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Medicare-Centered Curriculum For Limited English Proficient Beneficiaries

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MEDICARE-CENTERED CURRICULUM FOR LIMITED ENGLISH PROFICIENT BENEFICIARIES

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CHAPTER ONE

Introduction

In 2017, my retired father had major surgery. While at the hospital, we went to the pharmacy to pick up his prescriptions before he was discharged. After my mom picked up the prescriptions, she was visibly upset, their Medicare insurance card had been rejected and she had to pay $90 out of pocket. Having worked in the healthcare industry I knew my parents' Medicare coverage, co-payments, co-insurance, deductibles and I knew the hospital was "in their network." I intervened on my mom's behalf with the pharmacy staff. After 45 minutes, four phone calls and three people, the staff recognized a mistake on their end and refunded my mom $82. We all said, "it was a good thing someone knows something about Medicare, what would we have done if you didn't?" And then it occurred to me: what do new Americans and those who do not really understand the healthcare system do?

In a related aside, in working as an English as a Second Language (ESL) teacher for adults, I noted that often the curriculum includes materials about getting a job, advancing a student's educational goals or subjects related to working; however, I wondered how we assist new Americans to increase their knowledge of healthcare resources. The underlying question for this project is: *What might an instructional healthcare curriculum for limited English proficient (LEP) adults who are retiring look like?*

In this chapter, I note my involvement with insurance, and explain my background within the healthcare environment as well as my experiences related to teaching adults. I provide a brief overview of Medicare, why it was created, its membership, and what services it covers/provides. I briefly overview some of the difficulties Medicare members

experience including LEP adults. I will conclude this chapter with my concerns as a teacher for adult, LEP students who are moving into retirement age and the need for community-based language instruction programs directed at a Medicare-centered curriculum. I also provide an overview of Chapters 2, 3 and 4.

My Introduction to Health Insurance

In 1981, I left home after a one-year course at a local vocational college to learn legal secretarial skills. I was thrilled to be offered a job at an insurance brokerage firm. While I did not understand the information I was typing, I was efficient at processing what came across my desk. I continued at the insurance firm for three years and while I remember some of the terms were similar to my car insurance, I did not put the pieces together. Through the years, I continued seeking jobs in different industries where I could learn new skills. Along the path, I maintained health insurance, car insurance and renters insurance, but in truth, I did not understand any of them. At one point, I went to an urgent clinic and when asked to submit my insurance, I put the bill on a credit card, because I did not understand my health insurance coverage.

In the late-1980's I moved to working within the healthcare industry and started to learn more about the different types of healthcare insurance available through my employer. I am now aware that while my knowledge of health and health insurance was better, it was still lacking. This category of knowledge is often referred to as health literacy. My lack of health literacy is not uncommon. Numerous studies and research have shown that Americans lack health literacy (Baker et al, 2002; Kutner, Greenberg, Jin & Paulsen, 2003; Young, 2004).

For the purpose of my capstone, I am using the definition provided from the United States Department of Health and Human Services (HHS) website wherein they described health literacy as an individual's capacity to find, communicate and work with as well as understand basic health information and services needed to make appropriate decisions regarding health (HHS, Health Literacy, para. 3).

Changing Professions

I had always wanted to be a teacher and to this end, I received a Teaching English as a Foreign Language (TEFL) Certificate through Hamline University and joined the U.S. Peace Corps assigned to Mongolia for two years. Subsequently, I moved to Beijing, China and taught adults at large international corporations for another four years. While my first classes were admittedly haphazard and had little substance, my lesson planning and presenting improved and I found working adults connected best when they could use the information being taught. The experience was extremely rewarding and worthwhile as I felt I was directly impacting adults' achievements and advancements in their work lives.

The Researcher Today

Today finds me again working in the healthcare industry where I have become more knowledgeable of health insurance and I have recently had opportunities to broaden my knowledge of Medicare. As I watch my parents age and as I consider my options for how I will age, Medicare has become increasingly important to my life and those around me. As Medicare is the primary health insurer for retiring Americans, it is incumbent that I remain cognizant of its services. While I continue my career within the healthcare industry, I am volunteering with different organizations to teach adults who are primarily LEP Americans.

These adult-focused classes often are coordinated through organizations like the Minnesota Literacy Council ("Students," n.d.). Because of the complexities of Medicare and its powerful impact on retirement, I am concerned about LEP adults' ability to understand and navigate the system. Below is a brief overview of Medicare and its impact on retirees.

Author's note: To avoid ageist language the following terms are used throughout: retiree or people (over age 65), individual(s) (over age 65), beneficiary has been used for individuals with Medicare coverage. Other terms have been used only when in the context of direct quotes from sources.

Background on Medicare

Medicare History and Population Covered

Medicare health insurance benefits were signed into law on July 30, 1965 by President Lyndon Johnson (Centers for Medicare & Medicaid [CMS] "History," n.d.). Medicare's goal is to provide health insurance to retiring individuals and has been extended to include those with disabilities and kidney disease i.e. end stage renal disease (ESRD) (Davis & Burner, 1995).

Services Medicare Offers

Medicare is an insurance product that covers hospital insurance, Part A, and supplementary medical insurance, Part B (Davis & Burner, 1995). More specifically, Part A covers inpatient hospital services, skilled nursing facility care, home health care, and hospice care (added later). Part B covers physician services, durable medical equipment, outpatient medical services, and it has been extended to include preventive services (Davis & Burner, 1995, p. 231).

Medicare Eligibility

Medicare eligibility does not have a straightforward definition. There are a number of criteria to meet Medicare eligibility and, depending on circumstances, some Parts of Medicare are free and others require a premium. For purposes of this capstone, I am primarily interested in those individuals who may be permanent residents who have worked in the U.S. for 10 years or longer whose first language is not English and may be considered LEP. Pursuant to their website, HHS states:

- You are eligible for premium-free Part A if you are age 65 or older and you or your spouse worked and paid Medicare taxes for at least 10 years…
- If you (or your spouse) did not pay Medicare taxes while you worked, and you are age 65 or older and a citizen or permanent resident of the United States, you may be able to buy Part A. If you are under age 65, you can get Part A without having to pay premiums if… (HHS, "Who is eligible for Medicare?" n.d.)

Thus, one can see that Medicare's eligibility is not clearly defined, but has a number of nuances that make understanding difficult.

Member Understanding of Medicare

While Medicare has an immense impact on retirees' lives including what they pay for healthcare and what is covered by their health insurance, data shows there is a high level of confusion or misunderstanding about Medicare. On their website, Medicare Made

Clear™ (brought to you by United HealthCare®), they stated the following from the Medicare Made Clear Index:

- 7 in 10 baby boomers say they have a fair or poor understanding of Medicare
- 1 in 5 Medicare beneficiaries describes Medicare as confusing
- Most can't identify what Medicare Parts A, B, C and D cover
- 62% of those eligible have never shopped for Medicare coverage to fit their needs ("Did you know," 2013)

If the above statistics represent all retirees, then I wondered what LEP adults were to do to understand Medicare. I discovered that to ensure LEP beneficiaries are ensured coverage and care with Medicare the HHS' Office of Civil Rights mandates that services or materials are translated or interpreters are available (HHS, "Limited English Proficiency," n.d). This said, research shows LEP Medicare members have low health literacy and corresponding health disparities. LEP members face health vulnerabilities, do not have a usual source of care, have difficulty accessing and communicating about their care, and often do not receive care that is guaranteed to them with Medicare, especially in the form of preventive care (Jang, Yoon, Park, & Chiriboga, 2016; Ponce, Ku, Cunningham, & Brown, 2006).

Coming Full Circle: Healthcare and Teaching

In reviewing the statistics for Medicare-eligible adults in general and LEP beneficiaries specifically, I remain concerned that LEP adults who are retiring do not have the health literacy to understand the Medicare system. To this end, I believe that a

curriculum needs to be designed to provide lessons on Medicare and other resources that are available to LEP members.

Summary

In Chapter 1, I explained my background and experiences within the healthcare environment and teaching adults. I provided a brief overview of my lack of health literacy and overall information for Americans' lack of health literacy. I gave a brief historical overview of Medicare as well as eligibility, services, and areas of difficulties and my concerns related to LEP members who access the Medicare system. In Chapter 2, I review the Medicare program; communication mandates; laws and practices, especially those services/materials for LEP members; and finally, community-based adult education opportunities. In Chapter 3, I explain the curriculum project and intended audience and in Chapter 4 I summarize major lessons learned for me. Chapter 4 also delves into a review of the literature, implications, limitations, relevant next steps and my final analysis of the project.

CHAPTER TWO

Literature Review

As of this writing in 2018, there are calls for Medicare-for-All plans (Ghilarducci, 2018), where a single national health insurance program provides health insurance to all citizens of the U.S. The idea of universal healthcare has been on the American agenda for over 100 years. As a result of negotiation, public opinion and legislation, Medicare, health insurance for individuals 65 and older, was signed into law in 1965 (CMS, "History," n.d.). This literature review provides a brief history of Medicare, its services, funding and growth. The following sections will explore how Medicare is communicated, provisions for limited English proficient (LEP) beneficiaries, the struggles of LEP beneficiaries accessing Medicare and the healthcare system as well as a lack of educational opportunities for LEP beneficiaries to learn about Medicare. The section will cover elements necessary to answer the question: *What might an instructional healthcare curriculum for limited English proficient (LEP) adults who are retiring look like?*

Medicare Background

Medicare History

In 1915-1918 reformers promoted the idea of universal healthcare in the U.S.A.; however, their attempts failed as the idea did not catch on (Marmor, 2000; Oberlander, 2013, as cited in Oberlander, 2015, p. 1). Starr (as cited in Oberlander, 2015, p. 1) pointed out the concept of national health insurance was not brought up again until it resurfaced during the New Deal era. In 1935, the Social Security bill contained a single line sanctioning the study of health insurance (Oberlander, 2015). Because President Franklin

Roosevelt feared that one line could jeopardize the entire Social Security bill, he had it deleted (Marmor, 2000). In the years following, advocates within the Truman Administration proposed a modified strategy but it again never gained traction.

Rather than a universal health insurance program, advocates decided to focus on care for people 65 and older. Moon noted that in 1962, three years before the ratification of Medicare, 47% of families of 65-year olds lived below the poverty line (as cited in Oberlander, 2015). Marmor also noted that only about half of Americans age 65 and older had any health insurance coverage and those who did could only receive limited benefits (as cited by Oberlander, 2015). Health insurance was provided as a part of work. Once people retired, they had a difficult time obtaining and paying for insurance as health insurers felt the group was too big of a risk to insure and subsequently charged large premiums (Marmor, 2000). For these reasons, Medicare advocates leaned to the public's sympathy for this group as a focal point for their advocacy (Oberlander, 2015). Since people 65 and older had no resources, their healthcare became the financial burden of families (Marmor, 2000).

It was not until 1965 that Lyndon Johnson was able to sign into law Medicare, health insurance for individuals 65 and older (Marmor, 2000). The Centers for Medicare & Medicaid Services (CMS), an agency under the umbrella of The U.S. Department of Health and Human Services (HHS), administers the Medicare program ("HHS Organizational Chart," n.d.). Through the years, Congress has expanded the grounds for who may obtain Medicare to include the disabled under age 65, those with end-stage renal disease (ESRD), and those 65 and older who have chosen to select and pay for Medicare coverage (CMS, "History," n.d.).

Programs and Services Covered

According to Davis and Burner (1995), Medicare was originally split into two separate sections to match benefit packages available from private insurance companies at that time: Part A, Hospital Insurance and Part B, Supplementary Medical Insurance. These two parts are referred to as Original Medicare (CMS, "History," n.d.). Davis and Burner (1995) further described the differences of each Medicare Part:

> Part A covers inpatient hospital services, skilled nursing facility care, home health care, and hospice care for terminally ill beneficiaries…Part B covers physician services, durable medical equipment, outpatient medical services such as lab tests, physical and occupational therapy and ambulance transportation and preventive services. (p. 231)

Because Medicare does not cover all services for beneficiaries, gap, supplemental, or private-payer programs were offered (Oberlander, 2015). As a supplement to Original Medicare, beneficiaries can choose to purchase a Medigap or Medicare Supplement Insurance plan to cover the "gaps" of Original Medicare. Medigap plans are standardized across the nation and available from private insurers (Medicare.gov, "Medicare Advantage Plans," n.d.). In 2003, the Medicare Prescription Drug Improvement and Modernization Act (MMA) allowed private health plans to offer Medicare Advantage (MA) or Part C plans (CMS, "History," n.d.). These private health plans are approved by Medicare and cover both Parts A and B and in most plans, Medicare Part D, prescription drugs (Medicare.gov, "Medicare Advantage Plans," n.d.). If enrolled in a Medicare Advantage plan, the beneficiary pays the plan and the beneficiary must use the network of participating hospitals

and doctors within the prescribed network. Further, in 2006 an optional prescription drug benefit, called Part D, was initiated (CMS, "History," n.d.; Moon, 2006). Part D covers only prescriptions and is purchased in conjunction with other plans (e.g. Original Medicare and a Medigap plan or as part of a Medicare Advantage Plan). Original Medicare does not cover beneficiaries in the areas of hearing aids, dental services and eyeglasses (Davis & Burner, 1995). Some of the MA plans have value-added services or discounts to cover these healthcare needs (Medicare.gov, "Medicare Advantage Plans," n.d.).

Medicare beneficiaries need to be mindful of what combinations of plans are allowable and which are not. Table 1 lists combinations of plans that are permissible and those that are not (K. Greiner, personal communication, January 31, 2019).

Table 1

Medicare Plan Options: Combinations Available to Beneficiaries

Original Medicare (only)
Original Medicare plus Part D
Original Medicare plus Medigap
Original Medicare plus Medigap plus Part D
Medicare Advantage (only)
Medicare Advantage plus Part D

Combinations that Are Not Allowed and Not Available for Purchase

Original Medicare plus Medicare Advantage
Original Medicare plus Medigap plus Medicare Advantage
Medigap plus Medicare Advantage
Medigap plus Medicare Advantage plus Part D

In addition to different types of Medicare plans, beneficiaries need to be mindful of the unique offerings within each Medicare Advantage plan. Table 2 illustrates a detailed listing of some of the differentiators of the plans (Medicare.gov, "Medicare Advantage Plans," para. 3; K. Greiner, personal communication, December 4, 2018).

Table 2

Medicare Plan Offerings

Medicare Advantage Plan	**Unique/Special Features**
Health Maintenance Organization (HMO)	A beneficiary can only go to the network of doctors, healthcare providers and hospitals within the HMO's group for routine services. If there is a Point of Service (POS) Option, the beneficiary can go to out-of-network providers for a higher out-of-pocket cost.
Preferred Provider Organization (PPO)	Beneficiaries pay less if they go to doctors, healthcare providers and hospitals that belong to the PPO's network. Beneficiaries will pay more if they go to other healthcare providers outside this network.
Private Fee-for-Service (PFFS) plan	These plans have provider networks, but it is the beneficiary's responsibility to ensure the provider will accept the terms of payment each time they are seen. Otherwise, the beneficiary could be liable for all costs.
Medigap	**Unique/Special Features**
	As of this writing (2018), there were 10 CMS-approved, different Medigap plans available to beneficiaries nationwide. This does not apply in Minnesota as there are only three types of plans: Basic (with or without riders), Extended Basic and Medicare SELECT.
Part D, Prescription Drugs	**Unique/Special Features**
	Part D plans can be purchased as a stand-alone program to be used in conjunction with another plan or they can be part of a Part C Medicare offering, also known as Medicare Advantage Prescription Drug (MAPD) plans.

Medicare Funding

Each Medicare coverage option is funded differently and beneficiaries need to be mindful that some Medicare plans require additional out-of-pocket expenses when they are choosing Medicare options. Table 3 illustrates Medicare options and their funding. Part A

services are funded primarily through payroll taxes paid by employers and employees (Kaiser Family Foundation, "An Overview of Medicare," n.d.). Beneficiaries who are over age 65 and are eligible for any type of Social Security are automatically enrolled in Part A. Even those who are not automatically entitled to Part A may purchase Part A with a monthly premium (Davis & Burner, 1995). Part B is funded through a combination of beneficiary premiums and general revenues (Kaiser Family Foundation, "An Overview of Medicare," n.d., Oberlander, 2015). Part B is voluntary and is available to all Part A beneficiaries and most Americans age 65 and older (Davis & Burner, 1995). Part C or Medicare Advantage plans are offered by private companies and beneficiaries pay monthly premiums for supplemental benefits that are covered by the Medicare Advantage plan in addition to the Part B premium (Kaiser Family Foundation, "An Overview of Medicare," n.d.). Finally, according to the Kaiser Family Foundation website, "An Overview of Medicare," Part D plans are financed "…through general revenues, beneficiary premiums, and state payments" ("How Medicare is financed," para. 5).

Table 3

Funding Options for Medicare Programs

Original Medicare		**Medicare Advantage**		**Other Medicare Options**	
Part A	**Part B**	**Part A**	**Part B**	**Medigap**	**Part D, Prescription Drug**
Part A is usually funded by payroll taxes that have already been paid by the employee and employer (Kaiser, p. 20) Or Part A can be purchased individually through the government if a person does not qualify (Davis & Burner, 1995)	Members pay the government.	Part A is usually funded by payroll taxes that have already been paid by the employee and employer (Kaiser, p. 20)	MA enrollees need to pay the Part B premium plus an additional premium. Beneficiaries pay a private insurer	Beneficiaries pay a private insurer	Beneficiaries pay a private insurer or the amount can be deducted from Social Security. Part D can be included in MA (MAPD).

Options to beneficiaries. To guide people in choosing Medicare plans, the Minnesota Board on Aging's website provided "*Health Care Choices for Minnesotans on*

Medicare" wherein it listed five steps for Medicare beneficiaries that include: Enrolling in Medicare, Choosing Type of Medicare Coverage, Choosing Supplemental (Medigap) Insurance (for Original Medicare only), Choosing prescription drug coverage and reviewing Medicare health plan and Part D plan annually (MN Board on Aging, "Medicare Decisions," p. 30)

Parameters and Restrictions with Medicare

Beneficiaries need to understand the Parts of Medicare, providers of Medicare, plan offerings of Medicare, as well as their payment/funding choices. Further, beneficiaries need to be mindful of additional parameters and restrictions when choosing a Medicare option. These include the following:

- Beneficiaries could pay more if they miss the initial Medicare enrollment period
- Not all services/procedures may be covered "including long-term services and supports, dental services, eyeglasses, and hearing aids" (Kaiser Family Foundation, "An Overview of Medicare," n.d.)
- "…traditional Medicare has relatively high deductibles and cost-sharing requirements…" (Kaiser Family Foundation, "An Overview of Medicare," n.d.)
- "...[Traditional Medicare] places no limit on beneficiaries' out-of-pocket spending for services covered under Parts A and B" (Kaiser Family Foundation, "An Overview of Medicare," n.d.)
- HMOs, PPOs and PFFS have different provider networks
- HMOs, PPOs and PFFS have varying coverage options
- Part D, prescription drug, is voluntary

- Beneficiaries could pay more if they miss the enrollment period for Part D, prescription drug
- Not all drugs may be covered
- Beneficiaries can change plans during open enrollment (once per year)
- Once a beneficiary drops a Medigap policy (for a Medicare Advantage plan), they might have to go through underwriting before being accepted again for a Medigap plan (K. Greiner, personal communication, February 28, 2019 and Kaiser Family Foundation, "An Overview of Medicare," n.d.)

To sum up, Medicare, the health insurance product for individuals 65 and older, has different Parts. Within those Parts various options are available that a beneficiary may choose from and as an additional layer, those Parts are offered by different insurers. Further, Medicare beneficiaries need to understand how the different Parts of Medicare work together and are financed, who is responsible for paying for the different components and Parts, as well as the ramifications of their Medicare choices.

Medicare's Current Status and Future

While the idea of universal, national healthcare is continuing to be debated, Medicare remains one of the only options for healthcare insurance for those age 65 and older. As such, knowledge of Medicare services is critically important as people age. In 2018, the date of this writing, 60 million Americans are covered by Medicare, including those age 65 and older and the disabled (CMS, "Medicare Enrollment Dashboard," n.d.; Kaiser Family Foundation, "Medicare Quiz," n.d.). This is the equivalent of one in five or 20% of the population of the U.S.A. with approximately 10,000 people joining Medicare

each day (Kaiser Family Foundation, "An Overview of Medicare," n.d.). The Medicare population is expected to increase to more than 80 million beneficiaries in 2030 (Kaiser Family Foundation, "Projected change in Medicare," n.d.).

With the necessity of understanding Medicare as individuals retire as well as the enormity of the Medicare audience, the question arose: How does the federal government communicate to Medicare beneficiaries?

Communication of Federal Documents

Communication Practices

Among other responsibilities, CMS is tasked with communicating and administering a number of federally based programs. These programs encompass a diverse group of beneficiaries and it is imperative that CMS' information is accessible to all audiences. As an example, Medicare is administered by CMS on a national basis to 60 million Americans (CMS, "Medicare enrollment dashboard," n.d.). As a federal agency, CMS is bound to communication guidelines that meet the Plain Writing Act of 2010 (Medicare.gov, "plain writing," n.d.). Moreover, to ensure communications are user-friendly, CMS also provides information on their website on writing at the appropriate health literacy level for other healthcare providers or partners.

The Plain Writing Act and CMS. The Plain Writing Act was signed into law on October 13, 2010 ("plain language," n.d.) and "requires that federal agencies use clear government communication that the public can understand and use" ("plain language," n.d., para. 1). The law further stated government agencies should have reached the goal of plain writing to include internal training, procedures and staffing by July 13, 2011. Plain language

writing was to be in use and reported on annually starting October 13, 2011 ("plain language, deadlines" para. 2). As CMS is a federal agency, one assumes that information they provide meets these provisions. This was borne out at Medicare.gov's website that noted the actions taken to meet the Plain Writing Act as well as detailed information regarding the Plain Writing act (Medicare.gov, "plain writing," n.d.).

Definition of health literacy. In addition to Medicare, CMS also administers and oversees programs for low-income families via Medicaid and for children through the Children's Health Insurance Program (CHIP) (CMS, "Medicaid/CHIP," n.d.). To assist families, agencies, care providers and other partners in beneficiaries' care CMS' website contains an 11-part pdf communication toolkit (CMS, "Outreach and Education," n.d.). The toolkit provides partners with guidelines to ensure their writing is well designed, written for comprehension of a wide, diverse audience and provides strategies to ensure culturally appropriate translations (CMS, "Toolkit Part 01," n.d.). CMS noted the toolkits are not requirements but a guideline to assist organizations and people who may interact with beneficiaries in various capacities (CMS, "Outreach and Education," n.d.).

As a foundation for their writing guidelines, CMS' toolkit, part 1, noted the seminal study conducted by the National Adult Assessment of Literacy (NAAL) in 2003 (CMS, "Toolkit Part 1," pp. 3-4). In this study, NAAL measured health literacy as defined by the Institute of Medicare as well as objectives that the HHS labeled *Healthy People 2010* (as cited by Kutner, Greenberg Jin & Paulsen, 2003). The definition is as follows:

> The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. (Kutner, Greenberg Jin & Paulsen, 2003, p. iii)

The provisions of health literacy are complex and wide-ranging and include all facets of obtaining and interacting within the healthcare environment. This can include insurance, immunizations, appointments, services, medications, and meetings. The 2003 NAAL survey was structured to measure three areas: prose literacy, document literacy and a quantitative scale (CMS, "Toolkit part 1," p. 4). Scoring was based on a four-point scale of *Below Basic, Basic, Intermediate* and *Proficient* (as cited by Kutner, Greenberg, Jin & Paulsen, 2003, p. iv). Using these parameters, NAAL found that 36% of adults who took the survey were self-categorized as *Basic* or *Below Basic* in literacy skills (as cited by Kutner, Greenberg, Jin & Paulsen, 2003, p.v). Therefore, CMS makes a point to note that their toolkit is designed to assist the needs of individuals with a *Basic* level of literacy.

Health literacy and Medicare beneficiaries. Moreover, NAAL's seminal study on health literacy noted the following health literacy scores of Medicare beneficiaries: 27% *Below Basic*, 30% *Basic*, 40% *Intermediate*, 3% *Proficient* (as cited by Kutner, Greenberg, Jin & Paulsen, 2003, p. 18). This level of health literacy has been shown to adversely affect Medicare beneficiaries within the healthcare environment as well as their abilities in choosing healthcare options. Gazmararian et al. (1999) concluded that beneficiaries with lower health literacy may have challenges navigating a managed care Medicare environment. Further studies concluded that "health literacy is an independent risk factor for

hospital admission" (Baker et al., 2002, p. 1282) as well as decreased incidence of receiving preventive health services (Scott, Gazmararian, Williams & Baker, 2002).

In summary, the federal government mandated all federal agencies to adhere to the precepts of the Plain Writing Act. CMS, administrator of many Americans' healthcare services, met these provisions through various actions and personnel. In addition, CMS also noted the importance of communicating to the health literacy level of various beneficiaries within their programs and set up guidelines to assist in this effort. While these efforts have been taken, Medicare beneficiaries score lower on health literacy tests and have ensuing difficulties within the healthcare environment. The question then arose: What does CMS do to communicate Medicare to beneficiaries as they have a lower rate of health literacy?

Communication of Medicare

This section reviews the primary mechanism CMS uses to inform Medicare beneficiaries annually about Medicare as well as an analysis of this information. This is an important communication component as annually beneficiaries can choose various Parts of Medicare through either Original Medicare or private insurers during open enrollment from October to December (CMS, "Medicare open enrollment," n.d.). Prior to 2002, Medicare beneficiaries could change their Medicare choices monthly (McCormack, Garfinkel, Hibbard Norton, & Bayen, 2001). However, starting in 2002 Medicare beneficiaries could only make choices during the open enrollment period (Harris-Kojetin, McCormack, Jael & Lissy, 2001; McCormack, Garfinkel, Hibbard, Norton, & Bayen, 2001).

Background on the *Medicare & You Handbook*. In 1997 the Balanced Budget Act (BBA) brought changes to Medicare. One of which was the inclusion of Medicare+Choice

as a different avenue for how beneficiaries could receive services (Goldstein, Teichman, Crawley, Gaumer, Joseph & Reardon, 2001). In light of this change, CMS started the National Medicare Education Program (NMEP) in 1998 with multiple goals "to educate beneficiaries about their Medicare program benefits; health plan choices; supplemental health insurance; beneficiary rights, responsibilities, and protections and health behaviors" (Goldstein et al., 2001, p. 5). One of the key initiatives of NMEP was a redesign of the *Medicare Handbook* to the *Medicare & You Handbook* (Aruru & Salmon, 2010). Since 1999, CMS has mailed the *Medicare & You Handbook* to beneficiaries annually (Miller, 2018).

***Analysis of the* Medicare & You Handbook.** While the *Medicare & You Handbook* is updated and distributed each year, a number of studies have been conducted on its overall readability for Medicare beneficiaries especially noting their health literacy rates. In 2010, Aruru and Salmon analyzed the 2008 version of the *Medicare & You Handbook*. They used a Lexile Framework for Reading which generated a grade-level score based on sentence length and word frequency count. Of the 64 passages that they analyzed, nearly 30% (19 passages) scored at approximately a 12th-grade reading level. In addition, 70% of the *Handbook* scored between a 5th and 12th grade readability level (Aruru & Salmon, 2010, p. 313). It should be noted this analysis was conducted before the Plain Writing Act of 2010.

In 2011, an excerpt (section 3) of the *Medicare & You, 2011 Handbook* was analyzed by Bonk across various assessment techniques including readability, syntax, verb mood, content analysis and validated suitability of materials (SAM). Bonk's analysis concluded the *Handbook* contained an average sentence length of 15.4 words. When

calculated using a Flesch Reading Ease score, this made the document 'difficult' to read (Bonk, 2011, p. 181). Analysis of syntax and verb forms noted that a little over 20% of sentences were complex resulting in difficulty for comprehension. Further analysis showed that 33% used a conditional mood within complex sentences. As complex sentences combine independent and dependent clauses, they also "reflect relationships of time, outcome and other dependencies" and are thus more difficult to comprehend (Bonk, 2011, p. 181). The *Medicare & You, 2011 Handbook* was rated 'adequate' for suitability and received one 'superior' score for layout (Bonk, 2011, p. 183).

Finally, the *Medicare & You Handbook 2018* (HHS, 2017) was analyzed by measuring the number of words per sentence. Hill-Briggs, Schumann and Dike (2012) noted that text with a sentence length of less than 15 words corresponds to a 5th grade reading level (p. 295). Based on this formula of number of words per sentence, one could make the assumption that word counts of 20 or more would be difficult or cause incomprehensibility. Of the total sentences (2,245) analyzed, 532 contained 21 or more words, meaning 23.4% of the document may not be understandable to a Medicare beneficiary. Appendix A contains a detailed analysis of the *Medicare & You, 2018 Handbook* delineated by section, with a number of sentences per section and a total number of words. *Medicare & You 2018* aggregated word count data is shown in Table 4.

Table 4

Sentence and Word Count Analysis of 2018 Medicare & You Handbook

Section Title	**Total Number Of Sentences**	**Word Count 1-14**	**Word Count 15-20**	**Word Count 21-30**	**Word Count 31-40**	**Word Count 41-50**	**Word Count 51+**
Total	2,245	1,269	444	403	99	19	11

From the aforementioned studies of the *Medicare & You Handbook,* one might make the assumption that the *Medicare & You Handbooks* may not be comprehensible for some Medicare beneficiaries based on their health literacy scores by NAAL and various readability studies.

However, CMS' website notes that there is no single readability analysis tool and that studies may use varying readability formulas, e.g. the Fry formula, the Statistical Measure of Gobbledygook (SMOG) and Flesch tests (CMS, "Toolkit 7," p. 1). Many of these formulas analyze content to a grade level. CMS noted that the use of a grade-level basis is not a precise indicator of content. Further, they speculate that shortening words and sentences may not increase readability or cohesion within a body of information. CMS noted some formulas simply count the length of words or sentence as a barometer of difficulty. This, CMS believed, is faulty logic that takes the words and sentences out of context within sentences and paragraphs and that meaning is conveyed on syntactical and cohesive levels.

Further, they cited that these type of one-sided readability formulas do not take into account the active role of the reader including a person's experiences, prior knowledge and

ability to infer meaning from context. CMS noted that it is the choice of words used that assist with communicative ability. Even shorter words that are not known to a reader will cause confusion. It appears the various studies and CMS do not agree on readability standards or if the *Medicare & You Handbook* meets those standards.

Measuring communicative success of the *Medicare & You Handbook*. While CMS distributes the *Medicare & You Handbook,* one questions how or if they receive feedback from beneficiaries to make improvements. CMS' website provides an email address where individuals can send feedback or comments on the *Medicare & You Handbook* (CMS, "Feedback," n.d.). However, an automatic reply informs the writer that they will not be able to respond to any comments. It appears that while CMS requests feedback regarding *Medicare & You* that this information may not be available for the public.

While CMS' feedback data on the *Medicare & You Handbook* may not be accessible, other articles and surveys provide feedback and insight into the *Handbook's* usability. As an example, advocacy groups contacted CMS prior to the dissemination of the 2019 version of the *Medicare & You Handbook* noting that language in the newest *Handbook* did not provide a fair comparison of traditional fee-for-service programs (Original Medicare) and private offerings from Medicare Advantage providers (Miller 2018). This gave an unfair description of some of the Medicare Advantage offerings.

One way CMS communicates with beneficiaries about Medicare is through the *Medicare & You handbook*. While the efficacy of the document has been debated by various

sources, it continues to be distributed annually. This then raised the question: What provisions does CMS make for communication for LEP beneficiaries?

Federal Communications for LEP Beneficiaries

Because Medicare is national in scope and provides healthcare insurance to retirees, regardless of their English language abilities, a number of federal laws, executive orders and policy guidance decisions have been made over the years that encompass the LEP population.

Laws, Executive Orders and Policy Guidance for LEP Beneficiaries

Chen, Youdelman and Brooks (2007) noted that Title VI of the landmark 1964 Civil Rights Act stated:

> No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. (p. 362)

Hence, at its crux, this ensured non-English speakers could not be discriminated against when accessing healthcare as Medicare is administered by the federal government.

LEP was again in discussions when President Bill Clinton issued Executive Order (EO) 13166 entitled *Improving Access to Services for Persons with Limited English Proficiency* on August 16, 2000. This EO reiterated the original 1964 Civil Right legislation noting that all federal agencies are required to provide equal access to LEP individuals (Chen, Youdelman & Brooks, 2007).

In August 2003, EO 13166 was modified by President Bush with Policy Guidance (Chen, Youdelman & Brooks, 2007). The Policy Guidance provided a four-point framework that healthcare providers, institutions and programs could use to determine the language assistance that was required by law. As noted by Chen, Youdelman & Brooks (2007), these four parameters included:

1. The number or proportion of LEP persons served or eligible to be served – the more LEP individuals served, the more a provider of healthcare services needed to include language assistance services
2. Frequency of contact – As with #1 above, the more frequent the occurrence of contact, the more likely that a healthcare provider required translation/interpretive services
3. The nature and importance of service provided – the necessity and importance of services drove whether language assistance services are required to be provided
4. Resources and costs – This was to ensure that smaller companies were not unduly financially burdened. (p. 363)

Nondiscrimination provisions were again included as part of the federal mandates in Section 1557 of the Affordable Care Act (ACA) (Tran & Bhattarai, 2013-2014). The provisions of Section 1557 provided on HHS' website stated that no activities or programs who receive funding from the HHS can be discriminatory in their practices. This includes health programs or activities that HHS administers. It pointed out that it also included health insurance marketplaces and plans insurers offer on those marketplaces (HHS, "Civil rights," n.d.). It should be noted that Section 1557's definition includes Medicare Part B, but does

not include Medicare Parts A, C or D (Grooms, 2016). Section 1557 stipulated that those whose primary language is not English should be guaranteed access through various vehicles including: oral interpretation, written language access, and electronic information (Grooms, 2016).

Because Medicare and other public healthcare programs can be accessed by anyone, including those with a limited range of English comprehension, the federal government mandated a number of provisions to assist beneficiaries in various healthcare settings. The question then became: How many beneficiaries on Medicare are considered LEP beneficiaries and what have been their realities with Medicare and the healthcare environment?

LEP beneficiaries and Medicare

The 2014 ACS Public Use Microdata Sample showed there were roughly 8.7 million LEP persons in Medicare and/or Medicaid (Proctor, Wilson-Frederick & Haffer, 2018). The ACS 2014 study requested respondents to provide their preferred language or the language they spoke at home with surveys showing over 100 language groups (Proctor, Wilson-Frederick & Haffer, 2018). According to federal laws, no individuals, including LEP beneficiaries, can be discriminated against for obtaining Medicare as it is a federally financed program. To best meet the needs of LEP beneficiaries, CMS provides guidance through their Strategic Language Access Plan that provides a framework for avenues of communication that includes account translation of materials and interpretive services ("Strategic Language Access Plan," 2014). The charter of the plan is to ensure LEP beneficiaries receive CMS' services, program and activities guaranteed them by law. CMS

set out criteria for success that includes 12 initiatives with accompanying criteria and outcome measurements. As an example, the plan has a goal of ensuring 90% of beneficiaries who request LEP-related materials/assistance receive this information at the first attempt and 80% of those LEP beneficiaries are satisfied or very satisfied with customer service (Strategic Language Access Plan," 2014, p. 4).

For translations, CMS has continued its efforts to translate "vital" documents (Medicare.gov, "Other Languages," n.d.) . The Strategic Language Access Plan noted some "vital" documents are currently translated into the following languages: Arabic, Armenian, Chinese, Farsi, French, German, Greek, Haitian Creole, Italian, Korean, Polish, Portuguese, Russian, Spanish, Tagalog, and Vietnamese (Strategic Language Access Plan, 2014, p. 9). Moreover, CMS' Office of Minority health provides a 70-page document of "vital" documents that have been translated into various languages (CMS, "Index by language," n.d.).

Complications with Current CMS LEP Communication Efforts

While a number of provisions are made for LEP beneficiaries, these efforts at times face various challenges. Proctor, Wilson-Frederick and Haffer (2018) speculated that CMS lacks true numbers of the LEP beneficiary population because of limits on data collection. Moreover, while Proctor, Wilson-Frederick and Haffer's 2018 study is comprehensive in its depth, the authors note that the study does not also include analysis of LEP persons' health literacy capabilities which could provide further in-depth knowledge of LEP beneficiaries.

In 2009 the United States Government Accountability Office (GAO) reported on CMS' activities to meet their LEP strategic plan. The GAO noted that CMS translated into

Spanish 87% of 134 Medicare documents (United States GAO, 2009). Spanish was chosen as it was the most common LEP beneficiary language. However, the GAO reported that at the time of their report there was no agency-wide translation policy for CMS. Moreover, the GAO report noted that there was no guarantee at that time that CMS could ensure information would be translated in the future. The GAO also suggested a policy that would include principles and standards for the translation of written documents.

One also notes in the GAO report that the translation policy does not instruct if documents should be translated word-for-word or how to handle technical insurance/medical lexis which may not be known in other languages.

In reviewing CMS' indexed website of various languages and accompanying Medicare documents, one notes that the *Medicare & You Handbook* is not translated into all languages, the version shown is from 2015 and the attached documents/sites are no longer in use (CMS, "Index by language," n.d).

In addition to print media with the *Medicare & You Handbook,* Medicare information is also available on the internet. A multitude of information is available on the internet from vendors as well as the three federal agencies where a Medicare beneficiary can find information about Medicare: CMS, HHS and Medicare.gov. However, each of the websites provides information for various audiences and on various subjects with the CMS.gov website containing 24 topic headings all in English (CMS, "Medicare," n.d.). Also, some links transfer the researcher to a different website for information and the reader can go in circles. As the sites are in English, this requires the LEP beneficiary to know how to navigate the site through English to find their specific translation.

LEP Beneficiaries, Healthcare and Medicare

A number of studies have been conducted with LEP beneficiaries accessing and navigating the healthcare system as well as their interactions with Medicare. In their research, Ponce, Ku, Cunningham and Brown (2006) noted that LEP Medicare beneficiaries in California were less likely to receive preventive care and did not have a usual source of care. In another study, Ponce, Hays and Cunningham (2005) noted, "language barriers can impede access to health care, lower the quality of care, and result in dissatisfaction of care" (p. 786). In their respective studies, Paredes, Idrees and Beal as well as Kim, Kim and Paasche-Orlow (as cited by Proctor, Wilson-Frederick & Haffer, 2018) noted "LEP status is linked to multiple suboptimal health outcomes" (p. 82). Additionally, in two separate studies, Kim, Worley, and Allen and separately, Jacobs, Karavolos, Rathouz et al. (as cited by Proctor, Wilson-Frederick & Haffer, 2018) both found that health outcomes were correlated with self-reported challenges in communicating and understanding medical information (p. 82). These challenges included comprehending information from providers, written information at the provider's office and reading prescription bottles. Other studies note that LEP individuals "report barriers to seeking emergency care and experience significant health disparities, including being less likely to survive cardiac arrest than whites" (Meischke et al., 2011, p. 176). While provisions have been made for LEP beneficiaries, studies show LEP beneficiaries have difficulties within the healthcare environment.

One may conclude then that studies show that LEP beneficiaries continue to receive suboptimal care and have difficulties in navigating the healthcare landscape. While

translations of Medicare information are available from CMS, these translations may not include all information an LEP beneficiary requires and/or the beneficiary may require enough English to find this information and/or to be cognizant that it exists. This is primarily the case that some languages appear to have translations, others do not, and others have been translated but not the latest version. This is noted with the *Medicare & You Handbook* which serves as the key communication vehicle in providing information about Medicare programs, benefits, rights, and protections (United States Government Accountability Offices, 2009).

Based on LEP beneficiaries' needs and CMS current actions, the question then arose of how LEP beneficiaries were to learn of Medicare and its complexities.

Community-Based Adult Education

Adult Education Programs

Adults requiring assistance to adapt, orient and navigate in the U.S may be offered a variety of educational/vocational programs through a number of publicly and privately funded educational providers. This section provides a brief overview of some of the initiatives for adult education.

In 2014, President Obama signed the Workforce Innovation and Opportunity Act (WIOA) (U.S. Department of Labor, "WIOA," n.d.). WIOA's aim was to bring together goals of both the Department of Labor as well as the Department of Education to offer coordinated programs in developing skills. Two of their four initiative Titles are as follows:

- Title I – Adult, dislocated worker and youth programs that is, employment and training for adults administered by the Department of Labor; and …

- Title II, Adult Education and Family Literacy Act (AEFLA) that is, adult education and literacy programs and Vocational Rehabilitation state grant programs…in obtaining employment administered by the Department of Education. (National Immigration Forum, "What is WIOA Title II and Who Does it Serve?*,"* 2017)

As noted in the April, 2017 brief of The Council of State Governments, WIOA created an opportunity for business and education to work together to best meet the needs of those seeking employment and employers. They also noted:

> For program year 2016 the federal government appropriated more than $6.9 billion to states for the Core WIOA Program and approximately $3.4 billion in federal formula funding for partner programs, for total funding of $10.5 billion. Federal funding is also provided through competitive grants. (Counts, 2017, p. 1)

On its website, the U.S. Department of Education has a specific division devoted to adult education, The Office of Career, Technical, and Adult Education (OCTAE). The "OCTAE administers, coordinates programs that are related to adult education and literacy, career and technical education, and community colleges" (U.S. Dept. of Education, "OCTAE," n.d.).

At the U.S. Department of Education, The Division of Adult Education and Literacy (DAEL) within OCTAE administers the provisions of WIOA (U.S. Dept. of Education, "DAEL Monitoring Visits to States," n.d.). DAEL's multifaceted role includes "the responsibility for enabling adults to acquire the basic skills necessary to function in today's society so that they can benefit from the completion of secondary school, enhanced family

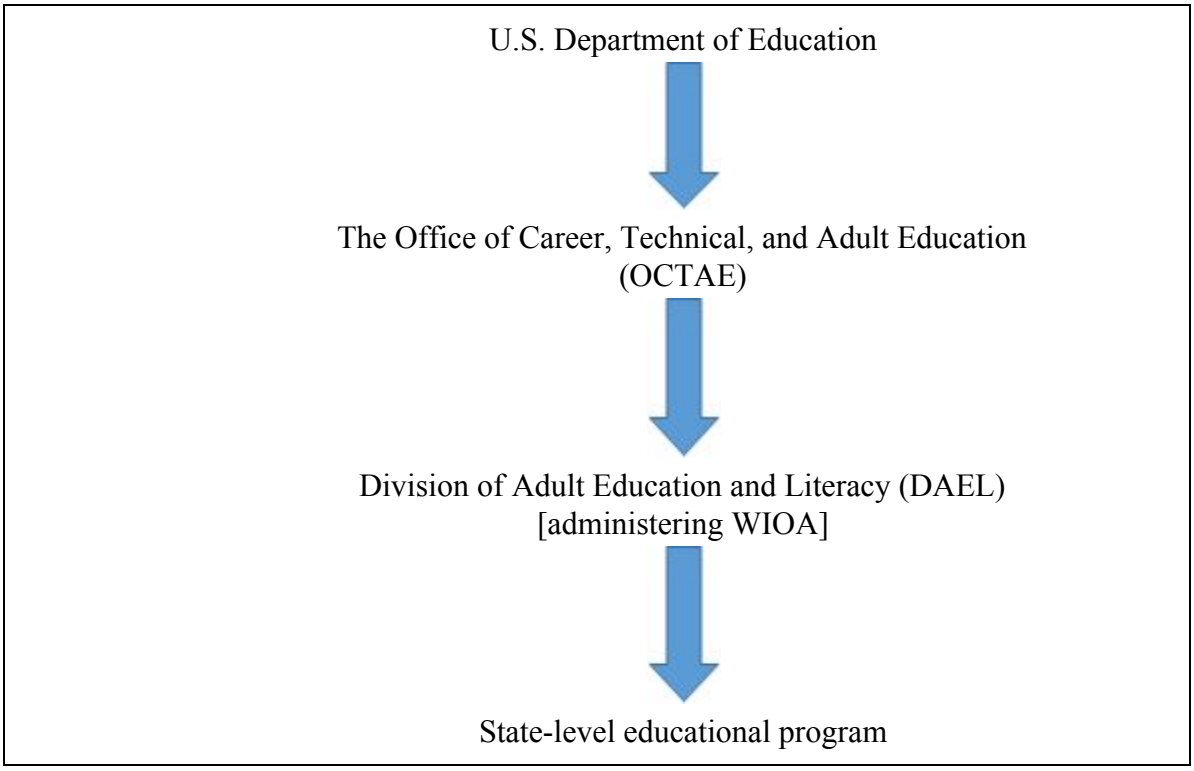
life, attaining citizenship and participating in job training and retraining programs" (U.S. Dept. of Education, "U.S. Department of Education Principal Office Functional Statements, B. Adult Education and Literacy Division," n.d.). On their website they list the following activities:

- Adult education
- Literacy
- Workplace adult education and literacy
- Family literacy activities
- English language acquisition activities
- Integrated English literacy and civics education
- Workforce preparation activities and
- Integrated education and training. (U.S. Dept. of Education, "Adult Education and Literacy," n.d.)

DAEL, in turn, provided funds to states who could apply for adult education and literacy programs. The specific calculation of funding was based on a formula established by Congress. States then disburse funds to their statewide educational organizations (U.S. Dept. of Education, "Adult Education and Literacy, n.d.). Table 5 notes the various departments and agencies involved in adult education funding.

Table 5

Flow down of Federal Funds for Adult Education



Adult Education and Performance Outcomes

To receive and maintain Title II WIOA, AEFLA funding for adult education, states must apply for grants and provide performance accountability in achieving outcomes (U.S. Dept. of Education, "The Workforce Innovation and Opportunity Act, Overview of Title II: Adult Education and Literacy," 2014). As an example, the following are adult basic education (ABE) performance outcomes that are measured or will be measured in coming years for WIOA funding:

- Measurable skill gain
- Employment at second quarter after exit
- Employment at fourth quarter after exit
- Median earnings at second quarter after exit
- Credential earned (and Entering Postsecondary or Employment)
- Employer engagement. (Minnesota Adult Basic Education, "Materials from Recent State ABE," 2018)

Further, to ensure accurate, consistent measurement, the National Reporting System for Adult Education (NRS)

> ...is the accountability system for the Federally funded adult education program, authorized by Section 212 of the Workforce Innovation and Opportunity Act (WIOA). The NRS includes the WIOA primary indicators of performance, measures that describe adult education students and their program participation, methodologies for collecting performance data, and program reporting procedures (National Reporting System for Adult Education, n.d.).

As an example, in the state of Minnesota there are three NRS-approved assessments for Minnesota ABE programs:

1. Comprehensive Adult Student Assessment System (CASAS)
2. Test of Adult Basic Education (TABE)
3. BEST Plus(™) 2.0 (Minnesota Adult Basic Education, "Accountability and Reporting," 2018)

Analysis of Adult Education

The 2002 Adult Education Program Study (AEPS) noted "that two-thirds of funding for adult ESL programs across the nation was from state and federal funds" (as cited in Eyring, 2014, p. 135). To receive and maintain funding of WIOA, adult education programs were measured on criteria related to employment and/or educational level gains. Further, these gains were measured by using standardized testing/assessment tools to ensure participant understanding and progress.

This said, while WIOA does not include all funding for adult education programs throughout the nation, one speculates that it provided the most funding per participant. Moreover, if WIOA was the primary funding entity and its overall goal was to improve educational and technical skills for participants, one is left to believe that LEP beneficiaries may be left to struggle to find information about Medicare as no single community platform exists.

Conclusion

In summary, Medicare is healthcare insurance coverage for those retiring individuals 65 and older that is provided in Parts or segments with some available through the government and others purchased with private health insurers. The primary form of communication CMS provides to Medicare beneficiaries is the *Medicare & You Handbook*. CMS must comply with various legislative mandates to ensure Medicare is compliant for LEP beneficiaries. However, there are various positions as to whether the *Medicare & You Handbook* is accessible to all Medicare beneficiaries including LEP beneficiaries. Studies show LEP beneficiaries have difficulties navigating the healthcare system and receive

suboptimal care and *Medicare & You* may not be translated into a LEP beneficiary's primary language. To date, adult education classes provide a variety of areas of instructions. However, most publicly funded classes were not created with retiree healthcare insurance in mind as their goals are for the working and educational needs of adults. As Medicare is available for purchase by anyone, with some Parts available to anyone who has worked in the U.S. for 10 years or longer, a need arises to teach LEP beneficiaries of Medicare and how to navigate their healthcare options in retirement.

The next chapter gives an overview of the curriculum development project with the main purpose and goal. The next chapter will delve into the framework of lessons within the constructs of a curriculum that moves from a less- to more-complex structure. The chapter reviews the intended audience of students and community-based organizations. The framework will contain an overview theory as well as lessons and goals.

CHAPTER THREE

Project Description

The purpose of this capstone project is to provide a structural framework for lessons for limited English proficient (LEP) beneficiaries to assist them as they navigate Medicare as they and/or their family members enter retirement. The fundamental goal of this paper and this chapter is to address: *What might an instructional healthcare curriculum for LEP adults who are retiring look like?*

This chapter provides an overview of the rationale for Medicare-centered lessons to assist LEP beneficiaries and their families that includes a theoretical model of lessons, the lesson plans, accompanying units and embedded assessments/evaluations. The units included are built on a hierarchical structure and include: understanding the Parts, types and availability of Medicare; components of insurance; comprehending and navigating the Medicare system for information; recognizing cross-cultural variations in accessing information, presenting information, requesting a supervisor, requesting clarification; and putting it all together in a final lesson.

Rationale for Medicare-Centered Lessons

Lack of Medicare knowledge

Currently, there may potentially be a lack of translated materials regarding Medicare for LEP beneficiaries (United States GAO, 2009) and while the government provides translated Medicare materials, they may not be understandable to LEP beneficiaries. A review of the *Medicare & You Handbook* noted long, complex sentence structures that usually decrease comprehensibility (Aruru & Salmon, 2010; Bonk, 2011). Medicare options

are currently designed to be compared and contrasted across plans (Medicare.gov, "What Medicare Covers," n.d.). As an example, the Medicare.gov website lists three steps and the Minnesota Board on Aging's website lists five steps to analyze Medicare options. On both websites, each of the steps presumes an ability to compare and contrast elements of Medicare as well as insurance information (Medicare.gov, "What Medicare Covers," n.d.; MN Board on Aging, 2018, p. 30).

Lack of cross-cultural understanding

The U.S. Peace Corps' handbook, *Culture Matters* (n.d.), noted that cultures differ on areas people believe they can control and manipulate. This "locus of control" for most native speakers in the U.S. means most believe that the locus of control is internal. This means Americans believe they make decisions, situations can be changed, it is appropriate to request something a second time, and if something does not sound accurate, it is not accepted. However, in other cultures, there is a belief that things just happen to a person. There are certain things that happen or just are and they need to be accepted (Peace Corps, n.d.). When accessing Medicare, there is a presumption that a beneficiary will call or ask for clarification (*Medicare & You Handbook*, 2018). Some prospective Medicare beneficiaries may not feel they have the locus of control to ask a second time, to clarify information or if they are not satisfied with the first request, to make a second contact.

Lack of direction

There is an overwhelming amount of information available to beneficiaries on Medicare. A web search on Google for "Medicare information" has over 133 million results ("Medicare information," n.d.). An abundance of information does not mean it is accurate or

understandable to LEP beneficiaries. Moreover, the source may presume a level of Medicare understanding by the beneficiary.

As an example, there are television advertisements that instruct the viewer to go to Medicare.*com* for further information (eHealthInsurance Services, Inc., 2018). This website notes that Medicare is administered by the federal government and information is provided on the Medicare.*gov* (not .com) website. It states that commissions are paid by the insurance plans the website promotes, and further information may be accessed at any time through one of their licensed sales agents. All of this information presumes a level of understanding with Medicare.

As stated above, as LEP beneficiaries struggle within the current environment accessing Medicare, it remains evident that provisions need to be made to assist LEP adults on Medicare including what it is, how to access it and what the ramifications of choice mean to the beneficiary. This begged the question: what would be a logical instructional framework to use for this purpose?

Instructional Framework

Bloom's taxonomy is one of the best known and widely used instructional frameworks for lesson planning and teaching. Bloom, Engelhart, Furst, Hill and Krathwohl published their findings in 1956 under the title, *Taxonomy of Educational Objectives: The Classification of Educational Goals* (as cited by Krathwohl, 2002). While many researchers were involved, it has come to be known by the shortened title, Bloom's taxonomy (Pickard, 2007). It has been referred to here as the Original Taxonomy. The Original Taxonomy was a pyramid-design framework moving students from a less-complex to more-complex and

concrete to abstract lesson plan framework (Krathwohl, 2002). The framework was ladder-like in structure that each higher step on the ladder meant the student had mastered the lower, previous step.

In their study in 2001, Anderson and Krathwohl made a number of revisions to the Original Taxonomy. Their changes in Bloom's Revised Taxonomy included: altering some of the categories to include a metacognitive category; using verbs and nouns instead of only nouns; and changing to two dimensionalities to reflect the way teachers write their lessons. As an example, teachers often use the phrase "students will be able to" as a guide and overview of the lesson (Krathwohl, 2002). Rather than a pyramid design of the Original Taxonomy, the Revised Taxonomy can be viewed as a table with the knowledge dimension shown on the vertical axis and the horizontal axis containing the cognitive process dimensions. Please refer to Table 6 for an example of the Revised Taxonomy in a table format.

Table 6

Bloom's Revised Taxonomy in a Table Format with Examples from Unit #1

	The Cognitive Process Dimension					
The Knowledge Dimension	Remember	Under-stand	Apply	Analyze	Evaluate	Create
Factual Knowledge	Listen to video and complete a worksheet Students will be able to: Recall and repeat					
Conceptual Knowledge		Matching exercise Students will be able to: Classify and identify				
Procedural Knowledge			Put procedures into correct Part A and B sections. Students will be able to: Categorize and choose			
Meta-Cognitive Knowledge						

(Adapted from Krathwohl, 2002, p. 216)

Because the Revised Taxonomy moves in a logical, sequential pattern of less complex to more, from concrete to the abstract, this is a logical theory to use as a structural framework for a Medicare-centered lesson-planning framework for adults. Moreover, this higher-order framework ideology was corroborated by Limbach and Waugh in their article "Developing Higher Level Thinking" (2010) when they discussed Bloom's revised taxonomy as a useful framework for teachers to help students moving to higher-level thinking. This is particularly pertinent for this curriculum.

As an example, students need to have a base knowledge of insurance and Medicare to be able to compare/contrast plans to make the best decisions. The lesson plans move along a continuum where the beneficiary needs to have an underlying understanding of all the subsequent 'lower' components to be able to make a comparison across plans. When choosing Medicare, students need to find the best option and understand the repercussions of their decisions.

Description of Lessons

Desired Results

The ultimate goal of this project is to provide a framework of Medicare-centered exercises and lessons based on the structure of Bloom's Revised Taxonomy. These lessons can be used to increase adult students' understanding of Medicare and to enhance their ability to navigate the healthcare system. As I am not currently teaching, I have made assumptions based on previous teaching experiences with adult education. It should be noted that the goal of this curriculum may be different than others in that there is no

educational or state/federal standard to be met. The final goal is that the students' knowledge increases. This curriculum is not teaching to a test or final exam.

Moreover, it should also be noted there is no 'right' answer at the highest levels of higher order processing. In the highest order LEP Medicare beneficiaries are able to compare and contrast Medicare programs provided by vendors, understand their respective features and the implications on what each choice will have on the beneficiary and their families.

Current and prospective adult classes

The following is an example of current adult classes where this lesson plan could be used. Adult classes are held on Tuesdays and Thursdays from 6:00 to 9:00 p.m. at the Minnesota Literacy Council's Open Door Learning Center venues located in the Minneapolis-St. Paul Metropolitan area. Classes start at 6:00 with some students coming to class as their job/home responsibilities allow, meaning some students may be arriving 15-25 minutes late. A 15-minute break occurs at 7:30. This allows teachers to move to different lesson plans or to different sections of assigned students. The class is designed for 10-20 high intermediate or higher English language functioning students with varying backgrounds. Students have worked in the U.S. for 10 years or more or they have family members who have and are within a year of retiring. One of the areas of concern is that adults cannot always attend each class and this may prevent them from moving higher within the curriculum framework. Having missed previous classes, students may not want to continue attending the Medicare-information course as they are behind when coming back to class.

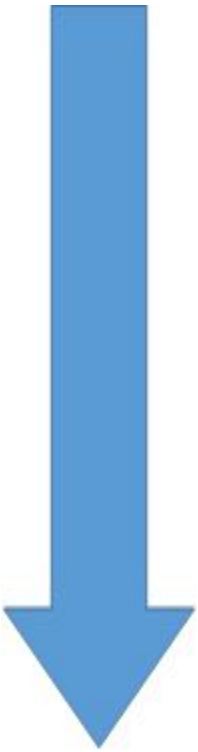
The tenets of Bloom's Revised Taxonomy states a logic-based curriculum assists students moving from lower-level to higher-order thinking and processing. Keeping in mind the current situation for adult educational options, the following logic-based curriculum has been designed.

Unit structure, framework, and timing

This Medicare-based framework is based on both a macro- and a micro-structure of Bloom's Revised Taxonomy. As Bloom's Revised Taxonomy moves a student from a lower-level of understanding to a higher level of understanding, so does the curriculum move students from a base understanding to higher-order levels with successful accomplishment of previous lessons. Being mindful of Bloom's Revised Taxonomy, the overall curriculum structure is built with an eight-lesson structure that moves from a less-complex to more-complex outline. The eight lessons, anticipated timeframe and levels of complexity are noted in Table 7 below:

Table 7

Medicare-Centered Classes Lessons, Timeframe and Levels of Complexity

Lesson/Unit	**Timeframe**	**Level of Complexity**
Lesson 1 – Parts of Medicare	2.75 – 3 weeks	Less complex
Lesson 2 – Part C, Medicare Advantage	1.5-2.0 weeks	
Lesson 3 – Insurance Terms	1-2 weeks	
Lesson 4 – Putting it together (Parts A, B, C, Medigap and Insurance Terms)	3-3.5 weeks	
Lesson 5 – Part D Prescription Drug Plans	2.5-3.5 weeks	
Lesson 6 – Insurance Terms for Part D	1-2.5 weeks	
Lesson 7 - Putting it all together (Parts A, B, C, D, Medigap and Insurance)	1-2 weeks	
Lesson 8 - Where to go for Information/Tips	1-2 weeks	Most complex

Within each lesson, the unit starts with more basic information and moves to more complex structures. Thus the smallest building block is the less-complex unit that builds to more complex units within the lesson. The first lesson, parts of Medicare, is the least complex and when students have mastered all lower-to-higher units within this lesson, they

move to lesson 2, Medicare Advantage, Part C. As an example, Table 8 gives the unit structure of lesson one, parts of Medicare.

Table 8

Sample Units for Lesson 1, Parts of Medicare

Lesson objective (SWBAT)	**Timeframe**	**Level of Complexity**
Unit 1 – Medicare Part A and Part B, Original Medicare	1.25 hours	Less complex  Most complex
Unit 2 - Medigap	1 hour	
Unit 3 - Medicare C Medicare Advantage	2.75 hours	
Unit 4 – Medicare D Prescription Drug	2.50 hours	
Unit 5 - Unit Assessment	2.25 hours	

For a student to be successful in lesson 2, they must have learned the lesser-complex units of lesson 1, parts of Medicare. The goal is for students to successfully learn each unit so that they may move to the highest level within each lesson to be able to use the knowledge of that lesson for higher order processing. The entire curriculum is built with a total timeframe of approximately 20+ weeks.

Lesson plan guidance. Anderson (as cited by Pickard, 2007) noted the framework in Table 9 is used as a guideline for lesson planning.

Table 9

*Assessment and Lesson Plan Creation Criteri*a

Dimension – Assessment and Guideline	**Examples of the cognitive processes involved**
Remember: can the student recall or remember the information?	Define, duplicate, list, memorize, recall, repeat, reproduce, state
Understand: can the student explain ideas or concept?	Classify, describe, discuss, explain, identify, locate, recognize, report, select, translate, paraphrase
Apply: can the student use the information in a new way?	Choose, demonstrate, dramatize, employ, illustrate, interpret, operate, schedule, sketch, solve, use, write
Analyze: can the student distinguish between the different parts?	Appraise, compare, contrast, criticize, differentiate, discriminate, distinguish, examine, experiment, question, test
Evaluate: can the student justify a stand or decision	Appraise, argue, defend, judge, select, support, value, evaluate
Create: can the student create new product or point of view?	Assemble, construct, create, design, develop, formulate, write

(Pickard, 2007, p. 48)

As an example, the teacher uses the following verbs from the list provided in Table 9, *define, duplicate, list, memorize, recall, repeat, reproduce, state*, to create activities to ensure students meet the assessment and guideline criteria. Assessments are embedded throughout the units and lesson plan to ensure the student can move to the next level within the lesson-pillar framework.

Assessments and evaluations. To date, many adult education programs in the U.S. are funded through the WIOA program whose overall mission has been

educational/vocation improvement. These programs, in turn, provide performance outcomes that are measured and assessed by the NRS.

This course, unlike other adult education courses whose purpose is education/work, is targeted for LEP beneficiaries who are retiring and will be accessing Medicare. It's obvious then that beneficiaries do not require improvement of their educational/vocational skills. LEP beneficiaries need guidance understanding the Parts of Medicare, knowing who are the providers of Medicare, recognizing plan offerings, payment/funding of Medicare as well as understanding ramifications of their choices. This is a new adult education program and there are no standardized performance outcomes or national assessments. Thus, creation of assessments and evaluations is a key component to ensure optimization of learning and attainment of teaching objectives.

Airasian and Miranda (2002) noted that Bloom's Revised Taxonomy with its two-dimensional diagram, as noted in Table 6 above, guided teachers in lesson objectives and planning instruction. These then lead to "…more clearly defined assessments and a stronger connection of assessment to both objectives and instruction" (p. 249). Airasian and Miranda also noted the inter-relation between outcomes, instruction and assessment and when the three components are aligned, the lesson plan objective drives instruction and, thereby, the assessment. In the end, the assessment results should be validated from the other components.

The University of Newcastle's (Australia) Centre for Teaching and Learning created a Guide for Assessment Task Completion related to Bloom's Revised Taxonomy. In their guide, the Centre provided a reference table noting a variety of assessment types, the

outcomes the lesson is hoping to achieve and what skills are developed (The University of Newcastle, n.d., "Assessment Task Activities"). Table 10 is an excerpt of the University of Newcastle's overview of the range of assessments based on the knowledge-cognitive dimensions noted in Table 6.

Table 10

Sample Assessment Task Completion

	Task Type	**Students will**	**Skills developed**
Remembering	Written examination Oral examination Comment on the accuracy of a set of records Write an answer to a client's question Short answer questions e.g. True/False/Multiple Choice Questions	Demonstrate knowledge and understanding through: Recalling Describing Reporting Recounting Recognising Identifying	Oral and/or written communication Information literacy
Understanding	Project Essay Report Applied task Applied problem Write journal entries, letters, commentaries from a famous person's perspective	Access and manage information through: Researching Investigating Interpreting Organising information Reviewing and paraphrasing information Collecting data Searching & managing information sources Observing Interpreting	Oral and/or written communication Teamwork Information literacy Ability to use technology

(The University of Newcastle, n.d., "Assessment Task Activities")

To ensure this Medicare-centered lesson plans have incorporated assessments and evaluations, each lesson has been broken down into separate units and each unit has again been separated into tasks/activities. The lesson plan template for each lesson/unit/activity, as shown in Table 11, incorporated an assessment component ensuring it was included in the lesson plan structure.

Table 11

Lesson plan template including assessment activities

Lesson Number – Name

Unit Goal	Unit X –
Objective/Outcome	Students will be able to:
Participants	
Level	
Activities	
Duration	
Assessment	
Teacher Observation	

Assessments play a critical role in the overall lesson plan as well as the teacher's knowledge that the participants have acquired the understanding to move to a higher level within the lesson/unit structure of the lesson plan framework. If participants do not have the underlying knowledge of a lower unit, they will not understand the next unit in the sequence.

Conclusion

Currently, there are no adult LEP education courses that speak specifically to the needs of beneficiaries entering Medicare. The logical framework for a Medicare-centered curriculum is based on Bloom's Revised Taxonomy of higher-order processing. Using this framework, the apex of higher levels of understanding will be the students' abilities to analyze/compare Medicare options as well as understand the real-world implications for those choices. This is pertinent for Medicare beneficiaries as they need to navigate a system that presumes they have an understanding of insurance, Medicare, the ability to compare and contrast insurance plans as well as navigate a complicated system.

In Chapter 4, I review my reflections and lessons that I learned from my project. I detail new findings based on my project and how those relate to curriculum structure based on Bloom's Revised Taxonomy. I explore the realizations, limitations and potential changes needed for future implications of my project. I will also provide a conclusion that summarizes the project as a whole.

CHAPTER FOUR

Critical Reflection

Introduction

This capstone project aimed to answer the research question: *what might an instructional healthcare curriculum for limited English proficient (LEP) adults who are retiring look like?* Chapter 1 reviewed my personal and professional background and experiences and why these lead me to delve into a lesson plan for LEP beneficiaries and Medicare. Chapter 2 was a literature review and examined the history of Medicare and why it was initiated. Because of the importance of Medicare, I reviewed federal communication practices, including specific communication practices for Medicare-specific information. I reviewed the efficacy of those communication patterns for LEP beneficiaries as well as the difficulties LEP beneficiaries have navigating the healthcare system including Medicare. Finally, I concluded the Chapter with the current status of adult education courses.

Chapter 3 described the need for a Medicare-centered lesson plan as well as the need to use a taxonomy that is built on a structure that moved students from less complex to higher-order processing. Because Medicare as well as its underlying insurance terms need to be the foundation for a Medicare beneficiary to compare and contrast their Medicare and insurance options, using Bloom's Revised Taxonomy was a logical choice for the lesson plan's structural basis. The lesson plans are built on eight lessons with accompanying units of tasks and activities. Bloom's Revised Taxonomy was used to structure the overall movement of the class and within the classes as well as. Student activities are based on learning foundations and moving from basic identification of information to categorizing

and finally applying information. While the lessons and units can be taught in order, the structure allows flexibility for a teacher to cherry-pick lesson plans that are relevant to their classroom's level and acquisition of information.

In Chapter 4, I will review the major project lessons I learned. This includes a review of the literature, and an analysis of the implications, limitations, and relevant next steps that include the future of this lesson plan, communication of those results and finally benefits to the profession including my personal reflection.

Major Lessons

The capstone project is a series of journeys based on the topic chosen. When I initially decided on the idea of Medicare as a capstone project, I did not realize some of the paths I would go down. My journeys were eye opening and at times frustrating but all very beneficial. My journey included learning the informational pathways of Medicare and how my lesson plans evolved and took on their own creation.

Medicare information. My first major lesson as a researcher and writer entailed the need for a foundation in Medicare. There is an abundance of information available about Medicare on the internet. In fact, there is too much information. As an example, a web search on Google for "Medicare Information" produced 133 million results ("Medicare information," n.d.). Parts of Medicare are available through the federal government, and administered by CMS. However, these same options and other Medicare choices can be purchased by private insurance companies. Part D, in particular, is only sold through private insurers (Medicare.gov, "Drug Coverage Part D," n.d.). The internet environment means that Medicare resources that may assist in understanding Medicare are found together with

policies that are being sold. Or licensed agents and private insurers provide some unbiased information but include other components that are purchased. The problem is that one needs to have some background or grounding to be able to choose sources of information. I had no idea how difficult it would be to try to navigate this system. I was inundated and at times exhausted. If a person does not have a foundation in Medicare, trying to find sources of information that are reliable is extremely difficult.

Evolution of the project. As I built the lesson plan, it evolved as I got into the material and tried to make things more foundational. The lesson plan is built on eight lessons. Originally, I started with fewer lessons and combined all Parts of Medicare into one unit. However, as I developed the curriculum, I realized that students needed groundwork in Original Medicare, Parts A and B, before moving into other Parts. Medigap is a supplement to Original Medicare so it was logical to teach that next in the series. Medicare Part C, or Medicare Advantage, is purchased through private insurers and includes Parts A and B and again it seemed logical to teach that following Medigap.

Beneficiaries can choose three options to receiving Medicare Parts A and B and they need to be able to compare and contrast plan options. Therefore, it became necessary to have the lessons move to insurance terms. Medicare Part D, the Prescription Drug benefit, is voluntary and purchased separately. This lesson requires students to have an understanding of different insurance terms and Medicare so it was logical to move it to a separate unit.

As a researcher and learner, this evolution of the flow of lessons was unexpected. I had initially prepared a skeletal outline of how I thought lessons would flow. To have it change so drastically was not what I had anticipated. I had thought I would follow the lesson

outline and move forward from there; however, the lesson plan seemed to take on a life or structure of its own and I had to follow along.

The Literature Review

For this project, I needed to do research to provide a foundational background of the history of Medicare, how federal government documents are communicated and what the implications are for the communication of Medicare. Then I needed to understand how all this came together into how Medicare was communicated for LEP beneficiaries and its effect. Finally, I needed to find out what adult education options are available for LEP beneficiaries. All of these components rested heavily on one pivotal study that influenced Medicare communications as well as the creation of the lesson plan. I will review this study, its implications and finally how it influenced my findings.

Medicare's Seminal study. Throughout my research on Medicare, the 2003 study conducted by the National Adult Assessment of Literacy (NAAL) has proven to be the principle study that is cited in measuring health literacy. The NAAL survey was scored based on a four-point scale of *Below Basic, Basic, Intermediate* and *Proficient* (as cited by Kutner, Greenberg, Jin & Paulsen, 2003, p. iv). Using these parameters, NAAL found that 36% of adults who took the survey were self-categorized as *Basic* or *Below Basic* in literacy skills (as cited by Kutner, Greenberg, Jin & Paulsen, 2003, p. v). CMS makes a point in their internet-based communication toolkit that those who interface with Medicare beneficiaries should design communications at a *Basic* level of literacy (CMS, "Toolkit Part 1," pp. 3-4). As the NAAL study was the basis for Medicare communication, I needed to research how it was used with communicating Medicare to beneficiaries.

Analyzing Medicare communications. I had presumed that with CMS noting the importance of NAAL's study and their encouragement to communicate at a *Basic* level that the primary communicative tool of Medicare, the *Medicare & You Handbook,* would be easy to understand. However, I found two research studies that had analyzed *Medicare & You Handbooks* of various years and both of the studies showed that the *Handbook* was difficult to interpret.

In 2010, Aruru and Salmon analyzed the 2008 version of the *Medicare & You Handbook*. They noted that nearly 30% of the passages scored at approximately a 12th-grade reading level (Aruru & Salmon, 2010, p. 313). In 2011, Bonk analyzed the *Medicare & You, 2011 Handbook* using various assessment methods and again found the *Handbook* 'difficult' to read (Bonk, 2011, p. 181).

To find out how the current *Medicare & You Handbook 2018* compared to previous years and the NAAL seminal study, I analyzed its content by counting the number of words per sentence. I note that Hill-Briggs, Schumann and Dike (2012) commented that text with a sentence length of less than 15 words corresponds to a 5th-grade reading level (p. 295). I was astounded to find that of the total sentences (2,245) analyzed, 532 contained 21 or more words. Table 12 notes some of the sentences were in excess of 50 words.

Table 12

Sample sentences from 2018 Medicare & You Handbook

Passage	**Word Count**
Find out if you're eligible for Part A and/or Part B and how to enroll, make changes to your Part A and/or Part B coverage, get a replacement Social Security card, report a change to your address or name, apply for Extra Help with Medicare prescription drug costs, ask questions about Part A and Part B premiums, and report a death (p. 17).	62 words
If you didn't sign up for Part B (or Part A if you have to buy it) when you were first eligible because you're covered under a group health plan based on current employment (your own, a spouse's, or if you're disabled, a family member's), you can sign up for Part A and/or Part B (p.21)	56 words
If you have coverage through an individual Marketplace plan (not through an employer), you may want to end your Marketplace coverage and enroll in Medicare during your Initial Enrollment Period to avoid the risk of a delay in future Medicare coverage and the possibility of a Medicare late enrollment penalty (p.23)	51 words

From the previous studies as well as my own analysis of the 2018 *Medicare & You Handbook,* I concluded that at its current writing, the *Medicare & You Handbooks* may not be understandable for some Medicare beneficiaries based on their health literacy scores by NAAL.

However, I was surprised to find that CMS refutes previous studies by noting that there is no single, universal readability analysis tool (CMS, "Toolkit 7," p. 1). Further, they stated that many comprehension formulas analyze content to a grade level and that this is not a clear indicator of content. They also suggested that shortening words and sentences

may not increase readability or cohesion within a body of information. They argued that meaning is conveyed on syntactical and cohesive levels and one cannot take words and sentences out of context. They also suggested that one must take into account the active role of the reader including a person's experiences, prior knowledge and ability to infer meaning from context.

Based on the analysis I conducted on the *Medicare & You 2018 Handbook*, I find it hard to believe that the NAAL-studied Medicare beneficiaries who scored *Below Basic* and *Basic* could easily comprehend the *Handbook*. This analysis confirmed my opinion to the difficulty of the communicative materials distributed to Medicare beneficiaries and it also helped shape the lesson plan.

The lesson plan needed to be built thinking of my audience's health literacy as well as what information was most critical to navigate the Medicare system. It became clear that I needed to create lessons with foundational information in lower-tiered lessons and build upon those to higher-tiered lessons. As an example, Lessons 1 through 3 provide the groundwork for Parts A, B, C, Medigap and insurance terms. Lesson 4 provides an opportunity to apply everything learned in Lessons 1 through 3. Lessons 5 and 6 provide the foundation of Part D. Again, Lesson 7 provides a lesson to utilize all information in Lessons 1 through 6. Lesson 8 is the culmination of all underlying lessons and includes navigational tools that include how to use and reference the *Medicare & You Handbook*.

Implications

In addition to providing information about the adult population in general, NAAL's 2003 seminal study also included health literacy scores of Medicare beneficiaries. Health

literacy rates for Medicare beneficiaries were: 27% *Below Basic*, 30% *Basic*, 40% *Intermediate*, 3% *Proficient* (as cited by Kutner, Greenberg, Jin & Paulsen, 2003, p. 18).

Further, the Kaiser Family Foundation stated on their website the following 2011 distribution of Medicare beneficiaries' educational levels:

- 22% Less than high school
- 29% High school graduate
- 29% Some college
- 20% College graduate or higher ("Distribution of Medicare Beneficiaries' Education Level, by Race/Ethnicity," 2011).

From this data, one can conclude that 57% of beneficiaries have a health literacy level of *Basic* and lower. Additionally, 51% of Medicare beneficiaries in 2011 had attended some/graduated from high school. Keeping in mind the health literacy of the Medicare population as well as their overall educational attainment, one speculates that the lesson plan created could be used universally for all Medicare beneficiaries. The lesson plans may need to be modified for native speakers compared to LEP beneficiaries; however, the foundational constructs may make Medicare accessible to more people.

In addition, with few opportunities for Medicare beneficiaries to learn about core foundational components of Medicare, policymakers should consider funding this curriculum to assist Medicare beneficiaries.

Limitations

Material limitation. When I was originally outlining this project, I thought I could move much faster creating the lesson plans. I did not realize the variables of the foundational pieces that were necessary before moving forward. As an example of this phenomenon, I take the unit on copayments. At first, the unit explained that copayments are paid on each visit of a doctor. However, after looking into different Medicare options, I had to expand the chapter to include copayment information that showed copayments can also vary based on:

- Predetermination of a plan
- Type of service
- Dollar amount
- Number of days
- In-Network or out-of-network providers (The Minnesota Board on Aging, 2019. pp.137, 187, .218).

To ensure a sound foundation of knowledge was built, the lesson plans took much longer to create keeping in mind the variables that are possible. The lesson plan was intentionally built to move from lower-order to higher order processing, but to ensure a solid foundation the creator needs to keep in mind variables that a beneficiary needs to know in order to make an informed decision.

Intended audience limitation. The material was designed for an audience of high intermediate LEP adults who will be retiring. Medicare, however, is available to anyone with certain eligibility criteria. The lesson plan as designed could move too quickly for a

person who does not have a higher level of English comprehension. This said, the material could be redesigned and taught for a different audience.

Future Projects/Communicating Results

This section overviews future projects and how those projects tie into communication of results. In the future, the logical next steps would be to finish the lesson plans. With the current structure being broken into eight distinct lesson plans, it would be logical to finish lesson 3 and move into completing lessons 4 through 8. While these lessons are being constructed, content expert feedback remains imperative. My content expert works with the Consumer Choices team for the Minnesota Department of Human Services and Minnesota Board on Aging. The Minnesota Board on Aging is a non-profit resource that provides assistance for Minnesota retirees and their families on all things related to retiring. Thus, it is critical that next steps include feedback and critical assessment from someone who is providing unbiased Medicare information.

In addition, as this is a primary non-profit platform for individuals to learn about Medicare, it would be a logical next step to interface with their staff on avenues for learners. By maintaining a working relationship this can prove to be a win-win situation whereby their staff can provide critical feedback and then use the information as a source of education or provide information on next steps on educating retirees. In an interesting twist, my content expert also plans to use some of the lesson plans for training their Senior Linkage Line staff (SHIP). All states provide State Health Insurance and Assistance Programs (SHIPs) (Medicare.gov, “Contacts,” n.d.). These are nationwide agencies designated per state who assist retirees understand Medicare. Having a content expert within

this agency was critical for lesson accuracy and will prove extremely beneficial for future teaching opportunities.

Benefit to the Profession

For all the information available about Medicare, there are few central sources to learn about the basics of Medicare. This is true for both LEP beneficiaries as well as other beneficiaries of Medicare. This lesson is a benefit to the profession in that it offers stepping stones of information that retirees can use to make informed decisions. This curriculum offers a step-by-step approach for students. The lesson provides foundational information for both Medicare and insurance and moves the student in a step-fashion of lesser-complex to more-complex information. The lesson allows a teacher the flexibility to cherry-pick lessons that are best suited for an individual classroom. As beneficiaries need to be able to compare and contrast Medicare information to make choices, the goal of the lessons is to move beneficiaries along a knowledge continuum to be able to have an understanding of Medicare to make decisions.

Summary

In this Chapter, I reviewed my major project lessons, including a review of the literature review and how that influenced my lesson plan design. I analyzed the implications, limitations, and relevant next steps that included the future of this lesson plan, communication of those results and finally benefits to the profession.

In Chapter 1 of this capstone, I told a story of the confusion my mom was having with a medical professional regarding Medicare and how I intervened. We all said how lucky we felt to have someone who understood Medicare. That was the basis for this

capstone. After researching Medicare, including how it is communicated as well as its complexity and importance, I remain firm in my conviction that teaching Medicare is an untapped requirement that needs to be met. In reviewing statistics for health literacy, insurance and Medicare understanding, the retiree population is left to make decisions and find their way through a maze of information and still make the "right" choice with confidence and understanding. It is my goal to continue to work with the Senior Linkage staff to continue to create this lesson plan and see it come to life to assist retirees in making educated Medicare choices.

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Appendix A

Analysis of *Medicare & You 2018 Handbook* for readability

Sentence and Word Count Analysis of 2018 Medicare & You Handbook							
Section Title	**Total Number Of Sentences**	**Word Count 1-14**	**Word Count 15-20**	**Word Count 21-30**	**Word Count 31-40**	**Word Count 41-50**	**Word Count 51+**
Section 1	88	69	6	8	3	1	1
Section 2	198	103	33	44	13	4	1
Section 3	604	314	124	121	30	9	6
Section 4	87	52	23	12			
Section 5	287	175	58	43	10		1
Section 6	73	43	11	14	4	1	
Section 7	274	151	61	45	13	3	1
Section 8	137	82	28	24	3		
Section 9	266	151	57	43	13	1	1
Section 10	144	87	20	30	7		
Section 11	87	42	23	19	3		
Total	**2245**	**1269**	**444**	**403**	**99**	**19**	**11**