2023

Trust in integrated medical care using a population-based normative approach

Heather Summers

Pepperdine University

Graduate School of Education and Psychology

TRUST IN INTEGRATED MEDICAL CARE USING A POPULATION-BASED NORMATIVE APPROACH

A dissertation proposal submitted in partial satisfaction
of the requirements for the degree of
Doctor of Education in Educational Leadership, Administration and Policy

by

Heather Summers

December, 2023

James Rocco DellaNeve, Ed.D. – Dissertation Chairperson

This dissertation, written by

Heather L. Summers

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF EDUCATION

Doctoral Committee:

James Rocco DellaNeve, Ed.D., Chairperson

Stephen Kirnon, Ed.D., Committee Member

Julianne Howell, Ph.D., Committee Member

TABLE OF CONTENTS

Page

LIST OF TABLES

LIST OF FIGURES

DEDICATION

This dissertation is dedicated to me and to anyone else this inspires to keep learning and growing. Life is a journey, it’s up to all of us to decide what path we carve and what legacy we leave behind. Through fulfillment of an Ed.D., the sky continues to be the limit with my professional pursuits. At the end of the day, I want to know that I’ve positively impacted individuals, my community, and the region in one way or another with a resource, hope, or a vision to do better by others.

ACKNOWLEDGEMENTS

Thank you to my family, I can now join many of you with the title, Doctor. This has been an odd and strange journey through COVID and beyond. I've received many questions from family and friends about why anyone would want to pursue a Doctorate. At the time, to be knee deep in a dissertation is really a tough question to answer and not for the faint of heart after coursework is complete.

I would like to thank several of my classmates, who grew to be much more than classmates; who really carried me through the program and inspired me to move forward when I was feeling both down and both up. Without your unwavering support and weekly calls, this may have been an all but dissertation. I would also like to thank my husband who puts up with me when I propose things that he doesn't understand but he chooses to support me anyways.

I would like to thank my dissertation committee, including my Dissertation Chair for all the resources, calls, and support in moving my dissertation forward.; thank you Dr. DellaNeve. Acknowledgements wouldn't be complete without thanking Julie Howell, part of my Committee, who served as the Subject Matter Expert and whom I learn from nearly daily, as a colleague at work. I want to acknowledge Dr. Kirnon for his interest in my dissertation topic, for his time on my Committee, and for his support and knowledge throughout the process.

Last but not least, I had an opportunity to connect through interviews with some extraordinary professionals in the fields of government, social services, and managed care. Listening to you and your expertise was invaluable, thank you for sharing your time with a stranger, friend, and as a professional working towards audacious goals. As one research participant mentioned, and I'm paraphrasing, why bother bringing people together if you're not tackling a wild and hard goal. I can’t wait for the next step in the journey with all of you. Thank you!

VITA

HEATHER L. SUMMERS

EDUCATION

Ed.D. Organizational Leadership Candidate | Pepperdine University | Anticipated May 2023
Master's in Social Work | University of Southern California
BA History | Michigan State University

WORK EXPERIENCE

COUNTY OF SAN DIEGO | November 2021 – Present

DIRECTOR SAN DIEGO ADVANCING AND INNOVATING MEDI-CAL| 2021-Present

- Stand up local County office implementing California Advancing and Innovating Medi-Cal referred to as San Diego Advancing and Innovating Medi-Cal.
- Liaise with internal County departments, community partners, State agencies and managed care plans
- SDAIM priorities are to coordinate care, expand services, fortify the safety net and innovate Medicaid

COUNTY OF SAN DIEGO | June 2021 – October 2021

TEMPORARY EXPERT PROFESSIONAL | 2021-2021

- Office of Homeless Solutions, HHSA, Whole Person Wellness (WPW) internal program evaluation lead providing oversight of two evaluation staff. Qualitative and Quantitative evaluation components that will highlight the successes', best practices and lessons learned of the WPW pilot unique to the County of San Diego.
- Programmatic lead for WPW patient transition to CalAIM and housing support during the last six months of the contract. Primary programmatic contact for contractors and internal oversight of the HDAP program during the WPW transition.
- Co-facilitator of Whole Person Wellness Clinical Review Team, Management Team and Contractor Meeting incorporating County Medical Leadership, seven Managed Care Plans, community partners and contractors
- DHCS contact for the Whole Person Wellness program and CalAIM transition.
- Contributing updated research around homeless solutions and offering integrative care ideas and suggestions to the newly formed Office of Homeless Solutions.

FAMILY HEALTH CENTERS OF SAN DIEGO (FHCSD) | 2006 – 2021

ASSOCIATE DIRECTOR OF SUBSTANCE USE DISORDER SERVICES | 2017 - 2021

- Reported to the Director of Special Populations, three Program Services Managers reported directly to the Associate Director of Substance Use Disorder Services. The size of the department that this role was responsible for was a total of fifty individuals.
- County of San Diego subcontractor for Regional Outpatient Recovery site, experience with revamp of outpatient substance use disorder services through the implementation of the Drug Medi-Cal Organized Delivery System (DMC-ODS).
- Oversaw intensive outpatient substance use disorder program which serves adults; facilitated growth and expansion to the South Bay Region in 2020; assisted in negotiating an additional grant of $1M with implementation of expanded contract. Met 4% new patient strategic growth goal annually.
- Crafted vision for department to include MAT services at each primary care site, drafted framework for Family Medicine Residency department. Developed Addiction Medicine site that will be built, Spring 2022.
- Infused Trauma Informed Care and Harm Reduction principles leveraging expert trainings to increase patient retention and patient outcomes.
- Provided training sessions on Medication-Assisted Treatment program; delivered training on trauma-informed care and training on substance use disorder services and stigma.
- Coordinated with the grants management department, brought in grants from DHCS Hub and Spoke, managed care programs, private foundations and the County to expand needed patient services. Recently received $350,000 for a Mobile MAT-TO-GO van to serve patients at the Clean Syringe Exchange based off the Boston Healthcare for the Homeless Model. Involved in proposal, budget and programmatic grant components. Achieved over 2M in grants FY 2020.
- Created model to bring in Addiction Psychiatry Fellows to increase Addiction Medicine expertise and psychiatry care to hire and retain Fellows and embed them in primary care. Used Fellows to add telepsychiatry services to increase access to mental health within outpatient regional recovery center.
- Increased co-occurring care competencies with SUD outpatient regional recovery center and mental health therapy site using a consultant and co-occurring capabilities assessment.
- Strengthened and designed case management services for justice involved co-occurring clients in outpatient program.
- Trained first referral specialist within SUD services by developing guides and talking points to appropriately screen and triage medical and behavioral health referrals. Created electronic referral order sets to uniformly screen all health center patients for alcohol use and opioid misuse, using SBIRT.
- Used data to document growth and retention of 80% for MAT patients retained past six months. Medication Assisted Treatment program was nationally recognized for patient retention rate by the Surgeon General.
- Embedded Substance Use Disorder Counselors within FHCSD’s 24 clinic sites; expanded Counselors to 4 additional Clinics over the last fiscal year. Due to workplace shortage of certified and registered staff expanded the use of behavioral health staff through introduction of ASW’s and MSW’s serving role of Substance Use Disorder Counselors.
- Achieved Joint Commission Behavioral Health Accreditation in 2021 and Drug Medi-Cal accreditation in 2018. Experienced in population health management and coordinated systems of care delivery involving primary care and behavioral health.

CLINIC DIRECTOR | 2015 - 2017

- Experienced Clinic Director working with Managed Medi-Cal plans, Fee-For-Service and Covered California. This was an upper management position, the Clinic Director reported to the Vice President of Operations and the Vice President Legal Counsel. Each Clinic had a different number of direct reports varying from twenty five to fifty staff.
- Managed 3 community-based Primary Medical Home Federally Qualified Health Centers in the greater San Diego area.
- Led clinics as standalone business with bi-annual strategic planning process to meet growth and quality patient goals; built and facilitated teams of peers, physicians, support staff, and direct reports.
- Incorporated criteria and standards of the Joint Commission and follow Primary Medical Care Guidelines, National Committee for Quality Assurance, and other regulatory and accreditation standards.
- Monitored individual and team performance for specific job roles and functions; evaluated them annually using annual performance evaluations with standard measures developed throughout the organization.
- Effectively represented FHCSD's mandate to partners, funders, policymakers, and community groups; worked with a local community organization to gain representation of a specific cultural group to design implementation in the community around reducing heart attacks.
- Tasked by Executive Leadership to develop 3 new service lines; hepatology and chiropractic; translated strategies in plans to operational implementation; worked to add newly constructed Vision Clinic and worked within a matrix organization to add a new primary care clinic that was operationalized and marketed within an underserved community. First Clinic Director to adopt and roll out and provide MAT Services.
- Facilitated and led a cross matrix PDCA using change management principles, LEAN methodologies, and strategies within the organization; promoted flexibility and achieved a shift of roles and responsibilities throughout the organization; increased organizational effectiveness by reducing ROI duplications to below 10% for 24 clinics.
- Received grant funding and developed an African American and Black Hyper Tension Heart Health program focused on serving mono-lingual Spanish Speaking adults and African American Adults; created 2 separate training and health education programs; achieved a decrease in weight, increase in exercise, and increased understanding in how cooking, food, exercise impacted health outcomes.

ASSOCIATE DIRECTOR OF HIV SERVICES | 2012 - 2015

- Oversaw 20 private, City, County, Federal grants totaling approximately $5M per year; provided monthly, quarterly, interim, and annual reports to funders detailing program delivery, sustainability, and progress.
- Directed HIV Services and supervised the Program Manager, one Federal grant, and one County grant focused on communities of color and serving LGBTQ males offering HIV testing and HIV prevention activities; provided intensive case management to individuals of color diagnosed with HIV.
- Provided direct supervision to 3 Program Managers and 1 Administrative Assistant over a 5-site department while managing a department of over 60 individuals. Reported to the Director of Special Populations.

- Implemented Trauma-Informed Care (TIC) training program as staff were having difficulty providing care to individuals experiencing a trauma; worked together with the consultant to develop training curriculum; enhanced professional development and increased skills within employees to improve quality of care for patients with HIV.
- Ensured smooth day-to-day operations of counseling and testing, case management, prevention services, outpatient alcohol and drug program, clean syringe program, and a specialty healthcare clinic.
- Spearheaded strategic planning goals related to quality and growth for the department and a consumer pool of over 20,000 patients annually; coordinated with other departments to meet agency and program requirements.
- Participated in oversight of HIV Specialty Clinic familiarity with PCMH, strategic planning, quality management, Baldridge award, and visual management.

PROFESSIONAL AFFILIATIONS AND CERTIFICATIONS

Pepperdine University | Consulting Certification | 2021
SDSU School of Social Work Field Instructor | 2002 – 2012
East County Chamber of Commerce | *Leadership Graduate "Blooming Onion" Awardee* | 2003

ABSTRACT

The role of integrated care partnerships in addressing health care and social needs to achieve whole person care is important as health care costs rise and quality of care outcomes are incentivized. Medicaid reform and 1115 Medicaid waiver programs are implemented statewide as innovative programs aimed at achieving cost savings and improved clinical quality of care outcomes. Understanding how cross sector partnerships can meet the needs of individuals through integrated care cross sectoral coordination between government, social services and managed care is needed. This research study examined the role of normative care values, vision, trust, shared care, and leadership. The qualitative, bicoastal, multicase study identified best practices within California and North Carolina. A total of eight subject matter experts were interviewed through purposeful sampling using open-ended questions. Four conclusions were drawn from thematic analysis. Conclusion one: state government must be proactive, transparent, communicative, and purposely involved in assembling partners together. Conclusion two: differing viewpoints on politics, leadership, and funding must be communicated during stakeholder partnership meetings. Conclusion three: the formula for trust is a commitment to open sharing, listening, communicating, and acting on feedback. Conclusion four: complexity theory and visioning can be combined to achieve a health equity lens across sectors of care. Evaluation and best practices during waiver pilot implementation should be considered during waiver implementation. Integrated care relationships are key to success. Future research recommendations include expansion to a larger sample, a quantitative study and exploring the relationship between power, politics, and legislation.

Chapter 1: Introduction

This dissertation is a qualitative multiple case study focused on integrated professional health care teams working together in the state of California and the state of North Carolina on Medi-Cal and Medicaid managed care innovative service delivery programs. Research focused on one integrated care dimension—normative care—as well as characteristics of internal health care professionals and community professionals working in conjunction to reduce health disparities and social inequities. California is currently participating in multiple Medi-Cal reform pilots: Whole Person Wellness (WPW) and Health Homes (HH). Each pilot seeks to offer care to homeless or unstably housed individuals who are high utilizers of emergency rooms and in-patient health and behavioral health hospitalization. The focus of the reform is to create a new benefit in California under Medi-Cal where there is currently a gap in care. North Carolina is expanding one of their pilots, referred to as the Healthy Opportunity Pilot. Primary components of each of the pilots are integrated care, collaborative teaming between public health and social service stakeholders, establishing trust, and cost effectiveness in service delivery and patient outcomes. Improving health outcomes is necessary to a healthy population, but this research sought to understand how addressing social determinants of care (SDOC) and reducing social inequity can improve outcomes for those served through the delivery of integrated care.

The Affordable Care Act (ACA) was enacted on March 23, 2010, in conjunction with the Health Care and Education Reconciliation Act of 2010 with the goal of increasing access to health insurance and expanding coverage across the United States for individuals or self-employed adults lacking insurance. The Supreme Court gave states the option to expand Medicaid or not to expand Medicaid. The ACA offered incentives to states that chose to expand. Six years after the passage of the reform expansion, the number of uninsured Americans was reduced by half, with an estimated 20 to 24 million newly accessing coverage (Wiki retrieved July 16, 2021). Each state made decisions on how to buy into coverage under the ACA and how to roll out their individual marketplaces (Rasmussen & Kominski, 2019). As part of this reform and to reduce costs of the uninsured, California began waiver programs to initiate pilot services to meet the needs of the homeless and individuals with co-occurring disorders who were high utilizers of the health care system and were lacking preventative health care. This research will focus on healthcare reform for Medicaid participants within the states of California and North Carolina and will examine one area of healthcare reform—the concept of integrated multi-disciplinary team care—within two managed Medicaid waived programs.

California began working on health care reform through the passage of several medical waivers and pilot programs to reach individuals who were uninsured or in need of specialty coverage under the Centers for Medicare & Medicaid Services (CMMS, n.d.). The Bridge to Reform Waiver was from 2010 to 2015. From 2015 to 2020, California created Medi-Cal 2020 to replace the Bridge to Reform Waiver which was extended in 2021 because of COVID. The Waiver transformed into a program called California Advancing Innovating Medicaid (CalAIM; Department of Health Care Services [DHCS], 2021a). CalAIM began implementation through a multiyear, population-focused rollout as of January 2021. It has three goals: (a) offer whole person care (WPC) by addressing SDOC, (b) create a braided and seamless system of Medi-Cal managed care across the state, and (c) improve the health of Californians by improving quality of care, health outcomes and reforming the payment system through health care incentives (DHCS, 2021a).

North Carolina recently received approval to expand one of their demonstration waivers, Healthy Opportunities Pilots, to expand services to individuals covered through another state-funded insurance program. In 2022, the Healthy Opportunity "pilot program is structured to employ evidence-based interventions to Medicaid beneficiaries addressing housing instability, transportation insecurity, food insecurity and interpersonal safety and toxic stress" (North Carolina Department of Health and Human Services [NCDHHS], 2022, para. 1). The NCDHHS anticipates this pilot will assist with achieving better health outcomes, assisting with continuance of the Medicaid program, and providing quality care to participants. This program has a strong evaluation component from the onset to test the efficacy of the intervention and has the potential to expand statewide if it demonstrates evidence of goal achievement. The primary focus of the program will be on nonmedical interventions (NCDHHS, 2022). Pilot programs in California and North Carolina have a focus on social services and health care interventions with the public health departments assuming the role of an additional stakeholder. Both pilots seek system transformation, quality care, and a combined health care and social service (nonmedical) model of care to address health equity.

SDOC influence health equity of individuals. The World Health Organization (WHO, 2021) lists several determinants of care: "income, education, employment, food security, housing, neighborhood, affordable and accessible health care, and non-discrimination" (p. 1). SDOC are best understood by health professionals in terms of their impact on individual health rather than the broader public. Research on SDOC has shown that 50% of individuals can have negative health outcomes such as a reduced life span and quality of life when social determinants are not addressed (Towe et al., 2021). Accountable health care organizations (ACOs) cannot focus on health care alone but on health care reform to address population health and mitigate social determinants. ACOs must consider how to build internal and external organizational partnerships and must also take into consideration how to evaluate appropriate external partnerships to offer the best integrated quality care for mutual patients (Murray et al., 2020). Population health is one approach focused on health outcomes and social equity that responsible ACOs must consider.

Population health is a relatively new field of study that has evolved over the last five years to a focus of study within medical schools and other related public health fields. As an emerging field, population health examines the root causes for health and disease through a social equity lens that bridges multiple disciplines to address SDOC and health equity (Gourevitch et al., 2019). Population health, SDOC, and health equity overlap within CalAIM in California within a strategy referred to as the Triple Aim. CalAIM's Triple Aim has three primary goals: (a) identifying and managing risk through a holistic person-centered approach addressing social determinants of health (SDOH), (b) transforming managed Medi-Cal to a seamless system of care that reduces complexity and increases flexibility, and (c) improving the quality of care outcomes for patients. Triple Aim addresses social determinants of patient health and uses a value-based or incentive-based system of care that translates to payment reform (Woolf, 2019). To facilitate managed Medi-Cal reform, it is vitally important for health care systems in California to understand how to foster and maintain community-based patient support beyond traditional health care incentives for better patient outcomes and quality.

There have been several statewide initiatives within the United States and global health care reform models seeking to meet the Triple Aim under a variety of care implementation models. The Triple Aim is defined as quality care, reduced health care costs, and optimal health outcomes. The Triple Aim is braided with the population health model of care. These models, however, have relied on funding mechanisms that have not fostered sustainability between health care professionals, academia, community partners, the public, and the patients they serve

(Marjanovic et al., 2020). Models include health extension networks where local universities or public health departments drive collaboratives or coalitions with primary and hospital partners around care, whereas other models are driven by independent collaborative boards, all of which lack funding sustainability in the long run. Within California under the 1115 waiver, two promising pilot models have been implemented that served as the foundation of CalAIM health care reform: WPC and HH.

The WPC program targets an individual's physical and behavioral health by tying in social services support and case management services (DHCS, 2016). The HH program works with Medi-Cal recipients to address physical health, which includes chronic conditions through long-term supportive services (DHCS, 2021b). Both programs' end goal is to reduce in-patient hospitalization days for behavioral or physical health. Individual California pilots can tailor their population based on their county's needs and aim to reduce the cost of in-patient days through both pilot programs. One of the specific aims of the pilot programs is to "increase, improve and achieve integration among County agencies, health plans, providers and other participating entities" (DHCS, 2016, p. 4).

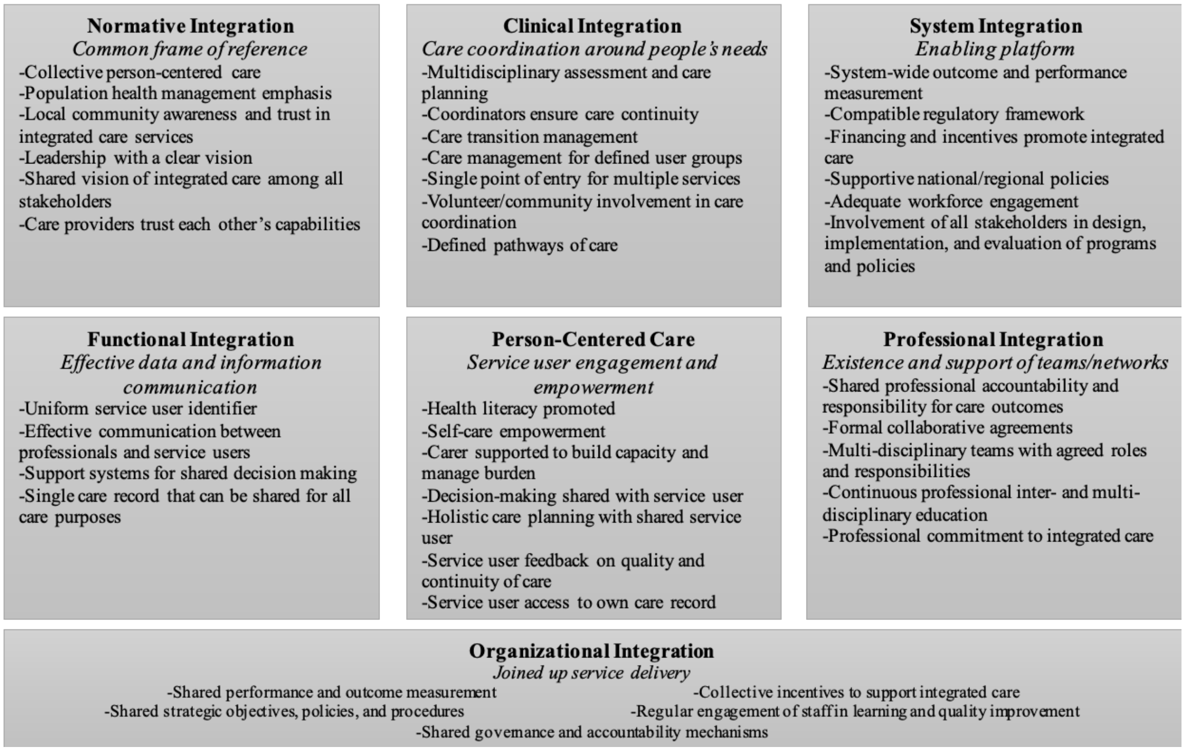
Both pilots appear to be promising practices in bridging population health and the Triple Aim goals, quality of care, cost reduction, and healthier patients in a sustainable funding model. UCLA is currently conducting a statewide evaluation of both pilot programs, which found during an interim report that emergency department visits were reduced under WPC and that there was general improvement in health and a reduction in mental health symptoms (Chuang et al., 2020). A cornerstone of each has been integrated care teams bridging community providers, hospital staff, managed care plans (MCPs), primary care, and local counties and governments working together via clinical and collaborative teams to address patient care outcomes. UCLA noted and discussed are coordination but does not seek to answer integrated care. North Carolina is working on expanding their Healthy Opportunities Pilot similarly to what California achieved under CalAIM, through a statewide and county rollout.

Integrated collaborative care research and health care reform models are lacking in the United States and globally. Integrated care, social equity, and population health are relatively new and require further study. The focus of this research was on evaluating normative integration as it relates to integrated care teams in California and North Carolina in participating 1115 waiver pilots. One global model that has been researched is called Project INTEGRATE (Read et al., 2019), which examines health care reform and its various aspects of care. It considers integrated care from six separate categories, which include normative, clinical, professional, functional, systematical, and organizational. Since this research was time limited and to narrow the scope for the purposes of this dissertation, one-sixth of the integrated care model was researched which is normative integration.

The Project INTEGRATE framework (Read et al., 2019) was developed and used in central Australia as a platform to analyze population health and integrated care. Its definition of normative integration was used for this study. Project INTEGRATE's (Read et al., 2019) definition of normative integration is uniform team vision, uniform population health management vision, trust between integrated community partners, and integrated clinical trust between members and stakeholders. These concepts were core to the research. Figure 1 is an illustration of the Project INTEGRATE model.

Figure 1

Project INTEGRATE Model



Normative Integration
Common frame of reference
-Collective person-centered care
-Population health management emphasis
-Local community awareness and trust in integrated care services
-Leadership with a clear vision
-Shared vision of integrated care among all stakeholders
-Care providers trust each other's capabilities

Clinical Integration
Care coordination around people's needs
-Multidisciplinary assessment and care planning
-Coordinators ensure care continuity
-Care transition management
-Care management for defined user groups
-Single point of entry for multiple services
-Volunteer/community involvement in care coordination
-Defined pathways of care

System Integration
Enabling platform
-System-wide outcome and performance measurement
-Compatible regulatory framework
-Financing and incentives promote integrated care
-Supportive national/regional policies
-Adequate workforce engagement
-Involvement of all stakeholders in design, implementation, and evaluation of programs and policies

Functional Integration
Effective data and information communication
-Uniform service user identifier
-Effective communication between professionals and service users
-Support systems for shared decision making
-Single care record that can be shared for all care purposes

Person-Centered Care
Service user engagement and empowerment
-Health literacy promoted
-Self-care empowerment
-Carer supported to build capacity and manage burden
-Decision-making shared with service user
-Holistic care planning with shared service user
-Service user feedback on quality and continuity of care
-Service user access to own care record

Professional Integration
Existence and support of teams/networks
-Shared professional accountability and responsibility for care outcomes
-Formal collaborative agreements
-Multi-disciplinary teams with agreed roles and responsibilities
-Continuous professional inter- and multi-disciplinary education
-Professional commitment to integrated care

Organizational Integration
Joined up service delivery
-Shared performance and outcome measurement
-Collective incentives to support integrated care
-Shared strategic objectives, policies, and procedures
-Regular engagement of staff in learning and quality improvement
-Shared governance and accountability mechanisms

Note. Adapted from "Using the Project INTEGRATE Framework in Practice in Central Coast, Australia," by H. Dalton, A. Booth, N. Goodwin, A. Hendry, & D. Perkins, 2019, *International Journal of Integrated Care*, *19*(2), p. 10 (http://doi.org/10.5334/ijic.4624). In the public domain

Integrated care is discussed from three approaches: micro, mezzo, and macro. The micro approach is one that seeks to address integration from the patient or clinical perspective of the patient—i.e., how the health or behavioral concern is addressed (Gray et al., 2020). The participant may view the micro level as implementation of a customized care plan and goals related to self-coaching and management of health and behavioral health goals (Leijten et al., 2017). The mezzo approach includes how professionals approach health care coordination and/or how the organization tackles health care coordination. The macro approach seeks to understand how the broad organizational and system structures tackle culture, leadership, and broader normative care concepts (Gray et al., 2020).

Collaborative care approaches and trust have long been used as models of care to develop a common vision within social services. Normative integration is a view of systems from a macro perspective. This systems view considers the perspectives of internal and external stakeholders around a common shared vision. Within a macro perspective and when working with internal and external partners to collaborate and coordinate, a level of trust must be established, and each partner relies on the other for their expertise and capabilities to follow through. Normative integration leads to normative gains as defined by shared ambitions, trust, mutual gains, and in the long-term, cultural transformation, which enhances the integrated care team approach. This dissertation focused on a macro approach using normative care concepts—complexity theory, attributed to theorist Stuart Kauffman (Cuff, 2007). Complexity theory was one framework of analysis in conjunction with the Project INTEGRATE normative care concepts.

Complexity theory was used and applied to understand how integrative care is practiced and connected within the roles of health care, government, social services, and complex system connections. Health care as a field has not had substantial systematic study of its inner workings, nor experimental research. Complexity theory was also compared to chaos theory (Litaker et al., 2006) and the theory of diffusion of innovations (Rogers, 2005), which are theories applied in public health settings. However, complexity theory was chosen due to its flexibility to look at the interweaving of multiple systems at one time and not just one individual system. Therefore, complexity theory has applications to look at integrated care teams as they function as a whole with multiple sectors of care convening and allowing individual contributors to be seen as a collective whole (Grol et al., 2007).

In summation, this dissertation sought to explore a relatively new field of health care focused on reform and the intersection of population health with integrated care using normative integration and complexity theory. To facilitate success with integrated teams in achieving the Triple Aim, this study attempted to understand best practices within successful Medicaid 1115 waiver programs for the most vulnerable patients. Social equity and health equity are key to achieving the best patient outcomes as health care cannot act alone to address SDOC nor achieve health equity without addressing collaborative and social components of care.

Problem Statement

Integrated care is not new in social services, but it is new to health care. When health care organizations and government entities attempt to partner with the community there is often a lack of quality, a lack of understanding of community resources or services, limited funding, and a lack of long-term sustainability. This was a qualitative study to determine best practices with two models of reform in California and North Carolina on key concepts necessary to establish integrated care. Also lacking is literature, research, and training of medical providers around the concept of population health, and while Triple Aim is the goal that bridges population health together, there is also a quadruple aim that focuses on workforce readiness, which is gaining traction as the realm of health care continues to reform and evolve.

Purpose of the Study

The objective of this qualitative, bicoastal, multicase study was to identify best practices within two counties and states in California and North Carolina that have experience implementing managed Medicaid 1115 pilot programs. Professionals and stakeholders working in counties, hospitals, and MCP organizations were interviewed and surveyed. Survey questions sought to understand how trust, vision, mission, leadership, decision making, and clinical care decisions are cultivated as part of integrated care teams through a normative macro level approach to population health in the United States surveying two counties within California and North Carolina.

Research Questions

Research questions were broken up into several normative care foci: collective vision, population health management, trust, shared leadership, and trust in the integrated care teams' capabilities. Change over time between the beginning and the end of the waiver or pilot will be collected, as appropriate. The research questions for this study were:

- RQ1: How do stakeholders address gaps in social determinants of health to improve patient and customer outcomes?
- RQ2: How do stakeholders from the sectors of healthcare, government, and social services establish a shared vision?
- RQ3: How does the role of shared leadership change over time?
- RQ4: How does normative care, trust, leadership, and clinical decision making change over time?

Theoretical Model

Health care systems and their inner workings are a collective of micro, mezzo, and macro activities and actions that, when braided together, are not predictable and are subject to change. When adding in external community partners and the concept of integrated care, systems of care are multifaceted and can be considered complex adaptive systems (CAS; Long et al., 2018). Complexity theory is rooted in complexity science, being complex, it's not a singular theory that can analyze complex systems, but a science that can examine multiple angles of systems complexity (Storkholm et al., 2019). As a framework, complexity theory has been used in health care systems and is the selected framework to untangle the confluence of multiple changing, nonlinear systems of integrated care teams (Storkholm et al., 2019). Health care organizations and ACOs are focused on achieving individual health outcomes and reducing health disparities. The fluidity of accountable health organizations and their non static nature allow them to evolve and build from the interworking of multidisciplinary teams internal and external to the primary health system (Jordon et al., 2010).

The concept of integrated care has multiple connotations, and no one set theory to address it. Integrated care includes interwoven components of structures, varied organizational structures, and people. There are different models that have been hypothesized to address integrated care but no models that have been researched and tested focusing on the macro systems related to integration and normative care (Singer et al., 2020). Project INTEGRATE's normative care's macro components have been used as part of the basis of the framework. Table 1 establishes the definitions of normative care (Dalton et al., 2018).

Table 1

Project INTEGRATE Normative Integration

Normative Integration Common frame of reference	• Collective person-centered care vision • Population health management emphasis • Local community awareness and trust in integrated care services • Leadership with a clear vision • Shared vision of integrated care among all stakeholders • Care providers trust each other's capabilities

Note. From "Using the Project INTEGRATE Framework in Practice in Central Coast, Australia," by H. Dalton, A. Booth, N. Goodwin, A. Hendry, & D. Perkins, 2019, *International Journal of Integrated Care*, *19*(2), p. 10 (http://doi.org/10.5334/ijic.4624). In the public domain.

Definitions

Several relevant terms used throughout this study are defined.

Accountable care organization (ACO) is a group of people who voluntarily come together to improve quality of care outcomes of their mutual Medi-Cal populations. This study references ACOs as key in the integrated care team process.

Health equity is defined as "a state characterized by the absence of systematic inequalities in health" (Farrer et al., 2015, p. 394). Health inequities arise when there are differences from the majority of the population, such as lack of transportation to make health appointments, lack of internet access to attend health appointments, and the overall role of SDOH.

Health extension refers to individuals, community organizations, collaboratives, academia, or any group of individuals external to a health care system that works to address and reduce SDOH in conjunction with health care systems.

Integrative care team collaboration is the clinical care team collaboration to achieve population health goals for unique patients utilizing partnerships between MCP, local government, community partners, hospitals, and primary care partners.

Managed care plan (MCP) refers to an insurance organization that that contracts with a government or private sector organization to provide coverage to specific populations, such as Medicaid or employees, and then creates a network of specific contracted medical and social service providers to provide care.

Medicaid refers to the joint federal/state safety net health insurance program that individuals quality for when meeting income guidelines and/or other categories such as age or disability. In California, this is called Medi-Cal but throughout the U.S. the program is referred to as Medicaid.

Normative care is integrated shared values, ambitions, trust, technology, teaming, mutual gains, and cultural care.

Population health is defined as an individual's health outcomes and their intersection with health equity and SDOH within a group. Population health seeks to redistribute negative social and health outcomes with groups of individuals (Kindig & Stoddard, 2003).

Social determinants of health (SDOH) refer to several factors that impact the overall functioning of individuals in society, such as financial stability, access to quality education, accessible health and quality health care, their community, and other social factors influencing their individual and community wellbeing.

Teaming is how several factors involve working collaboratively, including the environment in which the work takes place, the structure of the team, the processes in place with the team, individual contributions, and roles within teams (Mickan & Rodger, 2005).

Significance of the Study

The significance of the study includes benefits to local governments considering new health care reform models. MCPs benefit as they are seeking better population health outcomes for their enrollees. This includes increasing their understanding on reduction of hospital in-patient visits. Integrated care is a key component to reducing costs and maintaining a healthy population. The outcomes of this research could influence future studies on normative integrated care teams. This study may move the needle forward with additional opportunities for me to create secondary references and consult other states and counties on implementation of integrated health teams.

Gaps in literature are significant when seeking to learn how health care intersects internally within systems of care and gaps are nearly nonexistent with external partners.

Analyzing health care is complex and has not been substantially studied aside from a disease management reduction perspective. Models for analyzing and reviewing health care systems as a whole have generated frameworks for analysis, but many lack validity and have not been fully researched. There is a gap in literature around integrated teams, and the models that have been analyzed and published have been more prominently studied and available globally in Australia, the Netherlands, and Canada. The study is relevant to the changing landscape of policy and local health care changes associated with the ACA. Reducing health care costs, improving the health of the community, and understanding how health care and community partners can reduce social inequities are relevant to the United States and California. Health care is only a portion of the puzzle; SDOC and social equity are tied to the population living healthy productive lives.

Organization of Study

This study includes a total of five chapters. Chapter 1 provides the importance of the study, the significance, and the framework for addressing and evaluating normative integrated health care teams as health care reform measures are addressed. Chapter 2 includes an overview of the literature on health care reform, health equity, SDOC, integrated care, complexity theory, normative care concepts, and my intersecting study framework. Chapter 3 discusses the qualitative multicase study design which included a survey and interviews with stakeholders experienced in implementing managed Medi-Cal or Medicaid waived 1115 pilots. Chapter 4 presents the results of the research; interviews, sub themes and key findings. Chapters 5 discusses the findings, study significance, future implications, and recommendations for research.

Chapter 2: Literature Review

Integrated care takes place through two lenses: the micro lens which examines individual patient and clinical perspectives, and the macro lens which approaches how organizations coordinate with each other and how organizations as a system address culture and leadership. Research on integrated care within health care settings is more thorough from the micro lens, which looks at individual patient and care provider clinical perspectives in reaching satisfactory provider and patient outcomes.

This literature review considered how integrated care related to cross sectional professional teams in health care settings such as hospitals and professional social service settings. However, there is a gap in literature studying cross sector organizational teams. A gap in literature on the issue of trust and how trust is developed between health care professionals and social service providers was prevalent. A search on cross collaboration and integration between social service providers, government, and health care providers revealed that there is much more research on these areas outside the United States.

Introduced in Chapter 1 was one dimension of the Project INTEGRATE model, normative care. I sought to understand integrated care and its application between government, health care, and social service sectors. The topic of normative care and how trust develops from a systems perspective was difficult to drill down to the systems or macro level perspective as most examples were around specific patient outcomes or one shared clinical goal rather than integrated collaborative cross sector health care work.

To establish an understanding of Medicaid, health care reform, the next few sections provide information on the role of government in innovation, the ACA, Medicaid waivers, accountable health communities, and the role that government plays in working with integrated care partners. Health care reform, population health management, and SDOH are important for understanding how government can work with local MCPs, health care providers, and social service providers when designing health care systems. The topic of governance and the role of government spans a bicoastal east to west coast to include California and North Carolina.

The underpinning of this literature review is to understand and synthesize the current research that exists around the nexus of integrated care and normative values within health care. This review contributes to overall research on normative values and discusses areas where there are gaps in research to which this qualitative study can contribute. The review sets the foundation for current research on topics of integrated care, normative values, and connections to health care reform efforts, population health, and SDOC. The themes of trust, person-centered health care, health equity, SDOC, ACOs, and health care reform are included. Complexity theory was the framework used to support this qualitative case study. A conclusion wraps up the strengths, weaknesses, and gaps in literature.

Government, Health care, and Reform

The role of government in healthcare varies by state and by adoption of healthcare reform through expansion of the ACA and the change to Medicaid programs. Medicaid was established in 1965 and has been providing care to underserved populations such as the people with disabilities, pregnant women, and children with a focus on low-income individuals (Jarlenski et al., 2017). Congress established the 1115 Demonstration Waiver program under the initial legislation that created Social Security in the 1930s to allow the federal government and individual states to test new ideas through pilots to improve outcomes and reduce cost through new models of service. Medicaid waivers provide an opportunity for states to waive one or more of 83 statutory requirements that states must comply with in their Medicaid programs

(Thompson & Burke, 2007). Waiver programs can vary from state to state, so new service delivery models are tested and implemented based on the individual state request. Service delivery models may focus on the areas of care integration, payment reform, population health and SDOC; these are just a few examples of new service models that are put in place to reduce cost and improve delivery of care for individuals with a chronic illness (Shortell et al., 2010).

Service models may originate from pilot waiver programs as referenced above or grant funded programs through the federal government, such as the Center for Medicare and Medicaid Innovation (CMMS, n.d.). One such example implemented through Centers for Medicaid Services (CMS, 2022) is referred to as an ACO, which will be discussed further within this literature review. ACOs have been implemented throughout the United States with the intent to test out new reform efforts around payment.

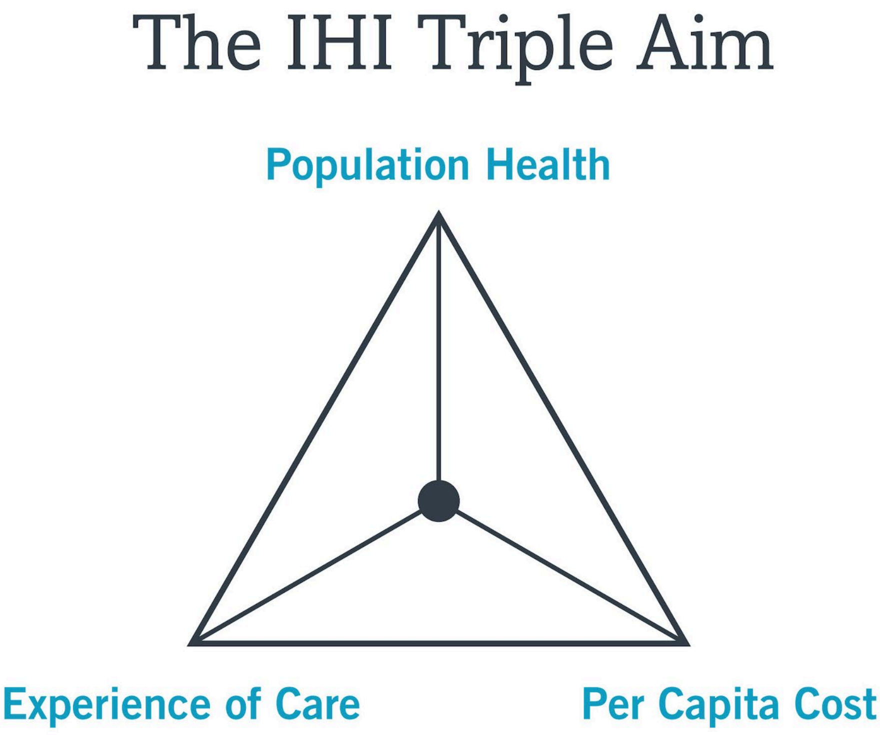
Accountable Care Communities

The concept of accountable care communities for health originated from the CMMS waivered demonstration and funded innovation projects. One of the primary purposes of accountable care communities is to align the health care sector with the community-based sector to achieve cost savings and quality care through innovation (Next Generation ACO Model, 2023). Since the expansion of the ACA, these appear to be promising in addressing social needs, reducing costs, and striving to meet the goals of the Triple Aim (see Figure 2). There are many different models with varying financial and community-based structures. Most recently, projects have been focused on merging social services and claims data to create a community score card to redesign the model from being accountable to health to working towards creating health (Tipirneni et al., 2015).

Figure 2 illustrates the various intersections between health care, public health, and social services the Triple Aim and system metrics (measures) correlate. Quality metrics include individuals or can be expanded to include population health management, which is a set of standard metrics to be achieved, tracked, or measured for a population at large. An example of quality metrics and population health is achieving social equity with the Medi-Cal population through housing resources and housing stability. A second example of quality metrics through a population health focus is achieving food equality through the security of food and appropriate nutritional needs for the medically fragile.

Figure 2

Triple Aim Design Framework Developed by the Institute for Healthcare Improvement in Boston, Massachusetts



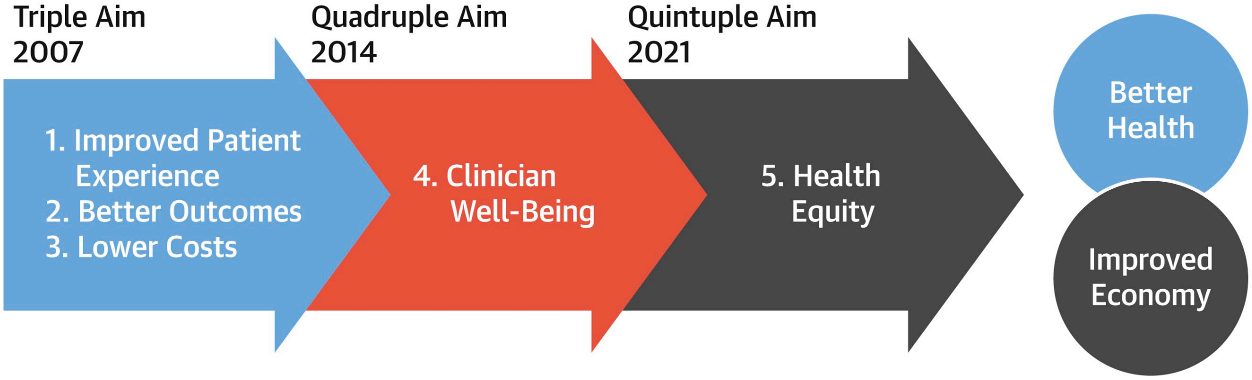
Note. “The IHI Triple Aim,” Institute for Healthcare Improvement, 2023 (https://www.ihi.org/).

With the establishment of the Triple Aim in 2007 there have been several evolutions. In

2014 the Quadruple Aim was introduced and as recently as 2021 the Quintuple Aim was introduced (see Figure 3). The Triple Aim was initially aligned with ACOs to address patient experience, patient outcomes, and cost savings (Itchhaporia, 2021). Provider and clinician wellbeing was added in 2014, and in 2022, clinician wellbeing was defined as workforce development and workforce health. The terms and definitions of health equity, social equity, and SDOH were added in 2021measured by economic and health improvement. The themes of "access, affordability and equity" (Shrank et al., 2021, p. 235) from a policy lens should be a focus of the United States' financing priorities with policy efforts centered around "expanding insurance coverage, accelerating the transition to value-based care, advancing home-based care, improving affordability of drugs and developing a high-value workforce" (Shrank et al., 2021, p. 235). Figure 3 outlines the evolution of the Triple Aim to the Quintuple Aim from 2007 through 2021 (Itchhaporia, 2021).

Figure 3

Evolution of the Triple AIM to Quintuple AIM



Note. "Evolution of the Triple AIM to Quintuple AIM," From D. Itchhaporia, 2021, *Journal of the American College of Cardiology, 78*(22) (https://doi.org/10.1016/j.jacc.2021.10.018). In the public domain.

While accountable care communities are being tested and implemented, they are not without their challenges. Understanding and navigating health care systems can be complex.

Many health care systems are not familiar with how to integrate with social service systems, and there is a lack of data to show and share on patients' social needs. As recently as 2020, with ACOs and newly waived 1115 CMS programs such as with WPW and HH, limited research has been published to date on how ACOs and social services can integrate (Murray et al., 2020).

Through the use of 1115 waivers, and in alignment with the quintuple aim and accountable health organization models, several pilot programs seek to demonstrate how health care and social service programs can braid services together to benefit communities in reaching health and social equity. Health care reform can be difficult to measure as health care is complex and its systems may not be readily researched. New and emerging research can be done to study how complex systems are implemented by accountable care communities, 1115 waivers, and health care reform occurring at federal, state and county levels.

Health Care Reform

Sweeping changes to federal health care reform began in 2010 with President Obama enacting the ACA and by amending the federal Health care and Education Reconciliation Act (Congressional Research Service, 2010). Prior to national implementation of the ACA in 2014, the federal government approved California's 1115 wavier, Bridge to Reform in 2010 (Mayer et al., 2018). Passage of this legislation provided funding to California to implement the Low-income Health Plan (LIPH) in 2011, also known as the Bridge to Reform. California officially passed state legislation to expand health care access for all. In 2015, the state piloted a waiver program to expand specialty care services through the Bridge to Reform and adoption of the 1115 waiver (DHCS, 2016).

California has long been a trendsetter and led the way with Medicaid expansion, as illustrated by state implementation of the LIPH. Within California, LIPH is often referred to as the early implementation step of the ACA. This program showed the most success with low-income Latinos gaining access to health care, and it paved the way for all children under 18 to receive health care coverage regardless of citizenship status in 2016 (Sommers et al., 2015). The LIPH program was phased out with implementation of the ACA in 2014 as current enrollees transferred to Covered California plans or to newly expanded managed Medi-Cal plans. California received eight billion dollars through Health and Human Services in 2014 to implement the five-year Bridge to Reform 1115 waiver. Further, California was the first state to offer the marketplace and health care exchange to any individual regardless of pre-existing conditions (Bindman & Schneider, 2011).

ACA implementation began in 2014 with the State of California creating the health care marketplace Covered California and opting to expand Medi-Cal as an early adopter. Within one year, nationwide estimates for states participating in Medicaid expansion showed a decreased rate of 9% or less of uninsured Americans (Ercia, 2021). There was an increase in health care access and appointment utilization within ACA early adopter states and an increase in 32% of health care appointments within Federally Qualified Health Centers (Ercia, 2021). With ACA and Covered California established as a foundational health care safety net, 1.3 million consumers were able to purchase and access health insurance. Uninsured Californians achieved similar enrollment benchmarks as other early adopter states, with 9.7% of 18–64-year-olds remaining uninsured. California chose to provide Medicaid to all individuals at or below 138% of the poverty level, and by 2018 roughly 13 million Californians were covered by Medicaid (Rasmussen & Kominski, 2019).

Within California, the ACA and 1115 waiver have positively impacted the number of individuals accessing health care and significantly dropped the number of uninsured

Californians. The 1115 waiver renewal in December of 2021, intended to maintain physical care enrollment but also to expand to social service coverage through CalAIM, was key to building on the success of the ACA and previous WPW and HH programs. What the literature does agree on is that the ACA has positively impacted the health and lives of Californians, and repeal of the ACA could produce dire unintended outcomes.

Each state has adopted some form of the marketplace, by running the marketplace by the state or participating federal marketplace. States can use 1115 waivers regardless of Medicaid expansion. North Carolina is an example of a state implementing an 1115 waiver through the Healthy Opportunities Pilot in a state pending Medicaid expansion. California implemented the WPW under Medi-Cal 2020, the 1115 Waiver. Three billion Medicaid dollars were provided in 2016 to 25 pilot programs within California. Each pilot was to implement integrated service delivery within the components of health, behavioral health, and social services. Care coordination was provided in efforts to reduce high risk service utilization, such as emergency room department visits, by coordinating primary care and social service care. Throughout the state, county and public health departments collaborated with local community-based organizations, healthcare organizations, hospitals, and public and private entities to implement the program. County staff were responsible for fiscal and reporting oversight (Chuang et al., 2020).

With the stage set under the ACA and with CMS approval to implement the 1115 waiver in California, the WPC program was a multi-county pilot aiming to innovate in the way that healthcare and social services address SDOC and healthcare utilization. Counties also began to work together in ways they had not previously to bridge partners from governmental public health departments, managed care Medi-Cal plans, and social service providers.

The County of San Diego completed a three-phase internal evaluation of WPW of their collaborative work. The following is a list of recommendations for WPW, some of which are clinical in nature while others are connected to cross sectoral work.

- Involve partners in program design and development early on.
- Ensure buy-in from senior leadership for all resources and commitment of all relevant stakeholders.
- Facilitate discussions to identify priorities and needs among participating agencies.
- Outline agency roles and responsibilities and manage expectations.
- Establish work groups for ongoing engagement and joint learning.
- Incorporate a robust Continuous Quality Improvement (CQI) measure and frequent feedback into program operations for all participating entities.
- Build a centralized data infrastructure that facilitates access and exchange and improves workflow efficiencies.
- Continue to conduct collaborative meetings with partners as a gold standard of any program implementation but first identify who needs to be at the table and in what capacity.
- Provide continuous cross-sector training to foster a culture of learning and establish a common language for effective communication (Asgari, 2022).

Normative Integration Model

Normative integration and care integration is defined by cross sectional collaboration to achieve common goals and common understanding in the areas of, vision, population health management, and trust. The origination of Project INTEGRATE was part of a European framework and pilot between 2012 and 2016. The framework was intended to be adopted by different hospital and nonhospital partners to discuss their progress and priorities as they relate to seven dimensions of integrated care. Partners were to utilize the framework working together to identify, prioritize, and measure success. Research did show that the framework could aid with implementation as integrated care partners used it and applied it within different European countries in different contexts and to address different chronic diseases, different medical conditions, and over different populations of focus. One of the primary goals funded by this European Commission collaborative was to increase the understanding of integrated care. The framework was created to respond to the growing aging population and the increase in the population living with long-term chronic health conditions. The key questions the framework sought to answer as integrated care was examined were: What does the European Commission Collaborative want to achieve? Why is the European Commission Collaborative doing what it is doing? How can the European Commission use a framework to gauge and respond to long-term chronic health conditions? What must exist for the project to succeed? How will the European Commission collaborative approach the work? The cornerstone was identifying how to bridge a framework on patient-centered care through engagement of integrated care partners focused on not only the delivery of health care but the delivery of social care (social services; Cash-Gibson et al., 2019).

The seven different dimensions within the framework all center around one dimension: patient care and how the other seven; person-centered care, clinical integration, professional integration, organizational integration, system or technological integration, functional integration, and normative integration—interact (Calciolari et al., 2016). Calciolari et al., described normative integration as:

> The extent to which different partners in care developed and shared a common reference

> frame (e.g.: vision, norms, values) around integrated care. This includes the “existence of a collective vision or person centered, holistic care (not disease centered), collective practice that places emphasis on population health management aiming to improve access and care experiences, as well as outcomes of specified populations, building awareness and trust in integrated care services with local communities, presence of leaders with a clear and common vision if integrated care and stakeholders (e.g. professionals, managers of organizations, service users) share a clear vision and degree of trust in each other’s reputation and in their ability to deliver effective care through collaboration. (Moos, 2006, p. 9)

Project INTEGRATE (Read et al., 2019) is a relatively recent framework implemented in 2012 to understand how population health and integrated care can be analyzed. Normative integration is defined by uniform team vision, uniform population health management, vision and trust between integrated community partners, and integrated clinical trust between members and stakeholders (Read et al., 2019). Much of the literature surrounding the topic of normative care is focused on team-based and population-based care in health care settings involving multidisciplinary teams. There is not a lot of peer-reviewed literature related to concepts of team-based, integrated care or multidisciplinary care involving community-based, government, and health care partners working collaboratively.

The concept of normative integration is a term used in the development of the international model of care and was not found during literature searches outside of the Project INTEGRATE model (Read et al., 2019). The concepts of normative integration are segmented by topic: (a) team vision, (b) population health management, (c) vision and trust between integrated community partners, and (d) integrated clinical trust between members and stakeholders. These topics were limited in their discussions around multisector integrated care. The topics were most likely researched in one work setting that may have different departments or teams but were less likely to be researched or compared with different sectors of care such as health care, government, and community-based organizations. Therefore, I tried to cover each topic from a range of perspectives. The first topic discussed under normative integration is leadership vision.

Leadership Vision

Leadership is integral to building and setting the stage for vision. The leader can assist the group at large in developing communication and trust to achieve the common vision. A practical step that can be taken include fostering active listening by all team members during team discussions. This includes all team members sharing their individual thoughts and opinions. Consideration should be given to smaller groups rather than larger groups to prevent group think and to increase trust and active listening, which can be more difficult to build across a larger group with a similar group of thinkers (Kocoglu et al., 2020). Vision achievement includes group identification of success, setting goals at the micro, mezzo, and macro levels, and ensuring that vision and conformity are not linked. A leader must be willing to call out behaviors that are not useful to the vision or the team and must reframe success for the group when needed (Calvert, 2018).

The concept of purposeful leadership is one to be embraced by leaders, which is defined by vision creation, fostering effective communication, and team trust. This can be achieved by designated roles for each of the group members, with each member responsible for a specific task and responsibility outside the group. This includes individual members outlining which expert needs to be involved in the communication and who is responsible for reporting back to the team. Members who report back on their findings external to the meeting should be prepared to report with facts and to contribute and share their own individual expertise (Calvert, 2018). The leader is responsible for creating a safe environment and assisting with each member understanding their "fit," which involves each member understanding their scope of practice, expertise, and clinical work. The leader can set the expectations that each team member can share and express their scope and not practice outside of it but facilitate a linkage to another individual who can help with a specific need by referring them to someone who can perform that scope of work (Brown et al., 2021).

Leaders working in virtual environments can assist with emphasizing leadership vision by arranging in-person meetings when applicable, as well as virtual trainings. Formal and informal team-building trainings are important in building trust and a common vision as everyone has an opportunity to share their visualization for tackling the work, as well as their background and understanding of each other's knowledge, skills, and abilities. Team building activities are important for new teams to practice the work they do with one another and to be open to receiving feedback by leadership and their teammates on how to improve team interactions (Hacker et al., 2019).

Within the health care field, health equity is where individuals live, work and play; health equity in the public health and health care field is linked to the SDOH. There are several studies and goals outlined in the Healthy People 2030 report that address SDOH and seek to achieve overall WPC for all and the role that health equity plays in overall quality of life (U.S. Department of Health and Human Services [USDHHS], 2022a). Addressing SDOH and health equity are part of federal, state, and local priorities. There are five core domains that SDOH is measured by: economic stability, education access and quality, health care access and quality, neighborhood, and building environmental, social and community context (USDHHS, 2022a). Different health departments may choose to measure different domains and adopt different framework of measurement depending on local priorities. To ensure health equity for all, different sectors will need to come together to address different domains, such as transportation, local medical health centers, clean syringe programs, reduced behavioral health options, medical appointment wait time access, lead abatement, clean air and water, and access to equal education. The Robert Wood Johnson Foundation has conducted several studies to document use of health and social indicators in communities. Within 100 of the largest U.S. cities and suburbs, there are:

> Substantial gaps in health and social status between whites who are better off-and other racial and ethnic groups…people in poor suburbs make up more than two-fifths of the total population in suburbs but use only about one-fifth of hospital care in the suburbs. (Andrulis, 2006, p. 1)

Rankings provided through Healthy People 2030 provide a way for local health departments to address SDOH.

Two studies were reviewed related to health equity and SDOH for purposes of this dissertation: one in California and one in North Carolina. In North Carolina, through a “raising the bar framework” set by the Robert Wood Johnson Foundation, counties are ranked to identify length of life and quality of life through measurement of health outcome rankings (access to care, quality of care), social and economic rankings (education, employment and income, family and social support, community safety), and the physical environment (air and water quality, housing, and transit; Muganda et al., n.d.). These rankings provide local jurisdictions with data and information to address health equity through multi-sector work. Similarly, the 1115 waivers through CMS allow local jurisdictions to address healthcare and social outcomes through the implementation of waiver pilot programs.

The 2022 San Diego Community Health Needs Assessment completed by the Hospital Association of San Diego and Imperial Counties (HASDIC) included qualitative data from 841 people who identified the top needs in the county around the areas of access to health care, aging care and support, behavioral health, children and youth wellbeing, chronic health conditions, community safety, and economic stability. The community's needs provide an opportunity for multisector partners to come together to address challenges. For example, the assessment showed that in the category access to health care, 56% reported they were unable to access health care, 45% were refusing to apply for medical coverage, and 42% were avoiding care, which can be related to stigma, financial burdens, etc. (Baker et al., 2022).

With consideration to health equity and normative care principles there is a call to action by leadership to address equity and SDOC. Health care leaders must work collaboratively beyond the traditional health care boundaries with private and public sectors. This call to action involves the following components: engaging the local community in decision-making processes involving equity and improving SDOH, offering health care for all through some sort of universal health care model, allocating resources and investments around population health principles and data, policy, and legislation to close gaps in health care and health equity, and last but not least, community care engagement and stewardship (Baum et al., 2009). There is a role for leadership in health care and legislative settings to move the needle through intersectionality work and by engaging leaders in public, private, and community-based settings. Engaging various stakeholders around a shared vision has been identified as key to achieving integrated care.

Stakeholder Vision

Brander et al. (2013) researched how health care providers, mid-level providers, and senior leaders enhanced hospital collaborative relationships through development of a common perspective. When developing a common vision organizational congruency was necessary for collaborative relationships, and a shared value of what the group was doing that everyone agreed upon and how things were labeled differently through different professional lenses were more important than a standardized approach to a shared model of care. A Dutch chronic care study with the elderly made a similar conclusion, that team effectiveness and quality of care were essential when supporting innovation and change through active participation in a shared mission and vision (van Dijk-de Vries et al., 2017). Teams that actively worked together to innovate get stronger, creating outcomes that are useful for all participants and evaluating the progress made to date as opposed to focusing all the efforts or success on the effectiveness of the indicator (van Dijk-de Vries et al., 2017). Consideration of the outcome of the team, how they came together, and what they achieved are important to evaluate to determine the impact of interprofessional care.

Shared care and a shared vision are defined as communication that includes informal communication, respectful dialogue, and common values—respect, authenticity, autonomy, compassion, trust, ethical care, and holism (Young et al., 2017). The central component around shared care foci is what the patient wishes for and their goals, whereas the goals of the providers are less prominent or researched as they relate to shared care (Young et al., 2017). A large body of research around shared team purpose and vision includes the input and development of the vision by the shared care team (Young et al., 2017). The vision of shared care is to be defined and developed mutually by the team, which fosters a consistent approach to care and increases each individual’s morale, motivation, and individual and group commitment to quality work (Al

Sayah et al., 2014; Atter, 2008; Epstein & Street, 2011; Ross et al., 2011; Sims et al., 2014; Wilson, 2005).

Building Blocks Collaborative in Alameda, California, is an example of a shared care vision where more than 100 partners and 50 organizations came together to develop a common vision and shared “bill of rights” to address health equity and life course to ensure all babies in Alameda County had the best start. Not one health outcome was established which was referenced as positive to meet the vision and goals for all nonhealth care partnering organizations. They focused on three tenets: food security, financial literacy, and mini grants for training and scholarships (Shrimali et al., 2014). This was an approach taken by government, local health jurisdictions, academic institutions, community-based organizations, justice partners, and more.

Shared care and the stakeholder vision must be paramount to address issues such as health equity, and the people must also be concerned about health care and health equity. The government, health care (private, public, and community-based stakeholders), and the community at large must rally around a central concern to address injustice and inequity. Stewardship that is designed around surveillance of health and social determinants should be shared and monitored, with training and education on SDOH amongst professionals and interprofessional coordination as a central component. Training of health care professionals and cross sector professionals as well as common research goals are keys to closing gaps and advancing advocacy when investing in shared care and a shared vision (Baum et al., 2009).

Integrated Care and Trust

Within the literature, integrated care and trust are described from two viewpoints. The first describes individual interactions between individuals or between two organizations from an individual approach or a micro lens. The second discusses how integrated care and trust are established between organizations and systems of care from a macro lens. From a micro approach, providers need to coordinate care to meet each patient's individual preferences and decisions of care, both within their social environment and when addressing medical needs. Integrated care is a combination of coordinated care across the patient's spectrum of needs over time that includes the responsibility of shared care across multiple providers to best address health needs (Singer et al., 2011). Singer et al. (2020) defined care integration as "unifying disparate parts of health care organizations to generate synergy across activities occurring within them and between them. It's critical to health care quality but often elusive" (p. 1034). A combination of external and internal entities may provide care to patients on an annual basis, which can include hospitals, primary care providers, specialists, and community social support providers. Individuals with chronic conditions see on average 16 different providers a year with the average provider and physician group interacting with 229 physicians and 117 practices per year (Singer et al., 2020). "Standardization helps pool interdependent individuals or groups that contribute to a common goal, such as when patients receive care from multiple providers" (Singer et al., 2011, p. 114).

From a micro perspective, communication, integrated care, trust, and communication are braided together as core concepts. Communication is a key theme to highlight when considering integrated care and interprofessional care. There are three common communication elements within integrated care meetings and communication processes. Fiorelli (1988) defined the interdisciplinary team approach as "a process which involves multidisciplinary participation, collaborative sharing of information, care coordination, and goal setting achieved through group input in the decision-making process" (p. 9). Discourse analysis impacts the social relationships and integrated team care, while collaborative discussions center around writing and sharing reports, and group discourse (Bokhour, 2006). Within integrated teams, communication is typically centered around a patient problem, improving the patient's quality of life, and team planning through the development of integrated care plans (Bokhour, 2006).

There are several key factors to enhance and build integrated care trust, including active team listening and working toward a mutual understanding of one another. The second key factor is to consider team commitment: How are the integrated team members chosen? Do they have time to commit when looking at their total tasks at hand? Does everyone think the same, and do team members have diverse backgrounds? Limiting group think is important. The third key element is following through as team members work to implement each other's ideas and keep their commitment to ideas (Kocoglu et al., 2020).

Provider and Team Trust

Coletti et al. (2019) analyzed the role of interprofessional education and interprofessional teamwork within health care settings. A key component to team-based care was a clearly established understanding of each team member's scope of practice. An increase in patient outcomes and patient satisfaction was connected to professional development and how it assisted in transforming each professional from independent practice to using the expertise of the entire team to improve patient outcomes.

A study in the United Kingdom found communication, participation levels, and task-based discussions versus interprofessional discussions varied between different medical professionals, nurses, and occupational therapists, physical therapists, and speech language pathologists. Multidisciplinary meetings could turn to focused tasks with certain medical professionals dominating meetings which can directly influence patient care outcomes. Training on how to work with multidisciplinary teams was recommended to enhance and develop leadership and interprofessional skills by all participating parties (Atwall & Caldwell, 2005).

Providers who do not typically work together but come together under a specific project or circumstance from various fields of work must understand how to form mental models of each other’s work. Team teaching includes sharing of each specialty’s language and developing a shared language and common ground through tacit knowledge. Shared care must include a solid foundation of each profession’s technical knowledge and conceptual framework (Gilligan, 2019).

Person-Centered Care

Direct service, interdisciplinary teams naturally lend themselves to managed care models as collaborative perspectives are important to person-centered care and population health. A collaborative care model or integrated plan should incorporate several patient care dimensions, including psychological, sociocultural, spiritual, and developmental. This type of model assists health care teams in identifying and prioritizing the patient and provider problem at hand (Marett et al., 1998). ACOs were introduced at the beginning of the chapter, and person-centered care and WPC are keys to addressing population health and health equity, which are critical concepts to optimal physical and social health.

There are several frameworks and constructs to examine different facets of patient-centered care, WPC, and management of patient outcomes through a collaborative and integrative approach, which are part of an ACO. Patient-centered care approaches patients from both social and health care perspectives. The Agency for Health care Research and Quality identified seven key areas needed to reduce health disparities (Kaufman et al., 2019). Lloyd et al. (2018) researched and established five core domains (Table 2) integral to managing patients with chronic health conditions while preserving a patient’s right to choose in the United Kingdom, principles akin with the United States model of a medical home. The American Academy of Pediatrics established six joint principles in the 1960s and 1970s, which follow the National Center for Quality Accreditation guidelines (Table 2; Philip et al., 2019).

Table 2

Patient-Centered Care Key Element Comparisons

Patient-Centered Care Reference	Guideline 1	Guideline 2	Guideline 3	Guideline 4	Guideline 5	Guideline 6
UK Domains akin to US Medical Home Model	Information and Communication	Care Planning	Transitions	Patient defined goals or outcomes	Shared decision making	
Agency for Health care Research and Quality	Relationships are key, health extensions can offer new systems a continuity of trusted relationships and linkages to needed resources	Long-term funding is needed to continue health extension work	Target outcomes may vary by stakeholders participating within the health extensions	Multidisciplinary representation requires flexibility	Power and control need to be navigated	Incentives must be aligned with payment models and may be outside of local physician group knowledge. Guideline 7: Coalition building takes time
American Academy of Pediatrics	Team-based care and practice organization	Know and manage patients	Patient-centered access and continuity	Care management and support	Care coordination and care transitions	Performance management and quality improvement

Ultimately, health extensions were determined to be good viable service models that can improve and expand linkages between primary care providers and community resources (Kaufman, 2019).

Population Health and Health Equity

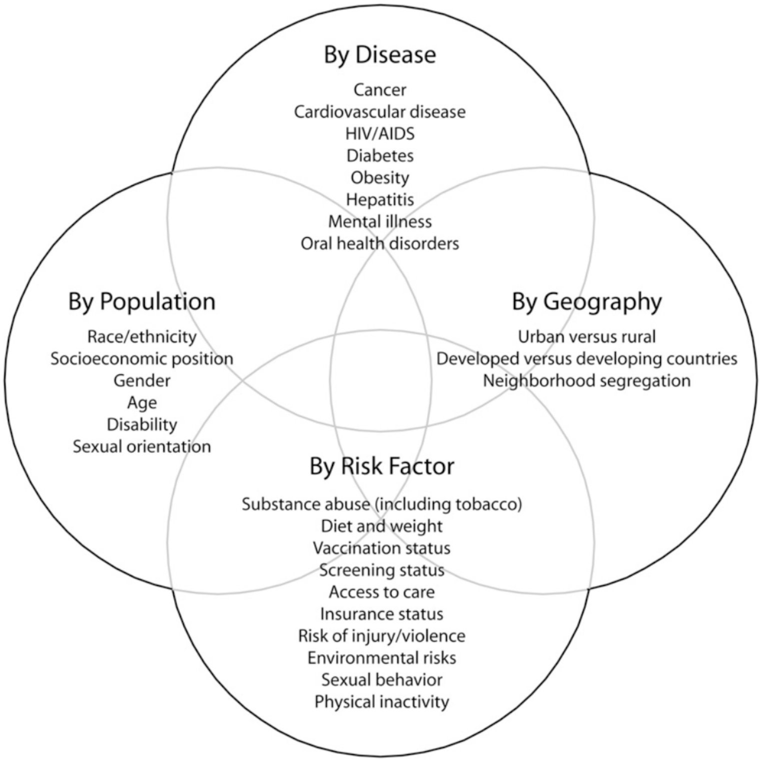
Population health is the examination of how large system factors in the environment and micro or individual factors influence a patient's health. Within the United States, chronic illness is a contributor to 70% of deaths, and 60% of Americans have at least one chronic illness (DeHaven et al., 2020). Population health seeks to examine how multiple organizations, providers, and the community can address poor environmental outcomes and disparities (DeHaven et al., 2020). The DHCS (2022c) defined population health as a system that moves from less reactive to a system of care that is proactive. Health equity is defined as "a state characterized by the absence of systematic inequalities in health" (Farrer et al., 2015, p. 394). The vision in California is a system that builds trust with individuals on Medi-Cal, shares data, focuses on the connection between health and social services, reduces health disparities, improves health equity, and coordinates care throughout an individual's lifespan (DHCS, 2022c). One of the goals of CalAIM includes the population health management approach by providing care management and coordination to individuals needing access to care to meet their health and social support needs. Similarly, a program in New Jersey called Trenton Health Team focused on five population health initiatives: (a) expanded primary care access, (b) community clinical care coordination, (c) data sharing across systems of care, (d) community engagement and ACO development which results in unified assessments, and (e) data sharing to increase the health of the community across social service and medical domains (Perry & Stephenson, 2013).

The Kresge Foundation (2012) as noted in the Institute for Alternative Futures found that 40% of one's health is out of their control and is tied to the social environment in which an individual resides. Addressing social drivers of health or SDOH takes collaborative long-term planning around common strategies and actions over a long period of time. Addressing SDOH in the environment is not quick short-term fixes. Changes in health equity, the environment, and SDOH should be studied over time (Institute for Alternative Futures, 2012).

Figure 4 combines several frameworks and overlapping issues on health disparities and social determinants. Ansari et al.'s (2003, as cited in Koh et al., 2010) model combines four different criteria/social determinants: (a) economic, social, and psychological factors; (b) behaviors influencing disease; (c) health outcomes; and (d) the health care system. A public health framework is also encapsulated in the overlapping circles in the figure to represent daily life, equitable distribution of resources, understanding of problems related to SDOH, and the impact of action in addressing problems. An integrated macro level approach is the last framework that represents factors within a population (gender, socioeconomic conditions), health risk factors (obesity, gun violence, substance misuse), and geography (urban, rural, developing country; Koh, 2010).

Figure 4

Multiple Overlapping Health Disparities and Social Determinants Framework



Note. From Translating Research Evidence Into Practice to Reduce Health Disparities: A Social Determinants Approach H. K. Koh, S. C. Oppenheimer, S. B. Massin-Short, K. M. Emmons, A. C. Geller, & K. Viswanath, 2010, *American Journal of Public Health*, *100*(S1) (https://doi.org/10.2105/ajph.2009.167353). In the public domain.

The concept of health equity and SDOH is a relatively new scientific field of study. Reviewing social, economic, race, and ethnicity factors and how they impact health outcomes was not viewed as essential to health outcomes until the late nineties. In 1999, with the publication of Healthy People 2000*,* that racial and ethnic disparities were considered and required to be reported on by the Centers for Disease Control (USDHHS, 2022b). Collaborations and new models to address health equity and inequity around SDOC examine how social, behavioral, and clinical sciences intersect. In 2003, the National Institute of Environmental Health Sciences established the Center for Population Health and Health Disparities, which funded initiatives and collaboratives to collectively analyze through a scientific analysis the impact of health disparities on population health (Warnecke et al., 2008).

Findings from collaborative relationships through the National Institutes of Health defined the difference between determinants of health and inequitable health outcomes. Determinants of health are aggregated outcomes that include patterns, rates, and averages in specific locations within counties, states, and the nation (USDHHS, 2022b). Aggregated information can provide statistical information such as zip codes, income, race and ethnicity, and segregation patterns. This newly established area of research needs to focus on inequitable population health outcomes across populations. Through a focus on aggregate data, inequitable health outcomes can be better viewed and compared to their results and lack of access to inequitable resources compared to other aggregate populations (Warnecke et al., 2008).

There are several models that use a collaborative approach to view one individual aspect of health disparities, which can include a disparity such as lack of access to transportation. A health impact assessment (Centers for Disease Control [CDC], 2022) is one such model that has been widely adopted in the United States to better understand the impact of an individual disparity on the population and the impact on health and health equity (Cole et al., 2019). The Health Equity Network of the Americas is an international model that evaluates health disparities through social determination and utilizes an environmental, planetary mathematical approach, and social policy approach to understand social impacts and health impacts. This model is meant to engage governments, academia, scientists, and international organizations (Castro et al., 2021). While models and analysis frameworks may vary, engaging the population in decisions that impact them in the community is seen as essential to improving health inequities (Cole et al., 2019). Using a macro approach and societal view, the social determinant of health root cause must be identified to achieve health equity. Otherwise, both targeted and universal approaches to achieving health equity may not address health inequity (Cerdá et al., 2014).

Health equity and the achievement of health equity can be viewed by the role in which SDOH and health disparities impact an individual, group, or community's health. At an individual level there is a broad belief among Americans that health disparities are impacted by behaviors rather than by inequities in the health and social system commonly attributed to SDOH (Towe et al., 2021). Blumenthal (2020) reviewed the concept of integration and health equity and found a lack of significance in the amount of literature and completed research on the role and impact of equity within integrated systems of care when compared to improving total health outcomes. Early studies on integration did not address institutional racism and did not have established measurements. This new field of study has yet to appropriately measure and capture these complexities. Complicating measurement are the various levels of technology adaptation (Blumenthal, 2020). Research to date shows that integration does not impact quality care. Thus, more research needs to be done to measure integration within large internal and external systems of health care, which are complex, at best, making it difficult to measure quality patient outcomes and the role data integration (interoperability) changes outcomes for the better.

Literature reviews have shown that health care delivery isolated by itself cannot reduce health disparities and inequities. Direct medical care impacts mortality of the population between 10% and 20% (Woolf, 2019). One way to address the gaps in literature and why the provision of direct medical care is only one part of the total puzzle when addressing equity and SDOC is through data sharing and direct engagement via partnerships and collaborative work between primary care, community partners, and the community at large. One such partnership was highlighted by Perry and Stephenson (2013). It took a population health-focused approach that included advisory board formation and overlapping data. Their work tackled ED utilization and the percentage of highest utilizers through a universal and standard health screening and community input. Five key initiatives and recommendations that sprung from this work include (a) increase primary care appointments, reduce wait times to decrease ED visits, implement standard screenings; (b) share information within the EDs by connecting primary care records; (c) increase data sharing to influence and expand care coordination community wide, reduce medical errors, and decrease duplication of services; (d) move towards establishment of a Medicaid ACO; and (e) engage residents in the community where the change is needed (Perry & Stephenson, 2013).

The literature review identified five different domains or lenses that are viewed and should be considered when evaluating change within population health. Auerbach's (2015) five categories of population health include:

(1) traditional clinical prevention interventions, (2) health indicators of the universe of

> patients treated, (3) health indicators within a similar community catchment area, (4) indicators of support for ancillary services that are patient-centered and evidenced based but often delivered outside a clinical setting or community level care, and lastly, (5) indicators of support for improving the living conditions in the neighborhoods, workplaces, and schools of the patient population. (p. 428)

Woolf (2019) also added to this growing body of research through identification of the role that health care, health behaviors, the environment (both physical and social), socioeconomic status, and public policy influence health equity. Going one step further, using data from 45 states, the 2015 County Health Rankings estimated that 45% of overall wellbeing is based on socioeconomic factors, 34% is based on health factors, 16% is from clinical care, and 3% is from overall care connected to the physical environment (Hood et al., 2016). The factors of length of life and quality of life were reviewed in the research which underscores the importance of not only providing health care but a holistic approach to care that addresses both social and economic conditions to appropriately tackle health equity within a patient population.

The Robert Wood Johnson Foundation developed a paper on utilizing a framework to mobilize a culture of health. The framework incorporated several areas under normative care such as a shared value around health, cross-sectional collaboration, and a focus on integrating health and social services. These areas are similar to several models in California and North Carolina deployed through waiver programs including WPW, HH, Healthy Opportunities, and CalAIM. Addressing population health, social equity, health equity, and SDOH will take new innovative approaches to care (Robert Wood Johnson Foundation, 2022).

In conclusion, literature on population health, health equity, and SDOH can be examined from both local and global multisector organizational views. From either viewpoint, policy advocacy is required to bring about political awareness in addressing SDOH and health equity (Lee, 2010). Further, emerging lessons from multisector organizations around value-based reform found it necessary to have a neutral facilitator to bring parties together and to encourage consensus; the neutral party must manage expectations, reconcile differing priorities, and find common ground with competitors (Conrad et al., 2014). Community engagement, research across disciplines, leadership vision, and a forward-thinking infrastructure are essential to eliminating health disparities locally and worldwide (Dankwa-Mullan et al., 2010).

Complex Adaptive Systems/Complexity Theory

Complex adaptive systems are defined by a myriad of individual agents that can act and change in ways that are not linear or predictable. Each individual agent has the flexibility to act on their own and impact the actions of other agents that may be interconnected so that one small change or adjustment changes the course of all agents (Long et al., 2018). For the purposes of this dissertation a more classical approach to complexity theory was used with consideration on how complex adaptive systems roll into complexity theory in health care settings. A classical approach seeks to understand the general rules that govern behavior, any local rules, policies, or regulations that can influence or be attributed to one or more agents, and any environmental patterns or attractors influencing the agents (Long et al., 2018). When applying complexity theory within health care, a social science view is necessary to understand this complex space and system. The social science view looks to understand the nested systems at play within complex systems. This includes breaking down systems by measurements. One can apply this by looking at geography as an example and how complex systems are nested within a geographic location. Using the example of geography, the nested space could be a nation, state, region, or locality (e.g., city, county), or neighborhood (Byrne, 2023).

Complexity theory and complex adaptive systems were selected as the framework for my study. The concepts of complexity theory and complex adaptive systems fit within health care organizations and provide an adaptable lens when interpreting the changing dynamics within these complex systems of care (Jordan et al., 2010). Complexity science has been applied within health care to understand how learning takes place within a complex adaptive system. It can also be applied to best understand the role of learning on behavior by looking at the complex steps of interconnectedness within a system (Pype et al., 2018). This theory has been applied within different health care settings as a framework and concept that lends itself to system interactions in their entirety (Braithwaite et al., 2017). Further research through a scoping review found that complexity theory may be adopted as a framework that can improve overall health care delivery; current research shows there is a lack of evidence illustrating use of the theory in designing health care systems overall (Brainard & Hunter, 2015).

While complexity theory may not be directly linked in literature to its use when designing health care systems, it can be used to describe relationships that may not appear to be linked through a linear process. Health care systems can evolve and change rapidly making them complex systems that adapt as relationships change and diverge from linear paths that respond to change in the environment, thus creating nonlinear relationships and pathways. Nonlinear relationships can be thought of as diverse agents that interfere with day-to-day operations to create flexible responses within health care systems to solve problems or offer flexible solutions. This could include a staff member attending a training and working to implement a new procedure or solution. It could also be a new team or group forming to fine tune, standardize, or create a new pathway to improve overall patient care. Health care defined as a complex adaptable system is an ever-changing learning system, a malleable system that is constantly changing itself, its relationships, and the systems within the ecosystem as it deploys new solutions to learn on the go (Jordan et al., 2010).

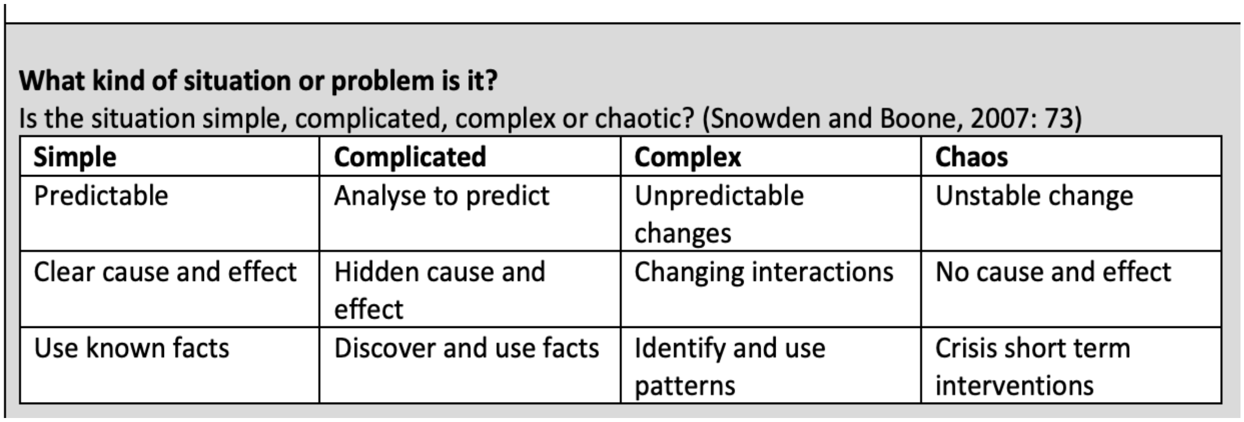
Complexity theory has been studied and used within the fields of economics, mathematics, and most recently in public services and health care (Sowels, 2021). The theory has been described as tying one phenomenon, behavior, or pattern to a complex system such as public service—similar to a butterfly flapping its wings in one geographic area and trying to understand and tie that action to a series of actions, behaviors, or patterns that are seemingly unrelated in another geographic region (Byrne, 2002). To illustrate the various overlapping patterns of behavior and complex systems, Brighton University developed a framework to use in public and hybrid systems of care. The framework was designed to answer seven questions:

- Are there boundaries of any one system?
- Who are the key actors involved, and where are they positioned in the system?
- What are the core activities, and where do they take place?
- Where do outputs occur and how do they relate to activities?
- Is there any logical order or connectivity of activities to present diagrammatically?
- What are the key points of connection for communication and to link complex processes of interaction?
- How do resources flow into inputs and activities? (Sowels, 2021)

When examining interrelated activities and problems using complexity theory, the question of what type of problem needs to be solved and the level of complexity can also be examined using the framework and asking whether the situation is simple, complicated, complex, or chaotic (Haynes, 2003). Table 3 defines a complex system as unpredictable, changing interactions, and as having the ability to identify and use patterns. Public service and health care systems are complex in nature, and when they are introduced, they interact with one another to render care. Complexity theory and analyzing their complex systems were determined best to utilize in this dissertation.

Table 3

Complexity Theory Table Identifying Complex Situations or Problems from Simple to Chaotic



What kind of situation or problem is it?
Is the situation simple, complicated, complex or chaotic? (Snowden and Boone, 2007: 73)

Simple	**Complicated**	**Complex**	**Chaos**
Predictable	Analyse to predict	Unpredictable changes	Unstable change
Clear cause and effect	Hidden cause and effect	Changing interactions	No cause and effect
Use known facts	Discover and use facts	Identify and use patterns	Crisis short term interventions

Note. This framework was developed and adapted by members of the Brighton Systems and Complex Systems Knowledge Exchange hosted by the University of Brighton, School of Applied Social Science, and the Community University Partnership Project (CUPP). The project was supported by funds from the Economic and Social Research Council award RES-192-22-0083. School of Applied Science, Community University Partnership Project, p. 73 (https://www.humanlearning.systems/uploads/Brighton%20Complex%20Systems%20Toolkit.pdf). From A Leader's Framework for Decision Making, D. Snowden, M. Boone, 2007, Harvard Business Review. Reprinted with permission.

Figure 5 represents Beer's (1984) visual management model as it was applied to a clinical, complex patient care model and health care practice system. Direct service and the systems perspective may not directly relate. However, the systems perspective of care and the normative care concepts between government, health care systems and community systems of care, illustrates the complexities of the system.

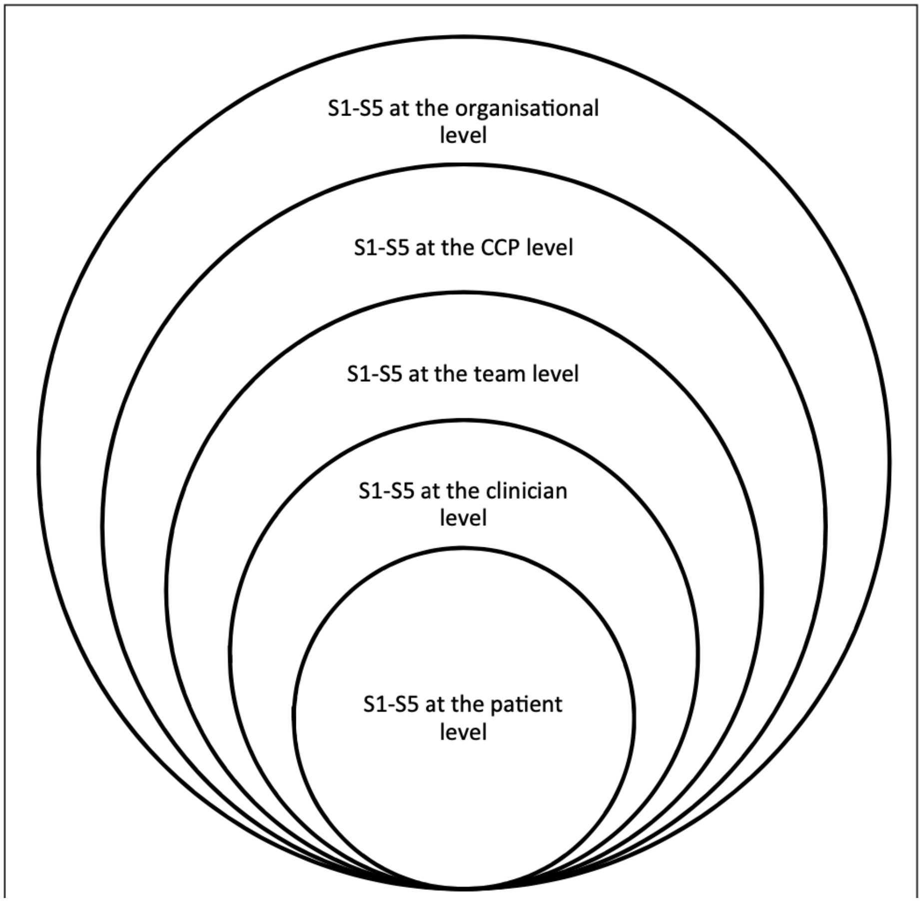
> S1 represents the system's core purpose…S2 is the coordination function of a system…S3 represents the reflexive internal regulation in response to changes within or external to a system…S4 accounts for intelligence knowledge of changes occurring

> inside and outside of a system that may require internal adaptation to stay relevant. (Borghmans et al., 2021, pp. 3–4)

The multiple systems of overlap between multiple sectors of care in my study were a useful analysis tool.

Figure 5

Beer's Visual Management Model



Note. This was used in a complex care model at a hospital and used as an application to analyze patient care and the complex and chaotic systems (Borghmans, 2022). From "Nested Systems Design Adapted by the Beer's Visual Management Model" by S. Beer, 1984, as cited in Borghmans, 2021. Reprinted with permission.

Several other frameworks were also reviewed, including complex adapted systems and chaos theory. However, these systems and frameworks alone are included within complexity theory and standing alone did not quite capture all the interrelated components of health care and public service that complexity theory encapsulates. Soft systems methodology as applied in health care systems was considered. A soft systems approach can be useful when seeking to identify a root cause or solve a system-wide operational issue (Augustsson et al., 2019). The normative care approach does not seek to identify a root cause but rather to best understand and research cause and effect, development, and how normative factors play a role in health care and social service delivery. This research did not seek a solution, which is when a soft system methodological approach can be applied and is most useful.

Integrated care, normative care concepts, health care, and complexity theory involve many varied components, players, and factors that intersect through nonlinear relationships as health care collaborations and services are provided. This evolution of the environment can create emergent outcomes, which can be defined as simple to complex in their interactions with one another (Petticrew et al., 2019). A systematic literature review of complex systems theory was completed. The application of complex systems theory in qualitative research was reviewed in the literature. There was a gap in literature, more research is required comparing complex social environments and complexity theory. I examined other theories that could measure public health such as the diffusion of innovations and systems theory, but they were found to be lacking in their application when applied to collaborative integrated health systems that provide both health and social services cause and effect. Diffusion of innovations was not chosen as it is typically a cause and effect of influencing uptick of one new behavior or innovation through acceptance, communication, and adoption of a social system. To justify why diffusion of innovations was not utilized, this theory doesn’t examine multiple complex factors all at once. The theory provides a cause and effect comparison, as an example, encouraging people to stop smoking or encouraging use of a new technology (such as adaptation of a mobile phone or laptop; Rogers, 2005). Complex adaptive systems provide an opportunity to seek boundaries between overlapping systems and how they interact with one another over time and in various scenarios; complexity theory seeks to understand how these systems interact with one another (Gear et al., 2018).

Conclusion

In conclusion, the gaps, limitations, and strengths from the literature review were discussed. Several gaps in the literature were identified including a lack of peer-reviewed and published research around the concepts of integrated care and ways in which health care systems and social service systems work together to collaborate and address patients' needs. In the United States, accountable health organizations have begun to address integrated care and 1115 demonstration waivers have been implemented to test new innovations and best practices from pilot programs in meeting the health and social service needs, such as WPC. There is more research on integrated care in Europe.

Globally, the concept of health equity and social determinants is a relatively new field of study which began 20 years ago. There is established literature and research demonstrating that 40% of people's health is tied to their environment, and 20% is directly related to health care provider interventions and access to health care. The concept of the Triple Aim has evolved over the years to a Quadruple Aim. When Project INTEGRATE was initially developed in 2012, the Triple Aim had been introduced and has since grown to encompass patient outcomes, community outcomes, and the provider workforce.

The literature review has shown that health care is complex at many levels of implementation; clinical outcomes, patient-centered choices, health equity, and SDOH are all complex and relatively new areas to study with standard data sets. Normative care and integrated care involve internal and external providers and systems interfacing with one another and the patient, which adds another layer of complexity. Complexity theory has been applied in public health settings. It is new in its application yet shows promise when applied to complex systems of change that involve ever changing attributes in an often nonlinear approach.

Chapter 3 discusses the research methodology within this study. This includes a statement of the research questions and research rationale. I used a qualitative case study approach to study normative care concepts in the United States through a bicoastal view of the 1115 waiver. I expanded on current research completed through local 1115 waiver evaluations and work of ACOs by examining the importance of integrated care through normative care concepts.

Chapter 3: Methodology

The purpose of this qualitative, bicoastal, multicase study was to identify integrated and normative care concepts within 1115 pilot programs implemented by California and North Carolina. State government, counties, MCPs, and community-based organization stakeholders were interviewed to understand how trust, vision, mission, leadership, decision making, and clinical care are cultivated as part of integrated care teams through a normative macro level approach to population health in the United States. The goal of this research was to understand how health care and community partners can work together to reduce SDOC, mitigate social inequity, and achieve positive health outcomes with Medi-Cal participants.

There are global models used to evaluate the micro and macro levels and various aspects of integrated health care systems, but research on how these concepts relate to practice is lacking. This study used one dimension of the Project INTEGRATE model (Read et al., 2019): normative care. A portion of the framework from Project INTEGRATE was studied to narrow the focus of integrated care to normative care concepts. Through qualitative analysis and coding, the dynamics between 1115 waiver programs and how integrated care between government, MCPs, and community-based organizations develop collaborative and coordinated teams to reach their beneficiaries' health and social goals were investigated.

An inductive approach to data interpretations was completed as part of the quantitative research study. This involved comparing cases from the research participants. Questions were drafted from the normative care integration model and from the literature. This process involved organizing the literature review coded data into patterns, categories, and themes to generate open-ended questions (Creswell, 2018).

Restatement of Research Questions

Research questions were broken into several normative care foci: collective vision, population health management, trust, shared leadership, and gaps in knowledge in the integrated care teams' capabilities. The case study and open-ended format allowed questions to be discussed and new questions to be posed based on stakeholder responses. There were nine research questions and several subquestions, which were only asked when prompts were needed.

Within the research perimeters, each stakeholder involved in the pilot program explored in what ways trust, leadership, and clinical decision making were determined and whether they evolved over time. In consideration of each pilot program's success, stakeholders discussed and considered changes in leadership roles within the pilot over time and what role shared leadership contributed to the success or detriment of the project. Interview questions and subquestions are in Appendix A.

The research questions are:

- RQ1: How do stakeholders address gaps in social determinants of health to improve patient and customer outcomes?
- RQ2: How do stakeholders from the sectors of healthcare, government, and social services establish a shared vision?
- RQ3: How does the role of shared leadership change over time?
- RQ4: How does normative care, trust, leadership, and clinical decision making change over time?

Research Methodology and Rationale

A qualitative study was chosen as the research methodology to gain a better understanding of the topic of normative care concepts within complex health care settings and community partners. Open-ended questions were created, and responses were gathered to get a better understanding from stakeholders. Qualitative data served to answer how the organizational and individual components of normative care and integrated teams work together as a system (Creswell, 2018). The end goal was to make sense of complex systems of integrated care and to understand how the systems work together and individually to achieve population health goals. Coding and analysis revealed whether there are any themes and whether there are differences in how counties, states, regions, and systems work with one another depending on their integrated care model and the roles and responsibilities of stakeholders in shaping the normative care concepts.

The process of how each county and state developed their pilot program and worked with local government, MCPs, and community-based organization stakeholders varies. A multicase study provided an opportunity to seek out commonalities in approaches. The studies were bound by geographic location by focusing on two counties in California and one or more regions in North Carolina. The interviews in North Carolina focused on the statewide implementation. There are currently three regions and three different lead entities running pilots in North Carolina. This case study was also unique as county, region, and state selection mandated involvement as a pilot program through an 1115 waiver. Both states have established 1115 waived programs and have different integrated care models involving government, community-based organizations, and MCP stakeholders. A multicase study was chosen as the method and best approach to analyze a complex system of partners and to understand the social phenomenon involved with integrated and normative care (Richards, 2013).

Ethnography, grounded theory, phenomenology, and discourse analysis were reviewed as potential qualitative methods but found not to be appropriate for this research study.

Ethnography is a method that is typically completed by field observation and participant observation, which did not take place during this study (Richards, 2013). Grounded theory was developed when working to formulate a theory, which is not the focus of this study (Richards, 2013). Phenomenology follows the definition of existentialism around the study of human behavior; while this study examined multiple systems of individuals and how they work together, it did not study human behavior at a micro level but rather how care is integrated at a macro level (Richards, 2013). Discourse analysis is the study of language, written or nonverbal, and the role of language in relation to what is being studied. The study purpose and questions did not involve the role of language (Richards, 2013).

Participants' knowledge of health care and the pilot programs was relied upon to provide responses to the semistructured, open-ended questions. The open-ended questions were arranged around several themes: collective vision, population health management, shared leadership, and trust in the integrated care teams' capabilities. The interviews were recorded using the Pepperdine student Zoom account, and verbal recordings were captured by a secondary recording device, as a back-up, and then transcribed. Transcriptions were downloaded from Zoom and were reviewed after interviews to confirm transcription validity.

Open-ended questions were developed, and the same questions were asked of each participant; questions were asked in a different order depending on the conversation. Certain questions were skipped or not answered by respondents if they did not have experience in that area. For example, if they did not have clinical experience, the clinical shared care question was skipped. Probes and common definitions were incorporated in an interview guide. The start of each interview required a discussion on the interview frame of reference. Participants would be answering the questions, from the perspective of their waiver experience and cross-sectoral coordination expertise.

If time allowed, participants were asked one additional open-ended question: Do you have anything additional you would like to share around values, mission, trust, or shared care? The semistructured format did not impact the responses as the question topics were based on normative and integrated care concepts. A paper or electronic version of the questionnaire was offered and made available, on request, for individuals who needed a visual representation of the questions (Richards, 2013). One participant submitted this request to have on file with their compliance department. Interview questions were vetted through an external subject matter expert during the pilot interview. Two of the interview questions were used by a scholar in the field from a past peer reviewed research study on normative integration.

Purposeful sampling was used in the study to choose participants who fit the stakeholder profile. The study was not statistically significant, but this sampling method was selected to target individuals and stakeholders who had past or present experience working in a waiver program within the sectors of government, social services, or managed care (Alchemer Blog, 2021). This type of sampling was time effective and targeted individuals with experience participating in waiver programs and coordinating care across sectors. Purposive sampling involved selecting participating California and North Carolina counties and regions for the study. Individuals were selected based on participation in the 1115 waivers and involvement in government, public health, health care, and social service sectors. The sample was deliberate as half of the participants had past waiver experience, and the other half was currently part of a waiver program (Richards, 2013). All pilot participants had experience working with all three sectors (government, social services, managed care) during pilot implementation.

Design Validity and Reliability

To assist with maintaining validity and reliability within this study a thorough review of different methods was done, and case study was selected as the best study method. The research questions were drafted from gaps in literature and similar studies recommending further qualitative research on normative concepts. As the data were collected, the process of analysis, creating questions, and interpretations were documented. As cross checks were completed to analyze code and themes, they were documented so a third-party reviewer could confirm the same meaning and data checks to ensure both validity and reliability. Cross checks included documentation of when, where, and how data interpretations were completed (Richards, 2013).

Population, Samples, and Sampling Strategy

Population

The target population was eight stakeholders, four from North Carolina and four from Orange County, California, a total of eight stakeholder interviews were completed. North Carolina as a state entity was interviewed, one county in California is equivalent to the population of North Carolina. From North Carolina, three stakeholders from government and one from managed care participated. In Orange County, one managed care participant and three from community-based organizations participated. One participant from government was interviewed but did not consent to be included in the research and preferred an informal interview. There were eight consented interviews and one informal interview, number nine, that was not included in the results.

Sampling Strategy

This research study included purposeful sampling, which sought specific counties, communities, and individuals to participate in the research based on their implementation of one of the California or North Carolina waived pilot programs (Alchemer Blog, 2021). The stakeholders were determined by the lead entities who were identified by their participation in a state-run waiver. LinkedIn was utilized as a marketing tool to advertise the study. As interviewees were identified and interviews were scheduled, participants provided referrals and often made recommendations of who to follow up with next.

North Carolina was picked as their entire state is currently undergoing Medicaid transformation, and they recently began implementation of the Healthy Opportunities Pilot (HOP). HOP involves cross-sector coordination, is relatively new (a year into implementation), and is involved in community, government, and managed care implementation. California was a focus for the long history of successful waiver program implementation, such as Whole Person Care, Health Homes, and many others.

For size comparison, Orange County in California equals a similar Medicaid population size in North Carolina. As an example, North Carolina has roughly 2.3 million people enrolled in Medicaid (Norris, 2023). Orange County has a census of approximately 3 million people, one in three people in California are enrolled in Medicaid (United States Census Bureau, n.d.). The North Carolina Healthy Opportunities Pilot was implemented by region in rural areas. In conclusion, Orange County and North Carolina HOP Medicaid numbers should be roughly equivalent, estimated at 1 million Medicaid lives.

Instrumentation

The materials developed for recruiting participants included a research consent form, a recruitment flyer, a formal e-mail invitation, and a data plan. The consent form contained information on the purpose of the study, participation requirements, what will take place during the study, how data would be used, and study risks and benefits. An interview protocol incorporated open-ended interview questions with interview prompts. Two-word documents were created, one that tracked interview details such as the date, time, date the consent form was received, participant name, and e-mail, and a separate word document that contained participant pseudonyms (Creswell, 2018).

There were six categories contained within the interview protocol. The first section was noted earlier, which contained basic interview logistical details within a Word document. Category two was the introduction, confirmation that the consent was received and an opportunity to ask the participant whether they had any questions about the consent. An overview of the interview was provided before getting started (number of questions, length of interview, and interview components). Pertinent definitions were covered as well as any questions by the interviewee before and during the interview. The third category or component was ice-breaker questions; participants were asked to share details about their role in the program, relationship to the topic, length of time in their role, and their personal connection to their job. Category four was the interview content and included the interview questions and subquestions to the central question asked. Several interview probes were embedded in the protocol to solicit additional details to the open-ended questions. These probes included requests for additional information or clarification (Creswell, 2018).

Human Subject Considerations

Pepperdine University’s Institutional Review Board (IRB) approval was exempt; the target population is not defined as being part of a vulnerable population. Study risks were minimal; there was a low risk of loss of confidentiality or emotional and/or physical distress because the interview focused on professional and subject matter expertise about collaborating across multiple service sectors. Participation in the study was voluntary, and participants could cease participation at any time. Refer to Appendix C for IRB Approval.

As required by the IRB, a consent form was distributed to each individual stakeholder prior to the virtual or telephone interviews. The consent form outlined the research purpose, participation requirements, audio, and video consent, and how the data would be stored and analyzed. The research included information based on their associated stakeholder group (e.g., MCP, local government). No stakeholder names, titles, or locality of professional work was disclosed in the data collection procedures. See Appendix D for the interview consent.

Data Collection Procedures

Data collection began once IRB approval was received. LinkedIn was used as the initial tool to reach potential survey participants. E-mails were sent out to potential participants to set up interviews once subject matter experts were identified. A survey flyer, introduction, and initial contact e-mail were made. See Appendix E for the recruitment flyer. Participant interviews were set up using the Pepperdine student Zoom account. On average, three interviews were completed per week, a few interviews were very early in the morning to accommodate the Eastern Standard time zone from the West Coast. The majority of participants were in executive level positions and their executive assistants worked to find time for them to meet. Out of eight interviews, seven of them were done virtually, and one interview was done by phone.

The average length of the interviews was 45 minutes, the quickest interviews were completed in 30 minutes, and a couple interviews lasted 60 minutes. The Pepperdine student Zoom account had an enabled waiting room as an extra security precaution. The title of the meetings was left vague to protect the confidentiality and not call out that participants were part of a research study. Stakeholders shared their professional opinions and feedback related to normative and integrative team formation of their pilot programs.

Six virtual interviews were scheduled, one virtual interview included two participants at once using the participants' own platform; this was an unanticipated interview. The sixth virtual interview involved participant 6 and participant 7. No recording took place during this interview, and all notes were written. Survey questions supported the normative and integrated care framework within the study. A data management plan was created, and a qualitative database was used to analyze, code, and theme the data. The data management plan is included in Appendix C.

Data Management

Data were collected during recorded virtual and telephone interviews. A USB digital voice recorder was used as a secondary device to record audio in case the virtual transcription become corrupted. The data from the interviews generated voice recorded data, or transcripts, which were saved on a secondary password protected and secure drive. As outlined in the data management plan, securing the data and metadata was integral to maintaining confidentiality of the data.

As study participants, the participants have rights to their own stories as they relay them. Under the IRB and data management plan, the rights to the metadata and data analysis produced from the participants' interviews belong to the principal investigator. All data gathered during the study was each participant's personal experiences implementing an 1115 Medicaid pilot waiver program. Interview data are maintained on an external drive that is kept in a locked house with password protection. The transcribed data will be kept on an external drive and stored for 3 years. Once the research study is complete, the files will be deleted from the external drive. Transcription files will remain archived for three years, upon which time they will be permanently deleted.

The technical and procedural protections for information were:

- Upon collecting confidential information (demographic information including name, location, and work sector), the participant's name, work location, and sector of work were replaced by a pseudonym for identification.
- All data produced from interviews are protected on secured, encrypted files and storage devices.
- Only I have access to these data.
- Recordings and transcriptions containing personal identification have been redacted and replaced with a pseudonym.
- Informed consent is being kept in an external drive that is password protected.
- Separate files with unique passcodes house consent forms, data transcripts, and audio recordings.
- The Pepperdine Zoom account was used to conduct the interviews, and the interview room was password protected.
- Participants were instructed not to provide their names, their employers, or the regions in which they work during the Zoom interviews.
- Audio recordings were saved using a pseudonym and have been deleted now that the transcription is complete.

Data Analysis

Managing and Organizing the Data

The interview transcriptions were downloaded, read, reviewed for accuracy, and placed in a Word document to be cleaned up, as necessary. Several transcriptions had data on multiple separate lines; however, the data were part of one sentence or a related paragraph. Survey transcripts and survey results were coded and reviewed within the qualitative database, NVivo. Interview transcripts were placed into NVivo, where the transcripts were coded and themed. The literature review was also coded and themed in NVivo allowing for comparisons of definitions and primary and secondary references to be compared. Normative care categories were coded and themed, and comparisons were drawn between the literature review, the interviews, and the normative care categories.

Coding

Interviews were coded using a first and second cycle of coding. The first cycle coding included reading the interviews, documenting first interpretations, and then rereading the interviews. Each individual interview was transcribed using grammatical, elemental, and data theming. A data dictionary was created to outline common definitions. The second cycle coding involved grouping meaning, units, words, and similar text together. Coding included organizing and identification of codes, subcodes, themes, and subthemes (Saldaña, 2021). This included line-by-line coding, individual word analysis, and indexing of common phrases, sentences, and words. A codebook was created using NVivo that held the definitions and codes. Codes were entered into a qualitative software electronic database allowing for ease when pulling together themes and subthemes (Saldaña, 2021).

Developing Interpretations

The third step in coding was developing interpretations from the interviews. Data were displayed on a chart according to the normative care concepts within the Project INTEGRATE model, including the categories of "collective person-centered care vision, population health management emphasis, local community awareness and trust in integrated care services, leadership with a clear vision, shared vision of integrated care among all stakeholder and care providers trust each other's capabilities" (Read et al., 2019, p. 3). Where possible, data were coded to any one of these six categories. Data were also coded and themed from the literature review and to interviewee responses. Data were further analyzed by reviewing word or theme repetitions and similarities and differences in answers, categories, and themes. Surprises and unanticipated answers were cross checked against the literature and existing research to compare the interviews to existing data when developing interpretations (Ryan & Bernard, 2003).

Representing and Visualizing the Data

Figures and tables were generated from the research results using the qualitative software to reference common themes, definitions, and responses provided by the open-ended survey questions. Qualitative data were incorporated into charts when appropriate to display the results. The display of data does not include regional information, nor does it tie in job titles or positions directly to participants. Representation and visualization of the data combines the results from the bicoastal study to preserve confidentiality and not directly attribute data to one particular region or individual.

Plan for Reporting Findings

Chapters 4 and 5 provide details on the results of the interviews. Chapter 4 contains tables illustrating the coding process, common themes, and interview passages from participant interviews. Key findings are also presented and discussed. Within Chapter 5, conclusions, next steps (e.g., plans for further study), and the summary are covered. The role of the integrated care, normative concepts and complexity theory are also included in Chapter 5. There is also a discussion on application of the study and implications for future practice. Contained within the final chapter are recommendations on how to apply the lessons learned within the study. As this was an exploratory study, what is now known compared to the start of the research is discussed.

Considerations on how to apply the lessons learned to other states working on waivers and embarking on health care reform topics are key findings discussed.

Chapter 4: Results

The purpose of this qualitative case study was to examine how government-managed care and community-based organizations work together to develop trust, a shared vision, clinical care, and other normative care concepts. This research fills a missing gap in the body of literature on how all three sectors work together when implementing a new 1115 pilot Medicaid initiative. Included in this chapter are the case study interview findings, identification of common themes, and research subthemes.

There was a total of eight interviews completed, six of which were recorded through Zoom; two participant interviews were not recorded and were conducted through Microsoft Teams in a combined interview. The recorded interviews were transcribed. A set number of open-ended questions were asked to all respondents; subquestions were included and asked only when additional prompts were needed to completely answer the question. Two of the interviews received partial questions, these interviews were held on Microsoft TEAMS and was an unanticipated group interview. The meeting on TEAMS that was scheduled for a half hour was anticipated to be an introductory meeting. The meeting turned into an interview; all nine interview questions couldn't be covered by two participants within thirty minutes. Both participants were in clinical roles, so I selected questions on vision, trust, and clinical shared leadership.

Survey questions focused on normative care values, shared vision, population health management, knowledge and gaps, trust, stakeholders, community clinical decision making, and leadership. Interviews involved professionals who were retired or were currently employed at the time of the interview and who had experience in the implementation of 1115 waivers representing the sectors of government, healthcare, or community-based organizations in North

Carolina or Orange County, California.

Description of Sample and Setting

During the research recruitment phase, I identified and contacted 14 individuals who met the research criteria. Individuals meeting the research criteria were employed at the time of the study or previously employed in one of the three identified sectors: government, healthcare, or a community-based organization. Professionals working within one of these sectors had experience working on an 1115 pilot waiver and were part of a 1115 pilot waiver in North Carolina or in Riverside or Orange Counties in California. No professionals from Riverside County responded with interest to participate in the study. Individuals working for two managed care plans vetted the consent form through their compliance department, and one managed care individual did not receive clearance to participate in the study. This individual did not meet with the researcher, no interview was set up. The consenting process in North Carolina was met with much more rigor and compliance review than in California. A total of eight interviews were completed that met the research criteria and the scheduling timeframe and that consented to participate.

Interviews were completed through a virtual video conferencing platform. Research participants were recruited through purposeful sampling. Due to the small sample size and to preserve confidentiality, naming of the regions, the state, the organization, professional titles, gender, titles and names were withheld. Pseudonyms were used to group participants by organizational sector and professional affiliations.

There were nine open-ended questions that focused on normative care concepts and emerging themes from the literature review. Questions centered around a participant's experience working in an 1115 pilot waiver, their perspective from their professional work sector, and insight with implementation and cross sector professional experiences. Research participants responded to questions on forming a shared vision, population health management, gaps in knowledge, trusting each other, stakeholders who help their patients, clinical decision making in clinical care teams, shared leadership, and the role of executive leadership. A couple participants had retired or had experience implementing 1115 waivers in more than one professional sector.

Demographics

To participate in the study several criteria needed to be met. Participants were 18 and older and must have experience over their career of implementing a 1115 pilot waiver while employed in a community-based organization, government, or managed care. This was a bicoastal study between North Carolina and California; professionals needed to have worked in one of these geographic locations in addition to having sector experience and 1115 pilot waiver experience. All participants met these criteria with the majority of participants having a medical degree and all but one sharing experience in executive level positions. Table 4 includes a listing of all eight participants, their roles, degrees, and sector of work.

Table 4

Participant Pseudonyms, Roles, and Demographics

Participant	Executive role	Health care sector	Medical degree
P1	X	GOV	
P2	X	CBO	RN
P3	X	MC	MD
P4	X	CBO	DNP, RN
P5		MC	MSN, RN
P6	X	GOV	MD
P7	X	GOV	MD
P8	X	CBO	

Note. P# = participant identification number; CEO = chief executive officer; MO = medical officer; PR = president; GOV = government; MC = managed care; CBO = community-based organization; RN = registered nurse; DNP = doctorate nurse practitioner; MSN = master of science in nursing; MD = medical doctor.

The participants were evenly split between men and women. Three of the participants worked at the same organization. One participant had retired, 75% of the participants had an advanced clinical degree as a doctor, psychiatrist, or nurse. Nearly 90% of participants served in an executive leadership role in government, managed care, or for a community-based organization.

Participant 1 (P1) has worked in government roles at the Center for Medicaid Services (2022) and for the state government on value-based care, care delivery, and improving social drivers of health. P1 currently serves in an executive role on direct implementation of the 1115 pilot waiver. Direct implementation of the waiver includes focusing on value-based care and social drivers of health. The state government agency name is not included to protect anonymity and confidentiality.

Participant 2 (P2) has worked in the healthcare industry and local hospitals as a registered nurse. P2 has served in an executive role for a community-based organization as an experienced CEO for over 15 years and continues to do so. The organization focuses its work on housing and other social support services, including implementation of 1115 pilot waiver services.

Participant 3 (P3) has worked for several managed care plan agencies throughout his career in executive roles ranging from chief medical officer, chief operating officer, and chief executive officer. P3 is retired but serves in a consultant role. P3 has participated in the startup of managed care plans and has worked with the state and community on 1115 pilot waiver implementation. The state is not named to protect anonymity and confidentiality.

Participant 4 (P4) is a seasoned chief operating officer who has worked with nonprofit organizations, social and family services, and the Healthcare for the Homeless organization. P4 was involved with two regional implementations of 1115 waiver pilot programs. Involvement with two regions included working with the local managed care plans, social service providers, and local and state government.

Participant 5 (P5) has extensive experience as a quality and clinical consultant within the healthcare system. P5 has worked in different roles during the implementation of the 1115 waiver with both the State government and managed care. One of the key career focus areas for this professional is on both clinical and quality of life outcome improvement.

Participant 6 (P6) has worked for the local health department and serves in an executive role with the state. P6 serves in roles with the Centers for Disease Control and the Health Resources and Services Administration, in addition to their role at the state. P6 has been integral in 1115 implementation working with the state and local health plans. The state government agency name is not included to protect anonymity and confidentiality.

Participant 7 (P7) currently works for state government and has clinical experience working with professionals and managed care plans on Medicaid and specialty care. P7 has served as medical director and specialty health medical roles for the majority of their career. Specialties include behavioral health and work with intellectual and developmentally disabled populations. The state government agency name is not included to protect anonymity and confidentiality.

Participant 8 (P8) has served in an executive role with a local community-based organization for the past few decades. P8 has worked with local and state governments and managed care plans. This participant specializes in finance and funding.

Interview Findings

Interviews using open-ended questions were conducted for this research project.

Inductive coding was completed, and each interview was thoroughly read and sorted into themes and subthemes using the qualitative database NVivo. All eight interview transcripts were analyzed through the coding process and grouped into thematic categories. All four research questions proposed were validated through thematic analysis, with details on their validation included throughout the thematic analysis.

Thematic Analysis

There were eight themes that emerged through the thematic analysis process. The themes and definitions are described in Table 5. Quotes from participants are included as part of the thematic analysis. Table 6 details the themes and subthemes from the participant interviews.

Table 5

Themes and Definitions

Theme	Definition
Stakeholder contributions	An ecosystem of individuals, community and organizations contributing to care of a common group, mission, or people
Shared leadership	Partnering, listening, contributing proactively with multiple stakeholders to solve a problem and hold each other accountable
Executive leadership	Elevates emerging and urgent issues to other like executives, local and state leadership. Diplomatic, transparent, convenes stakeholders. Involved in legislative decisions.
Patient outcomes	An improvement in social and physical health patient outcomes
Patient care and decision making	At an ecosystem view, balancing supply, and demand for services versus rates and overall patient health outcomes. The definition also represents individual clinical care decisions.
Vision formation	A representative group of stakeholders dedicated to improving Medicaid patients lives.
Social determinants of health	Reducing system barriers to primary, behavioral health and social care to improve overall population health
Establishing trust	Relationship building, open communication and leadership that follow up and follows through with actions.

Note. $N = 8$.

Table 6

Frequency of Themes and Subthemes

Theme	Subtheme 1^{o}	Participant							
		P1	P2	P3	P4	P5	P6	P7	P8
Stakeholder contributions		X		X					
Shared leadership				X	X	X			X
	Legislative and political leadership	X		X	X	X	X	X	X
Executive leadership				X	X	X			
Patient outcomes						X			
Patient care/decision making		X	X	X	X	X			
	Social Services/Non-Clinician	X		X	X				
	Rate setting			X	X				
Vision formation			X	X		X	X	X	X
	Problem or bifurcation	X	X	X	X	X	X	X	X
	Legislative mandate	X							
	Community meetings	X			X				
Social determinants of health		X	X			X			
	Screenings and assessment	X							
Establishing trust			X	X	X	X	X	X	X
	Trusted external partners	X	X	X					
	Acting on feedback	X	X	X	X				

Note. 1^{o} = theme; 2^{o} = subtheme; P = participant.

Theme One: Stakeholder Contributions

Research question one was validated, while research questions two, three and four were discussed in other themes. Participant P1 discussed how stakeholders came together to address patient and customer outcome data for domestic violence survivors that was not accessible due to data protection laws. There was a lack of coordinated care for domestic violence survivors related to limited access to protected data. This problem brought together a group of diverse stakeholders to discuss how domestic violence stakeholders could offer Medicaid support services to this group, which they could not readily identify.

"We worked with the…coalition against domestic violence for a few months, to try and figure out the best way to be able to provide these services through pilots in a way that's safe for domestic violence survivors" (P1).

Two participants discussed stakeholder coalitions, coordination, and group formation specific to the 1115 waiver pilot start up. These two responses were grouped together because the state was key in hosting, convening, or arranging for a third-party facilitator.

> We've been really engaged with the…coalition against domestic violence. One of our service domains that we offer is interpersonal violence and toxic stress and because of Department of Justice (DOJ) regulations around domestic violence survivors…their data and information is [protected]. Their data doesn't always align with Medicaid data sharing, and we've worked with the DV coalition against violence for a few months to figure out a way to provide these services through the pilots in a way that's safe for domestic violence survivors. (P1)
>
> There was a think tank for the state..[led] by a very seasoned, knowledgeable facilitator. Simply stated, a whole collection of people that would be affected and had an opinion on waiver changes. I was one of two health plan representatives out of fourteen representatives. Commercial plan representatives, public plan representatives, pediatric specialists, Children's Hospital representatives and parents. (P3)

Theme Two: Shared Leadership

Research questions three and four were validated under this theme, while research questions one and two were validated under other themes. Participant 5 discussed how accountability changed over time, using data to increase transparency. There was a change in infrastructure over time, from when a new pilot starts and becomes established. Publicly available data increased trust over time among stakeholders. Shared leadership roles change as data shifts, resources shift, politics change, financing shifts and legislative shifts occur. All of these changes impact stakeholder expertise and how shared leadership and trust are impacted. P1, P2, and P8 provide examples within this thematic analysis.

Four participants discussed the role of shared leadership, which included individual leadership perspectives, how leaders represented themselves in terms of demeanor, and how leaders and organizations enter into contracting relationships to ensure accountability. P3 described what happens when shared leadership takes a negative turn:

> People that remain and present in a calm objective manner have more credibility than individuals who spoke with fervor and passion. Let’s solve a problem for the State, spend time listening, you have two ears and a mouth for a reason…listen and digest.

“County partnered with us, we were the pioneer to submit an application with the County to do recuperative care. The health plan passed the responsibility over to a health care agency” (P4).

P5 described the trifecta of shared care and what is necessary for success with multiple sectors:

> Accountability for sure, resourcing to help deploy, not just from the full time equivalent (FTE) sense, but to ensure it, from the infrastructure and interoperability to be able to share information, is key to success. The trifecta of partnership transparency is financing, [sharing information] and outcomes to be realized. Look at publicly available data and information to show significance of need and importance. How is it going to be resourced appropriately, allow communication to come through, together with accountability to get the ball rolling quicker.
>
> The managed system of care came out of a subset of a project around the health care safety net [prior to the ACA]. We had a big coalition of organizations, including the government, Health Care Agencies, the public health plan, we created the Safety Net Project that had multiple components. One was the Children’s Health Initiative, the revenue from the project brought in 74 million dollars to keep people out of the emergency room, it worked tremendously through a 1115 waiver.

> We created committees under the managed system of care, this includes CEOs from the hospital system, the public health plan, to address the uninsured and uncompensated care through an intergovernmental transfer approach that worked pretty well. There was a common pool of money to reimburse those seeing more versus less uninsured people. It was an interesting and good approach until it blew up. (P8)

A subtheme of shared leadership emerged from several participants' interviews. Six participants discussed the role of state champions, elected officials, and the interplay between politics, state and federal legislation, financing, and rate setting. P1 described how coalitions and groups trust can be eroded by external politics and differing agendas:

> Our former secretary of state was vital in leading and gathering statewide buy-in to the idea of social drivers of health and whole person health. She was the state champion for the effort and got a lot of stakeholder buy-in. Through relationships, she was able to find advocates and associations, like the Family Physician Association, pediatric associations, hospitals, and health plan associations to [engage] in leadership conversations between her and the legislature to get the funding for the program (waiver program). It was a priority of our Medicaid executive leaders, and we were standing up opportunities during Medicaid transformation. The program stayed a high priority due to the partnerships with health plans, associations, and executive support.

There was a desire at the state to integrate children services (CCS) into health plans, this was placed by in the 1115 waiver by state leadership realizing there would be some overlap and administrative savings.

> Board of supervisors overseeing a public health plan, it's significant that the CEO would relegate to another person. Things can go downhill if perspectives aren't the same, it's

> important to identify, what's in it for me, what's in it for the other person and how can we bring mutual value to each other? (P3)

> A disconnect at the state with the waiver, is the amount of flexibility the state gave to the health plans. The expectations should have been clearer, you can try and be flexible with it but you can't not do it. Flexibility allows the health plans to [run different social supports in different ways], one plan gives retroactive pay up to 90 days and another up to 6 months. There is a disconnect between the State, the health plans, and community-based organizations [in how information is interpreted and contracted]. (P4)

"Legislation can be a friend or not, transparency can go awry if complicated and there can be unanticipated consequences without trust." (P6)

> Politics, a lot of people didn't like this [managed shared care idea], every government affairs person at the hospital hated it because their bosses were talking, and they weren't in the room. Those people talk to politicians, some who were less than honest. One of them was trying to take over a public health plan and they had friends conspiring to blow up the managed system of care. The government affairs people and [several organizations] conspired to destroy some people and organizations [involved in the effort] and the system fell apart. The politics cannot be overstated in trying to do things that involve lots of money. (P8)

Theme Three: Executive Leadership

Research questions three and four were validated under this theme, while research questions one and two were validated under other themes. Participant 5 discussed how accountability changed over time, using data to increase transparency. There was a change in infrastructure over time, starting from when a new pilot starts and is established. Publicly available data increased trust over time among stakeholders. Shared leadership roles change as data, resources, politics, financing, and legislative shifts occur. All of these changes impact stakeholder expertise and how shared leadership and trust are impacted. P1, P2, and P8 provide examples within this theme.

Three participants discussed executive leaders and how some leaders were chosen by their own organizations, by state government or by health plan leadership. The next few interview passages were coded together. Examples by participants referenced the role of Executive Leadership and the importance of leadership in hiring individuals with specific skill sets to work across sectors. Executive leaders made the decision to send representatives to the state to participate due to their background, knowledge, and skill sets to navigate with other health plans, community-based organizations, and the state.

> The state was assembling a dozen or so waiver workgroups to document public input and there were isolated issues being discussed. I think they were trying to pilot and understand the process. A local foundation picked up the dime to have individuals meet in person, I believe you have better discussions in person. Representatives from the public and organizations raising their hand to participate and nominate individuals with the support from legal, helped contribute [to] a solution. (P3)

> The best thing that happened is the Plan hired an Executive Director of CalAIM programs [that had community-based organization provider experience]. It depends on who's running the program on the health plan side, with the state at the top, they have mandated a lot for the health care plans. (P4)

> Sponsorship and leadership are key. I know there is a strong daily, weekly, monthly imperative from Medicaid leadership. The retired chief quality officer [gave] different

> perspectives to the state that helped move forward the health plan side, with large plan enterprises across the state they can show leverage. At the beginning of managed care, transparency helped. It wouldn't have been done otherwise if they weren't putting in their time equally as those implementing the process [Medicaid reform]. (P5)

Theme Four: Patient Outcomes

Research questions three and four were validated under this theme, while research questions one and two were validated under other themes. Participant 5 discussed how accountability changed over time, using data to increase transparency. There was a change in infrastructure over time from when a new pilot program is established. Publicly available data increased trust over time among stakeholders. Shared leadership roles change as data shifts, resources shift, politics change, financing shifts and legislative shifts occur. All of these changes impact stakeholder expertise and how shared leadership and trust are impacted. P1, P2, and P8 provide examples within this theme.

P5, when thinking of clinical care teams and patient care, focused on the outcomes of individual patients:

> Member level successes to be able to hear from the member themselves or the community-based, health service organizations that members are thriving and able to get appointments. For them to have vitality in their life, for us to see from a qualitative perspective. A ROI (return on investment), not a dollar ROI but in expanding [access], members having healthier, fuller lives.

Theme Five: Patient Care and Decision Making

Research question 1 and 4 were validated, as several participants discussed the importance of screenings to identify social determinants of health. Primary care messaging, care management models, and case conferences were discussed under Theme Five. Care team meetings and case conferences were identified as outcomes impacting patient care and decision making resulting from pilot implementation. This addressed a change over time in clinical decision making, therefore validating question 4. Participant 5 discussed this during their interview. Research questions 2-3 were focused on vision formation and changes in shared leadership, which were not validated.

Five participants discussed patient care and decision making. This included identification of social determinants of care and different stakeholders' views on messaging, care, and education. Clinical case reviews were highlighted by P1, which were the challenges of coordinating with health plan staff turnover and the importance of training and education as healthcare and social services are expanded under the waiver.

> We have providers and clinically integrated networks; we have a delegated care management model. We're trying to get care management done by local primary care providers (PCP's). Advanced medical homes delegate their care back to a clinically integrated network. We've developed messaging tools to PCP's to determine eligibility and there is no wrong door, anyone would have enough information to enroll in a pilot and get the benefits. (P1)
>
> Hospitals [medical care vs. social care] we can't do both, whatever goes beyond these doors were not concerned with. We hired social workers, but we can't do both, the champions to bring social determinants to the hospital system wasn't there. Fire, police, picked up on the need early, they were trying to address and delivery appropriate care. Lately, it's become the health plans and the community, the city, county, and the state, with COVID, there was a shift to the providers and non-profits were seen more as an

> equal partner, because they needed us. (P2)

> Nursing is key, substance use disorder counselors, case managers [care coordination]. We are starting to do that [pull in the health plan into case conferences] but there has been so much turn over on the health plan side, we're always meeting with someone new. [Plans with less turnover] we meet every two weeks with two people to go over cases. (P4)

> Patients, customers, stakeholders, societies, hospital associations, community health workers, personal care services, in-home services. A lot of our health care needs social drivers are uncovered during a PCP visit...identification through screenings. It depends on prioritization and who is involved, because of [the pilot] managed care and Medicaid requirement for screening, pilot counties have transparency, health equity, NCQA standards of health-related resources, [its] bringing people to the table to be included in care team meetings. (P5)

Social Services

Social services is a subtheme identified from patient care and decision making. Two passages are discussed from the interviews. Both passages mention the importance of social services and community-based organization coordination and expertise.

> Providers [Clinicians] were asking us for help, we developed trainings in collaboration with a stakeholder group with state and private subject matter experts in food, housing, and transportation to help clinicians understand when one service may be more appropriate than another. Preventative services have a lower uptake than they should have, awareness building of services, getting members screened and enrolled, identifying social needs is still a challenge. (P1)

P3 said, "It's important to have the right person at the table with the expertise, creditability, specialty…consider who is missing” (P3).

Rate Setting

Rate setting was a subtheme of patient care and decision making that was discussed by participants representing the community-based organization sector.

> It starts with money, [the health plans] mad sure they were paying the providers an equal amount or higher. Meetings between the health plan, children’s services, and children’s specialty care, [we met] to talk about our mutual challenging clients, what role we played and who had to pay for what and what it was. They had a detailed discussion and individual trials, that was really important. (P3)
>
> As a community-based organization, we had great success with our recuperative care model, that laid the foundation for hospitals to contract with us on a private basis; so, we negotiated, and hospitals started contracting with us individually for care. (P4)

Theme Six: Vision Formation

Research question 2 was validated within this theme, while questions 1, 3, and 4 were not validated.

P1 said:

> It takes serial vetting to come up with something that represents the various stakeholders organizational mission. It’s not something that somebody could just step up and say, this is what we do and how to do it. It works best when there is copious input and there is time to digest and review.

P5 said, “As a health plan, there are many conversations that occur with the state, standing meetings, how can be band together to ensure patient needs are met (social determinants of health).”

Participants described their experience working across sectors on vision formation and perspectives on shared vision. The participants in different sectors of care expressed differences when describing vision formation.

> When I started a non-profit, homelessness, everyone's going to need us. A gentleman said, you'll come to help people with this fire, they'll say no, find your own fire. People have their own vision and thoughts on how things should be done with passion but not a lot of evidence-based research. We didn't anticipate people working in silos in human services. Understanding the unmet need by whatever group we're working with in a community that had 7-8 strong providers, recognizing how each individual provider addressed the problem and not having your vision overlap. (P2)

Participant 3 (P3) represented the health plan perspective and responded to the question on the importance of developing a shared vision.

> I don't think the concept of a shared vision is important, it's can you vocalize what that is, it doesn't need serial vetting to come up with something that represents various stakeholders. What works best is when there is copious input and time to digest and review, that's important. (P3)

Participant 5 (P5) described the state perspective. They had initially started at the state and then moved to a health plan during pilot implementation.

> There were a lot of conversations working with the Health Plan Presidents and the State, standing meetings, [discussions] on screening for care needs, quality measures for percentage of care, social drivers or determinants of health and other health related resources. A questionnaire was adapted looking at food, transportation, housing, interpersonal violence, childhood trauma (ACES). The state was asking [with the

> screening results] what are we doing about it? How can we maximize Federal dollars to support improvement, buy in from the health plans was a huge feat in identifying these issues and to band together to ensure we can serve those needs.

The next two participants described vision formation from the state or government perspective. P6 stated, “Skepticism over change in the political sense and trying to take power against others.”

> The specialty services clinical vision was harder to form. There were political entities and boards involved, specialty clinical staff were not so influential. Specialty care had entrenched political entities and clinical leaders had less of an impact. Advanced medical health had less buy-in to whole person care management and provider base impact. (P7)

P8 represented the community-based organization perspective:

> Prior to ACA through the managed shared care system, we we’re working to help organizations get reimbursed [for seeing uninsured patients], everybody was dealing with is separately. We’re trying to have everybody deal with it together and maybe manage it a little bit, make some sense out of it. Figure out ways to get folks into care…don’t go to the emergency room if you can go to a clinic. The vision was a managed care system. In general, when building a vision, we’ve done a lot of collaborative work with both funders and different organizations, you need the right people in the room at the right time and there has to be common agreement on where you’re trying to go. Everybody needs to agree that there’s this big goal we’re trying to get too. I would say it’s not worth bringing people together unless there’s a big goal, it’s intense, time intensive, resource intensive and financially intensive. It’s hard to keep the group going, the average funder partnership lasts around 4 years.

Problem and Bifurcation

Problems and bifurcation of healthcare and behavioral healthcare was a subtheme that arose during the interviews. Participants described varied systems of healthcare, how the system changed with additional waivers, and waiver implementation. Gap identification was acknowledged as the state and local government gained an understanding of individual participant healthcare utilization and the necessity of social supports.

> All Fee-for-Service (FFS) Medicaid program bifurcated physical and behavioral health, two different insurers, different insurance cards, different networks. The legislature mandated managed care and our secretary at the time with collaboration from stakeholders wanted to use this as an opportunity to make sure we were addressing full person health in all of our health plans and a comprehensive set of benefits including behavioral health, social needs, pharmacy, long term care, an all in one integrated health plan. (P1)

> Medicaid Advantage, I think that drew people to older people in part because of reimbursement. The CMS waivers opened things up and there’s a lot of new entities that have entered the Medicaid market, we’re seeing them a lot more interested in community and public health. (P2)

P4 said, “Refer the highest utilizers of the health care system and start providing recuperative care. The hospitals reached out to the community-based organization, and asked, if we could help.”

> At the State, a collective gap realized would be the span of availability of resources. Organizations were willing to support and provide food. There are many gaps, justice

> served populations, behavioral health, lack of services and availability and accessibility geographically related to age or chronic conditions. Transportation is hard across the board. There was a shift, in the recent rollout (of the pilot program) because everything rolled out in phases would be the behavioral health and social emotional services. (P5)

Theme Seven: Social Determinants of Health

Research questions 1 and 4 were validated under this theme, while questions 2 and 3 were not. Three participants discussed social determinants of health, comprehensive screenings, personal stories working with patients, and the role of addressing social determinants of health in conjunction with healthcare benefits.

> Comprehensive care need screening that screens for physical, behavioral, and social needs. The social needs are statewide standardized social needs, if the needs are high enough, they're put into care management. Reassessed annually to see if their needs change, if they screen positive, they make a secure closed loop referral to a community-based organization. Rates are low (low number of screenings). The CBO's come up with really great ideas to implement, they bring a lot of helpful learning. (P1)

> Connecting homeless individuals and families to medical services…from a mom, she said, my child has diabetes and I'm connected to primary care, the medical part is great, but I can't keep meeting with you, I have unstable housing and it's more important for me to get housing than worry about diabetes right now. Transportation, food, employment, and housing; all four affected their help and I saw great improvement when we addressed those simultaneously. (P2)

> Thinking of the multiyear component of the pilot, mask of hierarchy of needs, basic needs, social drivers that will in turn improve a disease, lower progression disease rates,

> Medicaid as an eligibility benefit. Once people meet those needs and have food, work, transportation, housing, they could be ineligible for Medicaid, the state is starting to look at that impact now. (P5)

Theme Eight: Establishing Trust

Research questions 3 and 4 were validated under this theme, while questions 1 and 2 were not. Participants discussed the importance of patients gaining trust in direct service providers and community-based organizations. They also emphasized the significant role of patient trust in establishing effective care. Nearly all respondents provided input on trust, how trust is formed, and how trust can be eroded. The subtheme of having a trusted partner and acting on feedback emerged from the question around how trust is developed and how do individuals contribute to trust.

> The client is first, if they trust it, it helped foster trust with everybody in the working circle. It gave me a good idea of who was going to follow through on care. [When individual agencies were honest] they gave us honesty and that turned into trust. (P2)

> One is building relationship and entering an environment where everybody doesn't know one another, haven't established credibility, and haven't established name recognition. [In new groups] having a trusted facilitator that is known, allowing everyone to review, provide comments and keep notes from each of the meetings before final reports were submitted. Everyone had a say on what the final report was [waiver recommendation]. (P3)

> There was no trust [from the community-based organization] with the health plan. The health plan kept saying, we need for capacity, they had meetings with them; they staffed up and increased capacity and the health plan didn't want to write it into the contract.

> There wasn't enough volume, and the documentation was heavy, the health plans listened to some of it. (P4)

> Transparency requires everyone to be at the table and to share what you're doing. There's an inherent trust because it has to be put out into the public. Having managed care launch [with the pilot] helped, because there's a lot of sharing, everyone is coming to the table asking, How are you doing this? How are you doing that? (P5)

> A collaborative clinical setting to improve the system and address threats and opportunities. There was a weekly workgroup with the chief medical officers, the group became colleagues and collaborators as they discussed policies, notices, and screenings. A shared understanding developed from the workgroup. (P6)

P7 said, "Build trust from a clear vision, not from budget or legislation, put the member at the core. It's hard to argue with the member at the core of the vision."

> Nobody has all the answers, nobody knows everything about how to get it done. One the other hand, you'll have people who will do more than others. You will have some entities that will be more active than others, and that's okay. Don't ask anyone to do something they can't do. You might ask, and if they say they can't do it, don't badger. If this succeeds that everyone should take 100% of the credit, if it fails, the people that can absorb the failure can take the blame. You don't want to lose your influence or your job [through innovative work]. (P8)

Trusted External Partner

P1 stated, "Our network leads, we have external entities that host regular convenings where our health plans, network leads and providers all meet together monthly. The regular collaborations…trust building space."

> Communication challenges going back and forth, to make the system more efficient, the state assembled a facilitator, a trusted entity that was funded by a trusted health care foundation. From the start, you had funding by an entity that is trusted and respected. (P3)

Acting on Feedback

> I think one entity saw we were taking their feedback into consideration and making programmatic changes. That helped a lot, in gaining trust in the program and department. Community-based organizations were very overwhelmed at the thought of the program, they're having to change their entire operating model, to advance billing on a fee schedule. I think they had some concerns about the rates being high enough and the number of enrollees. Now that they're actually doing it, they feel proud to get this far. I think that I see more trust in the state health plans, the systems for troubleshooting and investment in the program with the health plans. (P1)

> With the health plans incentives, the health plans [would] get these services out as much as possible to pay less in the future. Upfront is where the frontline health plan staff have the time and monetary investment, it's a lot more work than they were anticipating, they're reminded of the financial incentives, but they weren't really effective enough. We're taking their feedback and making programmatic changes to simplify. (P1)

> In a board of supervisors meeting, one of the board members asked, do we have 6,000 homeless or 40,000? Why can't anybody answer that question? I remember looking to say, because I can't get data from anybody. The hospitals won't give anything, the plans won't give anything and now with automated intelligence [predictive analytics] we've come further. (P2)

> They were surprised to hear the health plans had case managers, quality indicators, utilization [metrics] and safeguards to avoid over or inappropriate utilization for fraud and abuse. The amount of communication, from the health plan and how it differed [public perception created] a good relationship with community-based organizations. The health plan ended up being a facilitator of multiple meetings, networking activities, conferences. We sent out staff out to CBOs to address HR issues and a plethora of resources they didn't [have]. (P3)

> Now [health plan executive] and the CBO executive are talking about the hospital presumptive approval of 14 days in recuperative care. The criteria are pretty loose, only three out of 10 would actually get in, now the vision is the CBO and health plan work together to get people services with the presumptive approval. Leadership and vision at the health plan, what they will pay for and there wasn't a lot of red tape in getting people authorized. (P4)

> The health plan executive director and team were responsive to the CBO that said we are referring patients to enhanced care management, but we don't know what's happening and why patients aren't getting care. The Health Plan came over with their team and the CBO facility, there were six or eight people in the same room, they did a little spaghetti thing on the board. Why aren't our referrals getting through? Where is the bottleneck?
>
> So, it comes down to relationships, how are we going to fix this together. (P4)

Chapter Summary

A total of eight professionals in the fields of government, community-based organizations, and managed care participated in the research study to discuss normative integration and integrated care. From the interviews, there were eight themes and nine subthemes that emerged. Shared leadership, vision formation, and establishing trust were the top three themes. All four research questions were validated under one or more of the eight research themes. Chapter 5 summarizes the research conclusions and discusses key findings, limitations, recommendations for future research, and implications for practice.

Chapter 5: Discussion

Chapter 5 provides an overview and conclusion from the culmination of research on normative care, integrated care, and stakeholder relationships during 1115 Medicaid waiver implementation. Stakeholder roles that were researched included managed care plans, government, and community-based organizations. Fundamental to the research was understanding how normative care (vision, trust, shared leadership, population health) was formed. The research questions examined how stakeholders address gaps in social determinants of care. Research questions asked how shared vision is established, and how shared roles in leadership, trust, and clinical decision making changes over time. Complexity theory was applied as the framework.

Problem Statement

When health care organizations and government entities attempt to partner with the community, there is often a lack of understanding on how each entity provides direct services. This can lead to numerous misunderstandings making it difficult to partner, coordinate, and implement new services. When new funding opportunities arise to pilot or implement a new benefit, health care organizations, government, and community-based organizations must work together to address community needs. Misunderstandings and misaligned goals, misaligned vision, and distrust can lead to a host of issues. Quality of care can suffer from misinterpreting community resources, service implementation, funding reimbursement, and myopic vision.

Absent in the literature is how stakeholders come together to establish integrated care. With the implementation of the Affordable Care Act in 2010 (Legislative Analyst's Office, 2010) and Medicaid expansion in California and recently passed in North Carolina, 1115 waivers provide states and counties with opportunities to innovate healthcare delivery (Hinton et al., 2019). Medicaid 1115 waiver pilots offer states, community-based organizations, hospitals, managed care plans, and local and state governments the opportunity to reimagine healthcare and social services (Chuang et al., 2020). State waivers can vary in how they implement new health and social service programs; however, the common thread between them are shared goals; reduced cost, improved service delivery, and better health outcomes (Shortell et al., 2010).

Prior to this research study, there were not many studies or evaluations on stakeholder collaborations between government, managed care, and community-based organizations during pilot implementation. Normative integration was used as a lens to understand how vision, trust, population health, and shared care are developed and applied across sectors (Read et al., 2019). Normative integration and complexity theory were used. Complexity theory is a science that seeks to understand the role of learning behavior and the complex steps included in that process (Pype et al., 2018). Understanding the ebb and flow dynamics between different stakeholders in achieving integrated care, normative integration, and complexity theory was central to the study.

Study Significance

Individuals enrolled in Medicaid receive insurance through a safety net program and qualify based on federal poverty level guidelines. Forty percent of one's health is completely out of their control and is directly correlated to the community and larger social environment in which they reside (Institute for Alternative Futures, 2012). Health equity and social determinants of health can impact individuals and families through differences in access to behavioral and social supports, disposable income, positive health outcomes, health care access, and quality of care (Koh et al., 2010). Public policy, such as implementation of 1115 waiver programs, directly influences health equity. In 2015, data examined across 45 states concluded that 45% of an individual's wellbeing is related to social-economic factors, 34% to an individual's health, 16%

to the delivery of healthcare services, and 3% of overall care in the physical environment (Hood et al., 2016).

Navigation of integrated care and social systems is complex. How individuals access and receive healthcare, behavioral healthcare, and social services is challenging. Both local and state organizations struggle with effectively integrating health and social supports when implementing pilot programs, such as accountable care organizations (Murray et al., 2020). Limited research on the topic of stakeholder integration (government, managed care, and community-based organizations), exacerbates the problem. The significance of this study was to understand how waiver programs develop and evolve through normative integration (vision, trust, and shared care). Integrated care is a key component to reducing costs and maintaining a healthy population.

This study adds to the body of literature on integrated care. The success of waiver implementation is one step to addressing health equity and social determinants of care. Information gleaned from this study can be utilized as a secondary reference for states and counties implementing waiver and pilot programs. Best practices from the research results will be shared and disseminated with 1115 pilot waiver entities.

Theoretical Framework

The literature was thoroughly reviewed to identify a theoretical framework that encompassed multiple systems of care and could be used to analyze normative integration. The theoretical framework of complexity theory was chosen. Complexity theory can be applied as a framework within health care organizations and captures the many changing day-to-day system dynamics within integrated care (Jordan et al., 2010). Research on implementation of waiver programs across stakeholder groups is a valuable contribution to the health, wellbeing, and social safety net. Integrated care systems are multifaceted systems constantly evolving and changing.

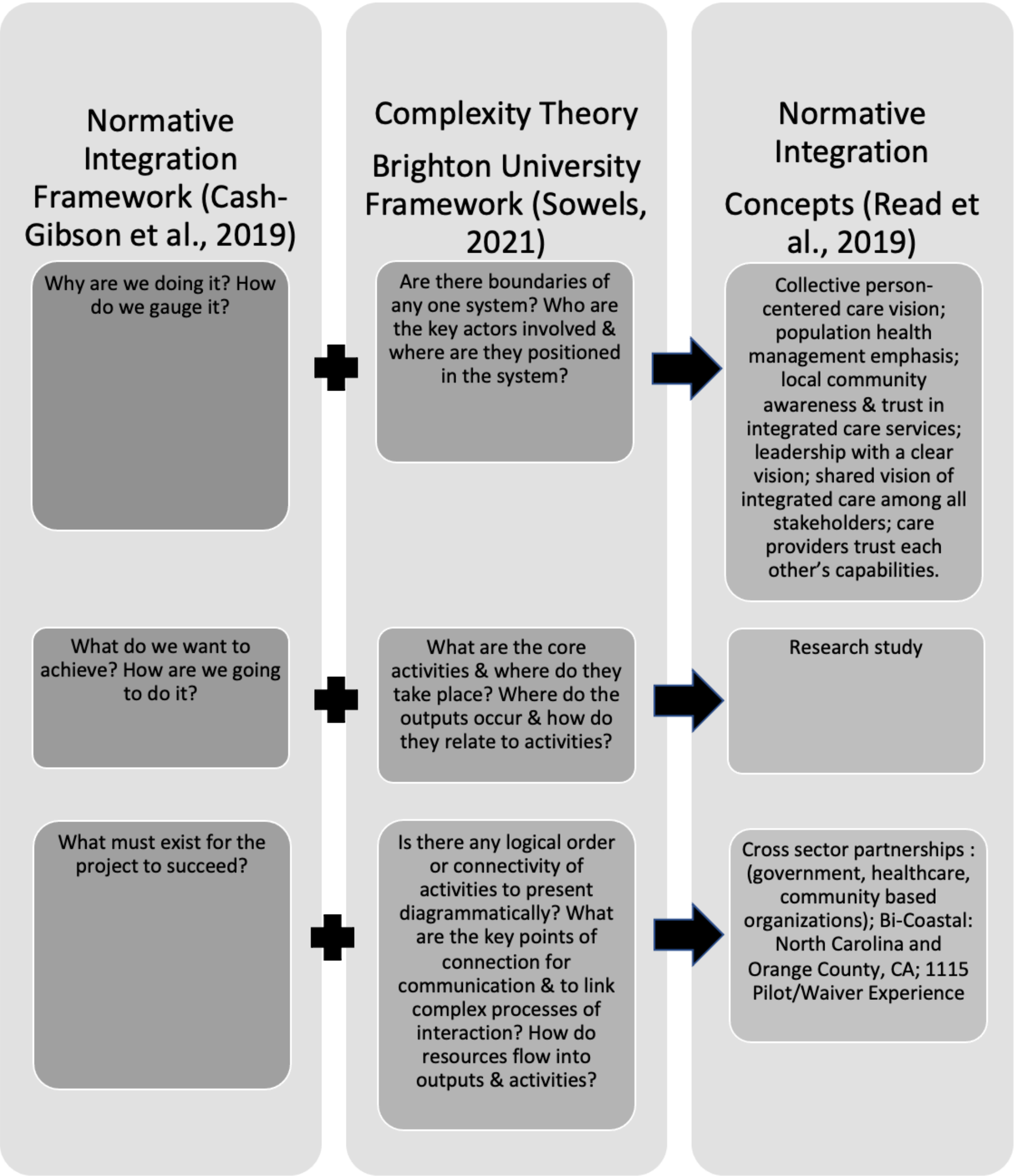
Complexity theory has been applied in health care settings. Complexity theory, when used as a framework, can improve health care delivery (Brainard & Hunter, 2015).

Normative integration concepts were researched in the literature as these concepts had been applied to an older adult system of care during previous studies. Collective vision, population health, trust, leadership, and shared care were used as the backbone for the research questions. Previous work on normative integration had not explored the role of stakeholders that included government, managed care, and community-based organization coordination.

Complexity theory has its own framework that can be applied similarly to normative integration. Figure 6 illustrates the connections between normative integration, complexity theory, and this study.

Figure 6

Research Study Conceptual Framework Intersections



Normative Integration Framework (Cash-Gibson et al., 2019)	Complexity Theory Brighton University Framework (Sowels, 2021)	Normative Integration Concepts (Read et al., 2019)
Why are we doing it? How do we gauge it?	Are there boundaries of any one system? Who are the key actors involved & where are they positioned in the system?	Collective person-centered care vision; population health management emphasis; local community awareness & trust in integrated care services; leadership with a clear vision; shared vision of integrated care among all stakeholders; care providers trust each other's capabilities.
What do we want to achieve? How are we going to do it?	What are the core activities & where do they take place? Where do the outputs occur & how do they relate to activities?	Research study
What must exist for the project to succeed?	Is there any logical order or connectivity of activities to present diagrammatically? What are the key points of connection for communication & to link complex processes of interaction? How do resources flow into outputs & activities?	Cross sector partnerships : (government, healthcare, community based organizations); Bi-Coastal: North Carolina and Orange County, CA; 1115 Pilot/Waiver Experience

During the research, normative integration concepts were discussed, and multiple complex systems of care were provided by the participants. Multiple system boundaries between shared care, leadership, and policy intertwined with government, managed care, and community-based organizations, as they began work on waiver programs. How individual agencies communicated across stakeholder groups and navigated shared resources (financial, contractual, services) added to system complexity. The framework and questions from complexity theory can be applicable to multiple stakeholder work processes.

Methodology

This was a qualitative bicoastal (North Carolina and California) stakeholder (government, community-based organization, managed care) case study. To qualify for the study, participants were required to have been involved in 1115 waiver or pilot programs while employed in government, community-based organizations, or managed care. Normative care integration concepts were used as the basis for the interviews to understand how vision, shared care, population health and trust, are formed through integrated care.

This was a purposeful sample using semistructured, open-ended interview questions to ask professionals about their experience coordinating work with different stakeholders during waiver implementation. Interview questions focused on the roles that normative integration and complexity theory play in developing vision, patient outcomes, mission development, trust, and shared leadership. Content validity included the incorporation of normative integration concepts that had been studied previously. A couple questions were adopted from studies on normative integration.

Professionals from all three stakeholder agencies representing California and North Carolina were interviewed virtually using the Zoom platform. A total of eight professionals were interviewed, and the majority of professionals interviewed had obtained professional licensure in nursing, behavioral health, and medicine. There were a total of nine questions and subquestion prompts. A pilot interview was run with a licensed medical professional who worked on a waiver program to determine the length and appropriateness of the questions. All questions were included in the interviews as verified by the pilot interview, and interviews were completed in 60 minutes or less.

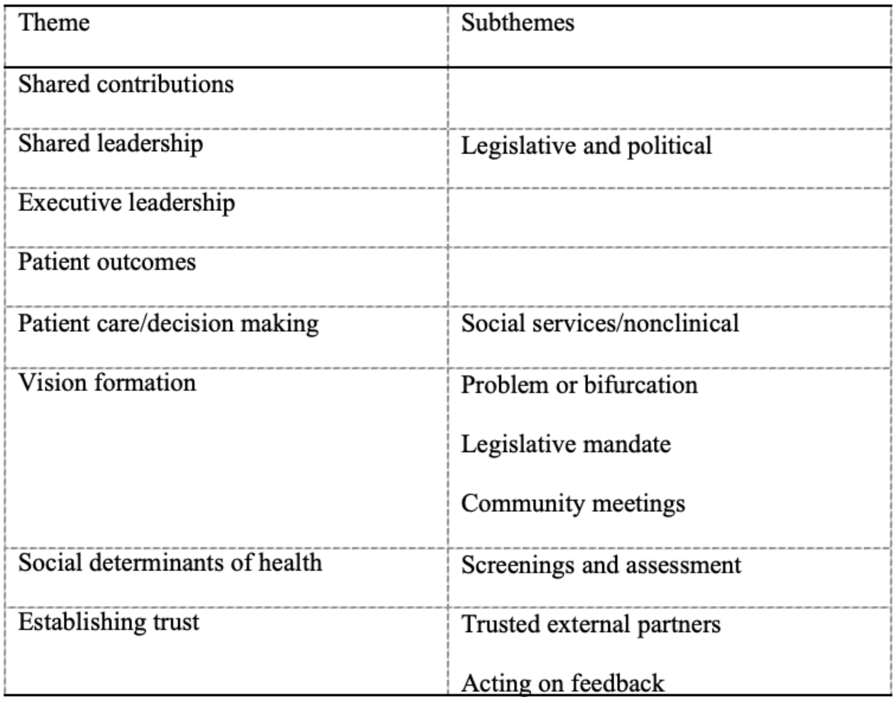
Key Findings

The individuals interviewed had a vast array of experience working across different areas of care, and many had dedicated the majority of their careers—over 20 years—in executive roles to coordinate cross-sector approaches. Eight participants were interviewed on normative care integration concepts. Participants needed past or present experience working on 1115 waivers and represented North Carolina and Orange County, California. A total of eight themes and nine subthemes emerged.

Themed categories were represented in the literature, as well as the interviews, and matched to normative care integration categories. Interview participants answered questions from their experience working in government, managed care, or community-based organizations. The interview questions centered around their experience working in one of the three stakeholder groups and in conjunction with other government, managed care and community-based organizations. Table 7 details the themes and subthemes that emerged from the study.

Table 7

Themes and Subthemes



Theme	Subthemes
Shared contributions	
Shared leadership	Legislative and political
Executive leadership	
Patient outcomes	
Patient care/decision making	Social services/nonclinical
Vision formation	Problem or bifurcation Legislative mandate Community meetings
Social determinants of health	Screenings and assessment
Establishing trust	Trusted external partners Acting on feedback

Study Conclusions

Shared leadership, trust building and vision formation we're concepts discussed most during the interviews. A total of four conclusions emerged from the research.

- Shared leadership: state government must be proactive, transparent, communicative, and purposely involved in assembling partners.
- Shared leadership (legislation and politics): differing viewpoints on politics, leadership, and funding must be communicated during stakeholder partnership meetings.
- Trust building: the formula for trust is a commitment to open sharing, listening, communicating, and acting on feedback. Stakeholders can foster trust in prescribed ways.
- Vision formation: complexity theory and visioning can be combined to achieve a health equity lens across sectors of care.

Conclusion 1

Shared leadership: state government must be proactive, transparent, communicative, and purposely involved in assembling partners together. Medicaid waivers vary state by state, it is through waivers that states can modify their Medicaid program (Hinton et al., 2019). Health care systems are complex. While government and managed care feel confident in navigating health systems, new waiver programs may face challenges integrating care with social service systems (Murray et al., 2020). Social services may not understand the health system of care, such as how to bill or code services, and government/managed care may not understand how community-based organizations navigate and render support services. A key finding that county government found from the start of a program is that partners must be involved (Asgari, 2022). Government can play a role in ensuring the appropriate leaders are on board and ready to be at the table (Asgari, 2022).

Half of the study participants responded to the theme of the importance of shared leadership. Subject matter experts from the interviews discussed the role and importance of local government in pulling stakeholders together to address a problem, propose a solution, and then act by applying for waiver funding. In practice, local and state government can share public data to illustrate the significance of need, so all parties understand the gravity of the gap and can move resources, as needed, to address the problem and be part of the solution.

Accountability, transparency, and communication were commonalities discussed by research participants. In practice, this can be achieved through (a) clear and shared communication, such as sharing meeting minutes, reports, and data; (b) hosting virtual and convening in person meetings; (c) listening and accountability; and (d) holding each other responsible and the collective as a responsible party. One tangible example from a participant was state government pulling together chief medical officers and cross-sectoral representatives to discuss implementation of waiver programs and Medicaid transformation. This included discussions around policies and procedures on capitated rates to address social determinants of health. Two interview participants discussed the importance of in-person meetings; both local and state government can serve as space conveners by bringing people together virtually and in person. Government can play a role in developing shared leadership at the onset of new programs and can be part of building trust.

Conclusion 2

Shared leadership (legislation and politics): differing viewpoints on politics, leadership, and funding must be communicated during stakeholder partnership meetings. An underlying subtheme identified during the interviews was around legislation and politics. State leadership can identify when there will be administrative savings through integration of new waiver services via managed care plans versus local government. Research on stakeholder partnerships focused on health equity, population health, and social determinants of care determined that a neutral facilitator is needed to reconcile differences, manage expectations, and find common ground with competing parties (Conrad et al., 2014).

Six research participants responded to shared leadership and the role of politics, legislation, and funding. The research study themes and subthemes indicated how politics can go awry when politicians assume leadership of public and private partnerships. In practice, leaders sent to represent stakeholder collaborations should be nominated by agency executives and agency governmental affairs teams and have the backing of local and state officials who understand the value and importance of participation. Managed care systems and government systems are large powerful entities with legal and political strongholds. If agency representatives feel left out from participation at meetings, or do not support collaborative decision making, efforts can be sabotaged through back door meetings. In practice, P3 suggested the following questions be posed to all participants: “What’s in it for me, what’s in it for the other person, and how you can bring mutual value to each other.”

Identified in the literature and through participant interviews was the need of leaders to engage in respectful communication, respectful dialogue, and respect for others in how they share common values of authenticity, compassion, and ethical care (Young et al., 2017). Shared care must be defined not only by the individual but through agency agreements to respect an individual’s motivation and group commitment (Polomeni et al., 2023). Individuals who participate in collaborative work must be able to listen to and communicate viewpoints they agree or disagree with or that are incorrect respectfully. In practice, it is up to the meeting facilitator or convener to set the expectations.

Conclusion 3

Trust building: the formula for trust is a commitment to open sharing, listening, communicating, and acting on feedback. Stakeholders can foster trust in prescribed ways. Stakeholders can foster trust in prescribed ways. Healthcare leadership must stretch themselves to work beyond standard boundaries with private and public sectors. This can be achieved through community engagement and decision making around health equity, legislation to address health equity, and differences in healthcare. Engagement in a shared integrated care vision is key (Baum et al., 2009).

Seven research participants discussed trust as a theme during the interviews. Respondents participating in the study stated that their community-based organization began trusting others after learning from the clients who they trusted. Trust is developed from honesty, organizational honesty is verified by giving your word and following up with what you said you would do. Honesty and trust come from working with partners to confirm what they said they would do, they did do, and clients who verified the trustworthiness of the organization. In practice, surveying clients and hearing from a client's perspective can be put in practice by all stakeholders.

Additionally, study participants discussed the importance of having leaders who communication openly, and in practice this can include review of meeting minutes by government and managed care organizations. This includes vetting any published communication. All stakeholders can benefit from practicing honest and open communication, even when the information is difficult to hear.

Leaders can earn trust through their actions. The research participants referenced one leader hired by a managed care plan who was responsive to e-mail, text, and phone communication. The leader followed up with action by coming to a community-based organization to work with their team to create a spaghetti flow cart to improve systems of care. Stakeholders need to identify key leadership roles and succession plans. Further, stakeholders must re-establish trust once the trusted leader changes roles or leaves the organization. Government must also play a role when working across sectors to maintain trust-building practices as best practices. Managed care plans and government can increase trust building in their day-to-day interactions through visibility in the community as a best practice.

Trust can be built and trust can be eroded or non-existent. An example of trust when it did not go well was asking a community partner to increase direct services. The partner promised an increase in referrals but was not willing to put those promises in a contract. This placed the community-based organization in a precarious financial situation.

Lastly, the research study showed that government has a role in building trust. The role of government is to convene stakeholders to meet and share their roles and viewpoints during meetings so all voices can be heard. Both managed care and government can increase trust by following up with both actions and words.

Conclusion 4

Vision formation: complexity theory and visioning can be combined to achieve a health equity lens across sectors of care. Just because an organization sets a vision to achieve and solve a health equity issue in the community does not mean that other agencies or stakeholders will see it as important or needed. It is important to map out similar providers of service and ensure that visions do not overlap. One participant did not see visioning as important but rather as something that can be vetted amongst all stakeholders and that is representative of all. In practice, a best practice is to get copious input and then move forward. In another participant example, stakeholders convened to discuss identification of social drivers of health and health resources. The stakeholders asked, “What are we going to do about it?” This led the state to pursue federal funding to move the screening process forward. A collective approach and a large win can be celebrated and show the importance of working together to accomplish big things.

Two study participants discussed how power and politics interplay with visioning. P6 expressed, “Skepticism over change in the political sense, in trying to take power against others, it was more political in nature.” Depending on the partners, getting acceptance for a new vision and a new way of doing things varies. As an example, P7 noted that “specialty plans, the clinical vision was hard to form. There were standard plans with strong political entities and boards involved.” This made it difficult to get the clinical view and vision across.

A connection between vision development and complexity theory is how interrelated activities, such as wanting to implement a statewide screening, can be applied in a framework to determine the level of complexity (ranging from simple to chaotic; Haynes, 2003). There are individual patient implications, implementation considerations at a clinical level and organizational level, and then overall county and state implementation. A soft system approach—a complexity approach—allows for some minor variations in screening implementation that may fit the needs of one organization or practice during implementation. Understanding social drivers of health and applying the complexity framework to address them through application of a complexity lens can be applied in practice.

Implications for Practice

A careful and thoughtful approach should be taken by executive leadership with the support of governmental affairs in selecting leaders with subject matter expertise, tact, diplomacy, openness to problem solving, and expertise/viewpoint in operational matters. When differing views are communicated, a venue for airing them and how they will be approached is essential. How can these views be resolved before they sabotage the work through politics, negative press, personal attacks, or back door conversations should be considered. Leaders must be brave and authentic and present their true selves yet represent their organizations with transparency and openness while balancing organizational image.

Managed care plans can extend olive branches to community-based organizations and local communities that are struggling with a health inequity or resources. This could include philanthropic assistance in funding hardware and time at a local site spent on problem solving and workflow diagramming. When pilot waiver programs are successful, the design of the program and program successes should be operationalized into permanent waiver implementation.

Recommendations for Future Scholarship

Researchers could investigate a network lead model as a potential best practice to implement services at a local level—this is a model one of the 1115 waiver pilot programs was utilizing. Future research on the role of politics, power, and funding should be considered and added to part of the normative integration framework when involving CBOs, government, and managed care. This interplay should not be negated when implementing waiver programs. Complexity theory as a framework for analyzing healthcare and health equity across integrated care is also an area to be researched further. The study can be expanded to include a mixed method or quantitative component to better capture the impact of normative care, complexity theory, and 1115 pilot waiver implementation best practices.

Study Limitations and Study Validity

According to Creswell (2018), qualitative validity is defined through corroboration of the findings and results from the perspective of the researcher, participant, or readers. Multiple validity checks were utilized as part of this study. The first validity check was the themed participant responses, which were grouped by similar ideas using a rich, thick description (Creswell, 2018). The second validity check was a pilot interview with a subject matter expert who worked on a waiver program. The third validity check was completed through the coding of the literature review. A peer reviewed the literature review coding, and both the peer reviewer and a subject matter expert reviewed the interview questions.

The following were identified as study limitations. The sample size was small; a total of eight interviews were completed. While government participants were interviewed, all consented individuals represented the state; there were no county representatives. Participants employed through managed care organizations advanced the consent form through their compliance departments, which thwarted an additional managed care interview. This may explain why there is such limited literature on cross-sector approaches to care involving government and managed care. Without a partnership to formerly evaluated cross-sectoral partnerships in place through the state or local governments, replicating similar studies may be difficult due to government bureaucracy. A direct connection through employment in a similar government sector aided in the completion of the study.

Another potential limitation is that the interview participants who had experience working in government and community-based organizations came from localities with a maximum of two managed care plans. State roles may shift depending on the number of counties and health plans implementing waiver programs. No county representatives were interviewed; they were invited to participate but did not respond.

Closing Comments

The outcomes of this research can influence future studies on normative integrated care teams. This study may move the needle forward with additional opportunities to create secondary references and consult other states and counties on implementation of integrated health teams. Bifurcation of models of care by populations of focus can limit progress and fidelity of models of care. State government may provide too much flexibility in models of care that allow managed care plans to interpret how to implement social service interventions with contractors. This was evident through research participant 4’s response; the community-based organization respondent was working with two managed care plans, one that preauthorized 3 months of service and another that preauthorized six months of service.

State government must provide sufficient structure and be involved when counties and localities struggle with implementation due to the level of complexity and multitude of varying factors. State and local governments must be conscientious of power and financing dynamics. Managed care plans can be seen as active and involved partners in the community and can develop positive reputations through direct action, transparency, and commitment to problem solving. This includes listening to and acting on feedback presented by the community and contracted community-based organizations. It may also include financial support outside of standard contracting to show good faith and support.

Local and state government can evaluate 1115 waiver programs at the start. The recommendation is to focus not only on patient outcomes but integrated care and what best and emerging practices created pilot success. Local government (county government) running individual evaluation efforts should share results with the state government or entity that has the contractual, financial, and political power to recommend best practices. The results of this research are similar to results from a local evaluation project done by one county's 1115 pilot waiver implementation evaluation.

In closing, there is a role for integrated care partners to be an active part of building vision, trust, and shared care. Power, politics, and funding can shift the discussions. It is important for local government and managed care to be transparent, communicative, and accountable and to know when to pull in a neutral facilitator. Implementation of pilot program best practices, if successful, should be evaluated early, and lessons learned should be followed closely during waiver renewal. Both complexity theory and normative integration have established frameworks that can be used with integrated care to unify the work. All partners have a role to play in meeting bold, audacious goals to better clinical health and social service outcomes for Medicaid recipients.

REFERENCES

Affordable Care Act. (2023, August 20). In *Wikipedia*. https://en.wikipedia.org/wiki/Affordable_Care_Act

Andrulis, D. (2006). R*esearcher document social and health issues affecting the 100 largest U.S. cities and their suburbs* (pp. 1–9). Robert Wood Johnson Foundation.

Alchemer Blog. (2021). *Purposive sampling 101.* https://www.alchemer.com/resources/blog/purposive-sampling-101/

Al Sayah, F., Szafran, O., Robertson, S., Bell, N. R., & William, B. (2014). Nursing perspectives on factors influencing interdisciplinary teamwork in the Canadian primary care setting. *Journal of Clinical Nursing, 23*, 2968–2979. https://doi.org/10.1111/jocn.12547

Ansari, Z., Carson, N. J., Ackland, M. J., Vaughan, L., & Serraglio, A. (2003). A public health model of the social determinants of health. *Sozial-und Praventivmedizin* [*Social and Preventive Medicine*], *48*(4), 242–251. https://doi.org/10.1007/s00038-003-2052-4

Asgari, P. (2022). *Whole person wellness pilot program evaluation*. County of San Diego.

Atter, L. (2008). Using creative transformational leadership in shaping our hospice’s journey to excellence. *Practice Development in Health Care, 7,* 134–142. https://doi.org/10.1002/pdh.261

Atwal, A., & Caldwell, K. (2005). Do all health and social care professionals interact equally: A study of interactions in multidisciplinary teams in the United Kingdom. *Scandinavian Journal of Caring Sciences*, *19*(3), 268–273. https://doi.org/10.1111/j.1471-6712.2005.00338.x

Auerbach, J. (2015). Creating incentives to move upstream: Developing a diversified portfolio of population health measures within payment and health care reform. *American Journal of Public Health*, *105*(3), 427–431. https://doi.org/10.2105/ajph.2014.302371

Augustsson, H., Churruca, K., & Braithwaite, J. (2019). Re-energising the way we manage change in health care: The case for soft systems methodology and its application to evidence-based practice. *BMC Health Services Research*, *19*(1). https://doi.org/10.1186/s12913-019-4508-0

Baker, C., Bradley, A., Parker, B., & Mina, V. (2022). *2022 San Diego community health needs assessment*. Hospital Association of San Diego and Imperial Valley. https://hasdic.org/file/2022-community-health-needs-assessment-report-2/

Baum, F. E., Bégin, M., Houweling, T. A., & Taylor, S. (2009). Changes not for the fainthearted: Reorienting health care systems toward health equity through action on the social determinants of health. *American Journal of Public Health*, *99*(11), 1967–1974. https://doi.org/10.2105/ajph.2008.154856

Beer, S. (1984). The viable system model: Its provenance, development, methodology and pathology. *The Journal of the Operational Research Society*, *35*(1), 7–25. https://doi.org/10.2307/2581927

Bindman, A. B., & Schneider, A. G. (2011). Catching a wave: Implementing health care reform in California. *New England Journal of Medicine*, *364*(16), 1487–1489. https://doi.org/10.1056/nejmp1014109

Blumenthal, D. (2020). Making integration work. *Health Services Research*, *55*(S3), 1031–1032. https://doi.org/10.1111/1475-6773.13575

Bokhour, G. B. (2006). Communication in interdisciplinary team meetings: What are we talking about? *Journal of Interprofessional Care, 20*(4). https://doi.org/10.1080/1356182-600727205

Borghmans, F. (2021). The radical and requisite openness of viable systems: Implications for health care strategy and Practice. *Journal of Evaluation in Clinical Practice*, *28*(2). https://doi.org/10.22541/au.161752250.03687889/v1

Borghmans, F., Fernandes, V., & Newnham, H. (2021). Applying complexity theory to a hospital complex patient care program. *International Journal of Integrated Care*, *21*(2). https://doi.org/10.5334/ijic.5634

Brander, R. A., Paterson, M., & Chan, Y. (2013). Using a common vision of partners in care to enhance hospital collaborative relationships. *Journal of Research in Interprofessional Practice and Education*, *3*(2). https://doi.org/10.22230/jripe.2013v3n2a109

Brainard, J., & Hunter, P. R. (2015). Do complexity-informed health interventions work? A scoping review. *Implementation Science, 11(*127). https://doi.org/10.1186/x13012-016-0492-5

Braithwaite, J., Churruca, K., Ellis, L. A., Long, J., Clay-Williams. R., Damen, N., Herkes, J., Pomare, C., & Ludlow, K. (2017). *Complexity science in healthcare-aspirations, approaches, applications and accomplishments: A white paper*. Australian Institute of Health Innovation, Macquarie University: Sydney, Australia.

Brown, J. B., Mulder, C., Clark, R. E., Belsito, L., & Thorpe, C. (2021). It starts with a strong foundation: Constructing collaborative interprofessional teams in primary health care. *Journal of Interprofessional Care*, *35*(4), 514–520. https://doi.org/10.1080/13561820.2020.1787360

Byrne, D. S. (2002). *Complexity theory and the social sciences: An introduction*. Taylor and Francis.

Byrne, D. S., Callaghan, G., & Byrne, D. S. (2023). *Complexity theory and the social sciences: The state of the art*. Routledge.

Calciolari, S., Gonzalez-Ortiz, L., Goodwin, N., & Stein, V. (2016). The project INTEGRATE framework. *EU Project INTEGRATE, EU Grant Agreement*, *305821*.

Calvert, K. (2018). Collaborative leadership: Cultivating an environment for success. *Collaborative Librarianship*, *10*(2), 79–90.

Cash-Gibson, L., Tigova, O., Alonso, A., Binkley, G., & Rosenmöller, M. (2019). Project integrate: Developing a framework to guide design, implementation and evaluation of people-centred integrated care processes. *International Journal of Integrated Care*, *19*(1). https://doi.org/10.5334/ijic.4178

Castro, A., Sáenz, R., Avellaneda, X., Cáceres, C., Galvão, L., Mas, P., Ritterbusch, A. E., & Fuentes, M. U. (2021). The health equity network of the Americas: Inclusion, commitment, and action. *Revista Panamericana De Salud Pública*, *45*. https://doi.org/10.26633/rpsp.2021.79

Centers for Disease Control. (2022). *Health impact assessment*. https://www.cdc.gov/healthyplaces/hia.htm

Centers for Medicare & Medicaid Services. (n.d.). *Innovation models*. https://innovation.cms.gov/innovation-models/aco

Centers for Medicaid Services. (2022). *Homepage*. https://innovation.cms.gov/

Cerdá, M., Tracy, M., Ahern, J., & Galea, S. (2014). Addressing population health and health inequalities: The role of fundamental causes. *American Journal of Public Health*, *104*(S4). https://doi.org/10.2105/ajph.2014.302055

Chuang, E., Pourat, N., Haley, L. A., O'Masta, B., Albertson, E., & Lu, C. (2020). Integrating health and human services in California's whole person care Medicaid 1115 waiver demonstration. *Health Affairs*, *39*(4), 639–648. https://doi.org/10.1377/hlthaff.2019.01617

Cole, B. L., MacLeod, K. E., & Spriggs, R. (2019). Health impact assessment of transportation projects and policies: Living up to aims of advancing population health and health equity? *Annual Review of Public Health*, *40*(1), 305–318. https://doi.org/10.1146/annurev-publhealth-040617-013836

Coletti, D. J., Yalakkishettar, P., Alexandri, M., Block, L., Martinez, J., Fornari, A., & Conigliaro, J. (2019). "A PCMH mind and a PCMH HEART": Patient, faculty, and learner perspectives on collaborative care in an interprofessional team-based training programme. *Journal of Evaluation in Clinical Practice*, *26*(4), 1162–1170. https://doi.org/10.1111/jep.13283

Congressional Research Service. (2010, March 25). *Private health insurance: Changes made by H.R. 4872, the Health Care and Education Reconciliation Act of 2010*. https://www.everycrsreport.com/reports/R41126.html

Conrad, D. A., Grembowski, D., Hernandez, S. E., Lau, B., & Marcus-Smith, M. (2014). Emerging lessons from regional and state innovation in value-based payment reform: Balancing collaboration and disruptive innovation. *Milbank Quarterly*, *92*(3), 568–623. https://doi.org/10.1111/1468-0009.12078

Creswell, J. W. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches*. SAGE Publications.

Cuff, J. M. (2007). C. S. Peirce, G. W. F. Hegel, and Stuart Kauffman's complexity theory: A response. *Zygon®*, *42*(1), 249–256. https://doi.org/10.1111/j.1467-9744.2006.00819.x

Dankwa-Mullan, I., Rhee, K. B., Williams, K., Sanchez, I., Sy, F. S., Stinson, N., & Ruffin, J. (2010). The science of eliminating health disparities: Summary and analysis of the NIH summit recommendations. *American Journal of Public Health*, *100*(S1). https://doi.org/10.2105/ajph.2010.191619

Dalton, H., Perkins, D., Goodwin, N., Hendry, A., Read, D., Booth, A., Handley, T., Davies, K., Bishop, M., Sheather-Reid, R., Bradfield, S., Wilcox, S., & Lewis, P. (2018). Using the project integrate framework for assessing progress towards Care Integration: Results from a formative evaluation of a complex intervention in Central Coast Local Health District, NSW Australia. *International Journal of Integrated Care*, *18*(s2), 182. https://doi.org/10.5334/ijic.s2182

Dehaven, M., Gimpel, N., Carmichael, H. K., Gutierrez, D., & Revens, K. (2020). Designing health care: A community health science solution for reducing health disparities by integrating social determinants and the effects of place. *Journal of Clinical Practice, International Journal of Public Health Policy and Health Services Research*. https://doi.org/10.1111/jep.13366

Department of Health Care Services. (2016). *Homepage*. https://www.dhcs.ca.gov/provgovpart/Documents/WPCProgramOverview.pdf

Department of Health Care Services. (2021a). *CALAIM 1115 demonstration & 1915(b) waiver, CalAIM 1115 and 1915(b) waiver renewals*.

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx

Department of Health Care Services. (2021b). *Health homes program*. https://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

Department of Health Care Services. (2022c). *CALAIM population health management initiative.* https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx

Epstein, R. M., & Street, R. L., Jr. (2011). Shared mind: Communication, decision making, and autonomy in serious illness. *Annuals of Family Medicine, 9,* 454–461. https://doi.org/10.1370/afm.1301

Ercia, A. (2021). The impact of the affordable care act on patient coverage and access to care: Perspectives from FQHC administrators in Arizona, California and Texas. *BMC Health Services Research*, *21*(1). https://doi.org/10.1186/s12913-021-06961-9

Farrer, L., Marinetti, C., Cavaco, Y. K., & Costongs, C. (2015). Advocacy for health equity: A synthesis review. *The Milbank Quarterly*, *93*(2), 392–437. https://doi.org/10.1111/1468-0009.12112

Fiorelli, J. S. (1988). Power in work groups: Team member's perspectives. *Human Relations*, *41*(1), 1–12. https://doi.org/10.1177/001872678804100101

Gear, C., Eppel, E., & Koziol-Mclain, J. (2018). Advancing complexity theory as a qualitative research methodology. *International Journal of Qualitative Methods*, *17*(1). https://doi.org/10.1177/1609406918782557

Gilligan, J. M. (2019). Expertise across disciplines: Establishing common ground in interdisciplinary disaster research teams. *Risk Analysis*, *41*(7), 1171–1177. https://doi.org/10.1111/risa.13407

Gourevitch, M. N., Curtis, L. H., Durkin, M. S., Fagerlin, A., Gelijns, A. C., Platt, R., Reininger, B. M., Wylie-Rosett, J., Jones, K., & Tierney, W. M. (2019). The emergence of population health in US academic medicine. *JAMA Network Open*, *2*(4). https://doi.org/10.1001/jamanetworkopen.2019.2200

Gray, C. S., Grudniewicz, A., Boeckxstaens, P., & Armas, A. (2020). Goal-oriented care: A catalyst for person-centred system integration. *Health care Services, Delivery, and Financing*, *20*(1). https://doi.org/10.1370/afm.20.s1.2767

Grol, R., Bosch, M. C., Hulscher, M. E. J. L., & Eccles, M. W. (2007). Planning and studying improvement in patient care: The use of theoretical perspectives. *Milbank Quarterly*, *85*(1), 93–138. https://doi.org/10.1111/j.1468-0009.2007.00478.x

Hacker, J. V., Johnson, M., Saunders, C., & Thayer, A. L. (2019). Trust in virtual teams: A multidisciplinary review and integration. *Australasian Journal of Information Systems*, *23*. https://doi.org/10.3127/ajis.v23i0.1757

Haynes, P. (2003). *Managing complexity in the public services.* Open University Press.

Hinton, E., Musumeci, M., Rudowitz, R., Antonisse, L., & Hall, C. (2019). *Section 1115 Medicaid demonstration waivers: The current landscape of approved and pending waivers. Issue Brief.* Kaiser Family Foundation.

Hood, C. M., Gennuso, K. P., Swain, G. R., & Catlin, B. B. (2016). County health rankings. *American Journal of Preventive Medicine*, *50*(2), 129–135. https://doi.org/10.1016/j.amepre.2015.08.024

Institute for Alternative Futures. (2012). *Community health centers leveraging the social determinants of health.* https://kresge.org/sites/default/files/IAF-CHCsLeveragingSDH.pdf

Itchhaporia, D. (2021). The evolution of the quintuple aim. *Journal of the American College of Cardiology*, *78*(22), 2262–2264. https://doi.org/10.1016/j.jacc.2021.10.018

Jarlenski, M., Rocco, P., Tipirneni, R., Kennedy, A. J., Gunturi, N., & Donohue, J. (2017). Shaping health policy for low-income populations: An assessment of public comments in a new Medicaid waiver process. *Journal of Health Politics, Policy and Law*, *42*(6), 1039–1064. https://doi.org/10.1215/03616878-4193618

Jordon, M., Lanham, H. J., Anderson, R. A., & McDaniel, R. R., Jr. (2010). Implications of complex adaptive systems theory for interpreting research about health care organizations. *Journal of Evaluation in Clinical Practice*, *16*(1), 228–231. https://doi.org/10.1111/j.1365-2753.2009.01359.x

Kaufman, A., Dickinson, W. P., Fagnan, L. J., Duffy, F. D., Parchman, M. L., & Rhyne, R. L. (2019). The role of health extension in practice transformation and community health improvement: Lessons from 5 case studies. *The Annals of Family Medicine*, *17*(1). https://doi.org/10.1370/afm.2409

Kindig, D., & Stoddart, G. (2003). What is population health? *American Journal of Public Health*, *93*(3), 380–383. https://doi.org/10.2105/ajph.93.3.380

Kocoglu, I., Lynn, G., Jung, Y., Dominick, P. G., Aronson, Z., & Burke, P. (2020). Actions speak louder than words. *Management Decision*, *58*(3), 465–494. https://doi.org/10.1108/md-09-2018-1018

Koh, H. K., Oppenheimer, S. C., Massin-Short, S. B., Emmons, K. M., Geller, A. C., & Viswanath, K. (2010). Translating research evidence into practice to reduce health disparities: A social determinants approach. *American Journal of Public Health*, *100*(S1). https://doi.org/10.2105/ajph.2009.167353

Kresge Foundation. (2012). *Community health centers leveraging the social determinants of health.* https://kresge.org/sites/default/files/IAF-CHCsLeveragingSDH.pdf

Lee, K. (2010). How do we move forward on the social determinants of health: The global governance challenges. *Critical Public Health*, *20*(1), 5–14. https://doi.org/10.1080/09581590903563573

Legislative Analyst's Office (2010). *The patient protection and affordable care act: an overview of its potential impact on state health programs. https://www.lao.ca.gov/reporTs/2010/hlTh/fed_healThcare/fed_healThcare_051310.aspx*

Leijten, F., Struckmann, V., Van Ginneken, E., Kraus, M., Czypionka, T., Stokes, J., Kristensen, S. R., Hoedemakers, M., & Rutten-van Mölken, M. (2017). The selfie project on integrated care for persons with multi-morbidity: Framework, promising programmes, financing, and evaluation. *International Journal of Integrated Care*, *17*(5), 257. https://doi.org/10.5334/ijic.3568

Litaker, D., Tomolo, A., Liberatore, V., Stange, K. C., & Aron, D. (2006). Using complexity theory to build interventions that improve health care delivery in primary care. *Journal of General Internal Medicine*, *21*(S2). https://doi.org/10.1007/s11606-006-0272-z

Lloyd, H., Wheat, H., Horrell, J., Sugavanam, T., Fosh, B., Valderas, J. M., & Close, J. (2018). Patient-reported measures for person-centered coordinated care: A comparative domain map and web-based compendium for supporting policy development and implementation. *Journal of Medical Internet Research*, *20*(2). https://doi.org/10.2196/jmir.7789

Long, K. M., McDermott, F., & Meadows, G. N. (2018). Being pragmatic about health care complexity: Our experiences applying complexity theory and pragmatism to health services research. *BMC Medicine*, *16*(1). https://doi.org/10.1186/s12916-018-1087-6

Marett, K. M., Gibbons, E. W., Memmott, J. R., Duke, L., & Bott, R. (1998). The organizational role of clinical practice models in interdisciplinary collaborative practice. *Clinical Social Work Journal*, *26*(2), 217–225.

Marjanovic, S., Altenhofer, M., Hocking, L., Chataway, J., & Ling, T. (2020). Innovating for improved health care: Sociotechnical and innovation systems perspectives and lessons from the NHS. *Science and Public Policy*, *47*(2), 283–297. https://doi.org/10.1093/scipol/scaa005

Mayer, M., Kenter, R. C., Morris, J. C., & Lucero, L. (2018). State implementation of the Affordable Care Act: Four case studies. *Politics & Policy*, *46*(2), 295–319. https://doi.org/10.1111/polp.12245

Mickan, S. M., & Rodger, S. A. (2005). Effective health care teams: A model of six characteristics developed from shared perceptions. *Journal of Interprofessional Care*, *19*(4), 358–370. https://doi.org/10.1080/13561820500165142

Moos, S., (2006). Conference report. *Journal of Integrated Care Pathways, 10*(2), 78–81. https://doi.org/10.1177/205343540601000208

Muganda, C., Hoffelder, J., Olson-Williams, H., Gennuso, K., Givens, M., & Johnson, S. (n.d.). *County health rankings and roadmaps, building a culture of health, county by county* (pp. 1–12). University of Wisconsin School of Population Health.

Murray, G. F., Rodriguez, H. P., & Lewis, V. A. (2020). Upstream with a small paddle: How ACOs are working against the current to meet patients' social needs. *Health Affairs*, *39*(2), 199–206. https://doi.org/10.1377/hlthaff.2019.01266

Next Generation Accountable Care Organization Model. (2023, October). Centers for Medicaid Services. https://www.cms.gov/priorities/innovation/innovation-models/next-generation-aco-model

Norris, L. (2023, April 18). *Medicaid eligibility and enrollment in North Carolina*. Health Insurance. https://www.healthinsurance.org/medicaid/north-carolina/

North Carolina Department of Health and Human Services. (2022, November 22*). Healthy opportunities pilots*. https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots

Perry, R. E., & Stephenson, C. (2013). Improving population health through collaboration and Innovation. *Population Health Management*, *16*(S1). https://doi.org/10.1089/pop.2013.0046

Petticrew, M., Knai, C., Thomas, J., Rehfuess, E. A., Noyes, J., Gerhardus, A., Grimshaw, J. M., Rutter, H., & McGill, E. (2019). Implications of a complexity perspective for systematic reviews and guideline development in health decision making. *BMJ Global Health, 4.* https://doi.org/10/1136/bmjgh-2018-000899

Philip, S., Govier, D., & Pantley, S. (2019). *Patient-centered medical home developing the business case from a practice perspective.* https://www.ncqa.org/wp-content/uploads/2019/06/06142019_WhitePaper_Milliman_BusinessCasePCMH.pdf

Polomeni, A., Bordessoule, D., & Malak, S. (2023). Multidisciplinary team meetings in hematology: A national mixed-methods study. *BMC Cancer, 23*(950). https://doi.org/10/1186/s12885-023-11431-y

Pype, P., Mertens, F., Helewaut, F., & Krystallidou, D. (2018). Health care teams as complex adaptive systems: Understanding team behaviour through team members' perception of interpersonal interaction. *BMC Health Services Research*, *18*(1). https://doi.org/10.1186/s12913-018-3392-3

Rasmussen, P. W., & Kominski, G. F. (2019). Sources of success in California's individual marketplace under the Affordable Care Act. *Journal of Health Politics, Policy and Law*, *44*(4), 679–706. https://doi.org/10.1215/03616878-7530849

Read, D. M. Y., Dalton, H., Booth, A., Goodwin, N., Hendry, A., & Perkins, D. (2019). Using the project integrate framework in practice in Central Coast, Australia. *International Journal of Integrated Care*, *19*(2). https://doi.org/10.5334/ijic.4624

Richards, L. (2013). *Readme first for a user's guide to qualitative methods*. Sage.

Robert Wood Johnson Foundation. (2022). *Culture of health taking action*. Robert Wood Johnson Foundation. https://www.rwjf.org/en/cultureofhealth/taking-action.html.

Rogers, E. M. (2005) *Diffusion of innovations*. Free Press.

Ross, S., Curry, N., & Goodwin, N. (2011). *Case management: What is it and how it can be best implemented.* The King's Fund, London.

Ryan, G. W., & Bernard, H. R. (2003). Techniques to identify themes. *Field Methods*, *15*(1), 85–109. https://doi.org/10.1177/1525822x02239569

Saldaña, J. (2021). *The coding manual for qualitative researchers.* Sage Publications.

Shortell, S. M., Gillies, R., & Wu, F. (2010). United States innovations in health care delivery. *Public Health Reviews*, *32*(1), 190–212. https://doi.org/10.1007/bf03391598

Shrank, W. H., DeParle, N.-A., Gottlieb, S., Jain, S. H., Orszag, P., Powers, B. W., & Wilensky, G. R. (2021). Health costs and financing: Challenges and strategies for a new administration. *Health Affairs*, *40*(2), 235–242. https://doi.org/10.1377/hlthaff.2020.01560

Shrimali, B. P., Luginbuhl, J., Malin, C., Flournoy, R., & Siegel, A. (2014). The building blocks collaborative: Advancing a life course approach to health equity through multi-sector collaboration. *Maternal and Child Health Journal*, *18*(2), 373–379. https://doi.org/10.1007/s10995-013-1278-x

Sims, S., Hewitt, G., & Harris, R. (2014). Evidence of a shared purpose, critical reflection, innovation and leadership in interprofessional healthcare teams: A realist synthesis. *Journal of Interprofessional Care,* 1–7. https://doi/org/10/3109/13561820.2014.941459

Singer, S. J., Burgers, J., Friedberg, M., Rosenthal, M. B., Leape, L., & Schneider, E. C. (2011). Defining and measuring integrated patient care: Promoting the next frontier in health care delivery. *Journal of Health care Management*, *56*(2), 147–148. https://doi.org/10.1097/00115514-201103000-00011

Singer, S. J., Sinaiko, A. D., Tietschert, M. V., Kerrissey, M., Phillips, R. S., Martin, V., Joseph, G., Bahadurzada, H., & Agniel, D. (2020). Care integration within and outside health system boundaries. *Health Services Research*, *55*(S3), 1033–1048. https://doi.org/10.1111/1475-6773.13578

Snowden & Boone. (2007). *University of Brighton, Brighton systems and complex toolkit framework*. School of Applied Science, Community University Partnership Project. https://www.humanlearning.systems/uploads/Brighton%20Complex%20Systems%20Toolkit.pdf

Sommers, B. D., Chua, K.-P., Kenney, G. M., Long, S. K., & McMorrow, S. (2015). California's early coverage expansion under the Affordable Care Act: A county-level analysis. *Health Services Research*, *51*(3), 825–845. https://doi.org/10.1111/1475-6773.12397

Sowels, N. (2021). A brief introduction to complexity theory in managing public services. *Revue Française de civilisation Britannique*, *XXVI*(2). https://doi.org/10.4000/rfcb.8103

Storkholm, M. H., Mazzocato, P., & Savage, C. (2019). Make it complicated: A qualitative study utilizing a complexity framework to explain improvement in health care. *BMC Health Services Research*, *19*(1). https://doi.org/10.1186/s12913-019-4705-x

Thompson, F. J., & Burke, C. (2007). Executive federalism and Medicaid demonstration waivers: Implications for policy and democratic process. *Journal of Health Politics, Policy and Law*, *32*(6), 971–1004. https://doi.org/10.1215/03616878-2007-039

Tipirneni, R., Vickery, K. D., & Ehlinger, E. P. (2015). Accountable communities for health: Moving from providing accountable care to creating health. *The Annals of Family Medicine*, *13*(4), 367–369. https://doi.org/10.1370/afm.1813

Towe, V. L., May, L. W., Huang, W., Martin, L. T., Carman, K., Miller, C. E., & Chandra, A. (2021). Drivers of differential views of health equity in the U.S.: Is the U.S. ready to make progress? Results from the 2018 national survey of health attitudes. *BMC Public Health*, *21*(1). https://doi.org/10.1186/s12889-021-10179-z

U.S. Census Bureau. (n.d.). Retrieved April 26, 2023, from https://www.census.gov/glossary/

U.S. Department of Health and Human Services. (2022a). *Healthy people 2030: Social determinants of health*. https://health.gov/healthypeople/priority-areas/social-determinants-health

U.S. Department of Health and Human Services. (2022b). *National institute of environmental health sciences*. https://www.niehs.nih.gov/

van Dijk-de Vries, A., van Dongen, J. J., & van Bokhoven, M. A. (2017). Sustainable interprofessional teamwork needs a team-friendly healthcare system: Experiences from a collaborative Dutch programme. *Journal of Interprofessional Care*, *31*(2), 167–169. https://doi.org/10.1080/13561820.2016.1237481

Warnecke, R. B., Oh, A., Breen, N., Gehlert, S., Paskett, E., Tucker, K. L., Lurie, N., Rebbeck, T., Goodwin, J., Flack, J., Srinivasan, S., Kerner, J., Heurtin-Roberts, S., Abeles, R., Tyson, F. L., Patmios, G., & Hiatt, R. A. (2008). Approaching health disparities from a population perspective: The National Institutes of Health Centers for Population Health and Health Disparities. *American Journal of Public Health*, *98*(9), 1608–1615. https://doi.org/10.2105/ajph.2006.102525

Wilson, V. (2005). Developing a vision for teamwork. *Practice Development in Health Care, 4,* 40–48. https://doi.org/10.1002/pdh.30

Woolf, S. H. (2019). Necessary but not sufficient: Why health care alone cannot improve population health and reduce health inequities. *The Annals of Family Medicine*, *17*(3), 196–199. https://doi.org/10.1370/afm.2395

World Health Organization. (2021). *Social determinants of health.* https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Young, J., Egan, T., Jaye, C., Williamson, M., Askerud, A., Radue, P., & Penese, M. (2017). Shared care requires a shared vision: Communities of clinical practice in a primary care setting. *Journal of Clinical Nursing*, *26*(17–18), 2689–2702. https://doi.org/10.1111/jocn.13762

APPENDIX A

Interview Questions

1. What was it like forming a shared vision and what did that process entail?
    a. How would you define shared or collective vision?
    b. What was the process of communicating and establishing shared/collective vision among your collaborators in health care, government, and social services?
2. How did you focus on population health management (social determinants of care and health) and what was the result of the customer/patient outcomes?
    a. Describe your focus on population health management in the context of the social determinants of care and health.
    b. What was the impact of addressing social determinants of care and health on customer and patient outcomes?
3. Were there any gaps in knowledge or a disconnected shared mission between stakeholders (health care providers, community providers, government), if so, describe the gaps and disconnect.
    a. Describe addressing any differences in knowledge between health care providers, community providers, and government.
    b. What are some factors that might indicate a disconnected share mission between the integration of health care providers, community providers, and government?
    c. What steps can be taken to improve gaps in knowledge and/or disconnected share mission between stakeholders?
4. “How did you trust each other’s contributions?” (Singer 2020)
    a. What are some examples of situations that would call for trusting in another

    stakeholder’s contributions?

   b. How would you compare your early experience with trusting the contributions of (stakeholders, care team) to your current experience?

5. “What stakeholders do you consider to be part of the team of people who help you care for your patients/customers? (Singer 2020)
   a. Who are the stakeholders as part of the team caring for patients in health care providers?
   b. Who are the stakeholders as part of the team caring for patients in community providers?
   c. Who are the stakeholders as part of the team caring for patients in government?
6. “How do you involve the care team in community and clinical decision making?” (Singer 2020)
   a. What are some examples of situations that would call for involving the care team in clinical or community decision making?
   b. How would you compare your early experience with involving the care team in decision making to your current experience?
7. How did you involve the care team in (shared) leadership?
   a. What are some examples of situations that would call for involving the care team in (shared) leadership?
   b. How would you compare your early experience with involving the care team in (shared) leadership to your current experience?
8. What were the roles of shared leadership in making this pilot successful or not successful?

   a. Describe the impact of the roles of shared leadership on the successes in the pilot.
   b. What were some of the challenges with the roles of shared leadership?

9. What roles did executive leadership play to make this pilot successful or not successful?
   a. Describe the impact of executive leadership on the successes in the pilot.
   b. What were some of the challenges with the roles of executive leadership?

APPENDIX B

Data Management

Data Description

Data will be collected during the virtual Zoom interviews using a Pepperdine student account. Zoom will be used to conduct the interviews. Interviews will be password protected to enter the meeting room and will be saved through a pseudonym. A USB digital voice recorder will be used as a secondary device to record audio should the initial Zoom transcription be corrupted. The interviews will then be transcribed, and the data will be coded by the research team. Transcriptions will be immediately deleted after coding and analysis.

Areas that are not applicable to the Principal Investigators/researcher's data management plan are the following:

- There is no existing data, this includes no data that is relevant to the project exists and will not be used as a part of this study
- There are no secondary users of data applicable to this research
- There are no legal requirements applicable to this research

Format

Metadata (if applicable) Storage and backup

The data from the Zoom interviews will generate voice recorded data. Data will be transcribed from the voice recording onto a secondary password protected and secure drive owned by the Principal Investigator. Each data source point, such as voice recording data, consent forms, data dictionary will be stored in separate files on an external password protected drive.

Security Responsibility

The researcher will have the responsibility of securing the data and metadata

Intellectual property rights

The study participants will own the rights to their stories. The researcher will own the rights to the metadata and the data analysis produced from the participants' interviews. A description of the information to be gathered; the nature and scale of the data that will be generated or collected. The data gathered during the research study will be each participant's personal experience working on implementing an 1115 Medicaid pilot waiver program.

Formats in which the data will be generated, maintained, and made available, including a justification for the procedural and archival appropriateness of those formats.

The data will be generated via a .mp4 file produced by an audio device recorder during scheduled interviews and stored on an external drive owned by the researcher. The external drive will be kept in a locked house with password protection in the researcher's residence. Transcribed data will be generated as text files. Once the data is transcribed the interview audio recording files will be deleted. The transcribed data will be kept on an external drive and stored for three years.

Storage methods and backup procedures for the data, including the physical and cyber resources and facilities that will be used for the effective preservation and storage of the research data.

An external drive will be the primary storage method used. Once the study is complete, the research files will be deleted from the external drive. The transcription files will remain archived for three years upon which time they will be permanently deleted.

A description of technical and procedural protections for information, including confidential information, and how permissions and restrictions will be enforced.

The technical and procedural protections for information will be as follows:

- Upon collecting confidential information (demographic information including name, location, and work sector), the participant's name, work location and sector of work will be replaced by a pseudonym for identification.
- All data produced from interviews will be protected on secured, encrypted files and storage devices.
- Only the researcher will have access to this data.
- Recordings and transcriptions containing personal identification will be redacted and replaced with a pseudonym.
- Informed consent will be kept in an external drive that is password protected.
- Separate files with unique passcodes will house consents, data transcripts and audio recordings.
- The Pepperdine Zoom account will be used to conduct the interview, the interview room will be password protected.
- Participants will be instructed not to provide their name, their employer, or the region they work during the Zoom interview.
- Audio recordings will be saved using a pseudonym and will be deleted once the transcription is complete.

<u>What are the Names of the individuals responsible for data management in the research project?</u>

Heather Summers, Principal Investigator and Researcher

<u>Entities or persons who will hold the intellectual property rights to the data, and how intellectual property rights will be protected if necessary. Any copyright constraints (e.g., copyrighted data collection instruments) should be noted.</u>

The researcher will own the rights to the metadata and the data analysis produced from the study participants interviews. No copyright is necessary for the data or data collection instruments.

Access and sharing

Audience

A description of how data will be selected for archiving, how long the data will be held, and plans for eventual transition or termination of the data collection in the future.

All files produced from the verbal data recordings will be deleted once data transcription and analysis is finalized. The transcribed data will be archived on an external drive for three years. After three years, the files will be permanently deleted and destroyed from the external drive.

Ethics and privacy

Participants' recordings and transcripts will be assigned a pseudonym. This includes a pseudonym for location, work sector and name. Confidentiality measures include not recording the name of the individual during the Zoom session and separate files will be maintained for consent forms, data recordings, etc. If a breach in confidentiality occurs, there is minimal risk of harm to the participants.

Each participant will be e-mailed an informed consent form prior to participating in the interview. The consent form will outline what is required for their participation and what their rights are as a participant. These documents will be signed prior to the researcher conducting any interview.

The interview audio recordings will be uploaded to the iCloud storage file and saved to an external USB drive as backup. Only the researcher will have access to both storage areas. The confidential information of the participant such as name, will be masked via pseudonyms.

The researcher will follow IRB's ethical principles including:

- Respect for persons; respect for participants autonomy
- Beneficence by maximizing benefit and minimizing harm
- Justice: equitable distribution of research burdens and benefits

Budget (if applicable)

The researcher will cover the costs that are study related, which include but may not be limited to:

- Associated costs to purchase external storage drives
- Qualitative Analysis software (NVivo)

Data organization

For each interview, a new audio file will be created. Each separate file will have three pseudonyms. These include one for the sector they work, one for their name and one for their Region. The date of the interview and the interview number will also be coded.

Examples: Interview1March0123A% and Interview2March0523B#

Chronological Interview Sequence (1-10)	Month (Name) Day (XX) Year (23)	Work Sector A=Social Services B= Government, C=Managed Care	Region % =North Carolina *=Orange County, CA #=Riverside County, CA
Interview 1	March0123	A	%
Interview 2	March0523	B	#

Quality Assurance

The researcher will use two recording devices to ensure quality and no loss of data.

APPENDIX C

IRB Approval

Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: March 17, 2023

Protocol Investigator Name: Heather Summers

Protocol #: 23-01-2079

Project Title: Trust In Integrated Medical Care Using A Population Based Normative Approach

School: Graduate School of Education and Psychology

Dear Heather Summers:

Thank you for submitting your application for exempt review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations 45 CFR 46.101 that govern the protections of human subjects.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Since your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chair

cc: Mrs. Katy Carr, Assistant Provost for Research

APPENDIX D

Consent Form

IRB #: 23-01-2079

Study Title: *Trust in Integrated Medical Care using a Population Based Normative Approach*

Authorized Study Personnel:
Principal Researcher: Heather Summers Research Chair: Dr. James Dellaneve

Invitation
Dear (name)

You are cordially invited to participate in a research study conducted by Heather Summers under the direction of James Dellaneve Ed.D. at Pepperdine University. This form is intended to assist you in deciding whether or not to participate, as participation is voluntary. Before deciding whether to participate, you should read the following information and ask questions about anything that you don't understand about the research study. You will be asked to sign this form if you choose to participate. Additionally, you will receive a copy of this form for your records. Please email the researcher with questions.

Why are you being asked to be in this research study?
You are being asked to participate in this study because you have experience, current or past, working on a Medicaid waiver pilot program (1115 waiver) in the state of California or North Carolina. You must be at least 18 years of age and have worked for the government, a managed care plan/managed care organization or a community-based organization piloting a Medicaid 1115 waiver. You've had direct involvement in the 1115 waiver implementation.

What is the reason for doing this research study?
The purpose of this qualitative case study is to determine best practices and key concepts necessary to establish integrated care between the government, managed care organizations and community-based organizations. Research concepts will include your expertise as a professional working in one of the sectors of care. You'll be asked questions about care integration concepts, such as population health, trust, leadership vision and shared vision.

What will be done during this research study?
If you agree to participate in this study, you will be asked to complete a 60-minute semistructured virtual interview consisting of approximately 15 questions via Zoom video conferencing at a mutually agreed upon date and time. The interview instrument (questions) was created by the researcher and reviewed by the dissertation chair and committee. Two colleagues with research and interview strategy experience and one colleague who is a subject matter expertise on 1115 waivers assisted with content validity and protocol development. During the interview, a USB digital voice recorder will be used as a secondary device to capture audio. The Zoom interview will be recorded to capture the voice transcript. Study participants will be asked

not to provide their name, the location they work or name their organization to maintain confidentiality.

How will my data be used?
Your interview responses will be transcribed, analyzed, and aggregated in order to determine the findings to the established research question.

What are the possible risks of being in this research study?
This study poses a low risk of loss of confidentiality, emotional, and/or psychological distress because the interview focuses on your professional and subject matter expertise in coordinating and collaborating across multiple service sectors. No anticipated financial, personal, social, or legal risks exist for participants. Participants may experience boredom or fatigue from the research questions during the interview process. Participants can request to not continue with the interview by notifying the researcher to end participation in the study, or request to take a break if fatigued. If a break is requested, the participant and researcher will work together to identify a mutually agreed upon break length and time the interview will resume.

What are the possible benefits to you?
While there are no direct benefits for the study participants, there are anticipated benefits to adding to literature and future research projects. Benefits could include best practices in working across cross sectors to improve trust, vision, population health and integrated care. Participants may request a copy of the completed research and invite the researcher to present their findings once the study concludes.

What are the alternatives to being in this research study?
Participation is voluntary in this study. Other than deciding not to participate, there are no alternatives to participation. Participants can therefore opt out at any time.

What will participating in this research study cost you?
There is no cost to you to be in this research study.

Will you be compensated for being in this research study?
No, you will not be compensated for participating.

What should you do if you have a problem during this research study?
If you experience a problem as a direct result of participating in this study, you should contact the principal researcher immediately. If your problem is not resolved, you may reach out the Pepperdine faculty research Chair.

How will information about you be protected?
Reasonable steps will be taken to protect your privacy and the confidentiality of your study data. The data will be deidentified and stored electronically through a secure drive and server and will only be seen by the research team during the study and until the study is complete. The only persons who will have access to your research records are the study personnel, the Institutional Review Board (IRB), and any other person, agency, or sponsor as required by law. The information from this study may be published in scientific journals or presented at scientific

meetings but the data will be reported as a group or summarized data and your identity will be kept strictly confidential.

What are your rights as a research subject?
Before agreeing to participate and while participating in the study, you may ask questions about the research which the Principal Investigator, Chair or IRB may answer.

For study related questions, please contact the investigator(s) listed at the beginning of this form. For questions concerning your rights or complaints about the research contact the Institutional Review Board (IRB):

Phone: 310-568-2305
Email: gpsirb@pepperdine.edu

What will happen if you decide not to be in this research study or decide to stop participating once you start?
You may decline participation in this research study and withdraw from it at any time, including before, during, or after the study begins, for any reason. Your withdrawal or refusal from this research study will have no effect on your relationship with the Principal Investigator or Pepperdine University.

Documentation of informed consent
You are deciding voluntarily whether or not to participate in this research study. Signing this form means that you've read and understood the consent form, or the consent form has been explained to you and questions have been answered. Per request, the research questions can be sent to you ahead of the interview. Signing the consent form is your agreement to participate in the research study. You will be given a copy of this consent form to keep, once fully executed.

Participant Name: ______________________________
(First, Last: Please Print)

Participant Signature: ____
Signature Date

APPENDIX E

Recruitment Flyer

RECRUITING PROFESSIONALS FOR A RESEARCH STUDY WHO HAVE WORKED ON A 1115 WAVIER PROGRAM IN CALIFORNIA OR NORTH CAROLINA

Currently seeking professionals that have worked on a 1115 Medicaid Waiver program in California and North Carolina while employed in one of the following sectors: government, a community-based organization or a managed care organization/managed care plan. A virtual Zoom interview will be conducted by Heather Summers, a doctoral student and Principal Investigator working on her dissertation in Organizational Leadership through the Graduate School of Education and Psychology at Pepperdine University.

Study Title: Trust In Integrated Medical Care Using A Population Based Normative Approach

Study Purpose: The purpose of this qualitative case study is to determine best practices and key concepts necessary to establish integrated care between the government, managed care organizations and community-based organizations. Professionals who have been part of a Medicaid 1115 demonstration pilot waiver will be asked concepts around trust, vision and population health from their experience working across integrated care sectors.

Research participants:

1. Are you 18 years of age or older?
2. Have you worked in government, managed care, or social services?
3. Do you have experience implementing or are you currently implementing a 1115 Medicaid pilot demonstration waiver?
4. Are you interested in sharing your experience around the themes of trust, common vision and how shared care intersect across the sectors of government, managed care, and social services?

Implementation location:

- Have you implemented or are you currently implementing a pilot in the state of North Carolina?

OR

- Have you implemented or are you currently implementing a pilot in California (Orange or Riverside County)?

If you answered yes to questions 1-4 and your experience has been in North Carolina or California (Riverside or Orange counties), you qualify to participate!

Include the following in your e-mail:

5. Name, phone number, reference to the study

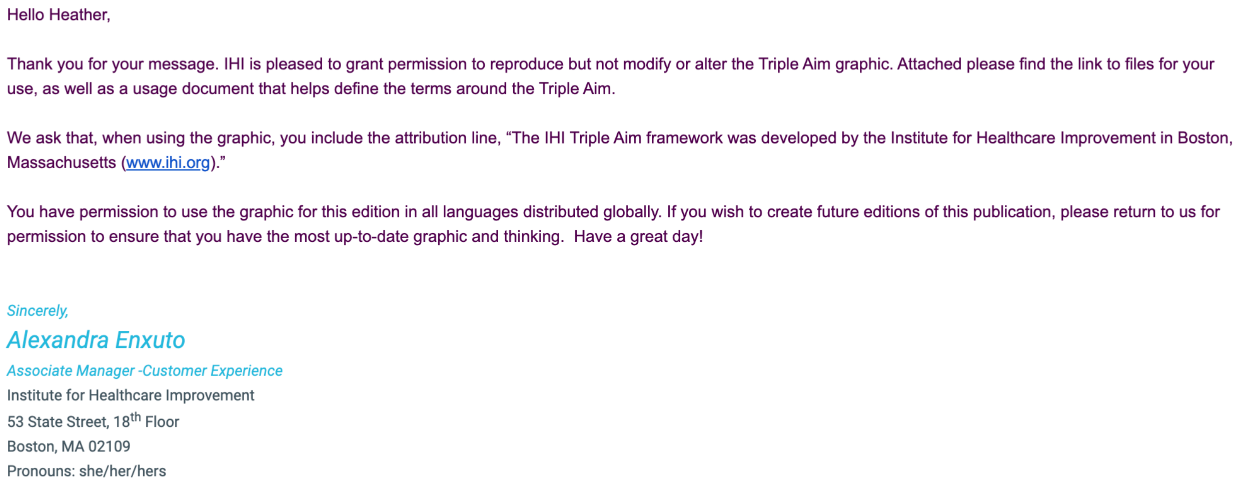
6. Work sector (government, managed care, or community-based organization)
7. Reference pilot implementation in North Carolina **or** Riverside County **or** Orange County

Recruitment Details/Next Steps:
Recruitment will take place in March-early April. Interested participants will receive an e-mail from the Principal Investigator, Heather Summers, within 72 hours with a consent form and will answer any questions via e-mail or phone. Once a signed consent is returned and study criteria is met, one 60 minute virtual Zoom interview, will be scheduled.

APPENDIX F

Table and Figure Copyright Approvals

Publishers and authors have been contacted to receive copyright approvals, when needed. Three e-mail verifications to use the information have been received. The remaining tables and figures are marked on the websites and publications as open access to be used and cited.



Hello Heather,

Thank you for your message. IHI is pleased to grant permission to reproduce but not modify or alter the Triple Aim graphic. Attached please find the link to files for your use, as well as a usage document that helps define the terms around the Triple Aim.

We ask that, when using the graphic, you include the attribution line, “The IHI Triple Aim framework was developed by the Institute for Healthcare Improvement in Boston, Massachusetts (www.ihi.org).”

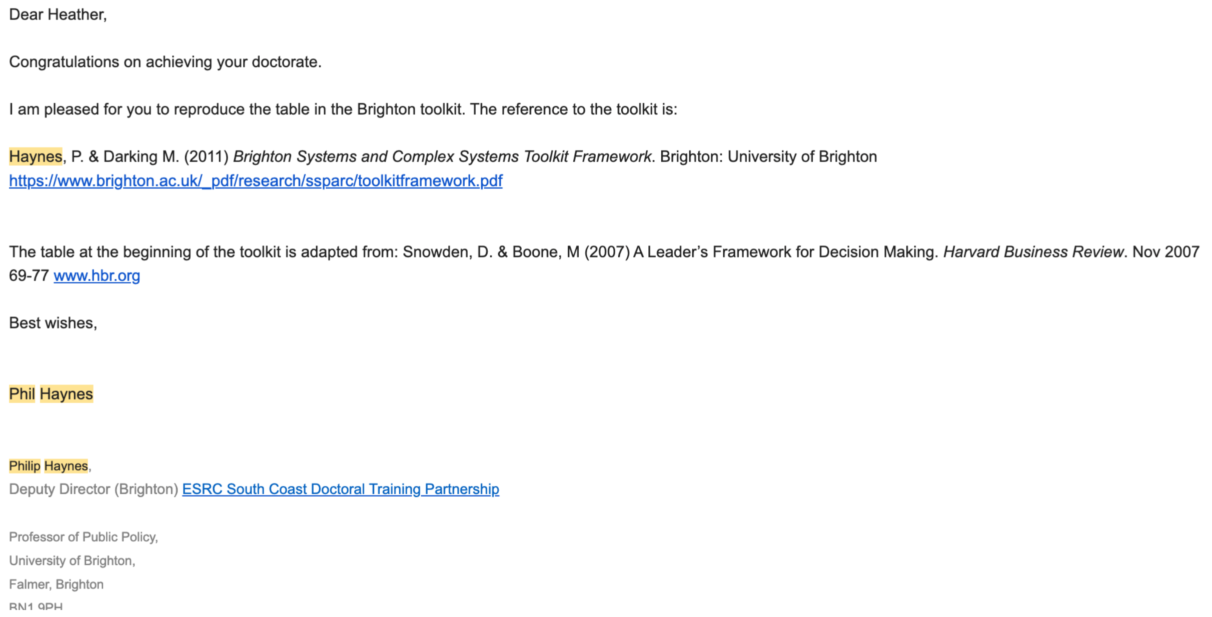
You have permission to use the graphic for this edition in all languages distributed globally. If you wish to create future editions of this publication, please return to us for permission to ensure that you have the most up-to-date graphic and thinking. Have a great day!

Sincerely,

Alexandra Enxuto

Associate Manager -Customer Experience

Institute for Healthcare Improvement
53 State Street, 18th Floor
Boston, MA 02109
Pronouns: she/her/hers



Dear Heather,

Congratulations on achieving your doctorate.

I am pleased for you to reproduce the table in the Brighton toolkit. The reference to the toolkit is:

Haynes, P. & Darking M. (2011) *Brighton Systems and Complex Systems Toolkit Framework*. Brighton: University of Brighton https://www.brighton.ac.uk/_pdf/research/ssparc/toolkitframework.pdf

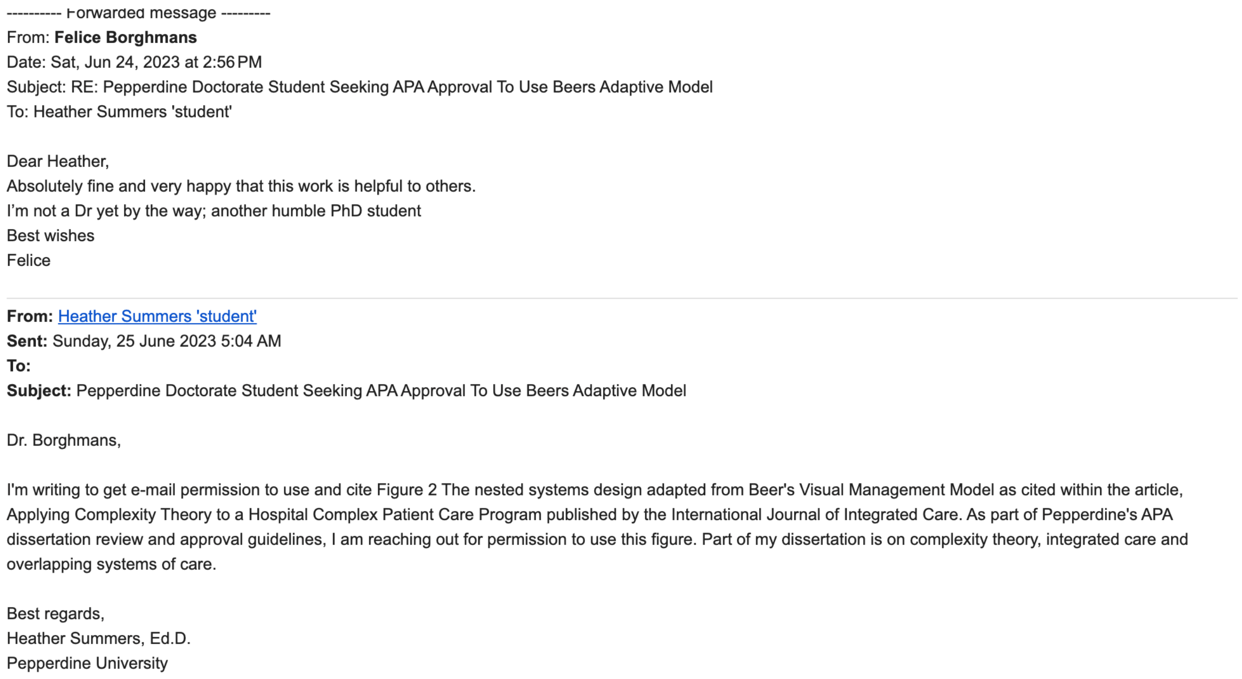
The table at the beginning of the toolkit is adapted from: Snowden, D. & Boone, M (2007) A Leader’s Framework for Decision Making. *Harvard Business Review*. Nov 2007 69-77 www.hbr.org

Best wishes,

Phil Haynes

Philip Haynes,
Deputy Director (Brighton) ESRC South Coast Doctoral Training Partnership

Professor of Public Policy,
University of Brighton,
Falmer, Brighton



---------- Forwarded message ---------
From: **Felice Borghmans**
Date: Sat, Jun 24, 2023 at 2:56 PM
Subject: RE: Pepperdine Doctorate Student Seeking APA Approval To Use Beers Adaptive Model
To: Heather Summers 'student'

Dear Heather,
Absolutely fine and very happy that this work is helpful to others.
I'm not a Dr yet by the way; another humble PhD student
Best wishes
Felice

From: Heather Summers 'student'
Sent: Sunday, 25 June 2023 5:04 AM
To:
Subject: Pepperdine Doctorate Student Seeking APA Approval To Use Beers Adaptive Model

Dr. Borghmans,

I'm writing to get e-mail permission to use and cite Figure 2 The nested systems design adapted from Beer's Visual Management Model as cited within the article, Applying Complexity Theory to a Hospital Complex Patient Care Program published by the International Journal of Integrated Care. As part of Pepperdine's APA dissertation review and approval guidelines, I am reaching out for permission to use this figure. Part of my dissertation is on complexity theory, integrated care and overlapping systems of care.

Best regards,
Heather Summers, Ed.D.
Pepperdine University