and that in order to qualify for Medicaid, applicants must meet resource eligibility requirements. Furthermore, eligibility for Medicaid is determined on an annual basis, and must be re-determined year after year. Once beneficiaries have qualified for Medicaid and have received their Medicaid card, they often assume that the program is available to them as long as they need it. However since eligibility is determined annually, case workers must usually complete another round of explanations regarding spend-down and resource eligibility requirements to dual eligibles.

Our interviews found that once beneficiaries have entered the Medicaid system, they understood in general terms that two separate programs covered their healthcare expenses. While dual eligibles may not exactly know the names of these programs or sometimes confuse them, they seemed to understand that there is one program that pays for one part of their care, and that the balance is paid by another program.

Unlike some full-benefit dual eligibles who may have had long-standing interactions with Medicaid due to the categorical nature of their eligibility, QMB-only beneficiaries may not have much exposure to the Medicaid program. We found that there are social service workers who provide services to the elderly who were also not aware of the QMB program. Individuals who are aware the program commented that in their experience, few beneficiaries know that programs such as QMB and SLMB exist. The weak link between QMB-only beneficiaries and the Medicaid program seems to be the result of inadequate information regarding the QMB program reaching the audience that is not already in the system. Our interview with the Department of Human Services in Tennessee revealed that it was relatively easy for case workers to determine the eligibility for QMB benefits for individuals that were already known to them, however it was

much more difficult to reach individuals in the community that had little or no prior connection to the Human Services office.

Beneficiaries who were knowledgeable about the QMB/SLMB programs did understand the nature of the program's benefits. Queries regarding QMB/SLMB programs centered around the eligibility requirements of the program. Specifically, beneficiaries did not understand the concepts of "federal poverty level" and "resources". Case workers explained that questions generally arise as to the actual dollar amount associated with the federal poverty level. Another source of confusion was the definition of "resources". Potential beneficiaries often did not understand what is considered to be a resource. A common misconception was that an individual's home was counted as a resource, whereas this is not the case.

Those who had heard about the QMB/SLMB programs also needed assistance with the application process and in knowing where to apply. Many beneficiaries were not aware that the local human services or the Medicaid office handled the application process. The lack of coordination between the Medicare and Medicaid systems forces beneficiaries to contact two separate offices to apply for benefits: the local Social Security office for Medicare benefits, and the local Medicaid or human services office for QMB/SLMB programs.

Finally, the concept of managed care is especially confusing to these individuals, many of whom think there are now three programs (Medicare, Medicaid, and managed care). Often dual eligible beneficiaries have not previously had a regular source of medical care, using local hospital emergency rooms when healthcare became their most pressing need. Not only does HCFA need to educate these beneficiaries conceptually about managed care, but also to overcome the habits of only seeking care in a crisis and using emergency rooms. Regular examinations, preventive screenings and inoculations are generally not priorities for the Medicaid recipient.

Strategies for Understanding Information Needs

There seem to be two distinctly different levels of interaction with dual eligibles: the one-on-one interaction of social service workers with the individual beneficiary, and the interaction at the larger organizational level. Many individuals we interviewed interact daily with dual eligible beneficiaries, helping to meet a variety of social, psychological and healthcare needs. We often found that social workers and others who work in local senior citizen facilities and community centers established long-standing and trusting relationships with their clients. These individuals seemed to mostly use informal mechanisms, such as their daily conversations with the seniors, to understand and respond to their needs. Staff at South Miami Plaza Senior Center, for example, monitored a single indicator of client satisfaction: attendance. When attendance at the senior center dropped, it nearly always reflected a personnel change at the center, usually the introduction of a new staff member. Seniors become very attached to the workers, and if one leaves, they are profoundly affected. It usually takes some time for clients to accept a new staff member and for him or her to demonstrate that they can be trusted.

Coordinating organizations who provide support for local agencies were more likely to use more structured and formal methods to understand the information needs of dual eligibles. The Tennessee Association of Legal Services (TALS) provides administrative and technical support for local legal

aid offices in the state of Tennessee. In developing their outreach program to screen hard-to-reach low-income elderly and disabled for eligibility for public benefits, TALS initially conducted focus groups. The focus groups were conducted with potential recipients of different government assistance programs (i.e., SSI, QMB/SLMB, and food stamps) to understand the different barriers that are associated with applying for these public benefits. The information obtained from the focus groups was important for developing materials and training local legal aid workers specifically to address barriers to participation and assist potential participants with the application process.

HCFA should use a combination of approaches to understand the needs of dual eligible beneficiaries: (1) a local community-based approach, accomplished by partnering with community organizations who can provide HCFA with information informally collected from their clients; as well as (2) establishing formal linkages with state Medicaid programs in which information and client data can be shared. A number of states have designed Medicaid Management Information Services (MMIS) which can be linked to HCFA's system to provide program coordination at the state level. In order to make effective and appropriate policies for dual eligibles, it is important for HCFA to have a good base of knowledge about their healthcare needs, what types of services they use, and how they differ from the general beneficiary population.

Communication Strategies

Communication strategies that were mentioned during our interviews focused on informing potential participants about the QMB/SLMB programs, identifying potential recipients, and assisting individuals with the application process.

Informing and Educating the Target Population. The main barrier to participation in the QMB/SLMB programs is that beneficiaries are not aware of the existence of the programs. Beneficiaries who have not previously qualified for Medicaid typically do not think of it as a resource. Informing and educating the dual eligible population and those who work with this group requires the use of a variety of delivery vehicles. Traditional communication avenues, such as public service announcements and print and media advertising in local communities, are appropriate to attracting the interest of potential eligibles or their families and relatives. Advertising the QMB/SLMB programs by using posters and fliers in places seniors frequent such as local grocery stores (as HCFA did in 1991), banks, churches was also recommended. Toll-free numbers were cited as another good communication channels they can be effective in providing an immediate response to questions about the programs. Additionally, the type or number of inquiries may help to gauge the success of outreach efforts.

The Social Security Administration (SSA) has used the mass mailing to inform beneficiaries about their personal benefits through a check-stuffer. In addition to including information about changes in COLA and Medicare premiums, SSA uses this mass mailing to communicate information about Supplemental Security Income and other special programs from which low-income, blind, or disabled beneficiaries may benefit. Beneficiaries also receive a handbook that reviews rights and responsibilities of social security beneficiaries. This handbook includes information about the SSI program and how to apply for other benefits for which beneficiaries can be eligible. The Social Security Administration also conducts a targeted mailing every two to three years by sending informational packets to those beneficiaries whose income levels are

below the federal poverty level or who otherwise meet eligibility requirements. These beneficiaries are identified by conducting internal matches between two databases maintained by SSA.

Another important communication channel for HCFA is to partner with or regularly provide information to local organizations who have day-to-day contact with potential dual eligibles. Building partnerships and coalitions with local agencies and organizations is critical, since these agencies provide front-line workers that can educate the community and bring potential dual eligibles into the system. These workers have credibility and the trust of their communities. We found that social service workers also tend to be protective of their elderly clients, and are usually diligent in learning about any available program for seniors.

> "I'm supposed to know about QMB and SLMB. I make it my business to know about programs to help my residents".
>
> -- Social service worker, Hialeah Housing Authority

We saw a good example of such an effort to partner with local organizations in Tennessee. In order to inform the public, the target population and providers, the Tennessee Association of Legal Services (TALS) conducted an outreach program that provided information specifically to organizations who have regular contact with low-income elderly and disabled individuals. The wide-range of organizations included the Area Agency on Aging, local home health agencies, agricultural extension agents, public housing agencies, senior citizen centers, social service agencies, Social Security offices, legal aid offices, economic development agencies, Alzheimer's groups, medical centers and hospitals, AARP members, churches, Salvation Army, mental health centers, and community health agencies. Trained professionals from each of these organizations were then able to inform their clients or patients, thereby extending the reach of the TALS program considerably.

The Social Security Administration has also partnered with community and advocacy organizations who traditionally serve low-income elderly, disabled, or blind individuals to identify those who may be eligible for SSI and other programs such as Medicaid or Medicare. The Agency understands that potential clients may sometimes feel more comfortable conducting their business through community intermediaries than through government contacts. Thus, the Agency regularly provides materials to community organizations so they can identify and assist potential clients. These organizations are then able to assist clients by directly providing transportation to the local office that accepts applications, helping to gather information needed to complete the application, assisting individuals with obtaining medical records, and so on.

Due to the connections between Medicare and Medicaid, those who have daily interaction with dual eligibles need training on both programs and any related issues. In Tipton County, Tennessee, the human services workers we interviewed lacked even the basic information regarding Medicare, and have little or no resources with which to obtain the information.

> "We need training on Medicare to help our Medicaid clients. We can be effective information givers".
>
> -- Case Worker, Dept. of Human Services, Tipton County, Tennessee

Provision of booklets or your *Medicare Handbooks* to these individuals would enable HCFA to easily reach many more dual eligibles.

Training social service workers who interact with seniors provides HCFA with the added benefit of being able to have them deliver face-to-face explanations of difficult concepts and terms to individual beneficiaries. Due to the generally low education levels among the dual eligible population, written communication is not a particularly effective communication strategy. A face-to-face meeting appears to be more effective, because case workers are able to use language that is more easily understood, and immediately check for understanding. For example, case workers would explain the concept of "resources" by developing the following message: "You could be eligible, if you have an income below this $ amount and you have this many $s in the bank".

Since dual eligibles seem to prefer face-to-face communication, written communication should be in a format that resembles spoken language, using short sentences. Moreover, pamphlets or brochures not only should convey the essential requirements of the program, but also include a single toll-free telephone number for those who need further assistance. The most recent HCFA publication *Savings for Qualified Beneficiaries* is a good example of providing concrete illustrations to reinforce abstract concepts such as "resources" and "income".

> "Income includes, but is not limited to, Social Security benefits, pensions, and wages. Interest payments and dividends can also count as income."
>
> --Excerpt from *Savings for Qualified Beneficiaries*

Identifying Potential Dual Eligibles. The Tennessee Association of Legal Services (TALS) developed a screening mechanism to identify individuals potentially eligible for a number of public benefits, including the Qualified Medicare Beneficiary Program, the Specified Low-Income Beneficiary Program, Supplemental Security Income, Medicaid, and Food Stamps. This mechanism is not intended to provide comprehensive information, but serves as a rough indicator of an individual's possible eligibility for programs. Case workers and others working with low-income individuals can use these screening mechanisms to quickly identify potential recipients. The screening mechanism is automated on computer, however a paper-and-pencil version is also available. It provides a step-by-step process for workers to use in determining an individual's eligibility. For example, the first question for QMB qualification on the screening sheet is "Do you and your spouse have more than $6,000 in resources?" If the answer is "no", the directions lead the case worker to the following questions; however, if the answer is "yes", the interview is terminated since that individual would not be qualified for QMB.

The TALS program called "Benefits Education for Senior Tennesseans" (B.E.S.T.) attempts to screen seniors for their eligibility for all government programs. Local agencies may be able to capitalize on synergies that exist among low-income programs, provided by Area Agencies on Aging, for example. Thus, an agency may screen a beneficiary who may not be eligible for full Medicaid benefits, however their income and resources may qualify them for the QMB program.

Assisting Individuals with the Application Process. The process of applying for benefits can be complex and intimidating for many beneficiaries. Many need the assistance of case workers and other individuals to complete the application, and some require the case workers to read aloud or interpret the documents sent by state or federal agencies. For example, one social worker in Miami spoke of the instance where beneficiaries came to case workers in a panic thinking that their benefits had changed or that they had lost them. In the letter they had received from the government, they saw a particular category of benefit marked "ineligible"; without being able to read or understand the letter. Upon more careful inspection, the worker found that the beneficiary was eligible for the benefit under a different requirement, which the letter discussed in some detail. In the general climate created by recent changes in the immigration laws, beneficiaries are already anxious and apt to misinterpret written information.

To summarize, the information needs of dual eligible beneficiaries fit within a myriad of other social service needs. Our interviews suggest that three types of information are needed: information on "spend down" and the eligibility criteria for full Medicaid, the availability of the QMB and SLMB benefits, and information about managed care presented very simply and with concrete examples. Both HCFA and the states have conducted extensive campaigns to publicize the QMB and SLMB programs, providing a platform from which additional efforts can be launched. Because of low literacy levels and other barriers, communication strategies other than written materials will likely be more effective, such as public service announcements and regularly providing local Medicaid offices with materials.

RURAL BENEFICIARIES

HCFA has identified rural beneficiaries as a group that may be "hard to reach." This section of the report contains a synthesis of the literature review and interview findings on this subpopulation. Because there is not a great deal of published literature on the information needs of rural beneficiaries, we also include an analysis of the responses of rural beneficiaries to a selection of public relations questions included in a 1995 round of the Medicare Current Beneficiaries Survey.

Areas considered to be "rural" are described in different ways, and the definition greatly affects the size and nature of the identified population (Hewitt, M., 1989). The Office of Management and Budget defines "rural" broadly, as "areas outside of metropolitan statistical areas (MSAs)." According to this definition, the three States with the greatest number of rural residents are Texas, North Carolina, and Ohio. According to the Census bureau, however, rural areas are defined according to population density and urbanicity, as "areas where individuals live in communities of less than 2,500," of which there are nearly 15,000 in the U.S. According to the Census definition, Pennsylvania, rather than Ohio, is among the three States with the greatest number of rural residents. Although States that are typically thought of as rural (e.g., Vermont, West Virginia, Mississippi, South Dakota, Maine) have smaller populations, and so do not have large absolute numbers of rural residents, over one-half of their populations live in rural areas, using either definition (U.S. Department of Commerce, 1993) (see Table 1 below for a summary of how different definitions determine state rankings).

Additionally, some states have large areas that are very sparsely populated. These "frontier areas," such as many in the western states, are characterized by having "six or fewer people per square mile or as an area within 30 minutes or more of travel time to centers with 10,000 or more people." (National Institute for Healthcare Management, 1994). Residents in "frontier areas" have unique problems in accessing even many basic services, including healthcare. By either definition, however, approximately one fourth of the U.S. population is a rural resident. (American College of Physicians, 1995).

The total number of people living in rural areas has grown from 54 million in 1950 to 62 million in 1990. In some areas, the elderly comprise nearly 20 percent of the rural population, compared with 12 percent of elderly in the overall U.S. population. In general, research has shown that individuals living in rural areas are older, more likely to live below the poverty level, and less likely to have health insurance or be covered by Medicaid than Americans living in urban areas. The literature confirms many assertions of our respondents concerning the demographics of elderly living in the rural South. What is most notable, however, is the estimated percentage of minority rural elders who live in the South: 95 percent (Abraham and Neese, 1993).

In 1920, 49 percent of the U.S. population was rural, and within seventy years, this had decreased to 23 percent. During the same time period, the rural farm population, a subset of the rural population, decreased from 30 percent to 2 percent. Today, the rural U.S. contains a heterogeneous mix of individuals engaged in farming, timber, tourism, and manufacturing, and includes both affluent and poor areas.

The implication for HCFA of rapid social change coupled with tremendous heterogeneity is that it creates a need for considerable flexibility, in both the content and format of messages, and in the vehicles used in the dissemination of information about Medicare.

Table 1. Ranking of "Rural" States using Different Definitions

State	Top 10 States - Number of Non-MSA residents (top 10 rank)	Top 10 States - Number of "Rural" Residents (top 10 rank)	More than 1/2 of the State Population in Non MSA Area	More than 1/2 of the State Population in "Rural" Area
Alaska			X	
Arkansas			X	
California		8		
Florida		9		
Georgia	3	7		
Idaho			X	
Illinois	4			
Indiana	10			
Iowa	8		X	
Kentucky	5		X	
Maine			X	X
Michigan		6		
Mississippi	6		X	X
Montana			X	
Nebraska			X	
New York		4		
North Carolina	1	3		
North Dakota			X	
Ohio	2	5		
Pennsylvania	7	1		
South Dakota			X	X
Tennessee	9	10		
Texas		2		
Vermont			X	X
West Virginia			X	X
Wyoming			X	

Rural areas often lack the resources to provide adequate healthcare for their residents, as they usually face a shortage of healthcare providers. For example, there are 44 percent fewer physicians per 100,000 residents in rural counties than in metropolitan counties. Low population density and high numbers of uninsured or publicly insured residents make some rural areas financially unattractive to physicians. The professional isolation associated with rural medical practice also discourages physicians from choosing these areas. Training options and some

specialized diagnostic procedures may be unavailable, and clinicians often have no back-up for weekends or vacations (Christianson and Moscovice, 1993).

Rural areas have also experienced the closures of many community hospitals over the last decade. According to the Office of the Inspector General, there were 2,489 rural hospitals in 1987. By 1995, the number had declined to 2,141, one quarter of which currently have negative operating margins and are at risk of being closed (Wright et al., 1995).

The options for insurance coverage that rural Medicare beneficiaries have tend to be more limited than those of their urban counterparts, but this may change as managed care plans begin to develop business in rural areas (Managed Care Week, January 27, 1997). Rurality, defined as "geographic isolation," has also been shown to exert an independent and statistical relationship on the likelihood of being in poor health. Researchers have found that independent of age, income, and race, living in a rural community is associated with having a greater number of chronic medical conditions (Cowart et el., 1995). Rural residents are 23 percent more likely to suffer from chronic health conditions than urban residents.

Rural communities exhibit considerable diversity from region to region across the U.S. For example, rural areas contiguous to urban centers often have relatively high population densities, especially in comparison to sparsely populated frontier areas in the western states, and well-developed social service networks. Regional economies differ widely, depending upon many factors, including the absence or presence of strong local employers. The problems of the rural South, for example, are not the acute problems arising from a sudden change in the economic environment (as in the Midwest), but rather more chronic problems of isolation and impoverishment. There are several implications for HCFA in designing communication strategies for "hard to reach" and diverse rural communities across the U.S.:

- Rural beneficiaries are at risk in many of the same ways as minority elderly, and a communication strategy for reaching them will be characterized by both a diversity of approach and heavy reliance on partnering with local social service organizations that have served rural elderly over time; and
- HCFA may want to expand the network of healthcare "providers" who serve as information intermediaries to include rural health clinics staffed by midlevel providers (nurse practitioners and physician assistants), school based health centers, mobile mammography units, and other non-physician providers.

Information Wants and Needs of Rural Beneficiaries

There is very little published literature regarding the unique health information needs or preferences of rural residents. According to one early study, residents of rural farming areas of Idaho and Washington preferred to obtain information about medical care through contacts with physicians, friends, neighbors, and relatives. The electronic media were mentioned by fewer than 1 percent of respondents in these areas leading researchers to suggest that for specific health information, people prefer personal sources (Reagan, J., and Collins, J., 1987). These findings

are consistent with later findings concerning the preferences of residents across the U.S. for interpersonal contact with an information source (Isaacs, S.L., 1996).

In 1995, a series of communication-related questions were asked as part of the Medicare Current Beneficiaries Survey (MCBS), which is a longitudinal, multipurpose survey of a nationally representative sample of approximately 14,500 aged and disabled persons eligible for Medicare. We include a description of the research findings regarding the information needs of beneficiaries residing in rural areas. In this analysis, "urban" and "rural" beneficiaries are those residing in metropolitan and non-metropolitan statistical areas, respectively.

Understanding the Medicare Program

Rural beneficiaries are a little less likely than urban beneficiaries to feel that they understand the Medicare Program. When asked, "do you think the Medicare program is understandable?" the proportion saying "yes" ranged from 68 percent to 71 percent for rural and urban beneficiaries, respectively.

Need for Medicare-related Information

Rural beneficiaries are a little less likely than urban beneficiaries to report needing at least some Medicare-related information. Needs for specific types of information appear to be similar for the two groups.

Sources of Medicare-related Information

Rural and urban beneficiaries appear to seek information about Medicare in similar ways. Rural as compared to urban beneficiaries appear to be somewhat more reliant upon Medicare publications and the media, and less reliant upon family or friends, social security or Medicare offices, and supplemental insurance companies for Medicare-related information.

Unmet Information Needs

If not finding information is combined with not having questions answered, rural beneficiaries in need of information do not fare as well as urban beneficiaries--42 versus 35 percent of those in need of information either did not find at least some needed information, or did not have at least one of their questions answered. This is especially true when it comes to obtaining information on finding a doctor that accepts Medicare assignment. Here, rural as compared to urban beneficiaries are much more likely to be left with unmet informational needs.

Understanding of Medicare-related Materials

Use of the *Medicare Handbook* is a little higher among rural beneficiaries, but among users of the *Medicare Handbook*, rural beneficiaries are somewhat less likely to rate the *Handbook* highly. Rural as compared to urban beneficiaries are more likely to report receiving an EOMB statement, and among those that receive statements, are more likely to report that the EOMB statements are "difficult," or "very difficult" to understand. Despite these apparent difficulties with written Medicare-related materials, rural beneficiaries are somewhat less likely than urban beneficiaries to feel that the materials mailed from the Medicare program could be improved.

New Sources of Medicare Information

There is a similarly high level of interest among both rural and urban beneficiaries in a weekly television program about Medicare. Somewhat fewer rural than urban beneficiaries are interested in a free telephone hotline. Expressed interest is high for a telephone service with prerecorded information about the Medicare program. Rural beneficiaries are somewhat less likely than urban beneficiaries to have a touch-tone telephone (needed by auto-attendant information services), but rural and urban beneficiaries are just as likely to feel that these systems are easy to use.

Interview Findings

We interviewed a sample of organizations and individuals in the rural South who are familiar with both the healthcare needs and information needs of Medicare beneficiaries in this region. Respondents noted several characteristics of the beneficiary population that influence their approach to providing services. First, because of the disparate systems of education in the South, illiteracy rates are high. High unemployment with fewer job opportunities also contributes to general economic conditions of hardship and poverty. Housing quality in the rural South is generally poor, with many elderly living without even basic amenities, such as telephones. Communication efforts have to be carefully tailored to the different audiences. For example, within the rural South there are two subpopulations each having their own distinct demographic characteristics: African Americans and white Appalachians. The South also has an even higher proportion of elderly than other rural regions: over 40 percent of the nation's rural elderly live in the South, compared to 24 percent in other rural areas.

Our interviews included several rural health clinics and state welfare offices, a church-based health system, a breast cancer clinic at a university-based medical group, an ESRD clinic, the local PRO, among others. Additionally, we returned to two federal agencies interviewed for the First Inventory Report, the CDC and SSA, in order to gather more detailed information regarding the strategies they use for communicating with the populations of interest.

We were told by most respondents that their elderly clients or patients have the most basic information needs concerning Medicare. A large proportion do not understand the Explanation of Medicare Benefits (EOMB) statement, and terms such as "deductibles", "co-payments", and "assignment" are not generally understood. Additionally, many beneficiaries do not understand the economic consequences of visiting a provider who does not accept assignment.

We interviewed the Breast Cancer Awareness Group, which provides information regarding breast cancer and promotes community mammography efforts. The group was started by a former social worker who has experience working with cancer patients, and who currently is the Patient Advocate for the University of Tennessee Medical Group. There is also a Breast Cancer Support Group, which meets regularly and includes a representative from Social Security who answers questions regarding Medicare. During these sessions, seniors are able to ask questions regarding the process for receiving Medicare benefits and the types of services covered by Medicare. (Seniors also question if Medicare is something they need to have.) The implication for HCFA is that information about Medicare can be "bundled" into other health education campaigns, because if the campaign is directed toward seniors, they will most likely be asking about Medicare.

We visited a rural health clinic in Crocket County, Tennessee, to learn about their approach to communicating with a special subgroup of their patients: seasonal workers. Most are Hispanic immigrants who are employed by United Foods, a producer of fresh vegetables. United Foods built a number of apartment buildings to house seasonal workers while they are in the area. Some workers remain in Tennessee for the entire year, while others work part-year in Texas. Many of these workers do not speak English, have very little education, and pose combined communication challenges to the staff of the clinic. Some patients who receive services at the clinic bring friends that are able to speak both English and Spanish to translate. Recently, the clinic was able to hire a physician from the Dominican Republic to treat patients from the Hispanic community, which has eased the situation somewhat. This provider can relate to patients in their own language, and from within their cultural framework, the importance of which was a finding from our First Inventory Report.

We were interested in visiting the ESRD clinic, because another finding from the First Inventory Report was that beneficiaries tended to know more about services they used regularly than about services they rarely used or did not use at all. We wondered about the information needs of rural ESRD patients, who are regular users of a specific set of intensive services. We were told that while some patients are fairly well-informed about their care and Medicare benefits, many more of them regularly bring their EOMBs to be interpreted by the social workers at the clinic. Because a good number of patients are illiterate, they need the social workers to read and explain the document to them. Others are panicked thinking that the EOMB represents a bill they must pay. Most patients do not understand even basic insurance information, such as the definition of the term "claim." This finding confirms the diversity of information needs among beneficiaries, from the most basic information to more complex and technical information, and that although a beneficiary uses a service, he or she may not understand how Medicare fits into the picture.

We were told that the more knowledgeable ESRD patients generally read the HCFA publication, *Medicare: Coverage of Kidney Dialysis and Kidney Transplant Services*, and those that did found it useful and informative. The social workers said they themselves regularly use the document, taking different parts of it and explaining them to those who cannot read.

After becoming Medicare eligible, some beneficiaries are disappointed that the program does not cover one of their greatest needs: prescription drugs. We visited a church-based Center which provides quality and affordable healthcare to the working poor and homeless in Memphis and Shelby Counties using volunteers. It has been nationally recognized as a model for church-based healthcare. We were told that Medicare beneficiaries have many questions regarding the EOMBs, such as what amount had been paid, and for how much is the beneficiary responsible? Also, there is a sense that many beneficiaries do not understand the distinction between Part A and Part B. Some beneficiaries do not apply for Part B because they do not have the financial resources to pay the premium, and think they are covered because they have Part A.

Another issue beneficiaries often ask about is Medicare supplemental insurance policies, as there have been instances in which beneficiaries purchased questionable supplemental policies. Respondents at the Center said that more information from HCFA regarding supplemental

policies is needed, specifically a simple explanation of who needs supplemental insurance, as well as comparative information on which policies meet certain needs, and the premium ranges for these policies. This type of information is particularly crucial to low-income beneficiaries, who are very sensitive to price.

Neither beneficiaries nor many physicians at the Center have heard about the QMB and SLMB programs for low-income beneficiaries. There is also considerable confusion regarding Medicare beneficiaries who are also on TennCare. Apparently, some dual eligible beneficiaries were coded in the Medicare enrollment process as "uninsured" and were then dropped from TennCare coverage. Respondents said it took months of "haggling" to straighten out the situation.

Strategies for Understanding Information Needs

In our interviews, we saw organizations using both formal and informal mechanisms to gather data on the information needs of rural residents. The Office of Rural Health in Tennessee, for example, has a close formal relationship with the Rural Health Association of Tennessee. These two organizations often collaborate in formulating policies or initiating legislation, as well as to work on special projects and initiatives. For special projects, the organizations partner with various community health agencies, most of whom are represented on local community health councils. Community health councils are the grassroots organizations that provide agencies with information on the day-to-day interactions within the rural community. These councils are best able to provide detailed and in-depth information regarding the health services needs of their communities, and to make recommendations regarding areas with the greatest need for the preparation of the State's Annual Health Access Plan, which is the mechanism for identifying and formulating funding priorities.

CDC collects data through many formal avenues and processes, such as disease surveillance, academic research, laboratory analysis, health surveys, environmental data, public opinions, social and behavioral science research, health insurance claims, vital statistics, and census, among others. This information is collected via passive as well as active surveillance. An example of passive surveillance is the CDC's National Electronic Telecommunication System for Surveillance (NETSS) which collects disease information from all states and territories, and then provides weekly transmission of over 40 conditions to state and local health departments.

Direct service providers generally have regular contact with beneficiaries, and are able to elicit their concerns and information needs directly either from them or from the families. Wherever possible, needs are met at the time, with staff both informally sharing their observations and making note in the medical record in instances related to the care.

We did not see any formal assessments of the specific information needs of the elderly living in the rural communities we visited. Generally, providers and others spoke of the various barriers to beneficiaries' obtaining information, including limited awareness of the availability of information or services offered by Medicare, difficulty in accessing healthcare due to distance and lack of transportation, and their efforts to over come them.

Two components of successful communication prove to be problematic in rural locations: *reaching* beneficiaries in economically depressed and sparsely populated areas, and *being understood* by beneficiaries who typically have lower levels of education than their urban counterparts.

Selecting appropriate media channels is critical to being able to reach a wide audience. It is documented that seniors spend more time watching television than engaging in any other leisure activity (Dorfman, 1991). Television produces both visual and auditory stimuli, which are important to individuals whose vision and hearing may be waning. A recent study found that the elderly obtain health information primarily from their physicians, but that television PSAs, medical columns in newspapers, and articles in magazines (such as *Readers Digest*) are also important information sources (DaVanzo et al., 1993).

As part of its current communication strategy, HCFA produces several communication products specifically targeted to rural residents which are available through central and Regional Offices and are listed below. ICAs in many rural states produce their own materials advertising the availability of their services, one of which is listed below. HCFA is currently producing materials for a variety of media (broadcast television, cable television, radio, video, the HCFA home page, brochures, posters, kiosks, etc.), some of which provide general information and some of which provide answers to specific beneficiary questions.

Selected HCFA Products Targeted to Rural Audiences

Flu Shot Campaign PSAs--Announcements featured by several cable TV systems on their televised bulletin boards. (Kansas City Regional Office)

Senior Health Insurance Information Program (SHIP)--Short video explaining the ICA program and how it can help seniors. (Iowa ICA Grantee)

Mammography Radio PSAs--Radio PSAs for the screening mammography campaign produced by the Indiana and Wisconsin carriers (Chicago Regional Office)

Migrant Farm Worker Resource Directory--A handbook for migrant workers listing where they may obtain services in the Denver region. (Denver Regional Office)

Newsletter for State Surveyors ("On the Old West Trail")--Articles include issues pertinent to rural health. (Denver Regional Office)

Screening Mammography Campaign--The carrier selected a pilot group of beneficiaries who either had a screening mammogram 23 or more months ago or had not had a screening mammogram in the past. The carrier targeted four urban, six suburban and six rural areas. (Philadelphia Regional Office)

For reaching the broadest base of seniors, a multilevel strategy was recommended by respondents, using a variety of media. It is most important to tailor messages to satisfy specific information needs, and to develop messages that are in languages and settings that relate to the intended audience. Often using a credible spokesperson (such as a political figure or health expert) can be helpful. Finally, carefully choosing media was recommended. The various media claim to deliver the same audience, but they really deliver different components of the audience. Targeted television and radio media campaigns are more difficult in rural areas than in urban areas, but advances in communication technology, such as direct broadcast satellite television

(DBS), may help bridge this gap in upcoming years. Five ingredients were generally recommended by respondents for a successful effort to provide information to rural beneficiaries:

- Thoughtful evaluation of available media,
- Creative application of media,
- Careful study and specification of target audiences,
- Messages that build on the audience's current knowledge, and
- Pretesting messages and careful evaluation of results.

Interactive television and computer networks are among the new media being used to bring health information and healthcare to rural communities. The costs of providing rural healthcare through telemedicine systems have declined, and as of 1992, as many as 25 states had or were planning such systems. The literature contains several examples of the successful use of these technologies. The Texas Telemedicine Project, for example, provides clinical consultation for rural residents and continuing health education for rural providers (Preston, 1995). Multimedia health education programs are available to rural Colorado residents through the Denver Free-Net at the University of Colorado Health Sciences Center. Here, an On-line Urban to Rural Education and Community Health (OUTREACH) Network provides rural residents access to the wealth of healthcare resources available at the University Health Science Center and hospital. The Network also promotes the goals of Healthy People 2000 allowing consumers to access healthcare resources and encouraging their active participation in health decisions (Sweeney, and Skiba, 1995). In Missouri, a college in Fayette is linked with outreach colleges and several rural school districts in central Missouri which allows the schools to serve as an information hub for their communities (Devaney, 1996).

The other component of communication seen as being problematic in rural locations is being sure that beneficiaries understand the message. Respondents recommended using media together with some form of interpersonal contact to maximize the likelihood that the beneficiary understands what is being conveyed. Rural health clinics, primarily staffed by nurse practitioners and physician assistants, are particularly well suited to serving the healthcare and information needs of the rural elderly, especially when they are able to provide transportation. The clinics may offer home visits, functional assessments, monitoring of chronic diseases, coordination of resources, and referrals, all of which serve as vehicles for providing needed information to beneficiaries. Because rural health clinics are paid on a retrospective basis, there is an incentive for providers is to perform a greater number of consultative services than might be provided under prospective funding. Time can be taken to be sure clients understand their treatment and follow up with them.

Findings from both the literature review and our interviews suggest that in rural communities, there can be a greater sense of closeness among people than in urban communities, due to the fact that many families know one another well. Because of this close interaction, peer pressure in a rural community can be powerful. Key leaders in a community can generate widespread approval or disapproval of an idea or a new person, simply through word-of-mouth. The literature contains the example of coordinated nursing services that can be used to extend physicians, hospitals, and other scarce health resources in isolated communities. In this instance, nurses were particularly

effective in marshaling community resources to provide education and health services to the elderly. (Fenton, M.V., et al, 1988).

We visited several rural health clinics and interviewed providers and their staff regarding their "best practices" for providing their patients with health and insurance information they can understand. When one clinic decided that it would be advantageous to hire a Spanish-speaking physician, it was not very long before most of the Hispanic clients began coming to the clinic on Wednesdays, the day this doctor was in. In addition to making sure Hispanic patients who visited the clinic knew of the new service, the clinic had placed advertising flyers written in Spanish at local schools for students to take home to their families.

We found that in rural communities, beneficiaries' relationships with providers were often long term and somewhat more stable than the relationships we observed in urban settings. Additionally, providers told us that one-on-one interpersonal channels were the most effective strategy with rural beneficiaries, because they were able to use local idiom and metaphors and be sure the patient understands. For example, one staff member of a rural health clinic explained that she draws pictures of the sun on the labels of prescriptions her patients are to take in the morning, and the moon on the ones to be taken at night. Even though her patients claim to be able to read, many cannot. At another clinic, a nurse practitioner reported that when she explained the hip joint, she often used a "trailer hitch" metaphor in order to link this unfamiliar medical terminology with something that is familiar within the patient's life. The following are other examples of explanations used by staff to help their clients understand aspects of some complex chronic diseases:

- Congestive heart failure: the heart acts like a "pump", and medication is needed to help the heart pump better.
- Diabetes: insulin is the bridge between the sugar and the cells.
- Lung disease: smoking makes the lungs look like "pond scum" (there is little running water in the area, so many of the ponds are stagnant often creating a film on top commonly referred to as "pond scum").

Federal Agency Approaches

The CDC uses a multi-level intervention approach for communicating health information and facilitating healthcare access to rural populations. The North Carolina Breast and Cervical Cancer Control Program (NC-BCSP) is a good example of this multi-level approach. At the interpersonal level, the NC-BCSP trains lay health advisors from the community to conduct breast cancer outreach. The lay health workers conduct a variety of one-on-one and group activities, particularly with those women isolated from the healthcare system by lack of transportation and/or resources. These outreach activities include:

- Helping women fill out necessary forms,
- Providing transportation to and from the mammography center,

- Accompanying women to their first mammogram, and
- Making follow-up calls or visits.

NC-BCSP also conducts outreach initiatives at the community level through the creation of community advisory boards, education of local government officials, and partnerships with community-based organizations (i.e., churches and social clubs). Healthcare providers are considered to be the most trusted source of information in rural communities. Thus, the program expends a lot of resources in educating providers specifically on how to counsel women about breast cancer and targeting physician office managers and public health officials to talk to women about breast cancer screening.

SSA uses a combination of mass mailings (check stuffers), targeted mailings to beneficiaries whose income is below the federal poverty level, and outreach through community organizations to reach as many beneficiaries as possible. In order to communicate individually with the beneficiary and help him or her understand, local Social Security offices provide one-on-one assistance to individuals who are dual eligible for Medicare and Medicaid. Since the SSI is a program of last resort, Social Security field offices consider themselves responsible for helping SSI claimants to obtain any other benefits for which they may be eligible. In the case of 1634 States, Social Security Offices can determine Medicaid eligibility through the general SSI application. Social Security Offices are also authorized to take food stamp applications from SSI applicants with potential food-stamp eligibility. Finally, individuals can receive personalized assistance by calling SSA's national toll-free telephone service.

Table 2 below summarizes the advantages and disadvantages of using various communication channels in rural locations.

To summarize, HCFA has already begun many outreach projects designed to target rural audiences. These activities provide a foundation on which to build a coordinated communication strategy that is consistent with local efforts, that leverages local resources, and makes use of advances in communication technology and information management capabilities.

Table 2. Use of Communication Channels in Rural Locations

	Advantages	*Disadvantages*
♦ **Mass Media** ♦ (PSAs on radio and TV, newspapers, and magazines,)	♦ can reach many people quickly and overcome distances ♦ can target particular audience segments ♦ can raise awareness ♦ can provide advertising ♦ can help change and reinforce attitudes ♦ can demonstrate the desired action	♦ are less personal and intimate ♦ are not trusted by some people ♦ do not permit interaction ♦ offer limited time and space ♦ offer limited opportunities to communicate complex or controversial information ♦ can be costly
♦ **Community Channels** ♦ (schools, employers, churches and religious institutions, community organizations)	♦ may be familiar, trusted, and influential ♦ are more likely than media alone to motivate/support behavior change ♦ can reach select groups of people at once ♦ can offer shared experiences	♦ can be time consuming ♦ can sometimes be costly ♦ may not provide personalized attention ♦ message may be altered to fit host organization agenda
♦ **Interpersonal Channels or Intermediaries** ♦ (hotline counselors, parents, healthcare providers, clergy, educators)	♦ can be credible ♦ can permit two-way interaction ♦ can be motivational, influential, supportive ♦ can provide a sustained and consistent message over time	♦ can be time consuming ♦ can have limited target audience reach ♦ can be expensive ♦ effectiveness dependent upon communication skills of particular individuals

Source: *Guidelines for Health Education and Risk Reduction Activities*. CDC, April 1995.

INDIVIDUALS ABOUT-TO-ENROLL IN MEDICARE

Individuals about-to-enroll in Medicare (aged 62-64) may be the most difficult segment of the beneficiary population to reach, as they often do not have an identifiable communication and information dissemination network--they have either been out of the workforce too long for HCFA to rely on employers to distribute information, or are too young to be heavily integrated into the "senior network" (of senior organizations or senior living communities) where HCFA materials are either distributed or housed. Additionally, beneficiaries who work for employers that do not provide insurance will be out of the "loop." The exception would be those individuals who receive retirement benefits and health insurance from their employers (usually larger companies such as GE and FedEx). In these cases, the communication channel is very reliable with retirees turning to their former employers for guidance on a broad range of issues, including retirement financial planning, life insurance and health insurance.

Interviews: Findings and Implications

Companies, such as Motorola, often have a customer service line designed specifically for retirees with operators trained to give current and accurate Medicare information for those "aging-in" to Medicare. For companies with a high percentage of active employees and retirees in managed care, a large effort is made to negotiate Medicare carve out programs so that retirees do not have to switch their health insurance carrier. GTE, which offers a carve-out option, distributes a retirement resource guide which helps retirees coordinate Medicare with GTE's insurance options. About to retire GTE employees also receive an information kit six months prior to retirement explaining the steps necessary to ensure that health insurance is not disrupted and that transitioning from the workforce into retirement is not difficult. In these instances, new Medicare beneficiaries are less concerned with Medicare as the enrollment process is very clear and requires few steps.

However, a significant portion of the about-to-enroll population is not connected to an employer network and does not have a knowledgeable support base to facilitate the crucial, initial decisions about Medicare coverage. As a result, these individuals' first encounter with Medicare can be very difficult and can potentially result in long-term consequences, such as a permanent Medicare Part B premium increase for late enrollment. It is important to note that for many individuals, Medicare is associated with the SSA, and most do not even know of HCFA. This is aggravated by the fact that the mailing of the Initial Enrollment Packet (IEP) by HCFA requires that the individual has first signed up for Social Security. The IEP is often an individual's first introduction to Medicare. It is also an appropriate forum for HCFA to make the distinction between itself and SSA, and briefly describe the Agency's role. Name recognition will be increasingly important as HCFA defines itself as a customer service agency, although there are many beneficiaries who are not interested in knowing who administers Medicare because their primary concern is whether or not they are receiving "hassle-free" coverage.

There are a sizable number of about-to-enroll beneficiaries who do not sign up for their Social Security benefit as soon as they turn 65, and consequently, HCFA knows nothing about them. They do not receive an IEP, and therefore may not know what they need to do. Furthermore, because about-to-enroll beneficiaries are increasingly faced with two-stage choices, such as an initial choice between fee-for-service Medicare or a Medicare HMO, and then choices among a range of

supplemental insurance policies and managed care plans, some type of understanding of Medicare is essential.

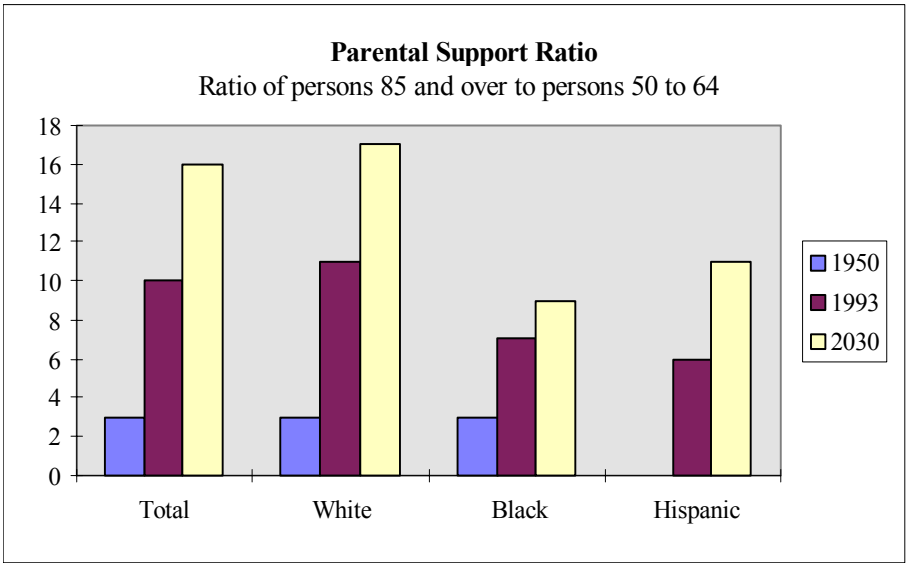
On average, working individuals who are approaching Medicare eligibility have more experience in choosing among a variety of health insurance plans than those out of work, those who retired well before age 65, and current beneficiaries. Companies typically offer an indemnity plan and a managed care option, so employees have usually had prior experience in choosing a plan. Employed also usually have an understanding of managed are, which is a confusing and difficult concept for current Medicare beneficiaries. The pre-65 population tends also to be more familiar and comfortable with technologically sophisticated channels of requesting and receiving information, and are accustomed to seeking information on their own. Many of these individuals regularly use computers in the workplace and are familiar with electronic interfaces, such as those used with ATM machines and touch-tone telephone menus. The organizations we interviewed who interact with the pre-65 population all agreed that this group is considerably more pro-active in their information seeking behavior than earlier cohorts. The Center for Healthcare Rights in Los Angeles reported receiving many calls from persons about-to-enroll, despite the center's low level of advertising to the non-Medicare community. While most questions focused on general enrollment and basic coverage information, some callers asked very complex questions, demonstrating a solid understanding of Medicare.

One of the most significant issues for the upcoming beneficiary generation is their overall frame of reference regarding retirement planning. Given the current financial condition of Medicare, its future is uncertain for many. As a result, the most pressing issue for the 55 to 64 year old individual is whether he or she has the financial resources to cover future needs. Needs could include healthcare, but they often reflect the larger picture of maintaining a reasonable standard of living and possibly financing the care of their aging parents.

As elderly live longer, it becomes more and more likely that the pre-65 cohort will find themselves in a caregiving situation, dealing with Medicare on behalf of an older relative. Table 1 illustrates how the balance between individuals aged 85 and older and those aged 50 to 64 has changed over the years across major racial groups as Americans are living longer. Though the table does not assume each person over 85 years old has a 50 to 64 year old caregiver, it does demonstrate the increasingly common interaction the about-to-enroll will have with the "older-old."

This increasing ratio raises two significant issues for agencies, such as HCFA, who are attempting to reach the pre-65 population. First, many will be introduced to Medicare before they themselves are eligible because of their caregiver role to their parents or relatives. In addition, these individuals will encounter the more complex issues regarding Medicare as their parents or relatives are likely to require long term care and experience debilitating health conditions. Second, the pre-65 population will likely reconsider the future costs of healthcare and their likely future health status. At the time of retirement, most individuals are primarily concerned with their financial status and future cost of living, without necessarily considering potential healthcare costs. Denial over "getting old" may further decrease the perceived importance of one's future health status for some. However, caring for older parents or relatives may force them to face the possibility of potential chronic health conditions, and to link their family history with their personal health future.

Table 1



Source: 1990 Data, U.S. Census Bureau

While the pre-65 age group may be a difficult audience to target regarding Medicare, the increasing parental support ratio may alleviate this problem somewhat because informed caregivers will eventually age into Medicare themselves. Additionally, heightened media attention will keep Medicare at the forefront of the healthcare debate and on the minds of those about-to-enroll, potentially educating them on Medicare in the process. The inventory interviews revealed a relatively insignificant effort on the part of senior and Medicare related organizations and agencies to proactively reach the pre-65 population, with the exception of AARP who sends materials to everyone turning 50. However, understanding the information needs of this population and recognizing the context within which the pre-65 population is contemplating their healthcare will be an important step for HCFA as the Agency works towards achieving a Medicare-knowledgeable population of beneficiaries, capable of navigating the system and making optimal healthcare choices to ensure healthy living. Respondents noted that over time, the HCFA Web page and the Internet will become important vehicles for reaching the about-to-enroll.

Information Wants and Needs of Pre-65 Individuals

As with all consumer groups, individuals about-to-enroll in Medicare are primarily interested in choosing coverage appropriate to their healthcare needs. They face many critical decisions at the time of enrollment, such as whether or not to join an HMO or the type of supplemental plan to buy. Having adequate information about all options, showing the pros and cons of each decision scenario, is therefore very important.

HCFA has already taken significant steps to provide information in this format with the San Francisco Regional Office pilot. The goal of this project is to design managed care plan comparison charts for HCFA Regional Offices. These charts will present side-by-side, region-specific managed care plan information. In addition, these comparison charts will be made available for all managed

care plans via the Internet by the end of 1997. The Philadelphia and Boston Regional Offices have adopted the design of the San Francisco office and have also developed comparison charts for their respective regions (McMullan, 1996). HCFA also has undertaken a pilot project in Texas to present live comparisons over the Internet. One important challenge for HCFA is to keep this information current and accurate while making it widely available through a variety of communication channels. Additionally, multilevel dissemination (such as media plus interpersonal) will be important, as HCFA will want to be sure that beneficiaries not only receive the charts, but are also able to understand them.

Strategies for Understanding Information Needs

Unless an organization makes use of information databases, such as those maintained by SSA or the Department of Motor Vehicles, it is difficult to identify individuals who are about-to-enroll in Medicare and assess their information needs through traditional methods. Respondents said that two of the most productive and effective methods for targeting individuals about-to-enroll is through retirement activities held by employer groups, and through family members for whom these individuals are caregivers.

Additionally, through building linkages with employer groups, community organizations, and provider groups, HCFA can regularly poll representatives and obtain their perceptions of the information needs of their respective constituents. For example, ICAs are often asked to provide speakers for quasi-social and other functions by these groups. During the question-answer sessions, ICA speakers can identify areas in which individuals have a lot of questions or do not seem to understand. Regular qualitative reports from ICAs to HCFA on perceived information needs can provide the Agency with an updated picture.

Communication Strategies. As discussed above, individuals about-to-enroll in Medicare are comparatively more difficult to reach than those already enrolled or those currently in the workforce. The about-to-enroll are also as diverse as the general population of beneficiaries, so while our findings are generally applicable, the analyses of the subpopulations may be more relevant for some about-to-enroll. Once an effective method for reaching this segment is developed, however, the actual communication strategies are fairly straightforward. On average, the employed pre-65 age group is generally knowledgeable of a variety of technologies, receptive to various forms of media and on average, has achieved a higher education level than the current Medicare population. A number of informants made the point that many in this group are interested in obtaining as much information as possible in order to make informed decisions. Carrier and HICAP inquiries reveal a distinct preference for materials that are written concisely and, when appropriate, presented in graphic or chart format. The two issues most important for HCFA when communicating information to those about-to-enroll in Medicare are 1) providing information that is essential to the decision process associated with Medicare enrollment in a timely way, and 2) understanding that this population is often "comparison shopping" for the type of Medicare coverage they will choose upon enrollment. Information should be presented in such a way as to facilitate an objective comparison or "shopping" experience.

Presentation for the "Comparison Shopper". As discussed in the First Inventory Report, the majority of companies offering health benefits to employees face similar communication and

dissemination challenges as HCFA in terms of explaining complex health insurance information and providing individuals with adequate information to make decisions. The benefits information packets obtained from companies, such as Nordstrom, GE, United Airlines and XEROX, featured company generated comparison plans or report cards for the managed care and indemnity plan options available to employees. This style of presentation was endorsed by all company representatives based upon the positive feedback from employees they had received via focus group and survey evaluations of benefits materials. This finding is particularly important for the Agency when communicating to the pre-65 population: this format is one that beneficiaries have likely become accustomed to through previous experience with employer human resources and benefits departments.

Layered Information Delivery. Since those about-to-enroll in Medicare are not currently making use of Medicare services, information on coverage details and deductible amounts are less relevant to them than the types of choices they will face once they reach eligibility. Because the IEP precedes the arrival of the *Medicare Handbook*, there is opportunity to implement a "layered" information dissemination approach. Covering the overall and essential Medicare issues very simply (such as eligibility, coverage options and where to find help) would better prepare the enrollee for receiving the *Handbook* in which they are described in detail. Because the *Handbook* is largely used as a reference, if used at all, new beneficiaries do not read it through, and hence may lack a basic overall understanding of Medicare. Presenting an overview of Medicare and the information that will be necessary to make informed decisions on coverage (comparison charts, phone numbers for HICAPs and ICAs) would be a manageable and beneficial "chunk" of information for a new enrollee. The *Handbook* could then be used to inform the beneficiary of more specific coverage and entitlement details, once he or she has been introduced to Medicare.

One effective strategy we encountered was used by the Illinois ICA (Illinois Department of Insurance - Senior Health Insurance Program). The ICA identifies individuals approaching age 65 from the Illinois Department of Motor Vehicles. The ICA sends these individuals a brochure--*Getting Off to a Good Start With Medicare*--giving them information on how to determine if they are eligible and other timely and relevant information. Detailed information, such as how many chiropractor visits are covered under Medicare is not included as consumers tend to seek out information only when it is immediately relevant. Specific coverage information is most helpful when the consumer is at the point where he/she is ready to make use of the service or has been diagnosed with a condition, the treatment for which is covered under Medicare.

Coordination with Employer Groups. The HICAP programs in San Diego and Los Angeles advertise their services at annual retirement seminars and conferences held by state agencies and consumer groups, and they also make presentations, upon request, at company retiree seminars. One barrier to this approach is the age group to which the information is targeted. According to the companies and organizations we interviewed, their average retiree is too young to be concerned with Medicare. As a result, retirement seminars tend to focus strictly on financial issues such as pension and 401K plans and are reluctant to include Medicare presentations. However, as more employers discontinue providing retiree health benefits, Medicare information will be increasingly valued. In addition, many individuals work well into their 60s and the gap between the "workforce network" and the "senior network" is diminished. Despite difficulties, working through employer

groups and community organizations that target either retirees or seniors remains the most effective outreach method for the pre-65 population.

Community Organization Efforts. The task of disseminating Medicare information is often limited to the community efforts of Medicare carriers, HICAPs, ICAs and HCFA Regional Offices. With restricted budgets, it is difficult for these organizations to broaden the scope of their outreach to include the pre-65 population. The main strategy for HCFA is to partner with other organizations or at least advertise that they provide Medicare information and materials, and have staff trained to answer questions. Transamerica Occidental Life Insurance, the Medicare carrier serving southern California, is organizing a Resource Conference which will allow advocacy groups, health related organizations and relevant government agencies to explain their respective roles in the healthcare arena and to inform other groups how and when to utilize their services. The intent is to minimize duplicated efforts by clearly defining each organizations' roles and capabilities. Transamerica also hopes to reach the pre-65 population by alerting area organizations, including retiree groups and employers, of the resources available to obtain answers to Medicare questions. In addition, by "putting the word out" they hope to get pre-65 individuals thinking about Medicare before they are faced with the daunting task of making healthcare decisions for themselves.

Provider Groups. Community oriented direct service providers are often a good source for reaching the entire family. Because of its community level focus, many of the providers are from the community or employ members of the community. Efforts are made to involve family members in each others' care. For example, the Watts Health Foundation, in the greater Los Angeles area, encourages the adult children of Medicare beneficiaries to accompany their parents or older relatives to doctor visits and consultations. Providers and other staff at the Foundation receive social work and customer service training in order to provide sensitive and comprehensive care to patients. The family focus allows the Foundation to keep an active communication channel open at all levels within the family. Adult children of beneficiaries are consequently familiarized with Medicare, having made or assisted in healthcare decisions for their parents.

Table 2, below, presents some of the questions and concerns of individuals about-to-enroll in Medicare, as well as a communication strategy recommended by interview respondents to address them. It is important to note that HCFA is currently providing vehicles to answer targeted questions, therefore, the issue for the Agency becomes one of refining these vehicles and improving dissemination and internal coordination, rather than developing entirely new materials.

Table 2

Beneficiary Question or Information Need	Recommended Communication Strategy
Do I qualify for Medicare?	Current IEP includes a questionnaire to help individuals decide whether or not they qualify. These questions are clear, concise and provide a logical sequence of action steps tailored to each scenario (e.g., already receives Social Security, government employee, spouse still works, etc.). The action steps should directly follow each defining question and clearly list deadlines for each action.
Medicare Overview	Explain Part A and Part B and introduce terms such as "assignment," "deductible," "co-insurance" as well as managed care terms such as "network" and "PCP." These definitions will familiarize beneficiary with terms they will encounter in the *Handbook* and other Medicare related documents and forms. Blue Shield of California has developed a packet of information that can be used as handouts for presentations or modified for more widespread distribution.
Fee-for-Service or Managed Care?	By far, respondents said the best strategy is the comparison chart which clearly states similarities and differences among available options. The Oregon ICA produces the *Consumers Guide to Medicare Supplemental Insurance and HMOs*, which explains the two delivery systems.
Supplemental Insurance	Region specific comparison chart - HCFA currently produces this through various ICAs, some respondents said beneficiaries find it confusing. A possible remedy is to modify it to clarify the message.
Managed care plans	Region specific comparison chart - Beneficiaries are generally confused by the marketing materials they receive from plans, and respondents said beneficiaries would like to receive more information from HCFA that is unbiased, simple, and clear.
Where to go with questions	Medicare wallet card with important telephone numbers. Blue Cross Blue Shield of Arizona provides pocket or wallet size calling cards.

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In actual numbers, 190,000 of 1.9 million eligibles participated in the SLMB program

In actual numbers, 3.3 million of 5.3 million eligibles participated in the QMB program.

Insurance coverage information is available for approximately 10,000 of the nearly 14,000 survey respondents.

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