

Building a Community Coalition to Increase the Health Insurance Literacy of Medicare Beneficiaries

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Abstract

Empirical studies and anecdotal reports from clients and hospital social workers suggest that many Medicare beneficiaries find the Medicare policy selection process to be confusing, resulting in a reliance on uninformed or untrustworthy sources when choosing coverage during open enrollment periods. This Capstone Project addresses the problem of low health insurance literacy of Medicare beneficiaries through the development of a community coalition to educate members of the community facing Medicare plan selection decisions. A review of the literature indicates that a lack of knowledge about plan options can lead to plan dissatisfaction, plan-switching, and undesirable health outcomes due to barriers in access to care found in some Medicare plans. This project uses Community Coalition Action Theory (CCAT) as a conceptual foundation for developing coalitions seeking to provide education to Medicare beneficiaries about Medicare plans, coverage, and benefits and to empower beneficiaries to identify and avoid unethical practices leveraged by some insurance brokers. Educational interventions can be developed using information from reliable public resources and then adapted with respect to the community context unique to every coalition. The Capstone Report is accompanied by an easy-to-follow guide to coalition building employing the 14 constructs of CCAT as applied across five stages of development. The guide is presented to assist citizens who wish to join together and help to improve the health insurance literacy of Medicare beneficiaries who live in local communities.

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I would like to dedicate this Capstone Project to every Medicare beneficiary, family member, and caregiver who has faced the confusion, frustration and barriers associated with navigating the Medicare program. I hope that this guide will help to empower others with the education needed to make informed decisions about their healthcare needs. As always, my foundation of faith in God is my touchstone and has been my guiding light as I have worked through this project. My husband, Justin, and our sons Zak and Josh deserve much recognition for their unwavering support, patience, and humor.

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Building a Community Coalition to Increase the Health Insurance Literacy of Medicare Beneficiaries

Section One: Introduction to Capstone Project

As the aging population in the United States increases, so does the number of those qualifying for healthcare coverage under Medicare. In 2023, over 66 million Americans were enrolled in a Medicare plan (Center for Medicare and Medicaid Services [CMS], 2023). Medicare plans consist of Traditional Medicare (TM) and Medicare Advantage (MA). Traditional Medicare was signed into law in 1965 to provide healthcare coverage to older Americans and was expanded in 1972 to provide coverage to persons with permanent disabilities and those with end-stage renal disease (Oberlander, 2015). Medicare Advantage plans were introduced in 1997 to provide beneficiaries a choice of health insurance plans beyond TM and to transfer to Medicare the cost savings and efficiencies produced by managed care providers (McGuire et al., 2011).

An important branch of health literacy is health insurance literacy. Health literacy is defined as the ability to comprehend basic health information and to make suitable health-related decisions (Barnes et al., 2018). Health insurance literacy more specifically is necessary for beneficiaries to make informed choices that balance their perceived healthcare needs with insurance plans' costs and quality (Park et al. 2021). However, if they do not have information or the ability to make those choices, specifically at the time of enrollment, this could lead to suboptimal choices that do not support their health needs. Given the complexities in healthcare, especially concerning service delivery, financing, and associated clinical outcomes, health insurance literacy is an essential skill for individuals.

Interestingly, many Medicare beneficiaries report difficulty understanding the Medicare program, and over half do not compare coverage options on an annual basis (Park et al., 2021). Almost 90% of Medicare beneficiaries are aged 65 and older (CMS, 2024), and research shows that older adults seek less information to assist themselves in decision-making (Finucane et al., 2002; Peters et al., 2008). Seniors have also been shown to take less time deciding, make less complex comparisons, and, to some degree, less consistency in judgement (Kim et al., 2005). Ensuring that senior individuals have appropriate assistance in understanding plan information is critical.

Medicare Advantage plans currently cover around 22 million beneficiaries, or 34% of all Medicare enrollees (Rivera-Hernandez et al., 2021). The Congressional Budget Office expects that MA enrollees will make up 47% of beneficiaries by 2029 (Freed & Damico, 2019) and 61% by 2032 (Freed et al., 2022). Among key differences between TM and MA is the requirement for prior authorization of services including prescriptions, medical services, and aftercare (American Medical Association, 2024). Aftercare includes home health care, skilled nursing facilities, and inpatient rehab facilities, and each plays an important role in the continued recovery of referred patients (Skopec et al., 2023). Enrollees in MA are shown to be approved less frequently for aftercare, which possibly contributes to higher mortality rates among MA beneficiaries (Skopec et al., 2023). Some enrollees in MA may be unaware of these requirements, and it is unknown if any information related to aftercare is offered at the time of enrollment.

Social workers face the challenge of assisting older adults and those with disabilities in navigating an ever-changing climate of Medicare plan choices where plan-switching, confusion, and dissatisfaction can result when understanding of benefits is lacking (Park et al., 2021). A gap in literature exists in examining Medicare beneficiaries' understanding of aftercare benefits

following acute hospitalization, and this demonstrates the need for social work intervention. Given what is already known about the learning styles of seniors, the opportunity exists for comprehensive, research-based public health education. In response to a federal insurance program that is ever-changing and evolving, this Capstone Project has produced a guide for community coalitions to inform and empower Medicare beneficiaries to make the best decisions for their individual health needs.

This project addressed a problem of practice relevant to social workers serving in the field of healthcare. A review of literature was provided that demonstrates the confusion experienced by Medicare beneficiaries regarding the enrollment process, dissatisfaction with coverage, and deceptive marketing practices. It described the negative impact the prior authorization process has on patient satisfaction and health outcomes. This project has provided a theoretical basis to support the use of community coalitions in the development and implementation of educational interventions to increase the health insurance literacy of Medicare beneficiaries. A plan for the creation of a community coalition was outlined and included the responsibilities of members to provide unbiased information in ways that increase comprehension and lead to improved health coverage and outcomes. Finally, the ethical responsibility of social work practice in addressing this problem was discussed.

Brief Statement of the Problem

Navigating Medicare enrollment has proven to be complicated for many beneficiaries. Around 30% of Medicare beneficiaries have reported difficulty understanding the Medicare program, and approximately 57% have reported not reviewing or comparing coverage options on an annual basis (Park et al. 2021). One related study found that Medicare beneficiaries with inadequate health literacy, when provided with choices of three different MA plans, enrolled in

plans that involved a lower-premium but provided less coverage than those chosen by beneficiaries with adequate health literacy (Braun et al, 2018). Medicare beneficiaries tend to rely on the advice and direction of insurance brokers, family and friends, and do not utilize unbiased resources when choosing plans. Therefore, beneficiaries are not equipped to compare plan information such as total plan cost, provider networks, and covered services to make informed decisions (Pearson & Stoycheva, 2023).

Beneficiaries with low health insurance literacy are at increased vulnerability to the deceptive marketing practices employed by some insurance brokers. For example, some MA agents have been found to sign up enrollees for plans under false pretenses, such as telling seniors the plan's network includes their preferred providers when it does not. Other abhorrent acts include agents changing seniors' and people with disabilities' plans without their consent and marketing to individuals with dementia (The United States Committee on Finance, 2023). A critical piece of information often omitted during the enrollment process is that prior authorizations are required from the insurance provider for an enrollee to receive care recommended by their physician. Of significance, there are high rates of dissatisfaction related to authorization denials. The Office of Inspector General found that Medicare Advantage Organizations have delayed or denied beneficiaries' access to services despite those requests meeting the medical criteria defined by the Centers for Medicare and Medicaid Services, which manages both Traditional Medicare and Medicare Advantage (Grimm, 2022). MA enrollees have been found to be less likely to receive needed aftercare services following hospitalization, and receiving fewer days when approval is provided (Skopec et al., 2020). Low health insurance literacy demonstrated by Medicare beneficiaries calls for social work intervention. Connecting

beneficiaries with available resources and offering appropriate educational interventions will empower enrollees to make decisions that align with their individual healthcare needs.

Purpose of the Capstone Project

This project investigated the problem of low health insurance literacy experienced by older and disabled Americans and developed solutions for increased understanding, satisfaction, and choice of healthcare plans that meet individual needs. It is the ethical responsibility of social workers to develop methods to lessen the impact of low health literacy using research-based interventions that ensure equity and accessibility to information. One way this can be accomplished is through grassroots, community coalitions comprised of trusted members who can serve as advisors. Coalitions can provide educational interventions in many ways and can reach vulnerable and marginalized populations. The learning needs of seniors are unique, so interventions must be thoughtful and comprehensive. Research shows that Medicare beneficiaries do not always access available resources of education, yet there are existing approaches that can be easily shared. This project concluded with how similar coalitions can be developed in other communities to reach Medicare beneficiaries with education and resources.

Capstone Questions

The following questions were crafted to find solutions to the problem of practice of low health insurance literacy of Medicare beneficiaries:

1. How can the health insurance literacy of Medicare beneficiaries be increased, with particular emphasis on post-acute care benefits?
2. Who are the stakeholders in the issues surrounding low health insurance literacy and how can they be engaged in community-level interventions?

3. How can existing research be translated into developing an effective community coalition that reaches older adults, those with disabilities, and other marginalized populations with Medicare education?
4. How can an effective guide to coalition building for public health initiatives establish transferability for implementation in other communities?

Section Two: Literature Review

A review of literature has identified who is affected by low health literacy and its impact on healthcare costs and outcomes. The differences between Traditional Medicare and Medicare Advantage plans were defined, including their history and enrollment processes. Further, the challenges of choosing appropriate Medicare plans and problems related to Medicare Advantage have been discussed, including the prior authorization process and deceitful marketing strategies. Evidence of plan dissatisfaction was explored as a measure of health insurance literacy.

Health Literacy

The Centers for Disease Control and Prevention (CDC, 2024) defines health literacy as “the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others” (p. 1). Health literacy is closely linked to health equity, which is the attainment of the highest level of health for all people (CDC, 2024). While health literacy is an over-arching goal, health insurance literacy is an important step to achieve it. Quincy et al. (2012) provided a comprehensive definition of health insurance literacy as “the degree to which individuals have the knowledge, ability, and confidence to find and evaluate information about health plans, select the best plan for their own (or their family’s) financial and health circumstances, and use the plan once

enrolled” (p. 6). Varying levels of health literacy affect people in different ways, and some populations are impacted more than others.

People who live in poverty, are older, members of a minority group, have lower education levels, do not speak English as their primary language, or have a disability are more likely to demonstrate low health literacy (Wray et al., 2019). Lopez et al. (2022) found that 88% of U.S. adults have shown inadequate health literacy to navigate the healthcare system and to make health decisions based in their best interest. Of those assessed, people aged 65 and older had the lowest incidence of basic health literacy, even when they reported high socioeconomic status and good health. Older age is considered a stronger predictor of low health literacy, and this is likely due to age-related decline in cognition (Lopez et al., 2022).

Health literacy impacts clinical outcomes in that people with low health literacy do not effectively manage chronic health conditions, do not pursue routine health screenings and self-report poor health status at greater rates than those with higher rates of health literacy. A staggering 77 million Americans struggle with utilizing health resources, seeking quality care, and maintaining healthy behaviors due to inadequate health literacy (Polster, 2018). Low health literacy is also financially costly to Americans. In their report, Vernon et al. (2007) shared that low health literacy costs the U.S. economy \$106 billion to \$238 billion annually. This contributes to the overall rising costs of healthcare.

Given the number of Medicare plan choices and increased complexity of plans, the need for health literacy in choosing the appropriate insurance coverage has never been greater. Enrollment in Medicare causes stress and confusion for beneficiaries who feel they must make decisions related to their plans quickly (Better Medicare Alliance, 2020). Additional challenges to the initial enrollment in Medicare include a limited timeframe for making decisions, number

of plan options, complexity in comparing plans, and inconsistencies in plan enrollment advising (Pearson & Stoycheva, 2023). As the popularity of MA grows, so does the number of plan choices offered to enrollees. For example, in 2022 the average enrollee was faced with 39 MA plans to choose from during the open enrollment period (Pearson & Stoycheva, 2023). When numerous choices such as these are paired with low health insurance literacy, the need for intervention is evident. Social workers can provide unbiased interventions to help enrollees select a plan that works best for their individual and unique health needs.

Traditional Medicare and Medicare Advantage

Medicare was signed into law on July 30, 1965, by President Lyndon Johnson following years of opposition by the American Medical Association stemming from the notion that the country was turning to socialized medicine, and that such a program would lead Americans to surrender freedoms to government programs (Oberlander, 2015). However, despite its rocky inception, Medicare has become the largest purchaser of medical services in the United States and is an important source of income for hospitals, physicians, and other medical providers (Oberlander, 2015). In 2022, Medicare spending comprised about 21% of all national healthcare expenditures and 12% of the federal budget (KFF, 2024). And while Medicare was originally created to provide healthcare coverage to older Americans, it was expanded in 1972 to provide coverage to persons with permanent disabilities and those with end-stage renal disease (Oberlander, 2015).

MA plans were introduced as part of the Balanced Budget Act of 1997 as part of an effort to end deficit spending by the federal government and to slow the growth of hospital Medicare payments (Bazzoli et al., 2004). Medicare Advantage plans offer beneficiaries a choice of health insurance plans beyond traditional Medicare (TM) and to transfer to Medicare cost savings and

efficiencies produced by managed care providers (McGuire et al., 2011). Both TM and MA are funded by Centers for Medicare and Medicaid Services, but MA pays a set amount for each person, rather than for each service performed, as in TM. This creates a financial incentive for MA plans to keep their enrollees healthy and reduce their costs (Park et al., 2021). A key incentive to MA is that some plans offer additional supplemental benefits not available in TM (Park et al., 2021). For example, many MA plans offer dental, vision, and hearing coverage, in addition to wellness plans, while enrollees in TM must purchase a supplemental insurance plan to provide those benefits (Better Medicare Alliance, 2020). As MA programs continue to grow in popularity, it is predicted they will cover over 60% of all Medicare beneficiaries by 2032 (Freed et al., 2022).

Beneficiaries can enroll in MA or TM during defined enrollment periods. An initial enrollment period occurs three months prior and three months following a beneficiary's eligibility to enroll. Annual open enrollment for Medicare beneficiaries to join TM or MA or switch among MA plans is from October 7th to December 7th with coverage to start January 1st of the next year (CMS, n.d.-a). Enrollment in TM includes Parts A (hospital insurance) and B (medical insurance), which cover acute hospitalization and outpatient services, and Part D for coverage of prescription medications. Enrollees may also choose a supplemental coverage plan, sometimes known as Medigap, to cover out-of-pocket costs (CMS, n.d.-b). Those who enroll in MA, or Part C, plans opt for a "bundled" plan that includes Parts A and B and usually D. Further, MA plans include extra benefits, such as hearing, dental, and vision, not offered by TM and may offer lower out-of-pocket costs (CMS, n.d.-c).

Some key differences between TM and MA can be found in beneficiaries' choice of physician and hospital. Traditional Medicare will cover costs of any hospital or physician who

accepts TM anywhere in the United States. Medicare Advantage plans typically cover costs only within an established network and service area. And while enrollees in TM can generally see a specialist without a referral, many MA plans require a referral prior to seeing a specialist. Further ways TM and MA are dissimilar are reflected in out-of-pocket costs, monthly premiums, and yearly out-of-pocket limits (CMS, n.d.-a). While TM and MA have several differences, perhaps where they differ most is the requirement of prior authorization for many services provided under MA. Widely condemned by healthcare providers and advocacy groups (American Medical Association, 2024; Center for Medicare Advocacy, 2019), the prior authorization requirement can contribute to confusion and frustration in enrollees.

Prior Authorization Requirement

Although MA plans are required to follow Medicare coverage rules for healthcare items and services, MA is allowed to apply additional criteria not developed by Medicare when determining whether to authorize or pay for them. Although these criteria must not be more restrictive than TM coverage policies, they are more detailed and are intended to assist in clinical decision making (Grimm, 2022). The prior authorization process is a way for MA to control costs and ensure that requested items or services are appropriate and medically necessary for the beneficiary to receive, as well as to ensure they meet the Medicare and Medicare Advantage coverage rules. Clinical staff employed by Medicare Advantage organizations decide if the requested service is reasonable for the beneficiary to receive (Grimm, 2022).

The prior authorization process of MA has been heavily criticized for interfering in continuity of care. Denials of prior authorization requests that meet the coverage guidelines of Medicare can delay or prevent beneficiaries' access to medically necessary care, lead to the beneficiary paying out of pocket for a needed service and create burden for the medical providers

who choose to appeal the authorization denials (Grimm, 2022). According to an American Medical Association (2024) survey of 1,000 practicing physicians, 94% believed that prior authorizations led to delays in necessary care for patients and 78% felt they have contributed to an abandonment of the recommended treatment plan.

Prior authorizations can negatively impact hospitalized patients who require aftercare services. Skopec et al. (2020) looked at post-acute care (skilled nursing facility, inpatient rehab facility, and home health) use among Medicare beneficiaries who were hospitalized following joint replacement, stroke, or heart failure. They found MA enrollees were less likely to receive care in a skilled nursing facility or inpatient rehab center and less likely to receive home health care. Patients were more likely to be discharged from the hospital to the community without any post-acute care. Further, MA beneficiaries who did receive post-acute care received fewer days than those with TM (Skopec et al., 2020). Post-acute care in a skilled nursing or inpatient rehab facility is significantly more costly than home health care visits, which may lead MA organizations to scrutinize the details of requests for these levels of care (Grimm, 2020).

Over 35 million prior authorization requests were submitted to Medicare Advantage organizations in 2021, and over two million of those requests were fully or partially denied. Medicare Advantage organizations are not required to disclose why a request is denied, such as if the request was not deemed medical necessary or insufficient clinical documentation was provided (Biniek & Sroczynski, 2023). Biniek and Sroczynski (2023) found that only 11% of denials were appealed, but over 80% of those appeals were overturned. Reasons behind physicians deciding against an appeal include not believing the appeal will be successful based on past experience, the patient not being able to wait on the determination, and insufficient staff, resources or time to devote to the appeal process (American Medical Association, 2024).

Seventy-three percent of physicians surveyed by the American Medical Association (2024) reported that prior authorization denials have increased somewhat to significantly over the past five years, and one in four believe their requests are often or always denied. The prior authorization process can be confusing even for healthcare professionals and is an identified opportunity for education of Medicare beneficiaries during enrollment periods.

Plan Switching and Changes in Coverage

Park et al. (2021) informed that plan switching can serve as evidence that some MA enrollees may not be satisfied with their plans. Plan switching includes a beneficiary's decision to transition from MA to TM or to remain in MA but change to a different plan. Plan switching can be an indicator of a member's dissatisfaction with plan benefits, costs, or provider networks (Park et al., 2021). Martino et al. (2021) added that plan switching in MA may also be an indicator of poor quality of care. There is evidence to show that beneficiaries with MA plans receive care from skilled nursing facilities and home health providers with lower quality ratings due to MA limiting a beneficiaries' network or providers (Meyers & Rahman, 2018; Schwartz et al., 2019). Voluntary disenrollment from MA plans is shown to occur at higher rates for beneficiaries younger than age 65, who typically have disabilities, and for beneficiaries in poorer health. Further, Ankuda et al. (2020) found a higher rate of plan switching from MA to TM following the onset of disability, which could indicate dissatisfaction of patients and their families with plan options, particularly the provider networks imposed by MA. Medicare beneficiaries may not be aware of the "Medigap trap" when switching from TM from MA. Medigap is offered by private insurers and guaranteed to a beneficiary when they initially sign up for TM. However, when beneficiaries try to switch back to MA, these insurers assume that

beneficiaries will likely require more expensive medical care and can either deny coverage outright or set the costs too great for the beneficiary to afford (Ginsberg & Lieberman, 2024).

Disparities in health care could also contribute to plan switching. Though racial and ethnic disparities in plan disenrollment from MA plans has not been widely studied, there are notable findings. For example, racial and ethnic minority members with low incomes show a disproportionate number of enrollees in MA (Rivera-Hernandez et al., 2021). This could be due to lower costs of MA plans in comparison to TM (Martino et al., 2021). When compared to White, non-Hispanic Medicare beneficiaries, racial and ethnic minority beneficiaries report worse care coordination, more difficulty receiving needed care, worse experiences with prescription drug coverage, lower rates of immunizations, and worse clinical care for depression, cardiovascular disease, and chronic obstructive pulmonary disease. Low health insurance literacy is more common among racial and ethnic minority beneficiaries than among White beneficiaries, thus making plan switching more difficult to navigate (Martino et al., 2021).

Decision-Making and Choice in Older Adults

While research has shown that older adults are as capable to make decisions as younger adults (Fitten et al., 1990; Stanley et al., 1984), Braun et al. (2018) found that some older adults may have difficulty comprehending health insurance, which leads to a disconnect between what they want from an insurance product and what they end up choosing at initial enrollment. Older adults have been shown to seek less information to assist them in decision-making (Finucane et al., 2002; Peters et al., 2008). Additionally, seniors have demonstrated they take less time deciding, make less complex comparisons (Kim et al, 2005), and have a greater reliance on shortcuts (Federman et al., 2008). These findings are concerning that beneficiaries show decreased likelihood to understand plan coverage and benefits.

Although there are existing resources available for Medicare beneficiaries, research suggests that most do not utilize them (Ochieng et al., 2022; Pearson & Stoycheva, 2023). A research poll conducted by KFF in 2019 for the open enrollment period of 2020 found that only 3 in 10 Medicare beneficiaries compared their current plan to other plan options in their geographic area. Further, only around half of MA beneficiaries checked their plans for potential changes for the upcoming year. Over half of beneficiaries did not use the Medicare.gov website and well over half (7 out of 10) did not call the Medicare hotline with questions (KFF, 2019). This demonstrates that informative resources offered through Medicare are not widely used. Additionally, beneficiaries with lower income and Black and Hispanic beneficiaries are even less likely to access resources, as are those 85 and over and dually eligible for Medicare and Medicaid (KFF, 2019). While resources exist to assist Medicare beneficiaries, they are not utilized to make educated decisions about healthcare coverage.

There are legitimate resources available to Medicare beneficiaries when choosing a plan. These include the *Medicare & You* handbook, Centers for Medicare and Medicaid Services (CMS) websites, Medicare.gov, Administration for Community Living (ACL), State Health Insurance Assistance Programs (SHIPs), and insurance brokers (Better Medicare Alliance, 2020). Despite these resources, older adults tend to rely on family, friends, and providers when choosing a plan. Additionally, some older adults are influenced by health plan recognition and marketing, leading them to choose by familiarity rather than facts (Jacobson et al., 2014). Enrollment in Medicare causes stress and confusion for beneficiaries who feel they must make the decisions related to their plan choices quickly (Better Medicare Alliance, 2020). Further, some seniors have found it difficult to compare plans due to the amount of information they are subjected to through the mail and media, such as television and radio. Seniors have expressed fear about

switching plans due to unforeseen out-of-pocket costs or changes to their existing provider networks and therefore remain in their existing plans (Jacobson et al., 2014).

Ali et al. (2021) reported that 96% of Medicare Advantage enrollees partner with insurance agents when making enrollment decisions, and those agents are not required to disclose all available plans. The broker tools used by agents during the enrollment process often contain less than half of the available Medicare Advantage plans, and enrollees may not be offered the top-rated plans. Concerns regarding deceptive marketing practices abound in MA to entice beneficiaries to enroll in MA or switch to another existing plan (The United States Committee on Finance, 2023). One practice of concern is the use of mailers made to look like official communication from federal agencies. Further, some MA agents have been found to participate in deceptive marketing practices, misleading beneficiaries in enrollment options and choice of plan. Some plans have experienced high rates of disenrollment due to misleading and aggressive marketing tactics, thus signaling dissatisfaction by beneficiaries. Although the Centers for Medicare and Medicaid are working to crack down on these marketing strategies, they continue to persist (The United States Committee on Finance, 2023).

Theoretical Framework

Community coalitions are defined as “a group of individuals representing diverse organizations, factions, or constituencies within the community who agree to work together to achieve a common goal” (Feighery & Rogers, 1990, p.2). Community coalitions bring people together and expand their resources to focus on a problem of common concern (Butterfoss & Kegler, 2002). The Community Coalition Action Theory, or CCAT, was first introduced by public health researchers Frances Butterfoss and Michelle Kegler in 2002 and provides an

overarching framework for what is known about coalitions from an empirical approach as well as through years of recorded collective experiences (Butterfoss & Kegler, 2009).

Community Coalition Action Theory is based upon 14 constructs that include stages of development, community context, lead agency/convener group, coalition membership, processes, leadership and staffing, structures, member engagement, pooled member and external resources, collaborative synergy, assessment and planning, implementation of strategies, community change outcomes, health/social outcomes, and community capacity. This framework imparts that coalitions go through stages from formation to institutionalization, and loop back frequently to earlier stages in response to issues that arise or as cycles are completed (Butterfoss & Kegler, 2002). Each stage is influenced by the community context, which is comprised of the sociopolitical climate, norms and values, geography, and any history that surrounds previous attempts at community coalitions. These factors impact who might participate in coalition activities and the types of intervention strategies that are practiced within the community (Kegler et al., 2010).

CCAT finds its origins in the theoretical foundations of the development and maintenance of community coalitions that include community development, citizen participation, political science, interorganizational relations, and group processes (Butterfoss & Kegler, 2002). The approaches of community development and community participation provide the underpinnings of communities employing the ability to solve their own problems and control, adjust or participate in how major changes impact their communities (Butterfoss & Kegler, 2002). Further studies in interorganizational collaboration have contributed to the development of CCAT, including Resource Dependence Theory, which considers how acquiring resources and reducing uncertainty contribute to collaboration (Mizruchi & Galeskiewicz, 1994; Sharfman et al., 1991).

Another contributing model is Institutional Theory, which imparts that organizations seek legitimacy through adjustment to institutional directives and norms (Gray & Wood, 1991; Gulati, 1995).

CCAT is primarily applicable to community coalitions and informs that a coalition should be comprised of organizations rather than individuals to reach its maximum potential. Further, it does not apply to short-term grassroots coalitions that form to address a specific issue and then dissolve once the goal is achieved (Butterfoss & Kegler, 2002). A defining feature of CCAT is that it combines practice wisdom with empirical data to explain how community coalitions can achieve change and the outcomes they are seeking (Kegler & Swan, 2011a). Finally, CCAT emphasizes change not only in social issues, but also public health matters (Kegler et al., 2010).

Practice in the community and advocacy for vulnerable populations are hallmarks of social work. Rothman (2008) conceptualized macro social work practice as social planning, locality development, and social advocacy. Social workers draw from knowledge about social determinants of health, health promotion, and measurements of inequality to better understand populations and the communities in which they work (Canty, 2021). Additionally, social workers hold expertise and practice wisdom to identify problems of practice within communities and develop macro responses for the betterment of those they serve. When considering older and disabled adults with low health insurance literacy, social workers must research and consider what interventions have proven effective, and how best to implement those practices in the community context. CCAT offers propositions that provide a basis for the development and maintenance of community coalitions and how they contribute to successful action and health outcomes (Butterfoss & Kegler, 2002). Community coalitions can potentially enhance the community's capacity to determine solutions for a wide range of concerns (Kegler & Swan,

2011b). CCAT will provide the strong theoretical framework necessary to confront the problem of practice of low health insurance literacy for the Capstone Project.

Section Three: Methodology

Practice Setting and Audience

The practice setting for this Capstone Project exists in multiple places but originates from the perspective of medical social work in an acute care hospital. Medical social workers in hospitals partner with patients and families to coordinate the most effective and safest discharge plans for patients. Evidence of patient involvement in discharge planning and the recognition of patient goals and desired outcomes is required by the Centers for Medicare and Medicaid Services (CMS) as a condition of participation for hospitals (CMS, 2024). Hospital discharge planning is heavily impacted by a patient's insurance coverage, or lack thereof, and patients who have Medicare Advantage plans often require increased time and effort to determine a plan due to the constraints placed by their individual plans.

Southwest Missouri is a primarily rural setting, with many small communities scattered throughout the area. The counties of Jasper, McDonald, and Newton demonstrate elevated levels of poverty coupled with lower levels of education (United States Census Bureau, 2022). Medicare beneficiaries in rural areas demonstrate higher rates of switching from Medicare Advantage to Traditional Medicare, and particularly those who have greater health needs (Park et al., 2021). This suggests a level of dissatisfaction with coverage, which may be related to more restrictive provider networks in rural areas and lessened overall value of Medicare Advantage plans (Park et al., 2021). Increased health insurance literacy could help to decrease levels of dissatisfaction among Medicare beneficiaries (Braun et al., 2018).

Aftercare entities, such as home health, skilled nursing facilities, acute inpatient rehab units, and long-term acute care hospitals serve as partners to hospitals and bear witness to how Medicare Advantage plans can limit patients' access to these needed services (Skopec et al., 2020). Additional stakeholders include staff of senior centers and the Area Agencies on Aging, which also provide services and access to seniors through community events. Those employed by these organizations could serve as valuable members of community coalitions as they offer helpful perspectives related to gaps in community education and can assist in identifying opportunities for educational interventions.

Direction on how to organize and manage a community coalition to educate Medicare beneficiaries could be helpful for other small communities throughout the nation as Medicare is a federal program and the most significant differences are likely found in coverage that is based on provider networks. Community members will have access to guidance in how to engage local stakeholders to form a coalition and then develop interventions specific to the socioeconomic and health needs of their regions. The processes undertaken for this community intervention can be shared with other acute care hospitals, physician clinics, aftercare providers, Area Agencies on Aging, and individual senior centers. Further, the plan for such a coalition could be adapted to larger regions rather than merely individual communities to further strengthen and expand interventions. The inclusion of key stakeholders in identified locations is necessary for the success of the coalition and is one of the first steps that must be taken.

Student Positionality

After serving over 17 total years as a medical social worker including 10 of those in leadership, I am a witness to the rise in popularity of Medicare Advantage plans as well as the impact they can have on aftercare options for patients. I have interacted with many patients

grappling with the realization that they were targeted by deceptive marketers and switched to Advantage plans without their consent or that their plan was switched without their knowledge. One meaningful example is the elderly gentleman with mild dementia and hearing loss who was baited by a marketer with the promise of free hearing aids via a phone call and switched to an Advantage plan. This man suffered a serious stroke just a few weeks later and was unable to transfer to an acute inpatient rehabilitation center for continued therapies due to a substantial daily copay that would not have been required had he remained with his Traditional Medicare plan. His family expressed dismay and helplessness and looked to me for answers. I shared their indignation, but I was unable to provide any comfort or assistance in that moment.

As similar situations continued to occur, I began to consider how I could advocate on behalf of not only the patients I serve through my job, but others in the community who are impacted. I concluded that insurance companies are not going to change and will forever be driven by profit. Therefore, the best way to advocate is to provide education to Medicare beneficiaries and give them the tools necessary to make educated decisions for their personal health needs. After personal consideration and conversations with fellow providers, I decided to pursue a Capstone Project in the form of a community-level effort to address the health insurance literacy of Medicare beneficiaries as well as their adult children, who may be assisting them in these important decisions. The timing was perfect to address this problem of practice through my Capstone Project, and to have access to guidance from experienced professors regarding the best methods of implementation within community settings.

I am admittedly biased against Medicare Advantage providers, and this is an area where I must maintain awareness. Some Medicare beneficiaries are unable to afford Traditional Medicare and are better served by Medicare Advantage through their plan's prescription coverage as well

as the often-added dental and vision benefits. Other beneficiaries argue that Medicare Advantage has served their needs well and they see no need to switch. Still others are locked into Advantage and are no longer eligible to switch back to Traditional Medicare without penalty (Ginsberg & Lieberman, 2024). I do not want to cause any beneficiaries to feel as if they are being shamed during interventions implemented by this coalition. Additionally, I must recognize and accept that Medicare Advantage may be the best plan for some people, and they have the right to choose. I must remain diligent to avoid imposing my beliefs on others to their detriment or to allow my feelings to bias project resources.

Capstone Project Design

Project Typology and Educational Artifacts

This Capstone Project developed a guide for community coalition building with action plans to increase the health insurance literacy of Medicare beneficiaries. This project's artifact is a guide created to share with communities that desire to create similar coalitions for Medicare education. As demonstrated in Figure 1, the guide is a macro-level intervention model. Its contents were comprised of information based on the constructs of the Community Coalition Action Theory (Butterfoss & Keglar, 2009) and presented in a manner that is easily followed and an appropriate reading level. Guide contents were organized into four sections that describe coalition formation, implementation, maintenance, and institutionalization. Chapters within each section of the guide further described the coalition formation, management, and sustainability of the coalition. The guide also offered a fifth section that included troubleshooting tips for coalitions navigating turf wars among members, member fatigue, and conflicts that inevitably arise when groups of people work together. The final goal of this manual, *Empowering*

Communities through Medicare Education, is for it to be widely shared and utilized by other communities with the common vision of serving Medicare beneficiaries.

Strategies of Community Coalition Action Theory

Coalitions have demonstrated the potential to be an effective approach to a myriad of social problems (Chen et al., 2023). They have been shown to be holistic and comprehensive, flexible and responsive, contributing to a sense of community, enhancing residence engagement in community life, and providing a route of empowerment to community members (Wolf, 2001). Wolfe (2001) has suggested that community coalitions can serve to address problems not only faced locally, but sometimes nationally. Tenets of community building include capitalizing on local capacity for problem solving, building of relationships between communities and resources, fostering community participation in the policymaking process, and dealing with the links between race and ethnicity and systemic inequity (Blackwell & Colmenar, 2000).

Engaging in the construction of a community-wide coalition requires a model that specifies tasks that occur as members work through engagement, formation, rule and norm setting, goal identification and other structural components of planned community action. To define these processes, the 14 constructs of the Community Coalition Action Theory were applied (Butterfoss & Keglar, 2009). Each of the constructs is influenced by the communities in which it exists and will experience threats and opportunities unique to the region, which in this case is the rural Midwest. The guidebook focused attention on the four stages of development and the cultivation of a variety of factors that predict success in coalition development, including overcoming common barriers to coalition success. These are summarized in Figure 1 which provides a visual explanation of how the stages of development differentially focus on cultivating various constructs necessary for a successfully functioning coalition. Additionally,

resources from the University of Kansas *Community Coalition Tool Kit* model were accessed to further reinforce coalition development (Center for Community Health and Development, n.d.).

For this Capstone Project, an explanatory guide was developed for use by other communities that wish to create a similar coalition. There is availability of instructional materials for coalition development, such as that provided through the Prevention Institute (Cohen et al., 2002). However, a manual specific to community coalitions addressing the gap around Medicare education has not been located. The guide was designed to be a creative and thoughtful product that is easy to understand by readers and could also be used by community members who are not social workers or healthcare professionals, but rather concerned citizens who wish to take action. The attitudes held by many Americans about health insurance were revealed in December of 2024 following the murder of the CEO of United Health Care. The frustration and powerlessness related to barriers to care placed by insurance providers was voiced by many, and the results of a poll by the Associated Press reflected that 7 in 10 adults believe that insurance companies hold “a moderate amount” of responsibility for the CEO’s death (Sanders et al., 2024). This level of frustration further reinforces community attitudes about barriers encountered with Medicare Advantage plans and serves to confirm the need for a coalition to serve Medicare beneficiaries. It is hoped that this manual will serve as a guide and for others who desire to assist seniors in Medicare education.

Theory of Change Models

Important functions of a community coalition are to plan and launch community initiatives and to pool resources (Center for Community Health and Development, n.d.). The goal of this Capstone Project was to use the Community Coalition Action Theory to design a guide that can be used by coalitions to increase the health insurance literacy of Medicare beneficiaries

(Butterfoss & Kegl, 2009). CCAT was considered as the foundation for community members to partner together to implement already existing educational interventions that are available through the State Health Insurance Assistance Program (SHIP) (Garrido et al, 2024) as well as interventions developed to help seniors identify deceptive marketing tactics by insurance brokers. However, interventions cannot be successfully implemented without a viable and functioning coalition with a shared vision. A thriving coalition could increase the strength and effectiveness of the community's response to the problem of low health literacy of Medicare beneficiaries (Butterfoss & Kegl, 2002; Butterfoss et al., 1993). A logic model outlining CCAT to coalition building is provided in Figure 2. The logic model illustrates the stages of coalition development and the roles of constructs in building a viable coalition. Distinguishing strategies and outcomes through a functional theory of change can increase the opportunities for success for a community coalition with such a goal.

The theory of change model for this Capstone Project is found in Figure 3 and clarified the purpose and focus of effort for a community coalition of this nature (Gienapp & Hostetter, 2022). This explanatory theory of change graphic was included within the guide to serve as a touchstone for stakeholders regarding the coalition's direction and focus. Strategies focused on ensuring that the coalition's purpose remains at the forefront and that the correct people are involved. It is shown that Medicare beneficiaries face overwhelming challenges when navigating enrollment options and choices among Medicare Advantage plans, and experience frustration with limitations those plans may later impose (Pearson & Stoycheva, 2023). Healthcare providers and other affected members of the communities of Southwest Missouri share these frustrations and have voiced the commitment to provide unbiased, community-based education efforts and are thus critical additions to membership. Additionally, efforts to include diverse

Medicare beneficiaries within the community will allow the coalition to better understand the challenges experienced by these individuals. The perspective of Medicare beneficiaries can demonstrate different viewpoints, how change can happen, and what might impede it (Gienapp & Hostetter, 2022). The strategies of the coalition seek to empower Medicare beneficiaries to make educated decisions regarding their choice of plans.

Ethical Considerations

When developing an ethical approach to educational programming, materials must be created with consideration of the needs of all potential recipients. For example, Medicare beneficiaries include older adults and those with disabilities, so ensuring equal access to education and informative materials to everyone is critical. Further, maintaining knowledge related to the frequent changes to Medicare plans and coverage is vastly important to confirm the correct information is being dispersed. This reflects the *Code of Ethics* in monitoring and evaluating policies, implementation of programs, and interventions for practice, but also serves to secure competence in what information is being offered (NASW, 2021, Section 5.02a). It is essential to not allow personal biases to drive how information is presented to steer the decision-making of others. A further step is ensuring availability of coalition members following educational presentations for follow-up questions, unbiased support, and resources. A final ethical consideration relates to the community stakeholders who comprise the coalition. As many of the members are employed by organizations who serve seniors in the provision of healthcare-related services, the potential for inducement is a valid risk that must be recognized. It is essential that the work of the coalition be kept separate from the services offered by participating organizations. This agreement can be established within the coalition framework as rules and regulations are defined.

Section Four: Solutions for Social Work Practice

This section will present the final Capstone artifact and discuss the plan for its dissemination. The Capstone Project's significance and expected contributions to social work practice will be discussed, as well as its limitations. Finally, a reflection on the Capstone process and the process of scholarly inquiry and academic growth will be shared.

Capstone Project Artifact

The guidebook, *Empowering Communities through Medicare Education: A Guide to Coalition Building*, is this project's artifact. Presented in a file that is supplemental to this report, the guide will be available to communities in both print and online forms. This guide leads the reader through 16 chapters that describe processes for the formation, maintenance, and institutionalization of a coalition based on Medicare education. Additionally, the guide addresses the transferability of coalition success from rural to urban areas and common barriers to a coalition's success.

Project Significance and Contributions to Social Work Practice

The National Association of Social Workers (NASW, 2021) *Code of Ethics* directs that a social worker's primary goal is to help people in need and address social problems. The barriers encountered by Medicare beneficiaries related to insurance providers are an identified and significant social issue that often seems insurmountable to address. Insurance providers are unlikely to change their approaches, and a social work response to this is to equip beneficiaries with the knowledge that empowers them in their healthcare decisions and decreases their overall sense of powerlessness. A social worker at the helm of a community coalition with the purpose of Medicare education and advocacy reflects the ethical principle of "promoting respect for the

value, integrity, and competence of the social work profession” (NASW, 2021, Section 5.02c). An experienced and knowledgeable social worker can provide the leadership and direction necessary for the success of such a coalition. Finally, a social worker who is also a scholarly practitioner can assist in evaluating the effectiveness of the coalition’s interventions and ensure they are adapting interventions as needed to meet the unique needs of all beneficiaries.

This project addresses a social issue that is recognized as a problem at the federal level. While the focus is on the establishment of a community coalition to address Medicare literacy, its impact could reach beyond neighborhoods to impact policies that drive the regulations imposed on Medicare by the Centers for Medicare and Medicaid Services. There are national organizations that focus on advocacy for Medicare beneficiaries, including the National Council on Aging, Center for Medicare Advocacy, AARP, and the Medicare Rights Center. The work of these agencies serves to reinforce that low health insurance literacy of seniors is an identified issue of concern. Sustained coalitions are more likely to establish credibility with policymakers (Centers for Disease Control and Prevention, 2008). Therefore, a successful coalition could secure relationships with state representatives that would lead to opportunities for advocacy at a much higher level of government.

Plans for Dissemination

The practice setting for this project originates in hospital settings, in this case Freeman Health System in Southwest Missouri. However, there are many other small, rural hospitals in the remaining regions of the four-state area that include Southeast Kansas, Northeast Oklahoma, and Northwest Arkansas. Some of these hospitals have added basic Medicare education to their websites, which indicates a recognized need for increased education not only for the patients treated, but others in the community. As hospitals are often trusted sources of information within

the communities they serve, they are a natural choice to serve as the lead organization in a coalition. This guide can be shared with leadership within hospitals, such as directors of social work, case management, and nursing, as well as those in administration. A potential outcome from sharing this guide with fellow hospitals is the strengthening of collaboration among neighboring communities over this common issue of concern.

Another opportunity for dissemination is via stakeholders who are members of the healthcare community. This includes those who serve in nursing facilities, acute rehabilitation units, home health agencies, and long-term acute care hospitals. Often, these providers work under the umbrella of a regional office. Therefore, contacting leadership at those levels would be necessary for agencies that are not privately owned. Regardless, employees of these providers are passionate about serving seniors and recognize how Medicare beneficiaries are impacted by low health insurance literacy. Further, they are often eager to help improve the lives of those they serve. Sharing this guide with regional directors will provide a tool for healthcare professionals to act within their own communities and develop distinctive Medicare education interventions.

A final method for dissemination is to present coalition outcomes at social work conferences. As the coalition evolves and initiates educational interventions to targeted populations, the impact on health insurance literacy within identified communities can be shared. While data related to interventions is essential, the role of the coalition could also be a subject of interest to conference attendees. The growth process of the coalition can be linked back to CCAT and its related constructs, and the contents of this guide can be used to navigate discussion points throughout a presentation about coalition development for Medicare education. As this is a rather unique topic for a social work conference, it may generate interest among those desiring to serve Medicare beneficiaries in their own communities.

Limitations

A notable limitation of this Capstone Project includes its planned scope in that only those living in Southwest Missouri are included. Southwest Missouri is poised among the four-state area of Southeast Kansas, Northeast Oklahoma, and Northwest Arkansas. The focus on Southwest Missouri prevents Medicare beneficiaries living nearby from receiving the benefits that the coalition could provide. Additionally, as membership will be limited to organizations and providers practicing in the Southwest Missouri area, it is questionable if the results achieved by the coalition could be transferable to surrounding areas due to the unique perspectives and experiences of participating members in different states. Coalitions in larger communities may achieve positive results, but through different interventions adapted to their areas.

Transferability is also a limitation when considering the creation of similar coalitions in larger communities. Lincoln and Guba (1985) describe transferability as the method in which the causal relationships in one study remain consistent in other populations, settings, or times. Transferability can ensure that approaches can be learned from and built upon by others (Stalmeijer et al., 2024). A wider and deeper pool of stakeholders in urban areas may contribute to coalition membership that looks much different than ones in smaller, rural communities. Further, goals of larger coalitions may differ due to beneficiary needs. While a larger coalition's structure can be built upon the constructs of CCAT, it must be adapted to better meet the needs of the communities it aims to serve (Butterfoss & Keglar, 2009). The achievements of smaller coalitions do not necessarily reflect what can be expected by others.

Sustaining the activities of the coalition is a limitation as members may become fatigued over time or leave to pursue other relevant social issues; others may become too busy with their daily commitments to make time for meetings. Eager and energetic members may experience burn out if responsibilities are not balanced throughout the coalition. Educational interventions may require time commitment outside of regular working hours, which impacts those with children or other family members who require their presence and care. A final and significant challenge to sustainability includes the potential for competition among aftercare providers, as they vie for referrals of Medicare beneficiaries to their services. This can create contention among members that leads to conflict and disruption. Employees of aftercare providers may be eligible to receive bonuses based on the number of referrals they retain, which can also contribute to the temptation to recruit new patients.

Scholarly Practitioner Reflection

I have served in the social work field for many years since completing my master's degree at the University of Kansas in 2006. I chose the administrative and advocacy tract, which I felt was a better fit for my skills and personality and have never regretted that choice. Following graduation, I briefly worked as a resource director/grant writer for a small nonprofit in Joplin, Missouri, before being hired at Freeman Health System in 2008 as a medical social worker. I then accepted a leadership role over the Social Services department in 2017, where I have served ever since. Despite being proud of my master's degree, I always felt there was more I could achieve to better myself as a social worker and to further develop the department I have been tasked to lead at the hospital. I investigated the PhD program but was hesitant to pursue it due to the life changes it would require and the impact it could have on my family and career, and I simply did not feel I had the extra time or energy to spare. I recall receiving a survey from

KU a few years ago regarding the DSW program and thinking that it would be a good fit with my career goals. I now stand on the brink of completing this new program and am very proud of this accomplishment.

Our cohort discussed impostor syndrome at length the first several weeks of class, and although this has continued to plague me throughout this program, it will never be at the level it was our first semester. My first day of class brought with it the realization that life would be changing, and the level of commitment required for this program would be different than anything I have experienced. It also became clear that the quality of work expected from us would be at a high level. Re-familiarizing myself with APA format and academic writing posed some challenges early on, but after receiving feedback on those first few assignments, I began to grasp the expectations. Finally, I was eventually able to adapt my daily life to include work, family, and classwork. Once I began to understand the big picture of the program and realized how supportive our instructors are, my anxiety lessened, and I could focus on learning. I also began to believe that, although the balance was precarious at times, I could still maintain my focus on my work and family while completing a rigorous and demanding doctoral program.

One of the exercises in our first leadership class included determining our strengths, and I discovered my top strength to be Harmony. While this was not surprising, it did confirm to me my guiding approach to leadership is that “we are all in the same boat, trying to get the boat where we are going” (Rath, 2007, p. 97). That assessment further revealed to me that I thrive in a problem-solving environment and can sometimes take care of issues myself instead of allowing my employees opportunities to grow and figure out solutions without my guidance. I still sometimes find myself intervening too quickly at work, but I can recognize this and have made effort to step back. The leadership class was very beneficial to me in that it allowed me to apply

theoretical approaches immediately to my daily work. It provided valuable insight into my leadership approaches and revealed weaknesses and strengths. A final takeaway from that leadership class was learning about servant leadership. This approach to leadership is something I strive to achieve, as well as to seek a healthy balance between being a supervisor and mentor to those I lead.

When our cohort was introduced to the field of implementation science, I recognized that I have a responsibility to assume an important role in closing the research to practice gap. A DSW stands in a unique and valuable position in that our experience in the social work field paired with knowledge about research can help to create a bridge between researchers and the communities they hope to impact. Further, it is the ethical responsibility of a DSW to advocate for others and ensure that the voices of those being impacted by interventions are actively pursued, validated, and immersed within the development, dissemination and adaptation of interventions. Implementation science is one of the fields of study where DSWs can make significant impact due to their substantial level of practice wisdom. This is necessary to protect individual clients and communities and to identify potential barriers to the overall success of interventions.

My initial consideration for my Capstone Project was related to overall health literacy. However, I soon recognized a valuable opportunity to impact the glaring lack of understanding held by many Medicare beneficiaries related to their benefits. This has been a constant source of frustration for me and many of my friends and coworkers who serve in the healthcare field. A literature review related to low health insurance literacy led me to a world of research related to the impact and outcomes this issue has on patients, and particularly those who enroll in Medicare Advantage plans. For example, although I am a frequent witness of the barriers placed on

aftercare for Medicare Advantage beneficiaries, I was unaware that those restrictions have been linked to higher mortality rates in patients (Skopec et al., 2020). I now feel responsible for using my knowledge and experience to help Medicare beneficiaries receive the level of care they deserve and to better understand what they are signing up for during Medicare enrollment.

It is a fact that insurance companies are unlikely to change unless required by law and will not place a patient's needs above their profits, so a practical intervention is to empower Medicare beneficiaries with education about both their plans and the measures taken by some insurance brokers to harass, mislead, and scam them about Medicare Advantage plans and benefits. It is not uncommon for patients to admit to the hospital with two different Medicare Advantage plans or to have been switched from one plan to another without their knowledge or consent. Many of these patients have some form of dementia or hearing limitation which impacts their capacity to make these important decisions. Often, the spouse or children of these patients are unaware that these changes have occurred and are unsure what to do. It is also disheartening to watch insurance companies deny patients needed aftercare following a serious illness or injury and to experience the frustration of physicians who must pivot discharge plans when their professional recommendations are dismissed.

I enjoy frequent interaction with representatives from community healthcare providers, such as nursing facilities, home health agencies, long-term acute care hospitals, and others as part of my daily work activities. For some time, we have been commiserating about Medicare Advantage and how we wish patients knew what they were signing up for when they enrolled in some of the plans. As time passed, I grew weary of complaining and considered that something needs to be done to better educate community members about Medicare. After a fruitful discussion with my Chair during a meeting about my Capstone Project, the idea of a community

coalition was formed. I then stumbled upon the Community Coalition Action Theory (Butterfoss & Keglar, 2002) and believe that it provides strong theoretical support for the community interventions I would like to implement. The 14 constructs that support the theory are practical and applicable to the development, maintenance, and sustainment of a coalition (Butterfoss & Keglar, 2002). I am very eager to see how this coalition can impact patients in the Southwest Missouri area, but I believe my Capstone Project will be a true success if other communities are able to use its artifact to build their own coalitions.

As the finish line to my DSW experience nears, I am experiencing many emotions. I do not feel that I am the same person I was when I began and have discovered that I have more grit and determination than I sometimes give myself credit for. I have grown in confidence in public speaking, and I believe my academic writing has been taken to a new level. The curriculum that was developed for this program has given me a broad foundation of knowledge that can be applied to many areas of my personal and professional life and will perhaps lead me down unexpected paths. And although I may not end up in academia, I am hopeful I will have opportunities to contribute to scholarly work in the future. I appreciate the challenge posed by this program and would not want it any other way. I will always treasure this experience and be proud to have been a member of the first cohort of the DSW program at the University of Kansas.

Summary

This Capstone Project addresses the problem of practice of low health insurance literacy of Medicare beneficiaries. Research reflects that many beneficiaries demonstrate low comprehension when comparing Traditional Medicare and Medicare Advantage, do not access existing resources for insurance information, and rely on friends, family members, and insurance

brokers to guide them in making decisions about their plan choices. Further, many seniors are unprepared to identify the deceptive marketing tactics practiced by many Medicare Advantage insurance brokers. It is social workers' ethical responsibility to defend this vulnerable population and equip them with tools to make the best decisions for their individual healthcare needs.

The artifact created for this project is titled *Empowering Communities through Medicare Education: A Guide to Coalition Building* and is a guide to building a community coalition that utilizes existing resources to increase Medicare health insurance literacy. Coalitions that choose to implement the guide will be comprised of stakeholders who recognize this problem and choose to collaborate with others to connect beneficiaries to resources and offer educational interventions. The guide is based on the Community Coalition Action Theory (CCAT), which offers 14 constructs on which to frame the coalition's structure, activities, and assessment. Although the coalition for this project focuses on the Southwest Missouri area, the guide can be used to assist other communities in building a coalition of their own. It is hoped that this intervention can be transferable and adapted to meet the needs of many communities. The ultimate goal of this project is to empower Medicare beneficiaries to demonstrate the skills necessary to make educated decisions about their health insurance coverage and to recognize and quash marketing tactics.

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Figure 1

Artifact Guide Content for Medicare Literacy Community Coalition Implementation Model

Section 1: Formation	Section 2: Implementation	Section 3: Maintenance	Section 4: Institutionalization	Section 5: Overcoming Barriers
<p>Section Chapters:</p> <p>Data supporting need for educational intervention</p> <p>Theory of Change Model</p> <p>Relevance of community context</p> <p>Assignment of lead agency</p> <p>Core members</p> <p>Development of gatekeeping mechanism</p>	<p>Section Chapters:</p> <p>Communication processes</p> <p>Norms and rules for meeting structure</p> <p>Development of leadership and coalition structure</p> <p>Implementation of Medicare education resources</p>	<p>Section Chapters:</p> <p>Sustainment of member involvement</p> <p>Pooling of member resources</p> <p>Mobilizing member talents</p> <p>Achieving synergy among members</p>	<p>Section Chapters:</p> <p>Embedment of coalition policies and approaches within the community</p> <p>Transferability of coalition processes to other communities</p>	<p>Section Chapters:</p> <p>Identifying and addressing member turf wars</p> <p>Overcoming member fatigue</p> <p>Transforming conflicts into growth</p>

Note. This guide will be organized into sections and chapters related to the stages of community coalition implementation based on the Community Coalition Action Theory.

Figure 2

Logic Model to Address the Health Insurance Literacy of Medicare Beneficiaries in Southwest Missouri Using a Community Coalition

Program Inputs	Initial outcomes	Intermediate outcomes I	Intermediate Outcomes II	Ultimate Outcome
<p>Constructs defined by the Community Coalition Action Theory</p> <p>Existing resources for unbiased Medicare counseling and education</p> <p>A demonstrated lack of health insurance literacy by Medicare beneficiaries</p> <p>Recruitment of core group members</p> <p>Initial meeting is conducted successfully</p>	<p>Members have knowledge of the needs of Medicare beneficiaries</p> <p>Lead agency is identified</p> <p>Establishment of a small leadership group</p> <p>Structure of the coalition is considered/discussed</p> <p>Shared direction of coalition is determined</p> <p>Mission and values of coalition are considered/discussed</p>	<p>Completion of SWOT analysis with evaluation of results</p> <p>Coalition mission and values are finalized</p> <p>Structure of the coalition is finalized</p> <p>Action plan for interventions is completed</p>	<p>Careful maintenance of coalition through fluid levels of participation</p> <p>Completion of the Coalition Effectiveness Inventory (CEI) by coalition members</p> <p>Increased synergy among coalition members</p>	<p>Creation of a viable community coalition</p>

Note. Program inputs distinguished by color-coded text identify the concepts that will be implemented in this project's artifact, which will serve to help coalitions attain remaining outcomes of the logic model

