

Implementing Peer-to-Peer Medicare Education for Older Adults

An Evaluation of the Medicare Rights Center's Seniors Out Speaking Medicare Minute Program

Prepared for the Medicare Rights Center

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Executive Summary

About the Evaluation

With support from the Atlantic Philanthropies and the Helen Andrus Benedict Foundation, the Medicare Rights Center engaged an independent evaluation team based at Columbia University to evaluate the implementation of the Seniors Out Speaking (SOS) Medicare Minute program. The purpose of the evaluation was to inform programmatic expansion efforts on a national scale by gaining an understanding of the key components and activities that contribute to the successful implementation of the Medicare Minute, along with factors that facilitate and pose challenges to program management, expansion, and sustainability.

Who did we talk to?

- **15 volunteers** in Westchester
- **Audience members** from **4 sites** in Westchester
- **Westchester SOS Director**
- **Westchester SOS Founder**
- **Medicare Rights State Program and Policy Coordinator**
- **SOS Coordinators** in Alabama, Florida, Kansas, Maine, and Wisconsin

Evaluation activities were carried out between July 2012 and July 2013 in Westchester County, New York, and five targeted states funded by the Atlantic Philanthropies: Alabama, Florida, Kansas, Maine, and Wisconsin. In-depth interviews were carried out with Medicare Minute volunteers, audience members, and coordinators in order to gather a detailed understanding of the experiences of program participants.

Key Findings

Why Do Volunteers Join and Why Do They Stay?

Volunteers join the SOS program for several reasons, including **having more free time** after retirement; searching for a **meaningful activity**; **having an interest** in the topic of Medicare and/or working with the senior population; and having a **previous career** in health care or education. Volunteers also appreciate the **flexibility** of the volunteer schedule and the **intensiveness** of the commitment.

Volunteers stay with the Medicare Minute over time because they feel they are **making a difference**; they enjoy being **involved in their communities** and **building relationships** with their audience and with other volunteers; and they experience **personal growth** in their own knowledge and skills.

Volunteer Skills

- Comfort with public speaking
- Ability to develop rapport with audience members
- Ability to gauge audience interest and comprehension and adapt presentations accordingly
- Ability to simplify complex information
- Ability to process and retain complex information
- Flexibility and patience
- Commitment to the intensive nature of volunteer work

What Makes the Medicare Minute Work?

Key Program Components

Program Design

- Consistency of presentations
- Short presentation length
- Relevance of topics
- Level of information provided
- Availability of additional services
- Peer education model

Program Management

- Program leadership and staffing
- Recruitment and support of qualified volunteers
- Recruitment of appropriate sites

Program Implementation

- Volunteer relationship with audience
- Availability for one-on-one questions
- Tailoring presentation to audience

It is essential that host organizations are able to **recruit and retain dedicated volunteers and staff**. Volunteers are the heart of the program. Program coordinators, particularly at the local level, play an important role in motivating volunteers and managing daily program operations.

Evaluation findings point to the **crucial role of personal relationships** in the success of the Medicare Minute program. Relationships between volunteers and audience members create a sense of trust and encourage audience members to approach volunteers with their Medicare needs. Relationships between program coordinators and volunteers support volunteer retention. Relationships between volunteers and site directors help foster buy-in and support from site directors. And relationships among volunteers themselves can develop a sense of camaraderie.

What Facilitates Program Implementation for New Host Organizations?

The experiences of Westchester and grantee states with the Medicare Minute program point to several factors that should be in place for the program's successful operation. These include: **allocating funding** to cover Medicare Rights' licensing costs and production and distribution of materials for volunteers; **securing buy-in from host organizations**; **ensuring adequate staff time** to get the program off the ground; and **designating local program coordinators** to manage daily activities and support volunteers. Interviews with Medicare Rights staff suggested that **gaining support for the program at a state level** would benefit both host organizations and Medicare Rights.

With regard to program volunteers, state coordinators indicated that **having an existing pool of interested and trained volunteers** facilitated the program's initiation. In grantee states, challenges with volunteer retention also pointed to the importance of volunteer interest and **accountability to the host organization**.

What facilitates program implementation?

- Buy-in from high-level AND front line staff
- CMS-affiliated host organization
- Centralized program management and local program coordination
- Qualified volunteers and existing volunteer pool
- Volunteer accountability

Recommendations for the Medicare Rights Center

- 1. Seek program support at a statewide level.** Adoption of the Medicare Minute program by a statewide agency is useful, as state agencies can license the Medicare Minute materials for distribution to a number of local organizations within the state. Statewide programs may also streamline the distribution process for Medicare Rights.
- 2. Determine extent of Medicare Rights support for host organizations.** It would be beneficial to consider the type and level of initial and ongoing support that Medicare Rights can feasibly provide to new host organizations, given Medicare Rights' staff capacity and the potential of an increasing number of states taking on the SOS program.
- 3. Link new and experienced host organizations.** Medicare Rights might consider organizing a mentorship arrangement whereby new hosts are linked with established SOS programs for support with program initiation and management. Medicare Rights might also consider videotaping Westchester presentations and otherwise digitalizing presentations to share with new host organizations.
- 4. Consider flexibility in program design and implementation.** Medicare Rights should promote the core components of the Medicare Minute program as identified in this evaluation. At the same time, Medicare Rights should continue to consider how much flexibility to allow host organizations and volunteers in implementing the program.
- 5. Solicit feedback from host organizations and participants.** Medicare Rights should continue seeking input from SOS host organizations and volunteers around the year's Medicare Minute topics. Medicare Rights may also wish to test Medicare Minute formatting and complexity more rigorously, for instance through focus groups, to ensure that they are most effectively reaching diverse audiences.
- 6. Explore program challenges in rural areas.** Because many states looking to adopt the Medicare Minute have large rural populations, it would be beneficial for Medicare Rights to explore the challenges to rural program implementation.

Recommendations for Host Organizations

Program Structure and Management

- 1. Seek program support at statewide and local levels.** Host organizations operating at a local level should consider encouraging their state SHIP or related organization to adopt the Medicare Minute program, in order to centralize the management of the program, effectively scale the program, and reduce the financial burden on local host organizations. For SOS programs that will be operating in multiple locations across a state, it is also crucial to reach out to local staff to gain their support for the program—and to designate local SOS coordinators. Local buy-in may be achieved by promoting the benefits of the program for the host organization itself, for volunteers, and for seniors in the community. At the same time, it is important to openly acknowledge and plan for challenges related to funding and staffing that host organizations may face.
- 2. Identify appropriate program locations.** It is important to consider how well the Medicare Minute model fits in different geographic areas and communities. For

example, based on the experiences of grantee states, the program model may be better suited to locations with greater population density. For many host organizations, it could be advantageous to start small, identifying a targeted region or regions and identifying program successes and challenges before expanding to a wider area.

- 3. Ensure access to referral services.** It is essential that volunteers are able to refer audience members to individualized assistance (e.g., a helpline or counseling).
- 4. Incorporate management duties into job descriptions.** Including responsibilities related to SOS program management in staff job descriptions can help institutionalize the program in the future.

Site Engagement

- 5. Identify sites that are appropriate for the Medicare Minute.** Presentation sites with regular monthly meetings or scheduled events are most conducive to the Medicare Minute. Program coordinators may benefit from pursuing existing relationships and also encouraging volunteers to identify sites that may be interested in offering the Medicare Minute.
- 6. Expand to other types of sites.** While senior centers may currently be the most suitable venue for a monthly Medicare Minute, interviewees suggested that host organizations consider reaching out to other types of venues, particularly since Baby Boomers and those newly eligible for Medicare do not necessarily visit senior centers.

Volunteer Recruitment, Training, and Support

- 7. Ensure that volunteers are committed to their role and properly trained and supported.** It is essential that volunteers are aware of the intensive nature of the volunteer opportunity and that they are comfortable with the public speaking requirements. It is also important that volunteers feel a sense of loyalty to the SOS host organization. New volunteers must also be adequately trained in Medicare. Ongoing monthly support in preparing for the presentations is also key.
- 8. Consider accepting volunteers who are not seniors.** While there may be drawbacks to a non-peer model in terms of being able to draw on one's personal experience with Medicare, adult volunteers under age 65 seem to be well received in certain locations.
- 9. Partner with outside organizations to assist with volunteer recruitment.** For example, in Maine the state SHIP has worked with AARP to promote Medicare Minute volunteer opportunities among their members. In Westchester, the SOS program has worked with local United Way-affiliated organizations to identify new volunteers.
- 10. Incorporate a mentorship component.** Volunteers should observe a skilled presenter before beginning as a presenter on their own. Initially this might be a SHIP/AAA/ADRC staff person, and in the longer-term can be experienced volunteers. Volunteers can also offer social support to one another, and it may be beneficial to set up an email list or group for volunteers to share information and experiences among themselves.

I. Introduction

Medicare Rights Center and the Seniors Out Speaking Program

The Medicare Rights Center (Medicare Rights) is a national, nonprofit consumer service organization working to ensure access to affordable health care for older adults and people with disabilities. Medicare Rights achieves this aim through a multi-pronged strategy including counseling and advocacy, educational programs, and public policy initiatives.

Recognizing that many older adults do not have a clear and accurate understanding of the Medicare system or their rights and benefits within this system, Medicare Rights' educational programs seek to empower older adults to become advocates for themselves and others by providing them with information and assistance about their health care benefits and options.

In 2001, Medicare Rights launched Seniors Out Speaking (SOS), a volunteer-led, peer education program that provides older adults with information about the Medicare system and benefits, giving them the tools to make educated decisions about their health care coverage. The SOS program began in Westchester County, New York, funded by the Helen Andrus Benedict Foundation, a Westchester-based family foundation with the goal of engaging older adults in their communities.

As the original program of Seniors Out Speaking, the Medicare Minute was designed to engage peer volunteers to visit community-based sites and deliver brief, monthly presentations to older adults ("audience members") focused on Medicare rights and benefits; inform audiences of upcoming policy changes; and offer brief, individualized assistance in navigating Medicare issues.¹ The Medicare Minute program expanded from Westchester County to sites in New York City in 2007-2008, with support from the Isaac H. Tuttle Fund. Around this time, SOS grew to include the Health Advocacy Players, a program that offers longer, scripted presentations on important Medicare benefits and policies. Also in 2007-2008, Medicare Rights began partnering with the Westchester Library System to train counselors to provide direct assistance in county libraries, through Senior Benefits Information Centers (SBICs), originally known as Health Advocacy Resource Centers.

Expansion to Other States

After witnessing the success of the Medicare Minute program in New York, Medicare Rights felt that the program objectives and model would replicate well in other areas. With support from the Jacob and Valeria Langeloth Foundation in 2008, and later the Public Welfare Foundation, Medicare Rights began assessing the usefulness of the Medicare

¹ Around the advent of the Medicare Part D prescription drug benefit in 2006, the SOS program began to offer what has been termed the "Extended Medicare Minute," which consists of one-time, hour-long presentations on basic Medicare topics. As the purpose of this report is to provide recommendations for the expansion of the full Medicare Minute program, this report focuses on the implementation of the traditional monthly Medicare Minute.

Minute model in states outside New York, including Kansas and Maryland, finding an interest in the program among AAAs, State Health Insurance Information and Assistance Providers (SHIPs), and related agencies.

In 2011, Medicare Rights received a grant from Atlantic Philanthropies to further expand the Medicare Minute component of the SOS program. The overarching goal of the project was to ensure that implementation of the Affordable Care Act would meet the needs of older Americans and those with disabilities. The Medicare Minute program's function in this project was to engage older adults as peer educators and advocates, providing a trusted source of Medicare information to communities in five targeted states (Alabama, Florida, Kansas, Maine, and Wisconsin).

Current Evaluation

The Atlantic Philanthropies designated a portion of its funding for an evaluation of the implementation of the Medicare Minute program in Westchester and grantee states. In 2010, Medicare Rights contracted with a team of independent evaluators affiliated with Columbia University's Mailman School of Public Health to design and carry out the evaluation. The evaluation purpose and methods are described further in Section II.

Organization of the Report

Section II discusses the evaluation purpose and methods. Section III presents findings pertaining to the implementation of the Medicare Minute program in Westchester County. Section IV discusses program implementation in five states: Alabama, Florida, Kansas, Maine, and Wisconsin. Finally, Section V summarizes the key evaluation findings, and Section VI presents recommendations for program expansion.

II. Evaluation Purpose and Methods

Evaluation Purpose

The current evaluation was undertaken with the aim of informing programmatic expansion efforts in other states. In order to achieve this aim, the objectives of the evaluation were as follows:

- 1) Identify commonalities and differences in program implementation across host organizations, volunteers, and presentation sites;
- 2) Gain an understanding of how the Medicare Minute program successfully engages volunteers and audience members; and
- 3) Identify elements and activities of the Medicare Minute program that appear to be key to its successful operation.

Evaluation Methods

The evaluation employed qualitative methods in order to capture detailed descriptions of the experiences of program volunteers, audience members, and coordinators. When looking to understand the nuances, subtleties, and complexities of a topic or experience, qualitative methods allow evaluators to gather holistic and detailed information, as articulated by individuals in their own words.

Data Collection Activities

In order to paint a comprehensive picture of the implementation of the Medicare Minute program, evaluation activities were developed to gain an understanding of the program from the perspectives of program staff, volunteers, and audience members. Data collection was carried out from July 2012 to July 2013 and included the following activities:

Who did we talk to?

- **15 volunteers** in Westchester
- **Audience members** from **4 sites** in Westchester
- **Westchester SOS Director**
- **Westchester SOS Founder**
- **Medicare Rights State Program and Policy Coordinator**
- **SOS Coordinators** in Alabama, Florida, Kansas, Maine, and Wisconsin

- 1) **In-depth interviews with Medicare Minute program volunteers in Westchester County.** Volunteer interviews were designed to explore how volunteers became involved in the SOS program, their experience with training and support received from Medicare Rights, a description of how they carry out their Medicare Minute presentations, and their perception of the key components of the Medicare Minute program. Before finalizing the interview guide, the lead evaluator piloted the interview questions with two volunteers from Medicare Rights' New York City-based Medicare Minute program. The evaluation team then selected 15 Westchester volunteers representing a range of demographic characteristics and experiences

with the Medicare Minute program, including age, sex, and length of time as a volunteer. Interview participants were initially recruited through an email sent by the Westchester SOS Director to all volunteers. Taking into consideration the characteristics of the participants who signed up voluntarily, targeted recruitment of interviewees took place in order to improve the diversity of the sample. Compared to Medicare Minute volunteers as a whole, interviewees had a similar number of years of experience with the Medicare Minute program, and a slightly higher proportion was female. Appendix B presents interviewee characteristics in more detail. Volunteers gave verbal consent to participate in the evaluation, and interview participants were offered a \$10 Amazon.com gift card. All interviews were conducted in person by the lead evaluator and lasted approximately one hour.

- 2) **Semi-structured discussions with audience members in Westchester County.** The evaluation included site visits to four Medicare Minute presentations in order to see Medicare Minute presentations in action, observe audience members' reactions to the presentations, and speak with audience members about their experience with the program. Sites were chosen in conversation with the Westchester SOS Director to represent a range of characteristics, including smaller and larger sites, sites served by newer and more seasoned volunteers, sites with lower and higher income seniors, and sites with higher- and lower-functioning audience members. Audience members were asked what they found to be the most helpful and satisfying aspects of the Medicare Minute. In order not to disrupt the sites' meeting schedules, the lead evaluator carried out informal discussions with audience members after (and sometimes before) the Medicare Minute presentations, during which time audience members were generally between activities. Discussions took place with small groups of 2-8 audience members, and depending on the structure of the site were held either at small tables or with small groups pulled aside from the larger seating area. Discussions with each group were brief, lasting no more than 5-10 minutes.
- 3) **Discussions with program staff in New York.** To gain a better understanding of the structure and operation of the Westchester SOS program, the lead evaluator held semi-structured telephone conversations with the current Westchester SOS Director and the Westchester SOS Founder (and former director). Conversations focused on the history and design of the Medicare Minute program, key components of program implementation, and recommendations for program expansion. Phone conversations and email correspondence with Medicare Rights' State Program and Policy Coordinator elucidated details about the expansion of the SOS program in grantee states, touching on aspects of program adoption, implementation, and interaction between grantee states and Medicare Rights. Informal discussions and email correspondence with staff from Medicare Rights' Education Department also helped provide important background and context for the evaluation.
- 4) **In-depth interviews with program coordinators in the five Atlantic Philanthropies states.** Interviews with SOS program coordinators in grantee states were carried out to explore how states implemented the Medicare Minute program, and successes and challenges related to program implementation. Interview topics included volunteer recruitment and retention, level of buy-in and engagement from presentation sites, audience satisfaction with the program, challenges to

implementation, and coordinators' desire and ability to sustain the program beyond their contract with Medicare Rights. Interviews were conducted by phone by the lead evaluator with one coordinator from each state. In the case of Wisconsin, whose SOS program was being operated separately in three areas of the state, a coordinator from one of the funded agencies was interviewed.

Data Analysis

Interview data were analyzed using ATLAS.ti, a qualitative data analysis software that allows data to be coded and explored in order to identify common themes. Collecting information from volunteers, audience members, and program coordinators allowed for data from multiple sources to be combined in order to provide a fuller picture of how the Medicare Minute program operates. During the analysis process, particular attention was paid to commonalities and differences among interview respondents, both within and across the different types of interviewees (volunteers, audience members, and staff).

Limitations

As with any study, certain limitations must be kept in mind when considering the findings. First, evaluation data were drawn from information provided by the relatively small number of individuals who participated in the evaluation, and therefore may not fully capture all of the variations in program implementation and experiences. For example, program volunteers who agreed to take part in the interviews may have been more involved in the program or more satisfied with their involvement. In light of this possible bias, efforts were made to ensure that interviewees represented a diversity of perspectives and experiences. During the analysis process, common themes among interviewees arose, which helped to increase confidence in the validity of the findings.

Additionally, the evaluation relied primarily on data self-reported by program participants. Because interviewees were asked to speak about many experiences that occurred in the past, there is a chance that their recall was imperfect. There is also the possibility of social desirability bias, in which interviewees respond in a way that they imagine the interviewer wishes them to respond or that is seen as the socially acceptable way to respond. Efforts to reduce this bias were undertaken by clearly stating the aims of the evaluation—the goal was to document the program implementation, not evaluate individual volunteers' performance—and ensuring the confidentiality of volunteers and audience members in the report. In addition, in-person interviews allowed the interviewer to develop rapport with interviewees and address any concerns about how the information would be used.

With these considerations in mind, the evaluation provides valuable insights about the implementation of the Medicare Minute that benefit both Medicare Rights and agencies that have recently adopted or are considering adopting the Medicare Minute program.

III. Medicare Minute Program in Westchester County, New York

A. Medicare Minute Program Background

How is the program designed and what services are offered?

Program Design

The Medicare Minute program was designed to train volunteers ages 50 and older to conduct presentations about Medicare to enable seniors to manage their health coverage. Medicare Minutes were intended to take place at senior centers and other venues where seniors congregate, such as clubs and libraries. The format of the Medicare Minute was developed by the SOS program founder to meet the needs of senior centers: initial discussions with senior center directors revealed concerns that the Medicare Minute would disrupt seniors' social activities. As such, the Medicare Minute was designed to include the following components:

- Presentations take place during a regularly scheduled monthly meeting or activity at the center;
- Presentations are short so as not to disrupt meeting time and to be appropriate for audience attention spans;
- Volunteers remain available after the presentation to answer any individual questions from audience members;
- The same volunteers present each month to allow for rapport building between volunteers and audience members; and
- Presentations focus on updates or changes in Medicare or remind audience members of important Medicare benefits.

Program Materials

Medicare Rights produces the following materials for the Medicare Minute.

- **Medicare Minute Script.** A one-page narrative with the basic details of the month's Medicare Minute topic. The script is designed for volunteers to be able to read aloud to their audience in 5-10 minutes.
- **Teaching materials.** Several pages of information that explain the Medicare Minute topic in more detail. Volunteers can use teaching materials to prepare themselves before giving the Medicare Minute presentations.
- **Handouts.** One-page summary of the Medicare Minute, sometimes including a Take Action item. Volunteers can leave handouts with audience members after the presentation.

Medicare Minute Services

The services offered through the Medicare Minute program in Westchester include monthly educational presentations and content; availability of volunteers to field one-on-one questions; and referrals to additional support services, including Medicare Rights' telephone helpline and one-on-one counseling through Westchester's Senior Benefits Information Centers (SBICs).

Medicare Minutes Quantified

The Medicare Minute program in Westchester completed its eleventh year in 2012. Since the program began in 2001, the number of program sites has grown from about 10 to over 40. In 2012, volunteers in the Medicare Minute program led 334 presentations at 44 sites, reaching over 2,300 individuals.

Table 1. Medicare Minute Program in 2012

Program Component	Numbers Reached
Number of volunteers	42
Number of presentation sites*	44
Number of presentations	334
Number of audience members (unduplicated)	2,304
Number of audience members (duplicated)	14,997

**Presented Medicare Minute at least once during the year*

Volunteer Characteristics

Most of Westchester's Medicare Minute volunteers are retired professionals. Many volunteers have had careers in health or in teaching, but a number have not had any professional experience with health or Medicare. Volunteers also generally have experience with public speaking. Some volunteers are members of the communities where they present; a few are even members of the senior centers or other community gathering places where they present. Many are involved in additional volunteer activities, including the SOS Health Advocacy Players and counseling through the Westchester Library System's Senior Benefits Information Centers. About 70 percent of volunteers are women. Volunteers have been with the SOS program from several months to 12 years—since the start of program—and are relatively evenly divided into four categories: 0-2 years, 3-5 years, 6-9 years, and over 10 years with the program.

Audience Characteristics

Audience members at Medicare minutes are generally retired professionals, many of whom have worked for government agencies and therefore have retiree insurance. Audience members range in age from younger seniors who have recently retired, to older seniors who have been attending the Medicare Minute presentations for 10-20 years or more. Most audience members are Caucasian. Medicare Minute audience members are generally consistent from one month to the next.

B. Medicare Minute Program Operations

How do program staff carry out program activities?

Program Staffing and Management

The Westchester SOS program is headed by two full-time staff members in Westchester County: the SOS Director and SOS Deputy Director. The SOS program also receives support from four staff members in Medicare Rights' New York City office. The Westchester-based staff take the lead in managing the day-to-day program activities and provide regular program updates to the New York City staff. Medicare Rights-based staff produce Medicare Minute materials, lead volunteer trainings, contribute to program development and outreach efforts, and are a source of support and technical information about Medicare for Westchester volunteers and audience members.

Site Recruitment and Engagement

According to interviews with volunteers and the Westchester SOS Director, Medicare Minute sites are most often recruited by the director, who reaches out to site directors directly to bring them on board. Some sites have also approached Medicare Rights with an interest in the Medicare Minute. In addition, several volunteers have reached out to sites in their communities where they felt the Medicare Minute would be a good fit. The Medicare Minute typically becomes part of a site's regular programming, taking place at regular meeting times, for instance before or after meals or games. Presentations typically occur monthly, though some sites do not meet for several months out of the year (e.g., during the summer). While volunteers usually present on the same day each month, some may change the date of their presentation if they have a personal scheduling conflict or if the site has another event scheduled.

Volunteer Recruitment and Engagement

The SOS program recruits volunteers through print and online publicity, as well as through word of mouth. The program director or deputy director interviews all applicants about their expectations and motivations for volunteering, and assesses whether their interests and communication skills are a good match for the volunteer role. Candidates are invited to attend an update meeting to meet experienced volunteers and observe how the program operates.

Once volunteers have been trained, they are matched with a site. While most volunteers present alone, several choose or are assigned to present in pairs. Generally volunteers are placed at existing Medicare Minute sites that are in need of a new volunteer, though some volunteers have initiated new sites in their communities. At times, there are no sites in need of volunteers and new recruits must wait to be assigned to a site.

Among volunteer interviewees, most became involved in the Medicare Minute program after connecting with Lois Steinberg, the program's founder and former director. Many

learned about the SOS program through an article in their local newspaper, after which they contacted Dr. Steinberg and participated in an interview. One volunteer described attending a gathering organized by Dr. Steinberg to publicize the program and recruit new volunteers. Another volunteer recalled being recruited by a friend who was a volunteer. Two volunteers learned about the program through volunteer positions at the AARP. A more recent volunteer mentioned hearing about the program through an online notice from the local library.

What attracts volunteers?

- Having more free time after retirement
- Searching for a meaningful activity
- Interest in Medicare and/or senior population
- Previous career in health care or education
- Flexibility of volunteer schedule
- Intensiveness of commitment

Volunteers reported being drawn to the SOS program for several reasons. Most joined the program after retirement, feeling a desire to perform meaningful work in their communities now that they had more free time.

A number of volunteers mentioned joining the SOS program not only to help seniors in their community, but also to educate themselves about Medicare, as many had recently become Medicare beneficiaries themselves. Some interviewees had had careers related to health care and considered the Medicare Minute to be a natural extension of their previous work. Several others had worked in education and therefore felt comfortable in a teaching atmosphere. Those volunteers who were not seniors when they joined the program also described wanting to fill free time with meaningful work, and several described having an interest in Medicare based on experiences caring for family members. One volunteer also noted that the ability to choose a site whose meeting fit with her schedule was a benefit of the program. Several volunteers also appreciated that the position required a substantial commitment, with one interviewee recalling, "I felt from the training program and the time that we were required to participate that it was not just some flimsy volunteer program.... There was more commitment to this type of a volunteer program than to some of the others" (Vol 3).

Volunteer Training and Support

The various modes of training and support that volunteers receive from Medicare Rights are described briefly below.

Initial in-person training. All volunteers participate in an initial training run by staff from Medicare Rights' Education Department. The training consists of four half-day sessions and includes modules on Medicare A, B and D, Medigap policies, and presentation skills. Volunteers are also briefed on volunteer requirements and responsibilities. The current program director noted that over the years the training has become "less intense," as some new volunteers expressed that the amount of information felt overwhelming. Instead, Medicare Rights offers additional trainings on separate occasions to supplement the initial training.

Initial web-based training. Recently, Medicare Rights developed a web-based training for applicants who are unable to attend the annual training or who join the program at another time during the year. The web-based training consists of 12-15 hours of training presented in case studies. After completing the training, applicants take an exam monitored by the program's deputy director.

Shadowing presentations. New volunteers are also required to observe at least one Medicare Minute presentation by experienced volunteers before beginning their own presentations. Shadowing is intended to model to new recruits effective ways of engaging an audience in the short time allotted to the Medicare Minute.

Monthly update meetings. Volunteers participate in ongoing training through monthly update meetings. The in-person meetings include a discussion of audience responses to the previous month's Medicare Minute topic, a review of the upcoming month's script, and updates on any changes in Medicare policies or coverage. During the meetings, the following month's script is generally read aloud by a Medicare Rights staff member, who also highlights key points in the teaching materials. Volunteers are expected to study the script and teaching materials in advance of their next presentation. The meetings are also designed to foster a sense of community among volunteers.

Additional support. Medicare Rights staff are available to volunteers for support and questions via email and phone. The Westchester SOS Director serves as a primary point of contact for volunteers' administrative questions, and volunteers can call or email her as needed. Tough Medicare-related questions posed during Medicare Minute presentations are referred to Medicare Rights' helpline. Medicare Rights' Medicare Interactive website also enables SOS volunteers and audiences to search for answers to specific Medicare questions online.

C. Volunteer Implementation of the Medicare Minute Presentations

What does the Medicare Minute look like in action?

Documenting how volunteers put the Medicare Minute into practice—including how volunteers use the script, teaching materials, and handout to prepare for their presentation, the format and style of their presentation, and how volunteers interact with audience members—allows for a more nuanced understanding of the program. Understanding the commonalities and differences in program implementation will ultimately contribute to a fuller understanding of the components and conditions that are key to a strongly implemented Medicare Minute program.

Preparing for the Medicare Minute

When preparing for the Medicare Minute presentation, most volunteers described reading through the Medicare Minute script several times and highlighting or making notes about the salient points they wished to present to their audience. One volunteer mentioned memorizing the script, although most volunteers noted specifically that they did not try to memorize the content. One volunteer described re-writing the script to fit his speaking style. Volunteers also acknowledged that newer volunteers may rely more on the script as they become comfortable as presenters.

Volunteer interviewees generally found that the Medicare Minute scripts contain a greater level of detail than is necessary for their presentation. However, several stated that they would rather begin with too much information and select appropriate material for their audience. Two volunteers mentioned preparing their presentation from the Medicare Minute handout rather than the script, as they felt the simplified handout contained a more appropriate level of detail for their audience.

Volunteers differed in how they described their use of the teaching materials provided by Medicare Rights. Some volunteers noted that they read the teaching materials to prepare for potential audience questions not included in the script or handout, while others commented that the additional level of detail is not necessary for their preparation. Others incorporate some of the detail from the teaching materials into their presentation if they feel it will be applicable for their audience. One volunteer described researching additional information about certain Medicare Minute topics online in order to prepare for the presentation.

Several longer-term volunteers observed that they have changed the way they prepare over time; having become more confident in their ability to anticipate and address questions from their audience, they now spend less time preparing their presentation.

Delivering the Presentation

A number of common elements emerged in the format and style of volunteers' presentations (see text box below). At the same time, all interview participants emphasized

the importance of tailoring the Medicare Minute to their particular audience and site. Volunteers noted that learning how to effectively adapt a presentation can take several months and requires a keen attention to one's audience.

Volunteers discussed a number of factors that they consider when determining how to deliver their Medicare Minute presentation, including:

- Placement of the Medicare Minute in the site's meeting schedule
- Audience size
- Room and seating arrangement
- Audience's health insurance characteristics
- Audience's level of comprehension
- Audience's interest and engagement

Based on these factors, volunteers tailor their presentation content, length, style, and materials, each of which is discussed in detail below.

Presentation content

Volunteers select and adapt presentation content based on their audience's level of comprehension and interest. Almost all volunteers noted that they present fewer details than are included in the Medicare Minute scripts. Volunteers expressed that the level of information covered should be general, but enough to encourage people to find out more details to cover their specific issue. Volunteers explained:

You shouldn't get too specific [with an audience] because if you start doing that you're not going to reach them...you don't want to give too much information. (Vol 9)

If it's too detailed you have to be extremely careful. You have to...pick out the salient points and put it in a conversational tone. (Vol 8)

Highlighting the importance of understanding one's audience, a long-term volunteer commented:

I may have a whole paragraph on my script, and you can summarize that in one sentence for the group [you're] speaking to, [because you know them over time]. Whereas if I didn't know them at all I would want to include the total content. I think everybody probably does that, if you know your audience. (Vol 13)

Common Presentation Elements

- **The script as a "starting point"**. Very few volunteers read from or present the script verbatim. Volunteers present the Medicare Minute in a style that works with their personality.
- **Rapport with audience**. All volunteers mentioned the importance of developing rapport with one's audience over time, though the degree to which volunteers formed relationships with their audience varied.
- **Availability for individual questions**. All volunteers discussed staying after the presentation to answer individual questions, though there were variations in the structure of and length of time dedicated to this activity.
- **Referrals to additional services**. Volunteers frequently refer audience members to the Medicare Rights helpline and/or Senior Benefits counseling at Westchester libraries.

In addition to synthesizing the information contained in the Medicare Minute script, a number of interviewees also mentioned simplifying the language included in the script, though there appeared to be variation in the degree to which volunteers simplify the script. Some explained that they simplified the language because their audience does not understand technical Medicare terminology. Others conveyed the importance of using “official” Medicare language. While most interviewees described simplifying or shortening the content to some extent, one volunteer who presents at a site in New York City observed that the scripts tend to present information in a way that is overly simple for her audience.

Volunteers also adapt the presentation content based on the relevance of the topic. Volunteers noted that as they learn more about their audience over time, they become more adept at accurately assessing the relevance of each month’s topic for their audience. A number of volunteers explained that they begin their presentation by asking their audience if the day’s topic applies to them, what they know about the topic, and if they have any questions or issues with the topic. Volunteers will then use the audience’s response to gauge the level of detail in which to present the topic. One volunteer explained, “We canvas them before we [get] into the subject because there [is] no sense in presenting to someone that really doesn’t have an interest” (Vol 8).

Volunteers take several actions when the Medicare Minute topic is less relevant for their audience. First, they may encourage the audience to listen to the topic and share the information with a friend for whom it might be applicable. Many volunteers also abbreviate the topic and instead reiterate a topic from a past Medicare Minute, reinforce basic information about Medicare, or bring in another topic that they know is relevant to their audience. For example, one volunteer described discussing the Elderly Pharmaceutical Insurance Coverage (EPIC) program with his audience, while another volunteer reiterated the importance of talking with one’s doctor. Volunteers may also ask audience members if they have any questions about Medicare and use that to direct the content. Volunteers also stressed the importance of repeating key information, especially for audiences that may not be as savvy. In this sense, as one interviewee articulated, volunteers use the script as a “starting point”; the script provides the necessary information, but volunteers must “pick the information that works” (Vol 9).

Volunteers may also modify the presentation content based on the meeting schedule of the site. Some sites may not meet every month, particularly during the summer. In this case volunteers may combine two or more Medicare Minute topics into one presentation, or they may skip topics that they determine are not relevant for their audience.

Presentation length

The length of the Medicare Minute presentations varies widely both across and within sites. While the presentation of the script is designed to take no more than a few minutes, the overall interaction can range from as short as five minutes to 45-60 minutes including audience questions and discussion.

Volunteers noted that the length of their presentation depends in part on site structure. For example, some sites have very structured meetings and allot a specific amount of time for the Medicare Minute. Other sites have more flexible schedules, and the Medicare Minute can extend longer if the audience is engaged and has questions. For example, one volunteer noted that while her site has a standing monthly meeting, sometimes the Medicare Minute is the only item on the agenda.

The level of audience engagement in the Medicare Minute emerged as a key factor influencing the length of the presentation. Volunteers explained that the length of the presentation can vary from month to month based on the relevance of the topic. Special events scheduled at the site may also lead volunteers to abbreviate their presentation. For example, when one site scheduled a party for the same day as the Medicare Minute, the volunteer considered skipping the presentation as she felt audience members would not be interested in the presentation while they were enjoying their celebration.

Volunteers' desired level of involvement in the program may also influence the length of their presentation. Some volunteers may prefer to follow the structure of the Medicare Minute as it is designed—a short presentation of several minutes, followed by a brief stay for individual questions—while others will add anecdotes, personal stories, and additional audience interaction to their presentation.

Presentation style

Volunteers develop their own presentation styles based on their personality as well as the characteristics of their audience and site. Elements of presentation style that volunteers discussed included the following:

Formality of style. Some volunteers described that they have a relaxed interaction with their audience during their presentation, pausing to tell jokes or personal stories; others reported delivering a more formal presentation of facts. Several volunteers discussed using humor, incorporating jokes or offering prizes for people who answer questions correctly. In contrast, several volunteers explicitly stated that they were “not funny” and did not attempt to use humor. One volunteer described using a somewhat more firm style in response to audience members who may question the credibility of the volunteer. Several volunteers who had substituted at other sites voiced a keen perspective on adapting their style to different audiences. For example, one volunteer at a small senior center with a paid director employs a casual, humorous style with her audience. However, when filling in at a large senior center with an elected president, she noted that a formal presentation style was expected.

Use of site space. Volunteers discussed several ways in which the structure of the site shaped the style of their presentation. Volunteers commonly noted that at smaller sites they can more easily engage audience members from the front of the room, while at larger sites they may choose to walk from table to table to engage their audience. Going from table to table was also noted as a strategy to connect with less engaged audiences or audiences that may have lower levels of comprehension. One volunteer described shifting her

presentation style upon noticing that audience members at the back of the room were not paying attention.

Audience engagement. Volunteers discussed strategies they have developed for engaging their audience. Several interviewees mentioned starting their presentation by asking audience members to share what they know about the day's topic, and continuing to ask the audience to share their knowledge and experiences throughout the presentation.

Use of examples. Noting that audience members relate well to concrete examples and tips for navigating Medicare, a number of volunteers mentioned sharing anecdotes from their own experience or experience helping a family member. The degree to which volunteers share personal stories is an individual decision informed by a volunteer's comfort level and preference about sharing personal information.

Responding to audience questions. Volunteers determine how to respond to audience questions based on audience preference, their own preference, and the site structure. Most interviewees noted that their audience members do not feel comfortable asking personal questions in front of a group and prefer to bring questions to the volunteer after the presentation. Volunteers manage this interaction in different ways: one interviewee described that in order not to disrupt the rest of the site's meeting, he will take individual questions in the hallway immediately after his presentation. Many interviewees noted that they stay until the end of the site's meeting and either sit at a table or walk around the room after the meeting to see if anyone has questions. One volunteer mentioned arriving before the meeting to engage the audience and take questions as well. If volunteers are unable to answer an audience member's question, most will offer to research the answer and report back to the audience member at the following meeting; some volunteers will call audience members personally with the answer.

Referrals. All interviewees described referring audience members to additional services if they are unable to answer a member's question or if the member needs more intensive individualized support. Volunteers commonly refer audience members to the Medicare Rights helpline, and most also refer audience members to counseling at Senior Benefits Information Centers operated out of Westchester libraries. At the same time, interviewees expressed that audience members prefer to receive information from someone they know and trust; as a result, volunteers often take on the task of seeking out answers for audience members.

Volunteer Skills

Volunteers rely on the following skills when delivering their presentations:

- Comfort with public speaking
- Ability to develop rapport with audience members
- Ability to gauge audience interest and comprehension and adapt presentation accordingly
- Ability to simplify complex information without "talking down" to audience
- Ability to process and retain complex information
- Flexibility and patience
- Commitment to the intensive nature of the volunteer work

Use of handouts and presentation materials

Volunteers also differ in their use of the Medicare Minute handouts. Some interviewees noted that they engage audience members by referring to the handout during the presentation, encouraging audience members to keep the handouts and file them for future reference, or asking audience members to share handouts with a friend for whom the topic may be relevant. For some, handouts are a useful way to provide audience members with more detailed information than the volunteer included in the presentation. Some volunteers distribute handouts to each table or each person, while others maintain a stack of handouts for audience members to pick up at the end, noting that holding handouts until the end can be a way to engage audience members. A few also mentioned that they post the handout on the site's bulletin board.

At the same time, a number of volunteers explained that they did not typically use the handouts. Some volunteers felt that the information included in the handouts was too detailed, some noticed that their audience did not seem interested in the handouts, and some explained that their site was unable or unwilling to make photocopies of the handouts. Particularly at larger sites, volunteers explained that it was not possible to print a sufficient quantity of handouts for the entire audience. In these cases site directors would sometimes make one handout per table, offer to make copies for interested audience members, or post the handout on a bulletin board.

One volunteer explained that she enlarges the handouts to make the print size easier to read. Another volunteer described adapting the Medicare Rights handouts to create her own presentation materials, both in large format to show to the group and in postcard size for individual handouts.

Personal Relationships and Level of Involvement

In addition to variations in presentation content, style, and length, interviews also revealed a wide range in the extent to which volunteers develop personal relationships with their audience members and site directors, as well as in their overall level of involvement in preparing for and delivering the Medicare Minute.

Relationship with audience

All interviewees emphasized the importance of developing rapport with their audience as a way to encourage audience members to engage with the presentation and feel comfortable asking questions. Several volunteers recalled that after a few months, their audience softened to their presence and began to treat them almost as friends. One volunteer shared:

It's nice to get to know the people and maybe come a little bit...before the meeting starts, and just make small talk and get to know the people so they feel comfortable with you. You'll find that then they get to expect you every month and be friendly, and hopefully that will help them digest whatever you're talking about. It's nice to be able to develop a little bit of a relationship with the group outside of the meeting (Vol 1).

Several interviewees also spoke about the importance of engaging with their audience as equals—without “talking down” to them or being condescending; these volunteers are able to engage their audience by making them feel like “we are in this together.” One volunteer summarized, “you just have to sell that you’re their advocate and that you’re there to help them” (Vol 13). Another interviewee elaborated,

If you can communicate to the people you are presenting to that “I’m one of you. I had a problem and I had to deal with this. I learned this.” It’s letting them know that it’s not easy. That they should not in any way feel faulted that they don’t understand this (Vol 5).

Interviews suggested that the extent to which volunteers form personal relationships with their audience varies widely, ranging from cordial relationships to more intensive involvement with audience members. For example, several volunteers mentioned that they are friendly with their audience, but their relationship does not extend beyond the presentation. Others noted that they live in the same community as many of their audience members and will sometimes run into them in the grocery store, where they are approached as the “Medicare lady.” One volunteer commented about her audience, “I’m talking to them socially as much as I’m talking to them about Medicare.” She continued:

If they think you’re just giving them information, a lot of them don’t want to hear it. They need to like you as a person. They need to really understand and appreciate that you want to help them as a group. I think building a relationship and gaining their trust is a main part of what you need to do in order to be effective (Vol 6).

Relationship with site director

Volunteers also discussed developing rapport with their site directors. Interviewees noted that developing this relationship requires both patience and flexibility, as site directors often seemed skeptical about the Medicare Minute program at first. Those volunteers who described having a friendly relationship with their site directors felt that the relationship enhanced the success of the Medicare Minute, noting that their directors were committed to engaging audience members in the Medicare Minute as well as providing logistical support. As with audience members, volunteers’ relationships with site directors ranged from pleasant interactions to genuine friendships.

Volunteers’ level of interaction with their site director also varied. While most interviewees did not mention communicating with their director outside of their visit, one volunteer described that before her presentation, “I will e-mail the director back and forth and tell him what the topic is. We sometimes decide that it’s not appropriate” (Vol 7). Another volunteer shared, “I got in the habit of getting up early on the morning I was supposed to go and calling, ‘Am I on the agenda? Do you expect me today?’”(Vol 10)

Volunteer level of involvement

The design of the Medicare Minute is flexible in that volunteers may become more or less intensively involved in the program. Among interviewees, a smaller number described a less intensive level of involvement—delivering the Medicare Minute and staying for a few minutes for questions, but, as one volunteer described, not giving anything “extra.” Many volunteers noted that they stayed through the entire hour-long meeting at the senior center, feeling it was important to demonstrate that they are invested in the seniors at the center.

Several interviewees mentioned that they give their phone number to the site director, who will contact them if audience members have individual questions (they are encouraged by Medicare Rights not to give their phone number directly to volunteers). Two volunteers relayed stories of visiting an audience member at home to help them work through a Medicare issue. Additionally, some volunteers with a background in health care mentioned answering questions beyond the scope of the Medicare Minute.

Volunteers also exhibited varying levels of involvement in preparing for the Medicare Minute. One volunteer felt it was not necessary for volunteers to learn information beyond what was required for the presentation; if audience members had questions beyond the Medicare Minute, they could be referred to the helpline. Others described putting in extra effort to stay up-to-date on Medicare issues by going to the optional trainings offered by Medicare Rights and by keeping up with the news. One also attended outside educational and training classes at local colleges.

Interviewees identified several possible reasons for more intensive involvement in the program, including having more free time, enjoying developing relationships and friendships with others in their community, and feeling it was part of their duty to share their knowledge of Medicare. As one interviewee expressed, “I just feel it’s no different than what you would do with a neighbor” (Vol 11). One volunteer also hypothesized that there may be a difference between male and female volunteers in this regard, with women more likely to go beyond the program’s requirements.

Case Study 1: Irvington Senior Center

The Irvington Senior Center is located in a large house on the banks of the Hudson River. The Center has a homey feel, with members walking around freely and spending time with one another in different living rooms throughout the house. As soon as Marilyn, the site's volunteer for the past five years, enters the house she is greeted by nearly all of the members, with whom she engages in friendly conversation. A number of members approach Marilyn with questions about their Medicare paperwork and bills, with one woman expressing distress about a bill she received from Medicare. Marilyn responds pleasantly and recommends that she bring the paperwork to her the following month or take it to a Senior Benefits Counselor at the library—going so far as to arrange for the woman to get a ride to the library the following day.

When it is time to begin the Medicare Minute, Marilyn goes upstairs to the meeting room, which is set up with 25-30 people sitting at small tables facing a podium. The site director gives several announcements and then introduces Marilyn. Marilyn begins her presentation in a conversational style, engaging the audience by asking them questions and integrating humorous comments. There is a lot of laughter. She also shares personal stories, showing her own Medicare bill to illustrate the topic of the month: how to read your summary notice. Most audience members appear attentive, consistently looking up at the podium, laughing, and nodding their heads. While there are not many questions from the audience during the presentation—Marilyn explains that her audience members tend to be fairly knowledgeable about Medicare—a number of members interject affirming statements, and one person asks a more detailed question.

In total, the presentation lasts about 10-15 minutes, after which coffee and cake are served. During this time, members chat informally with one another and Marilyn goes around the room making conversation with different audience members. As members trickle out, Marilyn says goodbye to the members and the site director, letting them know that she will see them again next month.

Case Study 2: Buchanan Senior Center

As Gilda arrives for the monthly Tuesday meeting at the Buchanan Senior Center, she encounters a particularly lively crowd. It is the Saint Patrick's Day party. There is a live band playing and several people are dancing. Most members are seated at two long tables, about to eat lunch. After being offered coffee and cake by several different people, Gilda takes some time to sit down and chat with members before the Medicare Minute begins. After two years as the volunteer at Buchanan, the members have come to know her.

The site director turns on the microphone and introduces Gilda, who takes the mic and engages the audience by asking them about the month's topic: *"Does everyone here know what your summary notice is?"* There are nods and sounds of agreement. Gilda takes care to appreciate her audience members' knowledge and understanding of Medicare, presenting the topic as more of a reminder of what one should pay attention to, rather than as new information. During the presentation, which lasts no more than 10 minutes, the audience appears attentive, with nearly everyone looking her way.

Before concluding the presentation, Gilda asks members to bring in their summary notices at the next meeting, telling them that she would be more than happy to sit down and review them on an individual basis. Afterwards, the Saint Patrick's Day party resumes and Gilda stays to talk with members and answer individual questions.

D. Program Participant Experiences

How do site directors, audience members, and volunteers experience the program?

This section discusses the experiences of site directors, audience members, and volunteers, including their perspectives on and satisfaction with the Medicare Minute program's design and implementation.

Site Director Involvement

While site directors were not formally interviewed for this evaluation, informal discussions with directors, along with interviews with volunteers and the Westchester SOS Director, shed light on site directors' experiences with the Medicare Minute. In general, volunteer interviewees noted differing levels of receptivity to the program. A number of volunteers commented that sites with paid directors tended to be more supportive of the Medicare Minute program, as these directors are often social workers or other professionals in charge of creating educational programming for the senior center. One paid site director expressed that she appreciates being able to refer her members to the Medicare Minute presenter, noting the volunteer brings important information about changes in Medicare and has been able to help a number of individuals. This site director commented that she often saves Medicare Minute handouts and sends them to audience members after the meeting.

In contrast, several volunteers from sites with volunteer or elected directors reported experiencing lower levels of support, which interviewees described as ranging from indifference to hostility. Interviewees also expressed that while site directors may initially be skeptical of the Medicare Minute—due to perceptions that their seniors will not be interested, that it will disrupt their daily schedule, or that the volunteer will not follow through on their monthly commitment—over time many volunteers are able to develop trust and gain the support of their site director.

Experience of Audience Members

Overall audience engagement

Audience members' level of engagement with the Medicare Minute varied both across and within sites. Volunteers identified several factors that they felt influenced audience members' level of engagement: audience characteristics; structure of the site and support of site director; rapport with volunteer; and, to a lesser degree, the relevance of the content. Several volunteers brought up examples of audience members who come to the senior center to play cards or bingo with friends and do not wish to interrupt their social activities to listen to the presentation. One volunteer observed:

There [are] a few [audience members] who are non-receptive. They do not want anything, not even the Medicare Minute, to interfere with their set schedule, which is Tuesday, 11 o'clock, I come to play bridge. Or Tuesday, 11 o'clock, I come to play mahjong. (Vol 3)

One audience member concurred, noting that “people are creatures of habit” and “would rather play cards than know what’s happening with Medicare” (Sinai). With regard to audience questions, volunteers noted that generally, between two and four people will come with specific questions after the presentation.

In general, interviews and site observations suggested that while a majority of audience members paid some attention to the presentation, few were actively engaged—as indicated by the number of audience members directing their attention toward the presenter; the number of audience members asking questions during and after the presentation; and conversations with audience members following the four presentations that were observed for the evaluation. A story from one volunteer suggests that audience interest can be hard to gauge on the surface, however. This volunteer observed that many audience members have never spoken up during a Medicare Minute, but recalled, “I’ve had six of them now come up and just stop and say ‘I just want you to know that I really appreciate all this wonderful information you’re giving us’” (Vol 11).

Volunteer observations on factors influencing audience engagement

- **Audience insurance characteristics.** The Medicare Minute is most relevant for seniors with Original Medicare; audience members with retiree insurance do not have to manage their own coverage and therefore have less of a need to engage with the content.
- **Audience comprehension.** There are diverse levels of functioning among seniors both across and within sites; some audience members can engage fully with the content of the presentation while others are not able to follow the presentation.
- **Site structure.** It can be more difficult to engage audience members at sites where seniors come to play cards or other games with friends, as well as at sites where the Medicare Minute is scheduled after a meal.
- **Site director support.** Site directors play a role in encouraging audience members to value the Medicare Minute. Supportive site directors can demonstrate enthusiasm for the Medicare Minute and ensure that other activities (e.g., playing cards) are minimized during the presentation.
- **Personal relationships.** When audience members feel a connection with their volunteer they are more animated and positive about the Medicare Minute.
- **Relevance of content.** Some topics, particularly those related to open enrollment and costs, are naturally more engaging for audience members.

Audience experience with volunteers

When speaking with audience members about their experience with the Medicare Minute program, it was striking that they most often commented about their satisfaction with their volunteer, rather than the information contained in the presentation. When asked about the Medicare Minute, audience members would often immediately respond with statements such as: “We love her,” “She’s the greatest,” and “She’s really a joy to have here.” One audience member shared that the volunteer had “become a close friend to all of us,”

while another expressed, “She makes you feel happy and that’s important.” In this way, audience members seemed to equate a positive experience with the Medicare Minute with a positive relationship with their volunteer.

Audience members commonly highlighted volunteers’ friendly personality, openness to questions, and respectful manner of engaging with the audience. Seniors appreciated that volunteers “[ask] for questions after each little segment to make sure we understand,” and shared that “people are very free in asking her questions.” Others commented, “She doesn’t make you feel stupid; you can ask any kind of question you want,” and “she is not condescending about our questions. You feel like you’re talking to a friend.” Audience members are also loyal to their presenters. As an example, several volunteers recounted that when they needed to miss a meeting for scheduling or medical reasons, although a back-up presenter was offered, their audience preferred to wait for their volunteer to return.

Audience members also valued the time that volunteers committed to socializing and answering questions. Some explained, “She doesn’t just run out like a lot of our speakers,” and, “She always seems to have time and patience.” Similarly, audience members seemed to appreciate feeling that volunteers were part of their group, and several volunteers described attending holiday parties or events at the senior centers. A number of volunteers also live in the communities where they present and encounter audience members outside the senior center; more than one volunteer described an impromptu counseling session after being recognized in the grocery store as the “Medicare lady.”

With regard to volunteers’ presentation style, audience members spoke positively about presentations that were concise and to the point, but not dry. One audience member noted that when the Medicare Minute first started, she was worried that it would be “a depressing subject.” She appreciated her presenter’s light approach to the topic, sharing, “She’s great, funny, gets us laughing.”

When asked to describe how volunteers had been useful to them, most audience members stated generally that their volunteer had been helpful, rather than pointing to particular instances of assistance. One senior noted that audience members often bring bills to show to the volunteer. Another specified that the volunteer refers audience members to outside resources, including counseling at the library-based Senior Benefits Information Centers, and several audience members echoed that they have sought counseling at these centers. One audience member described that her volunteer had been helpful in resolving an issue with her prescription drug coverage, and another shared that her volunteer assisted her by calling her insurance company directly. This audience member was particularly appreciative as she felt that her volunteer had “more clout” as someone associated with Medicare Rights.

Audience experience with program structure

Volunteers pointed to the consistency of the monthly presentations and the short presentation length as elements that tend to improve audience engagement. Audience

members concurred, with one senior noting that the presentation “fits with our attention span” and another appreciating that the presentations are short because “seniors don’t like to sit around and listen—we fall asleep.”

Volunteers mentioned that it is helpful for audience members to know that the Medicare Minute is part of their monthly routine, as they begin to anticipate the presentation and know that they can bring questions.

Audience experience with presentation content

When asked what they felt was most useful about the Medicare Minute, audience members mentioned that they liked receiving updates on any changes in Medicare, and being reminded “to watch out for certain things” related to their coverage and bills. However, when asked what information had been particularly helpful, audience members generally were not able to give specific examples—or they spoke only of the topic that had been presented that day. It is unclear whether this is owing to difficulties in recall, particularly for senior populations, or whether seniors have not retained information from past presentations.

A number of volunteers noted that if their audience is not currently affected by an issue, they will not be interested in the topic. One audience member concurred, stating, “If you don’t need to know, you don’t pay attention.” Audience members added that because seniors “all have different plans and ailments,” the relevance of the topics will vary for different people. According to volunteers, the most relevant topics included: open enrollment; explaining summary notices; vaccine coverage; topics related to costs; and the difference between original Medicare and Medicare Advantage plans, which volunteers agreed was not understood by many audience members.

Volunteers stressed that the months before open enrollment are the most important for presentations; at other times of year, people have largely made their decisions, and topics are less relevant. Nearly all volunteer interviewees observed that the Medicare Minute topics are less relevant for audience members with retiree insurance, explaining that the Medicare Minute is most applicable for seniors who have to manage their own Medicare. Several volunteers also noted that repetition of Medicare Minute topics from year to year can reinforce important information, though it can also lead to lower interest in the presentations. One senior agreed that it was helpful to have volunteers repeat important information, both to remind them of important issues and in case they miss a meeting.

During site observations, while audience members were not always engaged in the specific topic of the day’s presentation, many voiced concern about upcoming changes in Medicare as a result of health care reform (many members spoke about “Obamacare”), demonstrating an interest in issues related to health coverage. On this note, one audience member asserted that he was glad the Medicare Minute presentations were part of an independent, non-governmental organization.

With regard to the level of information presented, volunteers acknowledged that audience members' level of knowledge and functioning varies widely. In general, however, volunteers felt that the level of information was appropriate for their audience members. Several volunteers emphasized that audience members cannot digest information that is too detailed or contains too many numbers. One audience member expressed, "the less I know the better, because I think too much," adding that she appreciated that the volunteer presented only the necessary information.

On the other hand, volunteers described some audience members for whom the level of detail is too simple. Several audience members expressed that they already knew most of the information included in the presentations, with one volunteer explaining, "I don't need what she's saying because I go online" (Site 1). At the same time, several seniors appreciated the information, noting that the presentation "crystallizes my thinking" (Site 4) and "has been useful in verifying what I'm doing" (Site 1).

Experience of Volunteers

This section discusses volunteers' experience with the training and support they receive from Medicare Rights, their level of preparedness to lead the Medicare Minute, their impressions of the Medicare Minute structure and materials, and their overall satisfaction with serving as a volunteer.

Volunteer training and support

Initial volunteer training. Volunteers expressed that the required four-day training led by Medicare Rights was essential in preparing them for their role in presenting the Medicare Minute. In general, volunteers recalled that while the training included a great deal of information, they gained important knowledge and skills. A number of volunteers also mentioned the binder of educational materials provided by Medicare Rights, noting that they continue to refer to the materials after being trained. Several newer volunteers also mentioned that in addition to the training in Medicare content, the training in presentation skills was useful. Some volunteers recalled feeling that the amount of information was overwhelming, with one volunteer commenting, "you can get buried in this stuff" (Vol 9).

Observing Medicare Minute presentations. Volunteers emphasized that shadowing a more seasoned volunteer and visiting one or more Medicare Minute presentations before they began presenting was essential in providing a concrete understanding of what the Medicare Minute entailed and in informing their own presentation format and style.

Monthly update meetings. Most volunteers shared that the monthly update meetings are helpful in preparing them for the Medicare Minute, with some maintaining that the monthly meetings are critical to the program's success. One interviewee explained, "The monthly meeting was really where we got more training, got reinforcement, we got support, and I find the monthly training to be an absolute necessity" (Vol 3). Interviewees noted that the meetings are especially useful for receiving updates on any changes in Medicare benefits. The meetings are also helpful for hearing the Medicare Minute

presented and troubleshooting the script. Several volunteers mentioned that guest speakers help bring new information and reinforce knowledge. Some also emphasized the social component of the update meetings, in addition to the educational component, explaining that support and camaraderie from other volunteers is important in maintaining volunteer enthusiasm and morale. As one volunteer shared, “From a social aspect, it’s nice to be able to network with other people doing the same thing that you’re doing” (Vol 1). Those that found the update meetings less helpful tended to have more previous Medicare knowledge or previous public speaking experience.

Availability of Medicare Rights staff. Volunteers mentioned that it was important to be able to contact the Medicare Rights office directly with unanswered questions about Medicare. At the same time, volunteers noted that they did not do so often and stated that they felt comfortable looking for answers on their own.

Medicare Interactive. Several volunteers mentioned that Medicare Rights’ Medicare Interactive website was a useful source of information, although most volunteers did not mention this as a resource they used often.

Online support. Most volunteers have internet and email and are comfortable accessing materials online. Though this was not discussed frequently in interviews, several volunteers noted that the availability of the Medicare Minute scripts and materials online is helpful for those who want to prepare in advance, as is the ability to complete the required presentation logs online. One volunteer also mentioned that email is a useful way to receive immediate follow-up from Medicare Rights about questions that may arise during the monthly meetings.

Volunteer preparedness

Overall, volunteer interviewees expressed that they felt well prepared to lead the Medicare Minute. Several recalled that when they first began as presenters, they felt nervous that their audience would have questions they would not be able to answer. But interviewees agreed that over time they developed greater knowledge to respond to questions, with one volunteer estimating that it takes three to six months to become comfortable as a presenter. Interviewees also emphasized that even if volunteers possess different levels of knowledge about Medicare, ultimately the main objective is not to answer every question immediately, but rather to develop a relationship with one’s audience and either find the answers or refer individuals to additional services. As one volunteer stated, “You need to not be afraid of the questions, because you can always get the answers” (Vol 13).

Volunteers voiced different opinions as to whether they considered the Medicare Rights training and update meetings to be sufficient in preparing them for their role. Many interviewees stated that the trainings and meetings provided enough information, while some indicated that it was important to supplement the trainings by reading newspapers and other sources of information about changes in health care policy. Some interviewees anticipated that it would be difficult for a volunteer who had no background in the medical field to be adequately prepared after the four days of initial training. One volunteer

proposed that it was necessary to go beyond the Medicare Rights training to attend external trainings and seminars in order to prepare oneself for more complex questions audience members might have. This viewpoint highlights differences in interviewees' perspectives about how much information they should be able to impart as a Medicare Minute volunteer.

Most volunteers are also Medicare beneficiaries themselves, and interviewees explained that drawing on personal experience aids in their knowledge as presenters. Of the volunteers who are under age 65, many described managing Medicare coverage for family members, which also informed their understanding of Medicare.

Additionally, several interviewees suggested that volunteers who are involved in multiple SOS programs and/or in Senior Benefits Information Center counseling generally approach the Medicare Minute with a greater level of knowledge. They explained that library counselors receive more intensive training about Medicare issues that may arise, and volunteers who are also counselors often supplement their Medicare Minute presentations with examples from their counseling.

Overall satisfaction

Most interviewees spoke effusively about how much they enjoy their role as an SOS volunteer, and nearly all expressed interest in staying with the program. Through Medicare Minutes, volunteers feel that they provide a useful service to seniors and also learn to navigate their personal insurance questions more effectively. Two volunteers also responded that their involvement with the program had increased their confidence in public speaking and helped them discover personal strengths and interests. One of these volunteers shared, "When I heard about [the program,] I was not one who liked speaking publicly.... [T]his was, to me, a real learning process for myself, an accomplishment because now I feel so comfortable" (Vol 6).

Volunteers who expressed less certainty about their desire to continue leading Medicare Minutes cited reasons including the level of time commitment required, geographic distance from their Medicare Minute site, feeling that the program had changed over time, and believing that they could make a greater impact through other activities. For example, one volunteer who had volunteered for both the Medicare Minute program and as an SBIC counselor decided to continue with only the SBIC program as she felt she could be more useful by providing one-on-one counseling. Low levels of audience engagement with the Medicare Minute also emerged as a factor influencing volunteer retention and recruitment.

Why volunteers stay with the Medicare Minute

- Making a difference
- Relationship-building with audience
- Being involved in community
- Personal growth in knowledge and skills
- Camaraderie with other volunteers
- Proximity of presentation sites
- Rewards of intensive commitment

Interviewees also emphasized that being a volunteer is an intensive responsibility and therefore is not appropriate for everyone. However, volunteers involved in the program generally valued the fact that the position required a substantial commitment.

E. Key Components of the Medicare Minute

What makes the Medicare Minute work?

A central aim of the current evaluation was to identify the components of the Medicare Minute program that are most important to its operation. Interviews with program volunteers, audience members, and the Westchester SOS Director highlighted aspects of the program's design, management, and implementation that they believed to be key to the program's success. The sections below discuss each of these areas with the aim of identifying components that would be important to have in place in Medicare Minute programs carried out in other locations.

Program Design

Consistency of presentations. Monthly presentations by the same volunteer allow audience members to incorporate the Medicare Minute into their regular routine and to develop rapport with their presenter over time. Audience members look forward to bringing individual questions to their presenter each month. Volunteers explained:

Having a monthly presence so that [audience members] expect someone to come and talk to them...helps the seniors know that if they have a question they can bring it the next time" (Vol 6).

I think for a lot of groups it's the fact that they know that somebody is coming every month to give them a little bit of information (Vol 7).

One site director echoed these sentiments, noting that a key to the success of the program is the fact that volunteers return to the same sites each month. Monthly presentations also allow the presentation to remain short and limited to one topic per month. Consistency is also important for volunteers: as several interviewees noted, it takes time to become comfortable presenting the Medicare Minute, and to build rapport with audiences. One volunteer posited that less frequent presentations could make volunteers feel less invested in the program and thus negatively affect volunteer retention.

Short presentation length. The short presentation length also emerged as an important component of the Medicare Minute program design. Short presentations are appropriate for seniors' attention span and fit with sites' already-busy schedules. In this way, presentations are non-intrusive both to site directors, who may not otherwise be amenable

Key Program Components

Program Design

- Consistency of presentations
- Short presentation length
- Relevance of topics
- Level of information provided
- Availability of additional services
- Peer education model

Program Management

- Program leadership and staffing
- Recruitment and support of qualified volunteers
- Recruitment of appropriate sites

Program Implementation

- Volunteer relationship with audience
- Availability for one-on-one questions
- Tailoring presentation to audience

to hosting the Medicare Minute, and to audience members, who oftentimes do not wish to interrupt their social activities.

Relevance of topics. From discussions with Medicare Minute participants, it is clear that there is a need to provide seniors with relevant updates and reminders about their Medicare coverage. At the same time, the relevance of the Medicare Minute topics appeared to be a less important component of the program as compared to the value of developing relationships between volunteers and audience members (discussed below). Volunteers found the Medicare Minute topics to be most useful for seniors who are managing their own Medicare (as opposed to retiree coverage) and seniors with a sufficiently high level of functioning to absorb at least the basic content of the presentation.

Level of information provided. Related to the short length of the presentation is the minimal level of detail included in the presentations. Interviewees noted that it is important that the information be basic, not too specific, and confined to one topic.

Availability of additional services. Because Medicare Minute presentations are meant to appeal to a broad audience, it is essential to have referral services available for those with more complex questions that cannot be addressed in the span of the Medicare Minute visit. In Westchester, the simultaneous offering of counseling at library-based Senior Benefits Information Centers and referrals to the Medicare Rights helpline are key for seniors who need individualized assistance or whose questions require additional research. For referrals to in-person counseling, it is important that these services be geographically accessible for seniors.

Peer education model. Interestingly, while the peer model emerged as a useful component of the Medicare Minute program, interviewees voiced different opinions as to whether it was necessary for the program's success. When volunteer interviewees were asked to describe what makes the Medicare Minute "work," no respondent initially mentioned the peer component. When probed further about the peer-to-peer nature of the program, some said they felt it was essential, but many said it was helpful but not essential. The peer aspect did appear to be important to audience members, with several commenting that seniors have a better understanding of their experiences. As one audience member commented, a non-senior "would understand the technicality of it, but not the personality of it." At the same time, audience members have developed close relationships with volunteers who are not seniors. Based on conversations with volunteers and audience members, it appears important for audience members to feel that the presenters understand where they are coming from. In this sense, non-senior volunteers who have aging parents may still be able to relate to audience members, while much younger volunteers (e.g., college students) may have a more difficult time relating with the audience.

Program Management

Program leadership and staffing. Interviewees expressed that the presence of an energetic leader who is committed to the program is important for motivating program

volunteers. Many long-time volunteers credited their decision to join the Medicare Minute program to the enthusiasm and dedication of the SOS program founder. Speaking about the Westchester SOS Director, one volunteer shared, "If they're enthusiastic about the program it's transferred to us. That's what you really need" (Vol 8). The SOS Westchester founder concurred: "I think the heart of the program is the caliber of the person who's assigned to it at a local level." It is also important that volunteers are able to contact a staff member who can respond in a timely manner to Medicare-related questions that arise.

Recruitment and support of qualified volunteers. Successful implementation of the Medicare Minute program relies on the recruitment of volunteers who are interested in the topic of Medicare and are committed to the intensive nature of the volunteer position. Volunteers must also be able to learn and retain complex information, be able to simplify information, and have or be able to quickly develop skills in public speaking and audience engagement. Publicizing the volunteer opportunity in a way that emphasizes the degree of commitment required upfront, interviewing volunteers personally, and having volunteers visit a Medicare Minute presentation before joining can help ensure that each volunteer is a good match for the program. In order to adequately train and support volunteers, it is important that volunteers receive an initial intensive training as well as ongoing support. The intensive initial training also indicates to volunteers that serving as a presenter is not a "casual" activity. The ability to contact Medicare Rights staff or helpline volunteers with individual questions is also an important form of support. Other forms of support that were mentioned as helpful but not essential included interaction with other volunteers and online support. Interviewees also noted that it is useful to arrange volunteer assignments so that each volunteer has someone to serve as a back-up presenter in case of absence.

Recruitment of appropriate sites. When asked about the success of the Medicare Minute, one volunteer posited, "A lot...depends on how organized the [site] directors are, and it's kind of something out of our control" (Vol 1). Given this, it is important for the Medicare Minute to become part of the senior centers' regular schedule. The timing of presentations in relation to meals and other social activities is also an important consideration. Supportive site directors can help engage audience members and enhance the credibility of volunteers. Site directors also help with photocopying handouts and facilitating communication between individual audience members and presenters. The SOS program founder emphasized that when reaching out to new sites, it is important to understand the approval process and how much autonomy the center leader has to approve a new program.

Volunteer Implementation of Medicare Minute Presentation

Development of relationship with audience. Developing rapport with one's audience emerged as one of the most crucial aspects of the Medicare Minute program. Volunteers, audience members, and the Westchester SOS Director and the founder of the SOS program agreed that seniors' trust in the volunteers was paramount to their comfort in seeking help with Medicare issues. Importantly, the SOS director highlighted that the most important role of volunteers "is not as a presenter of information; their most important role is being there at the senior center to make relationships with the seniors so that they will come to

the presenter and ask personal questions.” The SOS Westchester Founder elaborated:

If you see the program as [only] an information-giving enterprise, it doesn't matter who the messenger is. If you see the program on a long-term level, as creating a reliable source [for] the most important kind of information that people over 65 need...that's a whole different kind of program. There's a very, very important component, which is trust.

While it is clear that a positive relationship with one's audience is key, it is not clear whether volunteers who go above and beyond the required level of involvement are more effective in engaging or assisting their audience. This would be an important area for further exploration.

Availability for one-on-one questions. Because the Medicare Minute presents a basic level of information, it is essential that volunteers are available to answer individual questions from audience members following the presentation. This is particularly important given that many seniors do not feel comfortable raising questions during the presentation. Speaking about what makes the program effective, one volunteer stated, “Your real [value] is if...they have a question they can ask you” (Vol 6). Another volunteer concurred, “I don't know how to make Medicare sound more interesting or more fun. It's just not a thrilling subject and that's just the way it is. But when someone has a question, we can be enormously helpful” (Vol 15). The SOS Westchester founder explained, “Seniors don't want to ask personal questions about health or money in a group; a lot of the info they need is info they will only want privately.”

Tailoring presentation to audience. While Medicare Rights develops scripts for each Medicare Minute topic, in order to engage audience members it is necessary that volunteers adapt the presentation to their audience. Volunteers must get to know the characteristics of their site and audience members and tailor the length, content, format, and style of their presentation accordingly.

F. Challenges to Program Implementation and Sustainability

What challenges do volunteers and program directors experience?

Interviews with Medicare Minute volunteers and the Westchester SOS Director highlighted several factors that can pose challenges to program implementation.

Challenges for Volunteers

Volunteer preparedness. As discussed above, some volunteers recalled that when they began presenting they were nervous about their level of Medicare knowledge, which can make the role feel challenging at first.

Site support. Interviewees noted that some senior center directors are less actively supportive of the Medicare Minute. This can result in a lower level of audience interest in the Medicare Minute, as enthusiastic site directors often encourage their members to engage in the presentation. Supportive site directors can also provide logistical assistance, including making handouts. As mentioned previously, interviewees observed that sites with paid directors tended to be more supportive than sites with volunteer directors. One volunteer described, “The site I’ve been [visiting] for four years is just run by the volunteers; I feel that that probably makes a little difference in how professionally run things are” (Vol 1). This volunteer continued:

When there was a paid director on site I felt that maybe the people were more engaged because she talked it up more and was very good about posting notices on the bulletin board and kind of giving us a little press and getting the seniors more enthused. [When] there is no paid [staff] person, it [is] kind of up to the seniors themselves...I think [this] kind of sway[s] how interested or uninterested the [audience will] be (Vol 1).

Speaking about the importance of supportive site directors, another volunteer observed:

[T]he coordinator of the group is very, very strong in her belief that this is important. This is an activity offered by the center and if you are a member of the center and you are here, you have to participate. So all other activities are suspended during the presentation and that is a tremendous help because we are assured an audience (Vol 3).

Site structure. Presenting at sites that are geared toward social activities can be challenging, as many audience members prefer to focus on card games or other activities. The timing of the presentation around mealtime can be both a challenge and an opportunity. When presenting the Medicare Minute after a meal, for instance, many audience members are anxious to leave or move on to their next activity, which leads to lower levels of audience engagement. In contrast, presenting before a meal gives volunteers a captive audience. The Westchester SOS Director attested to the challenging nature of presenting at senior centers, noting, “It’s difficult in terms of the culture of the senior center; you’re not the marquee event so it’s hard.” Volunteers also noted that presenting at large sites can make it difficult to engage audience members.

Audience characteristics. Several interviewees mentioned that audience members frequently raise political questions related to Medicare, and discussed the challenge of responding neutrally to these questions. Audiences can also be skeptical of volunteers at first, and it takes time to develop trust. Further, lower functioning audiences can be less engaged and responsive to the presentation, which can be discouraging for volunteers.

Logistical barriers. Volunteers whose sites are a greater distance from their homes at times feel it is a long way to travel for such a short presentation. Financial constraints at senior centers can also limit volunteers' access to handouts for their audience.

Challenges for SOS Directors

Reaching new populations. The Westchester SOS Director expressed that it has been a challenge to reach out to new audiences, such as Spanish-speaking and low-income communities. These populations have been hard to reach both in terms of recruiting qualified volunteers (e.g., those who speak Spanish) and finding appropriate sites. Recently, the program has had success in connecting with the Hispanic community in Westchester County, and is now contributing to a local Spanish language newsletter and developing a Medicare Minute script in Spanish. Reaching baby boomers has also posed a challenge, as this population is less likely to visit senior centers.

Expanding site types. In addition to reaching new audiences—and as a way to help reach new audiences—the Westchester SOS program seeks to expand the Medicare Minute to additional sites, including not only senior centers but also other types of venues where seniors congregate. Interviewees commented that it can be challenging to find sites that are welcoming and have appropriate structures for the format of the monthly Medicare Minute. For example, one volunteer attempted to initiate the Medicare Minute in her community's church but encountered challenges because the site did offer regular monthly meeting times. This volunteer also noted that at some sites, Medicare may be a "political hot potato" and thus the program may face initial resistance.

Volunteer retention. With regard to program volunteers, the Westchester SOS Director conveyed that maintaining the interest of long-term volunteers—"keeping the program fresh"—has arisen as a challenge as the program enters its twelfth year.

Program growth and management. As Westchester SOS has grown to include programs beyond the Medicare Minute, the responsibility of managing multiple programs has increased the workload of the SOS director and deputy director. Some volunteers shared their experience that the addition of new programs has reduced the amount of time and attention spent on the Medicare Minute during monthly update meetings.

Program funding. Because the Westchester SOS program has a limited budget, Medicare Rights is unable to provide copies of handouts to volunteers. If host organizations are also unable to make copies of handouts, volunteers are not able to distribute them to their audience. Continued funding to ensure the sustainability of the Medicare Minute program is also an ongoing challenge.

IV. Medicare Minute Programs Beyond New York

This portion of the evaluation presents findings from interviews with Medicare Rights' State Program and Policy Coordinator and Seniors Out Speaking coordinators in grantee states. The following sections address the Medicare Rights Center's recruitment and engagement of state and local entities (referred to as "host organizations") to implement the Medicare Minute program, the structure and management of the program among host organizations, and states' experiences with program implementation.

For ease of reading, all five states discussed here are referred to as "grantee states," as they were targeted under a 2011 grant from the Atlantic Philanthropies. It should be noted, however, that the SOS program in Alabama is self-funded. In addition, implementation in Kansas began in 2008, with funding from a previous grant; the Atlantic Philanthropies grant presented an opportunity for re-funding. As of August 2013, the Medicare Minute program in Kansas and two of the original three counties in Wisconsin were no longer making presentations, though new counties in Wisconsin are now participating in the program. One of two host organizations in Florida also ended its participation in the summer of 2013. At the same time, new partners in grantee and other states (e.g., Arkansas, Maryland) have launched Medicare Minute programs of their own. Table 4 below highlights program characteristics in each of the grantee states that are the focus of this report. In this section the terms "Medicare Minute" and "SOS" are used interchangeably, as the SOS program in grantee states consists solely of the Medicare Minute.

A. Engagement of SOS Host Organizations

How were grantee states brought on board?

Host organizations were recruited and brought on board through a combination of networking with existing partners and outreach to new organizations. Once the decision was made to expand the SOS program, Medicare Rights reached out to Area Agencies on Aging (AAAs), State Health Insurance Information and Assistance Programs (SHIPs), Aging and Disability Resource Centers (ADRCs), and non-governmental organizations to promote and provide information about the Medicare Minute. Medicare Rights publicized the program through calls, state webinars, and online and in-person informational presentations. Interested agencies were then invited to submit short proposals for an SOS program in their state.

According to Medicare Rights' State Program and Policy Coordinator, existing relationships with potential host organizations were important in facilitating discussions about program adoption. In Alabama and Maine, working relationships with state SHIPs and AAAs enabled a smooth transition into a contractual relationship. In Florida, Medicare Rights formed relationships with two nonprofit host organizations through ongoing policy work in the state. In Wisconsin, the SOS program in Wisconsin developed out of Medicare Rights' involvement in the state's SHIP Task Force, through which Medicare Rights formed a relationship with the director of the state's SHIP program.

Table 4. Characteristics of Program in Grantee States

	Alabama	Florida	Kansas	Maine	Wisconsin
Start date	2011	2011	2010	2010	2012
Coordinating agency (government/nonprofit)	Government - State Unit on Aging	Nonprofit - Alliance for Retired Americans; CHAIN	Government - Area Agency on Aging	Government - Maine Legal Services for the Elderly (part of the state SHIP)	Government - Aging and Disability Resource Centers
Program reach	Statewide - 13 local SHIPs	7 counties	2 local AAAs	Statewide (with focus on 4 out of 5 AAA Planning and Service Areas, or PSAs)	3 local ADRCs
Financial arrangement	State-funded through Unit on Aging (approved by CMS). One local SHIP receives funding and disburses to other SHIPs.	Subcontract from Medicare Rights; volunteers receive stipend for mileage and printing.	North Central-Flint Hills AAA receives grant funding and subcontract from Medicare Rights; works with one other AAA.	Subcontract from Medicare Rights; MLSE disburses funding to local AAAs	3 counties receive individual subcontracts from Medicare Rights
Coordinator position	State SHIP Director	Field staff for Alliance for Retired Americans; policy staff for Florida CHAIN	SHICK coordinator at North Central-Flint Hills AAA	Medicare Rights Advocate at MLSE; local SHIP coordinators at the AAAs	Elderly Benefit Specialists at the ADRCs
Number of volunteers (FY 2013)	~150	5	7	14	10
Number of presentations (FY 2013)	867	142	86	158	98
Audience members reached (duplicated) (FY 2013)	23,164	6,241	1,925	1,830	1,168
Status as of August 2013	Operating statewide	Discontinued	Discontinued	Operating in 2 SHIPs	Operating in 3 counties

B. Program Structure and Management

What does the program look like in different states?

Interviews with Medicare Rights' State Program and Policy Coordinator and with SOS coordinators in grantee states revealed a great deal of variation in the structure and management of states' SOS programs. According to Medicare Rights' State Program and Policy Coordinator, host organizations were provided with a set of essential program components and activities (see text box at right), but overall were given a fair amount of leeway in structuring the program to their unique contexts. The sections below describe grantee state host organizations, staffing and management, volunteer recruitment and support, engagement of presentation sites, and implementation support from Medicare Rights.

Host Organizations

In all but one of the grantee states the SOS program was hosted by a government agency. In Alabama, the program was hosted by the state SHIP and became a statewide program required for all 13 local SHIPs. In Kansas, Maine, and Wisconsin, the program was hosted by one or more local AAAs. In Maine, the state SHIP (Maine Legal Services for the Elderly) received funding from Medicare Rights and distributed funds and Medicare Minute materials to other SHIPs/AAAs in the state. Similarly in Kansas, Medicare Rights funded one AAA, which shared the Medicare Minute materials with other AAAs in the state. In Wisconsin, Aging and Disability Resource Centers (ADRCs) in three counties were each funded separately by Medicare Rights.² Florida was the only grantee state in which the host organizations were nonprofit agencies. Initially, the program was hosted by Florida CHAIN, a statewide consumer health advocacy organization. Later, the Florida branch of the national Alliance for Retired Americans (ARA) came on board as a host organization. In both cases, complicated questions could be referred either to Medicare Rights or to Florida's SHIP program, Serving Health Insurance Needs of Elders (SHINE).

Medicare Rights Instructions for Host Organizations

Necessary Program Personnel

- SOS coordinator(s)
- SOS volunteers

Program Management Activities

- Designate SOS coordinator(s)
- Recruit SOS volunteers
- Train and orient volunteers
- Distribute Medicare Minute materials to volunteers
- Identify presentation sites
- Assign volunteers to sites
- Coordinate monthly update meetings
- Collect presentation data and report to Medicare Rights

²It should be noted that only one of the three SOS program coordinators in Wisconsin was interviewed for this report. Medicare Rights' State Program and Policy Coordinator provided information about the operations of the SOS program in the other two areas of the state.

Staffing and Management

Interviews pointed to variation in program staffing based on whether SOS activities were coordinated centrally, locally, or both. Alabama and Maine took similar approaches to staffing in that each designated a central SOS coordinator for the state—housed at the central SHIP—along with local coordinators at the participating SHIPs/AAAs. Wisconsin designated local SOS coordinators at its participating ADRCs, but did not have a coordinator at the state level. In Kansas, the program was led by a local SHIP coordinator (Senior Health Insurance Counseling for Kansas (SHICK) is the state’s SHIP). The program in Florida was centrally coordinated by staff at Florida CHAIN and at ARA.

While program management responsibilities varied among states, central coordinators were generally in charge of distributing Medicare Minute materials, supervising local coordinators, training volunteers, running monthly update calls, helping identify presentation sites, and collecting presentation data. One state coordinator also described developing additional materials, including an informational sheet about the Medicare Minute. Local coordinators were generally responsible for recruiting volunteers, identifying presentation sites, maintaining regular contact with volunteers, and in some cases collecting presentation data.

Volunteers were in charge of some aspects of program operations for several host organizations, including identifying presentation sites and making photocopies of materials. Florida’s coordinator described the decision to place greater responsibility with volunteers: “I think it has to remain autonomous in that they’re volunteers...they wouldn’t stick with us if...I was micromanaging people.”

Volunteer Recruitment

Host organizations varied in their approach to recruiting SOS volunteers. States made use of existing volunteer pools where possible. For example, in Kansas, once AAAs began implementing the Medicare Minute program, all existing SHICK counselors in the participating AAAs were expected to carry out Medicare Minute presentations. In Maine, the SOS coordinator worked to identify existing SHIP volunteers who would be interested in leading Medicare Minute presentations. Maine’s SOS coordinator also noted that AARP had been helpful in recruiting SHIP volunteers.

For the most part, Alabama, Florida, and Wisconsin recruited volunteers specifically for the SOS program. Although the SOS program in Alabama is run through the local SHIP program, in contrast to Kansas, the SOS coordinator found that it was easier to recruit volunteers for the SOS program, noting that because of the intensive training required to become a SHIP volunteer, certain potential volunteers may be attracted to the less intensive nature of the SOS commitment. Alabama also found that some Senior Medicare Patrol (SMP) volunteers were interested in leading Medicare Minutes, in some cases in conjunction with the fraud awareness and prevention presentations they led for SMP. In Wisconsin, one ADRC partnered with a local faith-based organization and recruited volunteers from the organization’s membership. Similarly, with the SOS program hosted by Florida CHAIN,

CHAIN partnered with a local labor organization to form its volunteer base. Volunteers for the SOS program hosted by Florida ARA were handpicked by the ARA coordinator and Medicare Rights' State Program and Policy Coordinator to cover different geographic areas.

Volunteer Training and Support

As in Westchester, volunteers in grantee states were required to participate in an initial Medicare training as well as monthly update meetings. The provision of training and support to volunteers varied based on the type of host organization. SOS programs run by SHIPs/AAAs trained volunteers in house, in some cases with assistance from Medicare Rights. Medicare Rights provided a Medicare Minute orientation training to all partners, which they could either lead themselves or enlist Medicare Rights to lead for volunteers. Since volunteers in Kansas and Maine were SHIP counselors, they had in most cases already received extensive Medicare training through the SHIP. Kansas' coordinator explained, "I recognized right away that [Medicare Rights'] training materials are equivalent to our SHICK training, and at that point I determined that our volunteers needed to go through our SHICK training." In Alabama, new SOS volunteers received Medicare 101 training, though this training was not as extensive as the training required for SHIP volunteers. Wisconsin volunteers were trained by the SOS coordinator, an Elderly Benefits Specialist (EBS). As the only state in which the SOS program was not run by a senior-serving government agency, Florida's host organizations did not have the Medicare knowledge base to train volunteers and were trained annually by Medicare Rights.

In all states except Florida, SOS coordinators were also charged with running monthly volunteer update meetings. Medicare Rights' State Program and Policy Coordinator noted that it is necessary for Medicare Rights to participate in volunteer update meetings with organization that do not have a Medicare knowledge base, in order to answer any Medicare content questions that volunteers raise. As a result, Medicare Rights' State Program and Policy Coordinator noted that she hosted all of the monthly calls in Florida, and participated only occasionally in other states' calls to check in and offer support. Update meetings in grantee states generally occurred by phone, as volunteers were spread out geographically. As in Westchester, coordinators noted that monthly meetings consisted of reviewing successes and challenges from the previous month, reviewing the current month's script, and sharing support and suggestions among volunteers.

As in Westchester, it is important for SOS volunteers in other states to have someone to go to with both logistical and Medicare-related questions. In all states, SOS coordinators provided logistical support for volunteers in terms of scheduling and managing presentations. With regard to content support, again, SOS coordinators at SHIPs/AAAs were able to serve as a content resource for volunteers. In Wisconsin, volunteers were directed to contact the SOS coordinator at the local ADRC, or Medicare Rights. In Florida, Medicare Rights served as the Medicare expert, and content questions were generally raised during monthly update meetings. Most states also reimbursed volunteers for expenses such as photocopying and travel. Florida also provided volunteers with small stipends.

Engagement of Medicare Minute Sites

As with the program in Westchester, most presentation sites in grantee states were senior centers. SOS coordinators noted that some volunteers had also presented at other types of venues, including community housing sites, community groups, and even in volunteers' own homes.

Grantee states described differences in how they identified and engaged sites for Medicare Minute presentations. In some states, host organizations had existing relationships with senior centers and were able to draw on those relationships. In Kansas, for example, participating AAAs had contracts with senior centers throughout the state. Kansas' SOS coordinator described, "We have a direct service waiver and we provide the meals program [at senior centers], so most of those people work for us." She noted that because of this contractual relationship—and the fact that Medicare Minute presentations counted toward senior centers' requirements for educational presentations—it was not difficult to get buy-in from senior center sites.

In other states, SOS volunteers were largely responsible for identifying Medicare Minute sites. In Florida, the SOS coordinator explained that volunteers are instructed to reach out to venues they may have relationships with in their communities. The coordinator noted that she offered to help volunteers reach out to site directors if they were having trouble identifying sites.

Implementation Support from Medicare Rights

Interviewees described receiving support from Medicare Rights in several areas:

- **Introductory communication.** Before states launched their own Medicare Minute programs, Medicare Rights met with potential host organizations to present information about the program and discuss potential implementation challenges. In most cases these meetings occurred via phone, though in some states meetings occurred in person and were supported by Medicare Rights' grant funding.
- **Initial meetings about program design.** Medicare Rights also had both initial and follow-up meetings with host organizations after their SOS programs were approved. Again, some meetings occurred in person and some virtually. The purpose of the meetings was to explain the program to SHIP counselors and discuss potential challenges.
- **Medicare Minute materials.** Each month, Medicare Rights emailed SOS coordinators the Medicare Minute scripts, teaching materials, and handouts.
- **Volunteer training and support.** For host organizations without Medicare expertise, Medicare Rights conducted the initial volunteer training and monthly update meetings. In these cases, Medicare Rights also served as the contact for volunteers with Medicare-related questions. For SHIP/AAA host organizations, Medicare Rights was available for

initial volunteer orientations and was also able to provide support for monthly volunteer calls.

- **Referral agency for Medicare questions from audience members.** For host organizations without Medicare expertise, Medicare Rights served as the primary referring agency for audience members with Medicare questions. Audience members were directed to call Medicare Rights' helpline, but in some cases also contacted Medicare Rights' State Program and Policy Coordinator directly. The Medicare Rights helpline was also provided on the Medicare Minute materials as a resource for both volunteers and audience members.
- **Database support.** Medicare Rights provided an online database through which grantee organizations could submit reports on the numbers of presentations led, the number of audience members in attendance, and audience feedback.

C. Implementation of Medicare Minute Presentations

What do the Medicare Minute presentations look like in grantee states?

Though interviews were not carried out with program volunteers in grantee states, the evaluation explored differences and similarities in how the Medicare Minute presentations are led in different states, based on SOS coordinator feedback.

SOS coordinators appeared to offer volunteers a good deal of flexibility in carrying out their presentations. In Maine, for instance, the statewide SOS coordinator specified that management of the actual presentations occurred at the level of the local coordinators. Interviews with SOS coordinators suggested that volunteers developed diverse strategies for delivering their presentations. For example, one volunteer created a PowerPoint to present the Medicare Minute. Another volunteer hosted the Medicare Minute in her home each month. In another case, a volunteer went to the home of a senior each month to deliver the Medicare Minute. The number of sites each volunteer visits each month varied, with some volunteers presenting at more than one site.

With regard to Medicare Minute topics, interviewees described that host organizations do not always use the designated month's topic. Maine's coordinator noted that sometimes volunteers may be a month behind, unless the content involves month-specific material. Kansas' SOS coordinator mentioned that while volunteers generally present the materials for the designated month, the coordinator may skip a month's topic if it does not seem accurate to the region. As an example, one topic related to HMOs did not apply to the structure of health insurance in Kansas. The coordinator explained that sometimes their agency would skip certain months' topics: "We can't alter [Medicare Rights'] materials, so if it doesn't apply, we just don't use that one."

Some states chose to email the Medicare Minute materials to volunteers, while others elected to mail hard copies. The coordinator in Kansas felt that it was important to mail the handouts in order to simplify the process for volunteers, believing that volunteers might not pay as much attention to electronic communication.

For the most part, it appears that host organizations used the monthly presentation format as designed. An exception to this is Florida, where the SOS coordinator described that volunteers developed a "circuit" model of rotating sites each month. This system evolved based on volunteers finding that targeted sites were not interested in having a monthly presentation. The coordinator observed:

The program is structured so if you get a presentation for 12 months, you'll be more informed and empowered. But the [seniors] really don't want the same people to come every month.

Kansas' coordinator noted that because of budgetary constraints and the relevance of the Medicare Minute topics, the state moved to distributing materials to volunteers every other

month, though Medicare Rights staff confirmed that volunteers continued to lead monthly presentations. In Maine, volunteers added the Medicare Minute to existing “Welcome to Medicare” presentations led at sites several times per month.

SOS coordinators expressed different experiences with offering the Medicare Minute at sites that provide meals to seniors. In Maine, the SOS coordinator observed that presenting the Medicare Minute at meal sites felt intrusive, as seniors were there to socialize. In contrast, Wisconsin structured the program specifically around meals at sites and found it an effective way to capture audience attention.

Additional Services and Referrals

SOS programs hosted by SHIPs/AAs typically referred audience members in need of further assistance to one-on-one Medicare counseling through their SHIP programs. In Florida, where host organizations did not offer additional Medicare services, volunteers were instructed to refer audience members to the Medicare Rights helpline or to Medicare Rights’ State Program and Policy Coordinator. When Florida CHAIN was serving as a host organization, materials were co-branded with the state SHINE phone number, which audience members could contact for further services.

D. Grantee Perceptions of SOS Program

How do SOS coordinators experience the Medicare Minute program?

This section discusses host organizations' overall experiences with the SOS program, including perceptions of program benefits and interactions with Medicare Rights.

Program Benefits

SOS coordinators described a number of ways in which the SOS program benefited host organizations, volunteers, and audience members.

Benefits for host organizations

SOS coordinators discussed several benefits of the SOS program for host organizations. First, adopting a program with a structure and materials that had already been designed gave host organizations a new way to reach seniors, without having to design a program from scratch. For SOS programs run by state agencies (SHIPs, AAAs, or ADRCs), the Medicare Minute helped these agencies meet federal requirements from the Centers for Medicare & Medicaid Services (CMS) for educational presentations, which in turn helps these agencies maintain federal funding. In addition, Medicare Minute presentations helped state-funded senior centers meet state requirements for educational presentations. For example, Kansas' SOS coordinator described that many of the state's senior centers host state-funded meal programs, and in order to receive state funding, meal programs must meet a "two-two-seven" requirement: "They have to do two health presentations, two wellbeing presentations, and seven social events throughout the month."

Coordinators in Alabama, Kansas, and Wisconsin also noted that the SOS program helped their agency recruit additional volunteers, which served to provide a volunteer base for other programs and in some cases resulted in cost savings. For example, the Alabama SOS coordinator explained that the program has served as a stepping-stone for SOS volunteers to become SHIP counselors, a position that requires more intensive involvement. Coordinators in both Alabama and Kansas emphasized that SOS volunteers were instrumental in helping their agencies reach rural areas. In Kansas, the SOS coordinator noted that importantly:

Because we have 18 counties, to get out to some of our counties it's hopping in the car and driving more than two hours. It's important for us to have a bunch of volunteers out there, so we need to use every possible tool in our toolkit to help us recruit volunteers. Having people present Medicare Minutes in communities, especially if they branch out from the senior centers, can help other people become interested in what they're doing and in becoming a SHICK volunteer [themselves].

The Alabama state coordinator noted that as a result of their participation with the SOS Medicare Minute program, their state SHIP program received improved ratings from CMS:

[The SHIPs are] graded by performance based on geographical slices, and this is the first year that we have got the highest score you can get, which is a 10, and it's all because of this project. So for the SHIPS this is a huge way to get buy-in, because we're so performance- and numbers-driven.

Interviewees also noted that Medicare Minute materials were useful for organizations and volunteers beyond the Medicare Minute presentations themselves. Materials from Medicare Rights can help organizations augment staff and volunteers' education and training and can serve as a long-term resource. Maine's SOS coordinator shared, "Everybody's making notebooks of the Medicare Minute materials, because they're great."

Host organizations in Florida and Maine also mentioned that they co-branded Medicare Rights' materials, which helped increase name recognition for the coordinating agencies. Medicare Rights' State Program and Policy Coordinator added that Florida used the Medicare Minute presentations as a lead-in to their policy advocacy work.

Benefits for volunteers

Interviewees discussed several benefits of the Medicare Minute program for volunteers themselves. SOS coordinators articulated that the SOS program was useful in keeping volunteers engaged throughout the year, beyond the open enrollment period. The format of the program also helped educate volunteers about Medicare gradually, by giving them "bite-sized" teaching in the form of the monthly Medicare Minute. The coordinator further noted that some SHIP volunteers preferred leading Medicare Minutes to providing SHIP counseling, giving the example of retired university professors who are comfortable talking in front of groups and may be nervous about one-on-one counseling.

Benefits for seniors

Interviewees noted that the SOS program helps educate seniors and encourages them to engage with each other around issues related to Medicare. The SOS coordinator in Kansas commented, "We want to bring good, reliable information to seniors, from a trusted source, and we see Medicare Rights as providing that." In Alabama, the coordinator felt that "the greatest value [in the program] is the fact that the beneficiaries [volunteers and audience members] are getting educated, rather than just helped. They are becoming knowledgeable." In Wisconsin, the SOS coordinator shared, "I value the excitement that [the program is] generating for Medicare and seniors talking among themselves." Wisconsin's coordinator spoke about the audience's positive reception of one of the SOS volunteers:

They just love him. It's been way more successful than I could have imagined. There are always at least 25 people there. He talks right after they eat and right before they get to their event—bingo day.

While most coordinators did not specifically discuss the peer education model, Maine's SOS coordinator pointed out the benefits of seniors being able to relate to one another, commenting, "Peer to peer is the way to go."

Relationship with Medicare Rights Center

When asked about their relationship with Medicare Rights, interviewees spoke about the overall quality of Medicare Rights' work and the responsiveness of Medicare Rights' State Program and Policy Coordinator to their needs. One coordinator stated that she appreciated the "technical support and the time [Medicare Rights] spent to engage us about what [SOS] is, the nuts and bolts of the project." She added, "They have been fantastic partners—true advocates. I like that they really understand the SHIP network...that is so important."

One state coordinator recalled that communication with Medicare Rights seemed somewhat stalled at the beginning of the grant period, noting a gap in contact with Medicare Rights between awarding of the grant and beginning the program. Two state coordinators expressed that though Medicare Rights' reporting requirements were understandable, they felt somewhat burdensome given organizations' other duties and schedules. Based on interviews, it was also unclear whether all coordinators understood the financial aspects of the program—specifically whether they would continue to have access to the Medicare Minute materials after the grant period ended.

E. Facilitators and Challenges to Program Implementation and Sustainability

What makes program implementation easier and more difficult?

On the whole, state coordinators expressed that the SOS program model was simple to understand and the steps required for program implementation were straightforward. The sections below highlight key factors that interviewees identified as supportive of and challenging to program implementation.

Implementation Facilitators

High-level buy-in. In order for the SOS program to launch successfully, it is essential that the program receive support from upper management at host organizations. In many cases, necessary support also includes county- or state-level governing bodies.

Frontline staff buy-in. It is essential that host organizations garner support from local staff who will be involved in day-to-day program operations. For instance, even if the program has the support of the state director, it is critical that there be buy-in from the local SHIP coordinators as well. In recognizing the value of achieving buy-in from local staff, Maine's SOS coordinator recalled, "I went directly to the directors at each of the agencies [and] explained the program. People were very excited; it was not a hard sell." In Kansas, the SOS coordinator noted that incorporating SOS-related tasks in staff job descriptions helped formalize expectations for new staff.

Host organization type. Medicare Rights' State Program and Policy Coordinator noted that CMS-based organizations (SHIPs, AAAs, ADRCs) are the easiest to work with, both because they already have a Medicare knowledge base and because they have existing pools of qualified volunteers. In addition, state agencies are better prepared to support volunteers with Medicare questions and can offer additional support to audience members. In this way, host organizations that can operate without intensive involvement from Medicare Rights represent a more sustainable approach to expanding and maintaining the SOS program.

Centralized program management. Both Medicare Rights' State Program and Policy Coordinator and grantee state coordinators emphasized the importance of centralized management of SOS programs that operate in different areas within a state. As Alabama's SOS coordinator pointed out, "One of the most important things is to get a state coordinator at the very onset." Central coordinators are important from a program management perspective and also allow Medicare Rights to have a single contact within a state, which helps to streamline Medicare Rights' administrative responsibilities.

What facilitates program implementation?

- Buy-in from high-level and frontline staff
- Host organization type
- Centralized program management and local program coordination
- Qualified volunteers and existing volunteer pool
- Volunteer accountability
- External partnerships and relationships with presentation sites
- Streamlined administrative duties

Local program coordination. In addition to centralized program coordination for multi-site programs, interviewees noted that designating local SOS coordinators who can manage the day-to-day program activities is essential to successful program implementation. While centralized coordinators are involved in high-level project management, on-the-ground coordinators have the local networks and relationships to be able to identify and engage Medicare Minute sites and volunteers. Interviewees noted that local coordinators are especially important for larger statewide programs, where a centralized coordinator—often located in another part of the state—may not be attuned to the daily activities of volunteers. Interviewees also highlighted the key role of local SOS coordinators in supervising and supporting volunteers. Florida’s coordinator commented, “Whoever the manager is going to be needs to be fully *in* to support the [volunteers] and be willing to take their calls anytime.” Kansas’ coordinator emphasized the importance of an involved coordinator to check in with volunteers: “In order to make sure the program is running and viable, we have a staff member who I’ve assigned to call volunteers and encourage them to do the Medicare Minutes.” She explained, “Especially as we were getting organized in the beginning, that was very important, because volunteers weren’t picking up the program and running with it.” Medicare Rights’ State Program and Policy Coordinator concurred, noting, “On-the-ground coordination has proven to be really central to the success of the volunteers. [Coordinators are] like a cheerleader who’s there,” and adding, “I think the more engaged and involved the coordinator is, the better the program.”

Qualified volunteers. State coordinators emphasized that it is crucial that host organizations be able to recruit Medicare Minute volunteers who are committed to their role, are interested in being trained in Medicare, and have public speaking skills. Florida’s coordinator described her experience with several individuals who expressed interest in volunteering, but ultimately did not feel at ease speaking in front of groups. Alabama’s coordinator described how volunteers have taken steps to ensure that the Medicare Minute reaches seniors who may not otherwise access Medicare information: “One of the SHIP coordinators, she has very dedicated volunteers. One goes individually each month to a home-bound senior to give the Medicare Minute.”

Existing volunteer pool. State SOS coordinators and Medicare Rights’ State Program and Policy Coordinator noted that having an existing pool of volunteers to serve as Medicare Minute presenters (as was the case in Maine and Kansas) can facilitate the initiation and implementation of the program. Particularly at CMS-funded organizations, existing volunteers have already been vetted and trained in Medicare, which saves new host organizations time and energy in terms of volunteer recruitment.

Volunteer accountability. Interviewees observed that the ability to retain volunteers is key to the successful operation of the SOS program. Medicare Rights’ State Program and Policy Coordinator suggested that feeling a sense of loyalty to the SOS host organization plays a role in encouraging volunteers to follow through on their responsibilities and remain with the organization over time. Program coordinators who maintain close contact with volunteers are also key to promoting accountability, “because there’s always someone checking up on them.” Medicare Rights’ State Program and Policy Coordinator noted that SHIP coordinators have a particular incentive to encourage volunteers to carry out

Medicare Minute presentations, as their presentations are reported to CMS as well as to Medicare Rights. As a result, SHIP/AAA volunteers may feel “a stronger sense of accountability.”

Relationships with presentation sites. Interviewees noted that having existing relationships with senior centers and other venues helped both coordinators and volunteers bring sites on board for the Medicare Minute program. For example, as mentioned above, Kansas had contractual relationships with senior centers that run meal programs for seniors. In other states, interviewees noted that volunteers have been able to introduce the Medicare Minute to senior centers and other organizations with which they are affiliated.

Partnerships with other organizations serving older adults. Several host organizations described that relationships with outside organizations facilitated their ability to recruit volunteers. In Maine, for example, the SOS coordinator noted that AARP can advertise SHIP volunteer opportunities to a much larger audience than the AAAs themselves would be able to access. In Florida and Wisconsin, relationships with nonprofit organizations and faith-based organizations have provided a volunteer and presentation base for the Medicare Minute.

Streamlining administrative requirements. Several interviewees noted that actions to simplify reporting, both for SOS coordinators and volunteers, were useful in enhancing staff satisfaction. As an example, when sending the Medicare Minute materials to volunteers, Kansas’ coordinator began to include a return envelope with attendance sheets. In Alabama, the state SHIP director added required SOS reporting to the existing SHIP reporting mechanism in order to reduce the reporting burden for local SHIP coordinators.

Implementation Challenges

Interviewees mentioned several factors that can make program implementation more challenging.

Challenges securing buy-in for program model. With regard to the overall design of the Medicare Minute program, one interviewee discussed challenges with getting buy-in around the program structure, as the county governing body initially wanted Medicare Minutes to be presented at different sites each month. In response, staff at the AAA attempted to emphasize the importance of consistent monthly presentations, yet continued to face some resistance to the model. Another interviewee who is now very supportive of the Medicare Minute program expressed that she was initially skeptical:

What makes program implementation more challenging?

- Difficulty securing appropriate host organization buy-in/support
- Lack of staff time investment
- Lack of management structure
- Difficulty recruiting, training, and retaining volunteers
- Geographic challenges

The first time I saw it, I thought to myself, “Oh no, I’m not really comfortable with this idea,” because it’s very important to tell seniors correctly about Medicare, and...whoever was going to be charged with [presenting] these materials might say their own stuff, give their flavor, and I’m very protective about the seniors here, so I was anxious about it.

Another coordinator pointed out that cultural differences in parts of the state raised questions about whether the group presentation model was appropriate for a community that tended to be more comfortable with one-on-one programming.

Difficulty securing agency buy-in around program requirements. SOS coordinators expressed that gaining buy-in from organization staff was a key challenge in getting the Medicare Minute program off the ground. Because SOS staff in grantee states already work full time, interviewees noted that implementing a new program “can seem like just another responsibility on top of many responsibilities” (Alabama). Interviewees shared:

It seems like CMS is always loading the SHIPs up with more requirements...so I was like, “Oh gosh, I’m just asking them to do one more thing.” The biggest challenge was, “How am I going to get the buy-in that this will be beneficial?” (Alabama)

Initially [the AAAs] were wondering how to fit [this program] into already busy schedules. The AAAs are run on a shoestring....We don’t hire enough staff to do all the work there is to do here. Bringing in one more thing to do can seem like, “I don’t have time for that.” (Kansas)

Kansas’ coordinator also discussed challenges seeking buy-in from AAA directors due to tight budgets: “We went out to try to recruit other AAAs; going out and making those presentations and talking to those [Executive Directors], it’s been a sales job to do that. Especially since there’s not much money for the Medicare counseling program.” She summed up: “For SHICK coordinators it’s a matter of time, for the [executive directors] it’s a matter of money.”

Barriers to staff time investment. Several state coordinators shared that the time required to implement the SOS program—especially at the beginning—was a challenge. Kansas’ coordinator recalled, “The biggest issue I had...was trying to determine if we had time to pull it off. Initially organizing something like that takes investment and time.” Speaking to the time required to manage a multi-site program, Alabama’s coordinator stated, “I found that trying to coordinate 13 local projects took longer than anticipated.” Wisconsin’s coordinator commented, “It was time-consuming to start. The challenge was fitting everything in my schedule. I did a lot on my own time as well.” Wisconsin’s coordinator also noted that it was challenging to find time to supervise volunteers. Medicare Rights’ State Program and Policy Coordinator noted that in Wisconsin, staffing changes at one of the host organizations resulted in staff being overloaded with responsibilities; ultimately, the SOS coordinator was no longer able to devote time to distributing the Medicare Minute materials and maintaining monthly update meetings with volunteers.

Challenges with management structure. For states with multiple host organizations, achieving an optimal management structure can be difficult. For example, Alabama’s director stated, “Being at the headquarters office, you are more removed. [It is] hard to get a feel for what’s going on with volunteers.” She noted that it has been difficult to identify a coordinator to manage the day-to-day program activities—someone “who’s really going to take this project to the next level.”

Difficulty recruiting volunteers. All coordinators voiced challenges with at least some aspects of volunteer recruitment. Several interviewees emphasized the difficulty of finding volunteers to serve rural areas, which may require substantial driving. Some also expressed difficulties in finding volunteers with public speaking skills. In Florida, because the host organizations were nonprofit organizations without an existing volunteer base, it was difficult to identify how and where to recruit volunteers. Medicare Rights’ State Program and Policy Coordinator related that one of the Wisconsin coordinators explained that seniors in her community do not tend to be involved in volunteer work, so getting buy-in from potential volunteers was challenging.

Challenges with volunteer training. Interviewees noted that if volunteers do not participate in standard SHIP training, it can be difficult to ensure that they are adequately trained in Medicare. This is the case in Florida, where Medicare Rights provided the volunteer training. Florida’s coordinator reflected on the first year of the program:

Some people needed more support than I gave them. We did the training and I just turned them loose. You can’t do that with everybody. So this year when we had our training...we kept people for an extra half a day.

Florida’s coordinator also discussed an additional challenge in preparing volunteers for public speaking, explaining, “This year I did something different. I had everybody get up and talk and make a presentation, and I filmed them.” Medicare Rights’ State Program and Policy Coordinator added that some challenges have arisen in maintaining monthly update meetings for volunteers. The SOS coordinator in one state found that only a handful of volunteers were participating in the update call each month.

Difficulty retaining volunteers. All states experienced difficulties with volunteer retention. The challenges expressed by interviewees generally fit into three categories: inappropriate fit with volunteer interests or skills; a high level of volunteer responsibility; and limited volunteer accountability. In an example of the first, the coordinator in Florida attributed volunteer turnover to volunteers not having a good enough understanding of what their role would entail. In Kansas, volunteers are SHIP counselors who are not recruited specifically for the Medicare Minute; as a result, the role is sometimes not a good fit for volunteers’ interests, skills, or schedule. The SOS coordinator in Kansas stated that it is a “challenge keeping the awareness up among volunteers to go out and do the Medicare Minute.” She explained:

We have all of these volunteers, [and] not all of them are wanting to go out and present Medicare Minutes. I think some are intimidated by public speaking. In some cases they have full-time jobs and can’t go out.

With regard to volunteers' level of responsibility, in several states volunteers are in charge of identifying their own presentation sites—a task that coordinators noted requires motivation, energy, and skill in engaging site directors. Interviewees acknowledged that it can be challenging for volunteers to identify sites and to remain engaged in carrying out Medicare Minute presentations

Medicare Rights' State Program and Policy Coordinator also pointed to volunteer loyalty and accountability as another challenge to volunteer retention. The coordinator noted that when volunteers have looser ties to the host organization, they may be less motivated to follow through with their responsibilities as volunteers. In Florida, she explained, one of the host organizations ended their participation partly because the SOS volunteers were affiliated with a different agency and did not have formal ties to the host organization: “[There was] no relationship that made them feel compelled to give their presentations.”

Difficulty obtaining site buy-in and support. Interviewees in several states observed that at times, directors at potential presentation sites were initially wary about the program and what it would entail. Speaking about site directors, Wisconsin's coordinator noted, “At first they were a little leery about what this was all about.” Florida's coordinator observed the particular challenges associated with living in a state with a large senior population:

Finding the venue is a big deal. In Florida—and I don't blame the people at these senior and community centers—the seniors are really targeted by a lot of vendor type people who have things to sell...so people are a little suspect about what we really want.

Geographic challenges. In each of the five grantee states, a substantial segment of the population lives in rural areas. Coordinators expressed that there are significant challenges in reaching these communities, and explained that rural geography has affected volunteer recruitment, dissemination of materials to volunteers, and audience attendance. According to Wisconsin's coordinator, “Spread out geography can be challenging but workable.” In Maine, the AAAs in the most rural areas eventually stopped giving presentations. In Alabama, the coordinator observed:

The rural areas have been a big challenge also... Half of Alabama Medicare beneficiaries live in a rural county. We don't have the presence in those real rural counties. The SHIPs encounter that [rural] challenge with everything.

The SOS coordinator in Kansas also noted that rural geography impeded the host organization's ability to recruit other AAAs to participate in the program, explaining, “It's quite a distance for us to drive to get them involved.”

Sustainability Challenges

State coordinators were asked about their desire and ability to sustain the SOS program beyond the grant period. While most interviewees reported that they would like to maintain or expand the program in their state, they also raised concerns about funding and

staffing that could inhibit their capacity to continue the program after the end of their subcontract with Medicare Rights.

Funding issues represented the primary challenge to sustainability for host organizations. Of the five states included in the evaluation, Alabama was the only state that had committed its own funding to the program. At the time of the interview, Kansas' coordinator noted that the AAA had expanded to other AAAs and would like to encourage more volunteers to participate in the program. However, Medicare Rights' State Program and Policy Coordinator noted that as of August 2013, the program in Kansas was no longer operational, as the host organization was not able to continue licensing the Medicare Rights materials after their subcontract funding ended. In Florida, the SOS coordinator expressed a desire to grow the program, but explained that the host organization would not be able to continue without additional funding, mentioning that the host organization was currently losing money on the program. Similarly, Maine's coordinator commented, "We've got the volunteers; the skeleton is there...so it's just being able to get the materials, but we wouldn't have money to pay for them." SOS coordinators also raised funding concerns aside from licensing Medicare Rights' materials, including their capacity to copy and mail out the Medicare Minute materials to volunteers, and to reimburse volunteers for travel and photocopying expenses.

Staffing issues represented a second major challenge to program sustainability. While interviewees generally reported that the SOS program did not consume a large portion of their time, SOS coordinators continued to face competing responsibilities, particularly in a time of budget and staffing cuts. Medicare Rights' State Program and Policy Coordinator noted that as of August 2013, the SOS coordinators at two of the Wisconsin ADRCs had to take on additional duties and were no longer able to manage the program. Two new ADRCs have been identified to launch the program in Wisconsin.

V. Looking to the Future

A. Summary and Discussion of Findings

This evaluation has explored the implementation of the SOS Medicare Minute program in Westchester County, Alabama, Florida, Kansas, Maine, and Wisconsin. An examination of the perspectives and experiences of program staff, volunteers, and audience members has provided a keener understanding of the key program components and activities that contribute to its successful implementation, as well as factors that can facilitate and pose challenges to program management, expansion, and sustainability.

Key Program Components

Key components of the Medicare Minute presentations that emerged from interviews and site visits included **consistency of presentations and volunteers**; the presentation's **short length** and **general level of information**; **tailoring the presentation content and style** to fit audience and site characteristics; **availability of volunteers to answer individual questions** from audience members; and the ability to **refer audience members to additional support** services.

Evaluation findings highlight the **importance of dedicated volunteers and staff** for the success of the program's implementation. Volunteers themselves are the heart of the program and it is essential that volunteers are both qualified and committed. Host organizations that experienced challenges recruiting or retaining volunteers ultimately were not able to sustain the program. Enthusiastic program coordinators, particularly at the local level, play an important role in motivating volunteers, as well as in managing the day-to-day operations of the program.

Findings also point to the **crucial role of personal relationships**. Relationships between volunteers and audience members foster a sense of trust and encourage audience members to seek assistance with their Medicare needs. Relationships between program coordinators and volunteers encourage volunteers to carry out presentations and support volunteer retention. Relationships between volunteers and site directors help garner buy-in and support from site directors. Relationships among volunteers themselves can foster a sense of social support and camaraderie.

When considering Medicare Minute presentation sites, it is important that sites have scheduled monthly meetings, and that the populations served are appropriate for the content of the Medicare Minute presentations. Interviewees suggested that it is necessary to consider ways to **reach seniors who do not congregate at senior centers**, and pointed to **geographic challenges** in reaching rural populations. The Westchester SOS founder acknowledged that it would be easier to implement the SOS program in areas with greater population density.

Program Expansion Considerations

The experiences of Westchester and grantee states in implementing the SOS Medicare Minute program point to several factors that should be in place for the successful operation of the program. These include: **allocating funding** to cover Medicare Rights' licensing costs as well as production and distribution of materials for volunteers; **securing buy-in from host organizations**; **ensuring adequate staff time** to get the program off the ground; and **designating local program coordinators** to manage on-the-ground activities and support volunteers. Interviews with Medicare Rights staff suggested that **gaining support for the program at a state level** would benefit both host organizations and Medicare Rights.

With regard to program volunteers, state coordinators indicated that **having an existing pool of interested and trained volunteers** facilitated the program's initiation. In grantee states, challenges with volunteer retention also pointed to the importance of volunteer interest and **accountability to the host organization**.

Suggestions for Host Organizations from the Westchester SOS Founder

- **Create a program plan and marketing strategy.** Creating a plan for where the program will operate and a strategy for marketing the Medicare Minute are the key program management responsibilities for host organizations. It is important to have a plan in place before starting to promote the program. Organizations should first consider where in their state it makes sense to implement the program, taking into account where there are older adult populations and appropriate presentation sites. Then, coordinators should promote the program to potential presentation sites and local authorities.
- **Garner support from local authorities.** Establish the identity of the program and the credentials supporting the program with local and state and government authorities serving the program area.
- **Identify presentation sites before recruiting volunteers.** SOS coordinators should identify potential presentation sites and then recruit volunteers to serve those sites. This ensures that a program plan is in place before volunteers come on board, and paves the way for easy access for volunteers. Additionally, volunteers may not have the appropriate skills to promote the program and navigate the administrative requirements for program approval. It may be more appropriate for volunteers to be involved in identifying new presentation sites once the SOS program is in place and the model is understood among local organizations.
- **“Start small, test it out, then make changes.”** Host organizations should begin with an exploratory phase, first securing a small number of presentation sites, lining up volunteers for those sites, identifying challenges, and making program modifications. Only then should organizations expand to additional sites and volunteers: “They have to be careful not to implement [the program] all at once.” Particularly for programs that will be operating in rural areas, it would be useful to begin with 1-2 sites to pilot the program and identify challenges.

It bears repeating that the findings in this report are the result of discussions with SOS program coordinators, volunteers, and audience members. While efforts were made to ensure that volunteer interviewees represented the diverse characteristics and experiences of program volunteers, the findings may not represent the experiences of all volunteers. It is also important to note that this evaluation sought to explore the ways in which the SOS Medicare Minute program has been implemented; it is not a study on the impact of the program on seniors' behavior or overall health. In other words, the key program components identified through interviews and observations tell us what volunteers and audience members perceive to be the elements of the program that enhance audience engagement and encourage audience members to seek assistance for their Medicare-related concerns. However, further study would be necessary in order to assess the extent to which the Medicare Minute program is improving health coverage and care management for seniors.

VI. Recommendations

This section presents recommendations for program expansion. Recommendations are offered both for Medicare Rights and for host organizations. The recommendations for host organizations speak mostly to new organizations that plan to adopt the Medicare Minute, but also apply to existing host organizations in New York and other states.

A. Recommendations for the Medicare Rights Center

- 1. Seek program support at a statewide level.** Adoption of the Medicare Minute program by a statewide agency is useful first and foremost in reducing the financial burden on local host organizations, as state agencies can license the Medicare Minute materials and distribute them to a number of local organizations within the state. Statewide programs will also streamline the distribution process for Medicare Rights.
- 2. Determine extent of Medicare Rights support for host organizations.** It would be beneficial to consider the type and level of initial and ongoing support that Medicare Rights can feasibly provide to new host organizations, given Medicare Rights' staff capacity and the potential of an increasing number of states taking on the SOS program. Host organizations suggested that it would be useful to discuss and troubleshoot potential challenges before launching the program.
- 3. Link new and experienced host organizations.** In determining how to best support new host organizations, Medicare Rights might consider organizing a mentorship arrangement whereby new hosts are linked with established SOS programs for support with program initiation and management. Medicare Rights might also consider videotaping Westchester presentations and otherwise digitalizing presentations to share with new host organizations.
- 4. Consider flexibility in program design and implementation.** Medicare Rights should promote the core components of the Medicare Minute program as identified in this evaluation. At the same time, Medicare Rights should consider how much flexibility to allow host organizations and volunteers in implementing the program structure and the Medicare Minute presentations. For example, Medicare Rights might communicate aspects of the program that should not be changed, as well as aspects that can be adapted in different contexts.
- 5. Solicit feedback from host organizations and participants.** Medicare Rights already seeks input from SOS host organizations and volunteers around the year's Medicare Minute topics, and this should continue. Medicare Rights may also wish to test Medicare Minute formatting and complexity more rigorously, for instance through focus groups, to ensure that they are most effectively reaching diverse audiences.
- 6. Explore program challenges in rural areas.** Because many states looking to adopt the Medicare Minute have large rural populations, it would be beneficial for Medicare Rights to explore the challenges to rural program implementation before encouraging others to take on the program in a rural area.

B. Recommendations for Host Organizations

Program Structure and Management

- 1. Seek program support at statewide and local levels.** Host organizations operating at a local level should consider encouraging their state SHIP to adopt the Medicare Minute program, in order to centralize the management of the program and reduce the financial burden on local host organizations. For SOS programs that will be operating in multiple organizations, it is also crucial to reach out to local staff to gain their support for the program—and to designate local SOS coordinators. Local buy-in may be achieved by promoting the benefits of the program for the host organization itself, for volunteers, and for seniors in the community. At the same time, it is important to openly acknowledge and plan for challenges related to funding and staffing that host organizations may face.
- 2. Identify appropriate program locations.** It is important to consider how well the Medicare Minute model fits in different geographic areas and communities. For example, based on the experiences of grantee states, the program model may be better suited to locations with greater population density. For many host organizations, it could be advantageous to start small, identifying a targeted region or regions and identifying program successes and challenges before expanding to a wider area.
- 3. Ensure access to referral services.** It is essential that volunteers are able to refer audience members to individualized assistance (e.g., a helpline or one-on-one counseling).
- 4. Incorporate management duties into job descriptions.** Including responsibilities related to SOS program management in staff job descriptions can help institutionalize the program in the future.

Site Engagement

- 5. Determine sites that are appropriate for the Medicare Minute.** The Westchester experience suggests that presentation sites with regular monthly meetings are most conducive to the Medicare Minute. It is also important to ensure that the content and complexity of information provided is appropriate for sites' members. Program coordinators may benefit from pursuing existing relationships and also encouraging volunteers to identify sites that may be interested in offering the Medicare Minute. Ideally, sites should also be evaluated periodically to ensure that they remain a good fit for Medicare Minute presentations.
- 6. Expand to other types of sites.** While senior centers may currently be the most suitable venue for a monthly Medicare Minute, interviewees suggested that host organizations consider reaching out to other types of venues, including those listed below, particularly since Baby Boomers and those newly eligible for Medicare do not necessarily visit senior centers. Several states, including New York, have implemented presentations in churches or housing sites, though these have often been one-time presentations, rather than the monthly Medicare Minute.

- Places of worship
- Large employers (e.g., plants)
- Aging in Place communities
- Senior clubs (e.g., book clubs)
- Places where adult children of seniors congregate
- Places where younger seniors congregate
- Senior housing
- Large medical groups
- Libraries
- Waiting rooms of doctor's offices serving seniors

Volunteer Recruitment, Training, and Support

- 7. Ensure that volunteers are committed to their role and properly trained and supported.** It is essential that volunteers are aware of the intensive nature of the volunteer opportunity and that they understand and feel comfortable with the public speaking requirements. It is also important that volunteers feel a sense of loyalty to the SOS host organization, in order to promote accountability in their role. New volunteers must also be adequately trained in Medicare. Ongoing monthly support in preparing for the presentations is also key, and states should ensure that volunteers participate in monthly updates. For programs that are geographically spread out, coordinators might consider holding in-person meetings broken down by geographic area, rather than one large conference call, in order to achieve a greater sense of camaraderie among volunteers. Volunteers should also have access to a staff member who can respond to Medicare-related questions; if the host organization does not have sufficient Medicare expertise, Medicare Rights can serve as the referral.
- 8. Consider accepting volunteers who are not seniors.** While there may be drawbacks to a non-peer model in terms of being able to draw on one's personal experience with Medicare, adult volunteers under age 65 seemed to be well received in Westchester.
- 9. Partner with outside organizations to assist with volunteer recruitment.** For example, in Maine the state SHIP has been able to work with AARP to promote the Medicare Minute volunteer opportunities among their members. In Westchester, the SOS program has worked with the local United Way to identify new volunteers.
- 10. Incorporate a mentorship component.** Volunteers should observe a skilled presenter before beginning as a presenter on their own. Initially this might be a SHIP/AAA staff person, and in the longer-term can be experienced volunteers. Volunteers can also offer social support to one another and it may be beneficial to set up an email list or group for volunteers to share information and experiences among themselves.

VII. Appendices

Appendix A: Medicare Minute Program Logic Model

Appendix B: Interviewee Characteristics

Appendix C: Volunteer Interview Guide

Appendix D: State Coordinator Interview Guide

Appendix A: Medicare Minute Program Logic Model

Inputs	Outputs		Outcomes		
<i>(What we invest)</i>	<i>Activities (What we do)</i>	<i>Participation (Who we reach)</i>	<i>Short-Term (Short-term results)</i>	<i>Medium-Term (Medium-term results)</i>	<i>Long-Term (Ultimate impact)</i>
<ul style="list-style-type: none"> • Medicare Rights staff • Medicare Rights volunteers • Medicare Minute host organizations • Medicare Minute materials • Medicare Rights budget • Energy, enthusiasm and depth of understanding of Medicare law • Relationships with host organizations 	<ul style="list-style-type: none"> • Development of Medicare Minute presentations and scripts • Volunteer recruitment • Monthly volunteer trainings • Volunteer update meetings • Monthly Medicare Minute • Volunteers and staff supervision • Review of program activities and participant satisfaction • Facilitation of peer interaction • Engagement of staff, volunteers & audiences • Partnership development • Communication with media 	<ul style="list-style-type: none"> • Volunteers • Audience members • Host organizations • Community leaders • Local businesses, hospitals, elected officials & media 	<ul style="list-style-type: none"> • Continued volunteer engagement and satisfaction • Continued audience member engagement and satisfaction • Continued host organization engagement and satisfaction • Increased Medicare literacy among volunteers and audience members • Consistency in Medicare Minute programming across volunteers and sites 	<ul style="list-style-type: none"> • Increased volunteer retention and satisfaction • Increased audience information retention • Increased audience participation in Medicare Minute • Increased involvement of audience members and volunteers in Medicare policy advocacy • Engagement of younger, disabled individuals in Medicare Minute • Development of a common philosophy and language regarding educating seniors • Replication of Medicare Minute at other sites 	<p><i>Program-Level</i></p> <ul style="list-style-type: none"> • Standardization of a common philosophy and structure for Medicare Minute • Consistent implementation of the Medicare Minute program across multiple sites • Medicare Minute able to exist as standalone program <p><i>Participant-Level</i></p> <ul style="list-style-type: none"> • Increased Medicare literacy and empowerment • Improved health self-management skills • Improved health <p><i>Policy-Level</i></p> <ul style="list-style-type: none"> • Sustained policy advocacy by volunteers and audience members • Policy-level change

<p>Assumptions</p> <ul style="list-style-type: none"> • Seniors want information about Medicare • Host organizations are willing to have monthly presentations • Funding remains available
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<p>External Factors</p> <ul style="list-style-type: none"> • Changes in organization leadership • Staff and budget constraints • Changes in political landscape • Life events impacting the degree of volunteer/audience participation

Appendix B: Interviewee Characteristics

Interview number	Gender	Number of years with SOS program
Vol 1	Female	4
Vol 2	Female	10
Vol 3	Female	12
Vol 4	Female	10
Vol 5	Female	2
Vol 6	Female	6
Vol 7	Female	7
Vol 8	Female/Male couple	10
Vol 9	Male	11
Vol 10	Female	5
Vol 11	Female	12
Vol 12	Male	9
Vol 13	Female	6
Vol 14	Female	Less than 1
Vol 15	Female	Less than 1

Appendix C: Volunteer Interview Guide

Medicare Rights Center Seniors Out Speaking Evaluation Volunteer Interview Guide

Thank you very much for speaking with me today. My name is _____, and I am working with the Medicare Rights Center on an evaluation of the Seniors Out Speaking Medicare Minute Program. As you may know, the Medicare Minute program has already been expanded to several other states around the country, and the Medicare Rights Center is interested in expanding the program even further. As part of that process, we are conducting an evaluation of how the program has been implemented in Westchester – and we're particularly interested in talking with volunteers about your experiences, including how and why you began volunteering, lessons you have learned as a result of your participation, and advice you would offer to someone who is considering becoming a volunteer with the SOS program.

I want to emphasize that this interview is not intended to evaluate your performance as a volunteer, but to have an open conversation about your experiences with the program. If you don't feel comfortable answering some of the questions, please just let me know and we will skip them. You can also end the interview at any point. I also want to assure you that everything said here is confidential. Your responses will only be shared with members of the research team. We will be writing a report that summarizes everyone's comments, but we will not identify you by name.

Also, I would like to ask your permission to tape record our conversation so that I do not miss anything you have to say – the recording will not be shared with anyone outside the research team, and we will erase it after we complete our report. Is that ok?

Do you have any questions about the interview or the evaluation before we begin?

Background and Initial Engagement

1. To get started, I'd like to hear a little bit about how you came to be a volunteer with the SOS program.
 - a. How did you first learn about the SOS program?
 - i. Who, if anyone, was involved in getting you on board? (Medicare Rights staff, friend)
 - b. Why did you decide to become an SOS volunteer?
 - c. Once you decided to volunteer, what was the process of becoming a volunteer? (interview, training, etc.)
 - d. Do you volunteer with other programs in addition to the Medicare Minute?
 - i. Do you volunteer with other programs specifically through Medicare Rights? (e.g., Health Advocacy Players, library-based counseling)
 - e. Had you previously been involved in any other activities or efforts for seniors? (e.g. activities with a seniors group, advocacy efforts?)

- f. What, if any, kind of Medicare knowledge did you have prior to becoming a volunteer?
- g. What, if any, kind of teaching experience did you have prior to becoming a volunteer?

Training & Support from Medicare Rights

- 2. Now I'd like to hear a bit about the training and support you have received from the Medicare Rights Center as a volunteer.
 - a. When you first started as a volunteer, what type of training did you receive from Medicare Rights?
 - b. Since you began volunteering, what type of ongoing support have you received from Medicare Rights? (e.g., availability for phone calls/emails with questions)
 - c. What has been your experience with the volunteer update meetings?
 - i. Content of the meetings, level of information provided
 - ii. Structure of meetings
 - d. Is there any additional support from Medicare Rights that would be useful for you?

Implementation

- 3. Can you tell me a little bit about the site where you present?
 - a. Type of organization
 - b. Size of audience
 - c. Composition of audience (demographics; consistent vs. changing members)
 - d. Relationship with site director
 - i. What components do you think are necessary for a smooth relationship with an MM site?

Now I'd like you to think about a typical Medicare Minute that you lead...

- 4. Can you walk me through the format of a typical session that you lead? (e.g., introduction, presentation, question and answer period)
- 5. In what areas have you adapted the MM to your audience (added your own personal touch)?
 - a. Why did you make those changes?
- 6. What skills do you rely on most when carrying out the MM presentation?
 - a. What are the most important skills for a MM volunteer to have?
 - b. Are there any additional skills you feel would help you as a presenter? (E.g., public speaking, managing group dynamics, facilitating question and answer, greater Medicare knowledge)
 - c. When you go to present the MM, how comfortable do you feel with your level of Medicare knowledge?
- 7. What advice would you offer to a friend who was considering becoming a volunteer?

Continued Engagement/Retention

8. Do you anticipate continuing to volunteer over the next year? What about over the longer term?
 - a. If yes, why do you continue to volunteer? (e.g., rewarding, impact on others, personal connection to other volunteers or audience members)
 - b. If not, why not?

Core Components

9. Stepping back to think about the MM program as a whole, in your view, what makes the Medicare Minute program “work”?
 - a. What are the components that make the program have an impact? (e.g., the actual information presented, the fact that it’s presented by a peer, the fact that it’s short, the opportunity for question and answers)
 - b. What topics have been the most useful for audience members?
 - c. Are there any aspects of the Medicare Minute that have been more challenging for you?
10. “Magic Wand” question: if you could change two things about the SOS Medicare Minute program what would you change and why?
 - a. *Probe:* This can include the material, the format, or the training you receive – e.g., covering additional/different topics, length/format of session, level of training and support, etc.

Expansion

11. As we discussed, the Medicare Rights Center plans to expand the Medicare Minute program to additional states. Are there certain geographical locations, audiences or types of sites where you think the MM would be more or less appropriate?
 - a. *Probes:* What advice would you give to the Medicare Rights Center about recruiting volunteers; training volunteers; forming relationships with MM sites (types of sites, composition of audience); retaining volunteers over the long term?
12. Do you have any other recommendations for the structure or format of the Medicare Minute program?

Thank you very much for your valuable time – is there anything more you would like to add about your experience as an SOS volunteer that we haven’t covered?

If I have some brief follow-up questions after the interview, would it be ok to call or email you?

As a small token of appreciation to thank you for your time, we will also be giving you an Amazon.com gift card – which will be sent by email in the next couple days.

Appendix D: State Coordinator Interview Guide

Medicare Rights Center Seniors Out Speaking Evaluation State Coordinator Interview Guide

Thank you very much for speaking with me today. I would like to talk with you about your experiences implementing the Medicare Rights Center's Seniors Out Speaking Medicare Minute Program. Specifically, as the Medicare Rights Center makes plans to expand the Medicare Minute program to additional states, I am interested in learning more about your experience getting the program up and running in [state], specific successes and challenges you have experienced with implementation, and any advice you would offer to someone who is considering starting the Medicare Minute program in their state.

We will ensure that any information we include in our report does not identify you or the state you work in by name. Do you have any questions before we begin?

Introduction

1. To start off, can you tell me briefly about [organization's] mission and main activities, what your role is at [organization], and how long you have been in that role?

Initial Engagement

2. How did your organization first find out about the Medicare Minute program and decide to implement it?
 - a. Did Medicare Rights reach out to you? Did you reach out to them?
 - b. Why did you ultimately decide to implement the Medicare Minute program (i.e. to build volunteer capacity? Outreach to older adults? Possibility of securing long-term funding?)
 - c. What were some of your hesitations, if any, around deciding to implement the program?
 - d. How did you rally your organization around the idea of implementing a new program? Was your organization in support of the Medicare Minute program initially?

Implementation

3. When did you begin implementing the SOS program?
 - a. How many sites do you currently have? Is this the "right" number? Do you plan to expand further?
 - b. Our records show that you have [XX] volunteers in your state. Do you feel like this is the "right" number? Do you plan to recruit more volunteers?
 - c. Our records show that last month you reached [XXX] audience members. Is this more or less than you expected? How many do you hope to reach?

4. What has the process of implementing the program been like?
 - a. Overall, what has the process been like? What about it has been easiest and what has been most challenging?
 - b. At what point did you experience the biggest challenges? (e.g., when the program was first getting started? Getting buy-in from staff? Recruiting volunteers? Finding sufficient time to manage the program?)
 - c. Do you consider your Medicare Minute program fully implemented? If yes, how long did it take before you considered your Medicare Minute program to be fully implemented?
 - i. Has this process taken more or less time than you expected?

5. Have there been changes in how the program has been implemented over time?

6. Now I'd like to ask you about the sites that are currently implementing the SOS program...
 - a. What was the process of recruiting sites like? Did you already have an existing relationship with the sites you recruited? How did you reach out to sites? Did you generally experience that sites were enthusiastic? Skeptical?
 - b. What are the characteristics of your sites – urban/rural, small/large?
 - c. What, if any, kinds of assistance do you provide sites that host Medicare Minutes? (e.g., promoting the program, providing back-up counseling, etc.)
 - d. From what you know, is the Medicare Minute program implemented in the same way at all of your sites, or have some sites made modifications to the format of the program? (e.g., frequency of presentations, content, materials used, presentation format)
 - i. If modifications have been made, why?

7. Now I'd like to talk a bit about your volunteers...
 - a. What was the process of recruiting volunteers like? Did you already have an existing relationship with the volunteers you recruited? How did you recruit people? Was it easy or difficult?
 - b. What are the characteristics of your volunteers – older/younger, employed/retired, racial/ethnic background?
 - c. What, if any, kinds of assistance do you provide to volunteers (e.g., training, back-up counseling support, financial incentives, etc.)
 - d. From what you know, do all volunteers implement the Medicare Minute in the same way, or have some volunteers made modifications to how they deliver the presentations? (e.g., presentation style, format, materials used)
 - i. If modifications have been made, why?

Retention/Support

8. What kind of support have you received from the Medicare Rights Center? (e.g., materials, technical assistance)
 - a. What implementation materials (i.e. talking points, orientation slides, coordinator's guide) from the Medicare Rights Center did you find most helpful?

- b. Which implementation materials did you find least helpful?
 - c. Where there any materials you did not have that looking back would have been helpful in implementation of your Medicare Minute program?
9. Would you say the level of support you have received from the Medicare Rights Center has been just right, not enough, or too much?
10. How, if at all, could the Medicare Minute program be more responsive to your needs?

Core Components/Satisfaction

11. Thinking back to before you began implementing the Medicare Minute program, how, if at all, has your perception of the program changed over time?
12. What do you value most about the Medicare Minute program?
13. Is there anything that you would change about the Medicare Minute program?
14. Is there anything that you know now that you wish you knew when you began implementing the program?

Sustainability

15. How does the Medicare Minute program support your organization's mission?
- a. How does it fit in with your other activities?
 - b. What has been the response of other staff/administration to taking on this program?
 - c. Has it helped you promote your own services? Increase access to additional funding?
16. Do you envision wanting to sustain the Medicare Minute program beyond your contract period?
- a. If not, why not?
 - b. If so, what challenges do you foresee? (e.g., funding, staff time, support from administration, retaining volunteers)
17. If you had to put a dollar value on the Medicare Minute program for one year, including implementation materials, 12 months of Medicare Minute materials, opportunity for volunteer and community engagement, access to Medicare knowledge, etc., what would that dollar value be?

Expansion

18. Would you recommend that the Medicare Minute program be expanded to other states? Are there certain locations or conditions that would be more/less appropriate for the Medicare Minute program? What advice would you offer to others wishing to implement the program?

Thank you very much for your valuable time – is there anything more you would like to add?