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Strategies to Improve Corporate Financial Investment in Care Coordination Programs

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This is to certify that the doctoral study by

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Walden University
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Abstract

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MBA, University of Phoenix, 2004

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Abstract

Key drivers for care coordination programs may include reducing inflated health care cost and improving the quality of care for high-risk populations. However, health care leaders lack methods to support financial investment in care coordination programs. The purpose of this single case study was to explore the strategies that health care leaders use to improve corporate financial investment in care coordination programs that include the triple aim of reducing cost, improving population health, and increasing patient satisfaction. The triple aim model provided the conceptual framework for the study in which 6 health care leaders from Southern California with experience garnering financial support for care coordination programs were interviewed. Data from semistructured interviews were analyzed and compared with company documents to establish methodological triangulation. The 4 themes that emerged included reflecting a reduction in health care cost; focusing on high-need, high-cost populations; partnering with primary care practices; and providing patient-centered care. The implications for positive social change included the potential to provide health care leaders the tools needed to garner financial investment in care coordination programs that improve population health and influence the health of high-risk populations.

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Dedication

First, I want to thank God for providing me the strength to complete this journey. I dedicate this dissertation to my husband for his commitment to my journey. I especially thank him for his sacrifices, and I realize the magnitude of those sacrifices on our family. My biggest cheerleader has and always will be my mother. I dedicate this accomplishment to my mom who encourages me to challenge myself and strive to be better. As a parent, you strive to be a role model to your child. I dedicate this to my son who was a role model for me, in that he claimed this accomplishment for me many years ago. Thanks for believing in me.

Acknowledgments

I would like to thank Dr. Gwendolyn Dooley for giving me a reason to smile when I really wanted to cry. I appreciate the encouraging words and voice of reason during this journey. I use these words to say that there are no words to say how much I have appreciated my chair.

Table of Contents

List of Tables

List of Figures

Section 1: Foundation of the Study

Dual-eligible beneficiaries are those entitled to both federal and state health care benefits (Eggbeer, Bowers, & Morris, 2013). The dual-eligible population accounts for a disproportionate share of state and federal health care expenditures (Gimm, Blodgett, & Zanwar, 2016). Moreover, dual-eligible beneficiaries have a greater likelihood of poor health outcomes related to multiple chronic conditions, mental illness, and functional limitations than beneficiaries with single coverage (Eggbeer et al., 2013). Policymakers focused on reducing health care costs by improving the poor coordination of state and federal health benefits (Gimm et al., 2016). Health care leaders describe the dual-eligible market as a multibillion dollar opportunity to reduce health cost by using care coordination programs (Eggbeer et al., 2013).

The triple aim model (TAM) of reducing per capita health care costs, improving patient experience, and providing population health is a national framework to transform health care at the social and business levels (Bodenheimer & Sinsky, 2014). Improving coordination may require health care leaders to assess current processes to determine appropriate resource allocation to realize the financial benefit of program implementation. Providing financial justification for health care interventions is a challenge for health care leaders (Wilf-Miron, Bolutin, Gordon, Porath, & Peled, 2014). Some health care leaders struggle with reflecting the benefit of investing in care coordination programs (Perry & Stevens, 2013). Wilf-Miron et al. (2014) indicated the need for additional research on presenting the financial impact of implementing care coordination programs. The aim of this study was to explore strategies health care leaders

use to improve corporate financial investment in care coordination programs that include TAM objectives.

Background of the Problem

The older adult population with both federal and state health care benefits is accountable for 39% of state expenditures and 31% of federal expenses (Gimm et al., 2016). Eggbeer et al. (2013) indicated the total health care costs associated with the dual-eligible population totaled $320 billion. The enrollment of dually eligible beneficiaries in a managed care organization can save the public health care programs an estimated $13 billion in health care cost over a 5-year period (Frank, 2013). Therefore, policy leaders authorized 3-year dual demonstration programs that outsourced the care coordination of the dual-eligible beneficiaries to managed care plans (Eggbeer et al., 2013). Sixty managed care plans in 10 states received a capitated, risk-adjusted payment to provide services for dual-eligible beneficiaries (Craver, Cuellar, & Gimm, 2016). Managed care leaders within a capitated payment model set care coordination program cost at $150 to $195 per beneficiary per month (Eggbeer et al., 2013). The change in the regulatory landscape challenged health care leaders to provide sustainable solutions to address the $20 billion loss associated with the lack of care coordination for the dual population (Eggbeer et al., 2013). According to Hendrikx et al. (2016), leaders pursue TAM objectives to ensure a sustainable health care system. Moreover, TAM goals of achieving population health, reducing per capita costs, and improving patient satisfaction are the framework defining the systematic social and business changes required in the health care industry (Bodenheimer & Sinsky, 2014). According to Miranda, Ferranti, Strauss,

Neelon, and Califf (2013), health care leaders use TAM objectives to define the transformation of the health care system. Health care leaders must take an individualized approach to developing a business strategy for care coordination programs based on the drivers of profit margin and the mission of the organization (Perry & Stevens, 2013). The results of this study may impact the field of business by providing strategies for health care leaders in the position of manager, director, and vice president to improve corporate financial investment in care coordination programs that include TAM objectives.

Problem Statement

Care coordination programs for dual-eligible beneficiaries cost between $150 and $195 per enrollee per month (Eggbeer et al., 2013). Health care leaders must limit allocation to care coordination programs to $125 to $150 per member per month to realize net savings (Brown, Peikes, Peterson, Schore, & Razafindrakoto, 2012). The general business problem was a lack of financial investment in care coordination programs by managed care organizations, which results in loss of profitability for the organization. The specific business problem was that some health care leaders in the position of manager, director, or vice president lack strategies to improve corporate financial investment in care coordination programs that include TAM objectives.

Purpose Statement

The purpose of this qualitative single-case study was to explore the strategies that health care leaders use to improve corporate financial investment in care coordination programs that include TAM objectives. The target population was health care leaders in the role of vice president or higher from one health care organization with experience

implementing strategies to improve corporate financial investment for care coordination programs that included TAM objectives. The geographical region was Southern California. Health care executives may consider the findings from this study as a contribution to social change if recommendations improve the quality of care for the dual-eligible population.

Nature of the Study

I selected the qualitative method for this study. Qualitative researchers can use interviews to seek an understanding of the uniqueness of events from the perspective of the participants, which extends beyond a comparison of variables (Stake, 2010). The qualitative method was appropriate because I used interviews for an in-depth exploration of a distinct event. Conversely, quantitative researchers use numerical data to test hypotheses (Hanson, Balmer, & Giardino, 2011). The quantitative approach was not appropriate because I did not intend to test hypotheses or use an experimental setting for the study. In mixed-methods research, researchers combine qualitative and quantitative methods when a single method is insufficient to provide a comprehensive understanding of the topic or results require additional clarification (Wisdom, Cavaleri, Onwuegbuzie, & Green, 2012). The mixed-methods approach was not appropriate because the integrative approach would have complicated the scope of the study beyond the collection of descriptive data to reflect the insights of the participants.

I used a case study design. Researchers can use interviews in a case study design to conduct in-depth research on a contemporary event within the bounds of the case study site (Yin, 2014). The case study design was appropriate because the objective of the study

was to conduct in-depth research of current strategies used by health care leaders to garner financial support within the bounds a single organization. The ethnographic, phenomenological, and narrative designs were not suitable for this study. Researchers use the ethnographic design to understand the culture of the environment by engaging in extended relationships with research participants (Wolcott, 1999). The objective of this study was not to engage in an extended relationship with participants to gauge the culture of the organization. According to Moustakas (1994), phenomenological researchers study lived experiences of participants and the perceptions of those experiences. In this study, I did not seek to provide an understanding of the lived experiences of the participants. Finally, researchers using the narrative design provide a sequential account of the participant's personal stories regarding his or her life experience (Hays & Woods, 2011). The narrative design was not appropriate because I did not take an account of a sequence of events to tell a story.

Research Question

The central research question was as follows: What strategies do health care leaders use to improve corporate financial investment in care coordination programs that include TAM objectives? The interview questions included the following:

Interview Questions

1. What successful strategies did you use to improve corporate financial investment in care coordination programs?
2. What strategies did you find worked best to improve corporate financial investment in care coordination programs?

3. How did you communicate the corporate financial investment strategies to executive leaders?
4. How did you evaluate the cost effectiveness of care coordination programs?
5. What are your recommendations to health care leaders pursuing care coordination investments?
6. What other information can you share regarding this study?

Conceptual Framework

TAM, which was developed by Berwick and the Institute for Healthcare Improvement in 2008, is a framework that provides the social and business constructs required for health care transformation (Vetter, Boudreaux, Jones, Hunter, & Pittet, 2014). The key tenets of TAM are population health, reducing per capita health care costs, and improving patient satisfaction (Miranda et al., 2013). According to Whittington, Nolan, Lewis, and Torres (2015), leaders are successful in deploying TAM when there is investment capacity to integrate the key tenets and alignment in the organizational governance structure. The development of business strategies requires leaders to align with the key corporate metrics driving the decisions of senior leaders (Harvard Business Press, 2011).

Anderson and Bjarnadóttir (2016) posited that health care leaders face difficulty in defining the cost effectiveness of care coordination programs due to variations in program models. Likewise, Katon and Unützer (2013) indicated that defining the financial structure at the organizational level is a hindrance in the adoption of new care coordination models. According to Ory et al. (2013), TAM objectives are the measures of

successful care coordination implementation. Therefore, TAM was applicable because I explored the strategies health care leaders use to improve corporate financial investment in care coordination programs that included TAM objectives.

Operational Definitions

Capitated payment: Capitated payments are payments fixed per enrollee per month (Quinn, 2015).

Care coordination: Care coordination is a set of activities to manage the health care needs of a population, resulting in a cost saving (Scholz, 2015).

Corporate financial investment: Corporate financial investment is money attributed to an asset with the expectation of an increase in the future value of the asset (Chaysin, Daengdej, & Tangjitprom, 2016).

Dual-eligible: Dual-eligible beneficiaries are beneficiaries receiving federal and state-sponsored health care benefits from a single source that integrates the financing and delivery of care (Prindiville, 2013).

Managed Care Organization for the Older Adult (MCOOA): MCOOA is a capitated, risk-adjusted organization that provides services to a defined older adult population (Morley, Walsh, & Wilkin, 2013).

Risk adjustment: Risk adjustment is the process of adjusting payment to the MCOOA based on the severity of illness for a beneficiary qualified for the federally sponsored health care program (Hellander, Himmelstein, & Woolhandler, 2013)

Star quality rating: Star quality rating is the federal quality rating system that rates MCOOA on a 1 to 5 rating scale (Reid, Deb, Howell, & Shrank, 2013).

Transition: Transition is the process of changing from one health care level to another (Cleave et al., 2013).

Transitional care: Transitional care includes services provided to support continuity of care between care transitions during a specified time interval (Verhaegh et al., 2014)

Assumptions, Limitations, and Delimitations

Assumptions

Assumptions are the components of the study that validate the relevance of the research topic (Thomas, Nelson, & Silverman, 2010). The underlying assumption of this study was that health care leaders in the position of manager, director, or vice president consider care coordination programs a viable solution to impacting costs within an MCOOA. There was an assumption that the MCOOA leaders consider TAM objectives of reducing per health care capita cost, improving patient experience, and improving population health as the foundation for health care transformation. The next assumption was that the inclusion criteria would allow me to identify participants with the knowledge base to provide in-depth answers to the interview questions. Finally, I assumed that participants would provide honest responses during the interview process.

Limitations

The limitations are the weaknesses of the study that are outside the control of the researcher (Thomas et al., 2010). The single case study design limitations included sample size and generalizability. According to Yin (2014), the single case study design limits the study to a single unit of analysis, which may not represent the activities of other

organizations. In addition, the sample size in a single unit of study was a limitation. Finally, documentation as a source of evidence was a limitation based on retrievability, biased selectivity, reporting bias, and access (Yin, 2014).

Delimitations

According to Thomas et al. (2010), the delimitations are within the capacity of the researcher to control and are used to identify the bounds of the study. I delimited the study to participants with the breadth of knowledge and willingness to participate in the study. The participants included leaders within a bounded managed care system delimited to a single eastern county of Southern California. In addition, the case study site contracted to provide care for beneficiaries receiving federally sponsored health care benefits, state-sponsored benefits, employer-based benefits, dual-eligible beneficiaries, and the uninsured. The delimitation was to the beneficiaries dually eligible for federal- and state-sponsored health care benefits.

Significance of the Study

A challenge to the health care system in the United States is to convert a fragmented system into one that focuses on reducing costs through integrated service delivery, enhanced population health, and improved quality (Enthoven, 2016). TAM is the framework defining the health care systematic changes required to control costs (Bodenheimer & Sinsky, 2014). The core objectives of TAM include improving population health, reducing the cost of health care, and improving patient satisfaction (Bodenheimer & Sinsky, 2014). According to Fuse-Brown (2015), cost containment is a critical component of the Affordable Care Act (ACA). The transformation of the

provision of care for the 10.2 million beneficiaries of federal and state health care reflects the social and economic influence of the ACA (Craver et al., 2016). Therefore, health care executives have an interest in strategies to control the cost for the dual-eligible population because the population has a higher incidence of chronic conditions, social needs, and mental health disorders (Zainulbhai, Goldberg, Ng, & Montgomery, 2014). According to Murphy and Neven (2014), the cost of inpatient utilization has led to national attention to care activities designed to reduce costs. Senior executives can have an awareness of the need to develop innovative programs; however, leaders must present an evidence-based business strategy to support the use of scarce resources (de Waal, Beaumont, & Mitchell, 2013). The study of strategies for health care leaders to improve the corporate financial investment in care coordination programs that included TAM objectives may be valuable in maintaining the financial solvency of MCOOA, reducing fragmentation of health care, and improving the quality of care to the older adult.

Contribution to Business Practice

The dual-eligible population accounts for 20% of the U.S. federal program enrollment and approximately 40% of the total expenditures (Frank, 2013). Moreover, the dual-eligible population has a greater incidence of emergency hospitalizations, chronic conditions, homelessness, and frailty (Ortega, 2016). In the capitated model, the MCOOA will receive a prospected, blended payment to manage services for beneficiaries (Rahman, Keohane, Trivedi, & Mor, 2015). According to Kennedy (2013), beneficiaries of federal and state health care programs spend $300 billion annually. Reinhard (2013) identified an opportunity to increase market share and profitability for those MCOOA

with the capacity to integrate and coordinate care for the high-risk dual population. Furthermore, Zainulbhai et al. (2014) indicated that new strategies to improve access, control costs, improve the quality of care, and reduce barriers are essential to managing the financial burden of the dual-eligible population. Health care leaders, however, may not have the competencies to develop a business case presentation to support the implementation of new strategies (de Waal et al., 2013). The results of this study may contribute to efficient business practices by identifying the strategies aligned with TAM objectives of reducing per capita costs. The results may also influence business practices by providing strategies for health care leaders in the position of manager, director, or vice president to gain access to corporate resources for the implementation of care coordination programs.

Implications for Social Change

MCOOA accounts for 25% of the enrollment for beneficiaries with federal- and state-sponsored health care benefits (Reid et al., 2013). Therefore, MCOOA could have a positive effect on the federal health care program by improving the quality of care (Newhouse & McGuire, 2014). Deficient care coordination during transitions from the hospital to the community can lead to adverse outcomes and readmissions (Feltner et al., 2014). Hodin (2013) indicated that fragmented care for dual beneficiaries has an adverse influence on their overall health outcomes. The results of the current study may contribute to positive social change by supporting TAM objectives of population health and improved patient experiences. Furthermore, the results may have a positive impact on social change by providing insight into the strategies health care leaders positioned in the

role of manager, director, or vice president use for care coordination programs designed to impact the adverse outcomes experienced by the dual-eligible population.

A Review of the Professional and Academic Literature

There is an increased focus on preserving federal and state funding by encouraging innovative approaches to improving the quality of care for the dual-eligible population. However, care models must align with new payment structures and quality initiatives for MCOOA sustainability. Health care leaders strategize on how to create a business case for coordinated care programs when the traditional business model is not applicable (Perry & Stevens, 2013). The focus of the current study was to explore the strategies health care leaders use to improve the corporate financial investment in care coordination programs that include TAM objectives. The literature review reflected the core business implications for MCOOA to implement care coordination programs for the dual-eligible population and the position of industry leaders.

I employed a systematic approach using journal articles, scholarly books, and dissertations to guide the literature review. A gap existed in the literature on strategies for leaders to garner financial support for care coordination programs for the dual-eligible population. The gap may be due to the July 2014 implementation of integrated benefits for the dual-eligible population. As illustrated in Table 1, the literature review included 246 publications, 87% with publication dates between 2013 and 2017. Of the 246 publications, the peer-reviewed articles accounted for 90%. The electronic databases were EBSCOHost, Academic Search Complete, Science Direct, Thoreau, and ProQuest. I also used the Google Scholar search engine. My strategy to extract relevant literature

started with a broad search of terms narrowed to a specific term search. First, the search included *triple aim*, *dual-eligible*, *readmission*, *care coordination*, *patient-centered medical home*, *accountable care organization*, *Medicare Advantage*, *health care reform*, *health care cost*, *Medicare costs*, *corporate sustainability*, *corporate social responsibility*, *stakeholder theory*, *shareholder theory*, *Star ratings*, *medical loss ratio*, *risk-adjustment managed care*, *qualitative research care coordination*, *qualitative research health care*, *health care leadership*, and *health care leaders.* Next, the specific terms included *cost of dual-eligible*, *Affordable Care Act*, *Financial Alignment Initiative*, *triple aim objectives*, *population health*, *transition of care*, *business case*, *business case health care*, *business case care coordination*, *cost-effectiveness of care coordination*, *cost-benefit analysis*, and *care coordination return on investment*. The results of the term search guided the inquiry. Additionally, the linked articles feature within the electronic databases contained resources for the literature review. As I cataloged references, themes emerged to define the seven sections of the literature review. I organized the literature review into these sections to present the analysis and synthesis of the literature based on the focus of discussion: (a) comparative theories, (b) MCOOA, (c) Affordable Care Act, (d) care coordination, (e) dual-eligible population, (f) readmissions, (g) relationship of study to previous research.

Table 1

Source of Literature for the Literature Review

	Total	Percentage
Peer reviewed articles	197	90%
Publication between 2013 and 2017	214	89%

Seminal books	16	7%

Comparative Theories

The comparative theories for critical analysis included TAM, corporate social responsibility theory (CSRT), corporate sustainability theory (CST), stakeholder theory, and shareholder theory. Bodenheimer and Sinsky (2014) indicated that TAM represents the interdependent business and social objectives required to re-engineer the health care system. Similarly, Eccles, Ioannou, and Serrafeim (2014) noted CST has interrelated dimensions of social, economic, and ecological activities. The fundamental principles of CSRT are the organization's socially responsible activities (Husted, Montiel, & Christmann, 2016). According to Eccles et al., maintaining a positive profit margin for the shareholders in an environment free of fraudulent practices is the central social obligation of organizations grounded in the shareholder theory. Conversely, stakeholder theorists extended corporate accountability to shareholders and multiple stakeholders due to the interrelated aspects of business and society (Queen, 2015).

Triple aim model. The conceptual framework guiding this study was TAM. Health care researchers at the Institute for Healthcare Improvement (IHI) proposed TAM in 2008 as a concept to address health care deficiencies (Whittington et al., 2015). TAM is the health care framework defining the systematic changes required to control health care costs (Bodenheimer & Sinsky, 2014). Moreover, the core objectives of TAM include achieving population health, reducing the cost of health care, and improving patient satisfaction (Bodenheimer & Sinsky, 2014). The researchers at the IHI posited that societal changes were necessary to realize global transformation in the health care

structure (Whittington et al., 2015). Similarly, Miranda et al. (2013) indicated that leaders use the TAM objectives to define health care system transformation.

Policymakers structured the ACA programs to make systematic changes from volume-based health care to a structure grounded in the value of health care (Cason, 2015). Strong, Hanson, Magnusson, and Neiger (2015) indicated that the ACA provisions align with the goal of achieving TAM objectives. Therefore, health care leaders use the TAM model to define the success of health care reform initiatives (Katon & Unützer, 2013). Strong et al. noted that the strategies of implementing TAM include isolating a population, defining measures of success, achieving system-level outcomes, and providing an expeditious evaluation of effectiveness. However, Hendrikx et al. (2016) indicated that differences in the industry definitions of TAM objectives cause variation in the means of measuring successful implementation. Eapen, Lauer, and Temple (2014) posited that measuring the achievement of TAM objectives required clinical trials with adequate sample sizes to measure clinical outcomes. According to Panzer et al. (2013), measuring TAM objectives requires health care leaders to define the benchmark performance for each measure.

Triple aim objectives. The components of TAM include reducing per capita costs, achieving population health, and improving the patient experience (Bodenheimer & Sinsky, 2014). Vetter et al. (2014) indicated the cost of health care in the United States would represent 19.3% of the GDP by 2019. Similarly, Jackson et al. (2013) posited that the United States spends a greater percentage of the GDP on health care than any other country; however, this does not equate to higher quality outcomes. TAM is integral in

addressing health care waste and increasing costs (Coyne et al., 2014). However, provider payment models lack incentives for lowering the per capita cost of health care (Whittington et al., 2015). Gage and Albaroudi (2015) posited that the focus of policymakers shifted from cost control to improving the value of health care.

Population health encompasses the clinical outcomes of a defined group of individuals (Kindig & Isham, 2014). Whittington et al. (2015) pointed out that health care leaders must engage in completing a population assessment and choose populations whereby the three objectives of TAM apply. Furthermore, Hendrikx et al. (2016) noted that measures of population health differ and result in various means of implementation based on regional social needs. Moreover, Kindig and Isham (2014) indicated that improving population health requires the collaboration of numerous organizations to address the multiple social and physical determinants of health, and a single organization cannot accomplish population health. Miranda et al. (2013) noted that health care industries lack the analytical tools to support population management. Similarly, Phillips et al. (2015) indicated that deficient data exchange at the level where patients access care has an adverse influence on the capacity to achieve population health. George and Shocksnider (2014) indicated nurse leaders require financial knowledge and access to key business drivers to gain support for care coordination programs aimed at population health.

Harder, Krulewitz, Jones, Wasserman, and Shaw (2016) indicated measuring patient experience is a critical component when transforming the structure of the health care system. Cook et al. (2015) described the patient experience as the patient's

perception of care. Similarly, Bernabeo and Holmboe (2013) noted that patient engagement and shared decision-making is a key system-level competency required to achieve TAM objectives. Hibbard and Greene (2013) indicated that increasing patient engagement improves the perceived patient experience. Hacker and Walker (2013) added that the influence on patient experience is essential because patient behaviors account for 60% of health outcomes. According to Cook et al. (2015), improving health outcomes involves utilizing patient experience feedback to guide patient engagement and quality initiatives.

Hacker and Walker (2013) indicated that the accountable care organization (ACO) and the patient-centered medical home (PCMH) are key concepts to implementing TAM. The PCMH is a transformative concept of care aimed at re-engineering the primary care practice (Jackson et al., 2013). The core tenets of the PCMH include (a) team-driven care, (b) holistic care for the patient, (c) care coordination across the continuum of care, (d) innovative methods of communication to improve access, and (e) systematic approach to quality and safety (Jackson et al., 2013). According to Hahn, Gonzalez, Etz, and Crabtree (2014), the National Committee for Quality Assurance introduced the PCMH model to improve the quality of care within a primary care setting. Health care organizations, however, may pursue the PCMH recognition as a label versus a transformative process to improve the quality of care (Hahn et al., 2014). Similarly, Howard et al. (2016) indicated that the pursuit of a PCMH extends beyond the verbiage used to describe the practice to include the actions that support a transformation in the culture of the organization.

The ACO is an ACA concept to transform the health care delivery system to meet TAM objectives (Sandberg et al., 2014). In an ACO, there is a consortium of providers contracted to reduce cost by creating a systematic, quality-based approach to managing a population (Auerbach, Liu, Hussey, Lau, & Mehrotra, 2013). According to Kelleher et al. (2015), the ACO success is in the ability to reduce cost and improve quality, thereby improving the value of care. However, Rose, Zaslavsky, and McWilliams (2016) pointed out that an ACO retaining a fee-for-service payment methodology for physicians and specialists can cause conflicting priorities with volume versus value. Moreover, the drivers of the ACO framework are the state and federal financial incentives for achieving reductions in health care costs (Pham, Cohen, & Conway, 2014). Colla et al. (2014) pointed out that the ACO framework allows for cost savings based on evidence-based practice versus indiscriminate reductions in services.

Golden (2015) indicated there are more than 700 ACOs that provide health care for an estimated 23 million people. According to Berkowitz and Pahira (2014), the core elements of ACO development are as follows: leadership, governance, information technology, analytical capacity, population health management, and care coordination. Similarly, Hofler and Ortiz (2016) indicated that the two defining goals for an ACO are enhancing the quality of care for a defined population and improving care coordination to reduce the costs associated with hospitalizations and emergency room visits. However, Golden indicated that policymakers will not realize the estimated $5 billion dollar saving by 2019.

Corporate social responsibility theory. According to Carroll (2015), Bowen

initiated the CSRT body of literature to discuss the relationship between business and society. Queen (2015) added that CSRT is an organization's determination of the cost-benefit of social initiatives. According to Husted et al. (2016), organizations grounded in CSRT influence local communities by improving social benefits and decreasing social problems. Scholars of the CSRT define the instrumental value of CSRT as the view of societal issues based on the benefit to people (Husted et al., 2016). Theorists of CSRT indicate the benefit of organizations engaging in socially responsible activities is a positive reputation (Chernev & Blair, 2015). Additionally, Korschun, Bhattacharya, and Swain (2016) pointed out that communicating CSRT initiatives to customers and employees supports a high-performing work environment and positive reputation. There is an economic value of maximizing on short- and long-term returns based on positive public images (Tang, Gallagher, & Bie, 2015). Cheng, Ioannou, and Serafeim (2014) posited that performance of CSRT philosophies affects business investments by lowering capital constraints that could reduce the capacity to engage in strategic projects. Likewise, Korschun et al. (2016) indicated that there are greater returns for organizations with high CSRT activities. However, the CSRT was not the appropriate conceptual framework for this study due to the emphasis on the social drivers of decision-making. TAM was the most suitable framework based on the interrelated social and business objectives driving systemic health care changes.

Corporate sustainability theory. In 1987, the World Commission on Environment and Development introduced the CST to address environmental and social problems that will impact future generations (Linnenluecke, Verreynne, Scheepers, &

Venter, 2017). Rego, Cunha, and Polónia (2015) posited that the definition of corporate sustainability is diverse, resulting in the varied application of practice and theory. Furthermore, Lozano (2015) indicated the organization's leaders are the driving force for implementing CST practices. The focus of corporate sustainability is on an organization's ability to meet the needs of internal and external stakeholders while maintaining consideration for future stakeholder needs (Montiel & Delgado-Ceballos, 2014). Similarly, Milne and Gray (2013) defined sustainability as a general concept about consumption of natural resources and the impact of the consumption on future generations. Hahn, Figge, Aragon-Correa, and Sharma (2015) noted a deficiency in defining how organizations lessen the impact of activities on ecological systems. Additionally, Milne and Gray stated the ecological component of the concept is inconsistent among organizations, and business leaders debate the defining criteria for the ecological contribution to society. Similarly, Whiteman, Walker, and Perego (2013) indicated that scholars of the CST failed to provide a detailed account of how organizations can operationalize CST interventions. The concept of sustainable development is a blend of social, economic, justice, environmental, business, politics, and legal activities to maintain future resources (Hahn, Pinkse, Preuss, & Figge, 2015). Hahn, Figge, et al. (2015) noted that sustainable development is the fundamental principle guiding CST.

Hahn, Pinkse, et al. (2015) describe the business implications for CST as a profit-based strategic plan to address environmental and social pressures. Similarly, Eccles et al. (2014) posited that there is a positive impact on the bottom line through economic

sustainability occurring in concert with ecological and social aspects of the business. Moreover, the business considerations for CST require the integration of environmental influences with the social and econimic factors (Whiteman et al., 2013). CST involves the organization's role in managing the ecological factors, social considerations, and external perceptions (Eccles et al., 2014).

Hahn, Figge, et al. (2015) indicated the business considerations include the potential for positive returns when investing in environmental and socially driven initiatives. In this study, I did not focus on the ecological impact of business decisions on future generations. Therefore, the CST was not the appropriate framework for this study. TAM defines the objectives for systematic health care changes by implementing the social and business tenets of improved population health, reducing per capita costs, and improving the patient experience (Bodenheimer & Sinsky, 2014). Thus, TAM was the more appropriate framework to study strategies health care leaders use to influence decision making for care coordination program implementation.

Shareholder and stakeholder theory. Organizations grounded in shareholder theory indicate the organization's societal obligation is to maintain profitability for its shareholders (Eccles et al., 2014). The morality of shareholder view is the right to freedom of choice and ownership of personal property, without a violation of that right for others (Mansell, 2013). In contrast, Friedman (1962) argued that only the individual could possess social responsibility, not an organizational structure (Mansell, 2013). Shareholders are owners that have the right to determine resource allocation (Mansell, 2013). The critique of the shareholder view is that resource allocation grounded in

maximizing owner profits is to the detriment of charity, employee morale efforts, and other stakeholders (Queen, 2015). According to Mansell (2013), managerial staff is contractually obligated to act based on the interests of the shareowners.

The stakeholder view expands the corporate relationship to multiple stakeholders (Queen, 2015). Moreover, Kull, Mena, and Korschun (2016) posited that the outcome of an organization depends on multiple stakeholder relationships. Critics hold that a focus on broad stakeholder initiatives consumes managerial time in negotiations (Queen, 2015). However, Kull et al. indicated that mutual trust developed with stakeholders provides a competitive advantage. The critique of the stakeholder theory is the conflicting priorities for managers to align with the separate agendas of owners versus stakeholders (Queen, 2015).

The stakeholder and shareholder theory are not mutually exclusive concepts, and a balance between stakeholder costs and shareholder benefit is optimal (Queen, 2015). Therefore, as individual conceptual frameworks, the stakeholder theory and shareholder theory were not appropriate for this study. TAM was most suitable for this study to determine how leaders make decisions that may influence social and business objectives of health care.

Managed Care Organization for the Older Adult

The federal government contracts with risk-based managed care organizations to provide services to federal health care beneficiaries (Newhouse & McGuire, 2014). Newhouse and McGuire (2014) indicated that the intent of the managed care organization for the older adult was to reduce costs and provide federal beneficiaries with an option

beyond federally sponsored health care. Twenty-seven percent of recipients of federally sponsored health care enroll in one of the 3,300 managed care plans (Hellander et al., 2013). MCOOA have the capacity to offer competitive benefit packages and care coordination for beneficiaries (Landon et al., 2015). MCOOA receive a higher federal reimbursement than traditional fee for service programs; however, the increase in spending is not equivalent to a rise in quality (Hellander et al., 2013). Managed care plans receive approximately $10, 123 per enrollee, which estimates to $136.2 billion a year (Hellander et al., 2013).

Although the intent of MCOOA is to control health care expenditures, the federal government spends $282.6 billion more for MCOOA than traditional fee for service programs (Hellander et al., 2013). Baicker, Chernew, and Robbins (2013) pointed to a shorter length of stay and reduction in hospital costs counterbalancing the additional payments to MCOOA. Landon et al. (2015) support the assumption by indicating MCOOA have lower utilization than the traditional federal health care program due to network contracting and care management program implementation.

The federal government used the Star Rating system to determine MCOOA performance based on the quality of care provided (Xu, Burgess, Cabral, Soria-Saucedo & Kazis, 2015). Moreover, Reid et al. (2013) revealed the Star Ratings affect beneficiary enrollment decisions; thus, influencing the MCOOA total enrollment and revenue. The Star Ratings reflect Healthcare Effectiveness Data and Information Set (HEDIS) measures, Consumer Assessment of Healthcare Providers and Systems surveys (CAHPS), Health of Seniors surveys (HOS), and administrative data (Reid et al., 2013).

The provisions of the ACA reduced the higher payments to MCOOA and linked payments to the quality of care through Star ratings (Xu et al., 2015). Landon et al. (2015) stated the MCOOA could provide better quality than traditional federally sponsored health care programs based on the use of flexible benefits and vast networks of providers. The traditional federally sponsored health care program consists of benefits determined by legislation and standard fee schedules (Baicker et al., 2013). According to Reid et al. (2013), the Star Rating system is an essential business driver for MCOOA because the federal government linked Star Ratings to the MCOOA's financial reimbursement in 2011. Additionally, state officials can enact quality payment withholds based on the quality performance measures selected by the state (Morley et al., 2013; Zainulbhai, et al., 2014).

The Obama Administration enactment of the PPACA modified the payment structure of MCOOA requiring changes in business practices to ensure financial solvency (Rak & Coffin, 2013). Moreover, the ACA changes in the health care reimbursement structure include bonus payments and an increased capacity to enroll new members (Xu et al., 2015). The current payment structure is that MCOOA receives capitated risk-adjusted reimbursement from the federal government per enrollee for a given period (Craver et al., 2016). According to Brown, Duggan, Kuziemko, and Woolston (2014), the capitated risk-adjusted methodology is critical in eliminating the incentive to overutilize services in a fee for service model. Morley et al. (2013) indicated that policymakers reduced payments to MCOOA through the Financial Alignment Initiative.

The ACA included provisions to control costs and quality activities by regulating

the medical loss ratio for MCOOA (Harrington, 2013). Hall (2014) indicated tracking medical expenditures is a key performance measure of the ACA. Conversely, Harrington (2013) indicated a decreased focused on medical cost control would allow leaders to increase spending on quality-based, clinical services. However, Harrington indicated there was a decrease in the willingness to invest in innovative strategies without measurable results. Harrington noted that the medical loss ratio regulation ensures the health plans attribute the appropriate percentage of premium revenue for the medical care and activities to improve the quality of care. Furthermore, the medical loss ratio of 80% to 85% established by the ACA requires MCOOA to provide a rebate to insurers when premium payments exceed the cost of providing medical care and specific quality-based activities (Harrington, 2013). Health care economists suggested the ACA has decreased the rate of health care spending (Hall, 2014). Proponents argue the recession and existing downward trends may account for the deceleration of health care expenditure (Hall, 2014). However, those supporting the medical loss ratio indicate it is a solution to the lack of transparency causing increased administrative costs (Harrington, 2013).

Affordable Care Act

The core components of the ACA include increasing health care coverage and redefining the health care system (Berwick, Feeley, & Loehrer, 2015). On March 23, 2010, President Obama enacted the ACA into law and increased the insured population by an estimated 16 million by 2015 (Hamel, Blumenthal, Abrams, & Nuzum, 2015). However, Sommers, Buchmueller, Decker, Carey, and Kronick (2013) indicated the goal of the legislators was for the ACA provisions to increase the insured population by 30

million. According to Orentlicher (2014), the ACA changes improved the health insurance market by eliminating high premiums and coverage denials based on preexisting conditions. Conversely, Hamel et al. (2015) indicated that increasing health care coverage occurred by allowing the selection of affordable coverage through a health plan marketplace, through federally sponsored expansion of the state-funded health insurance program, extending dependent health coverage, and prohibiting discrimination due to pre-existing conditions. Orentlicher indicated expanding state health care coverage extends coverage to those previously uninsured, but does not equate to universal coverage or better health outcomes.

Redefining the health care system is a complex component of the ACA provisions (Hamel et al., 2015). Public and private organizational leaders focused on the development of new care structures to transform the health care system (Berwick et al., 2015). According to Hamel et al. (2015), redefining the health care system includes changes in the payment structure, delivery models, workforce, and degree of innovation for sustainability. Mery, Majumder, Brown, and Dobrow (2017) indicated that achieving the objectives of TAM is the measure of transformation in the health care delivery system. Likewise, Whittington et al. (2015) noted that TAM framework became a national model to implement the health care redesign strategic objectives of the ACA. Hamel et al. pointed out that systematic transformation of the payment structure included readmission penalties, pay for performance strategies, reducing hospital-acquired conditions through incentive payments, and bundled payment structures. Likewise, Franklin and Busis (2016) indicated that the ACA provisions include investments in

billion dollar grants for care coordination and payment models aimed at achieving the objectives of TAM.

Hirsch et al. (2014) indicated that ACA legislators introduced the, the Independent Payment Advisory Board (IPAB) and the Patient-Centered Outcomes Research Institute (PCORI) as the accountable agencies for redesigning the health care infrastructure. The objective of the IPAB administrators is cost containment (Hirsch et al., 2014). The IPAB commissioners evaluate payment methodologies for the federal health care program based on changes in the per capita costs thresholds (Hirsch et al., 2014). Frank, Basch, and Selby (2014) indicated that the role of the PCORI administrators is to fund research that represents the voice of the community and supports providing research to support informed health care decision-making. Moreover, the PCORI aims to increase evidenced based health decision by funding clinical research (Hirsch et al., 2014). According to Jain and Shrank (2014), legislators introduced the Innovation Center to develop programs to improve care, advance system integration, provide preventative initiatives, and improve state-based programs. Moreover, the Innovation Center administrators are responsible for the evaluation of ideas to improve the quality of care and reduce health care costs (Jain & Shrank, 2014)

The ACA legislators introduced the Federal Coordinated Healthcare Office (FCHO) to ensure the integration of federal and state programs. In addition, the Financial Alignment Initiative of 2011 is one of the Innovation Center programs to integrate the payment and delivery of health care for the dual-eligible population (Prina, 2016). According to Craver et al. (2016), the aim of the Financial Alignment Initiative is to

develop cost effective care models to minimize cost shifting between federal and state health care programs and to reduce the fragmented approach to care delivery for the dual-eligible population. The Financial Alignment Initiative presents opportunities to augment service delivery models (Craver et al., 2016). Effective April 2014, 10 states signed a capitated financial alignment memorandum of understanding with the federal government to provide care to dual-eligible beneficiaries (Verdier, Streeter, Chelminsky, & Nysenbaum, 2014). Verdier et al. indicated that the state and federal government officials reduced the reimbursement to MCOOA based on the amount of savings expected for the year. Moreover, the Welfare and Institution Code noted that MCOOA expected to achieve savings through managing utilization patterns versus reducing reimbursement to providers (Cutler, Rich, & Yee, 2013).

Care Coordination

Collaborative health care is a process recognized as a strategy to achieving TAM (Katon & Unützer, 2013). Desjardins (2015) indicated care coordination is the organization of patient care activities amongst multiple providers aimed at appropriate health care utilization. According to Morton et al. (2015), coordination of care is important in avoiding duplication of services, consistently delivering evidenced-based guidance and improving access to care. Similarly, Xing, Goehring, and Mancuso (2015) indicated that poor coordination of care and access issues are key drivers of increased health care costs.

Care coordination is an essential component to addressing TAM objectives by structuring payment models to promote physician involvement in care coordination

(Moreo, Moreo, Urbano, Weeks, & Greene, 2014). According to Aronson, Bautista, and Covinsky (2015), the adjustment to the payment structure for clinicians represents a cost efficient, evidenced-based change to the health care system. Similarly, Shaw, Asomugha, Conway, and Rein (2014) indicated that the ACA legislators promote the advent of innovative strategies to improve care coordination to reduce health care cost. Moreover, the ACA provisions include contracts and grant opportunities for care coordination at various levels of the care continuum (Desjardins, 2015). The ACA changes included the FCHO to facilitate research of care coordination programs aimed at reducing cost and integrating services for dual population (Frank, 2013).

Care coordination programs differ in approach, settings, provider, and population (Marek et al., 2014). The variation and customization in programs present a challenge for health care leaders to define successful implementation (Schultz, Pineda, Lonhart, Davies, & McDonald, 2013). Schultz et al. (2013) noted that the industry lacks consistency in defining care coordination, developing evidenced based practice, and measuring coordination of care. Hong, Siegel, and Ferris (2014) revealed successful care management models included: (a) customization, (b) qualitative and quantitative methods for member identification, (c) a primary focus on care coordination, (d) relationship building with patients and providers, (e) interdisciplinary team based on needs, (f) training for team members, and (g) use technology to improve care. Tricco et al. (2014) added that targeted interventions should include modifications with proven success such as changes in the team, case management, and self-management strategies. Care coordination becomes of increasing importance with an aging population with chronic

illness and comorbidities (Daveson et al., 2014). Similarly, Xing et al. (2015) noted that targeting the care coordination intervention for the high-risk population is an effective strategy for improving health care outcomes.

The return on investment for care coordination programs may vary. A review of primary care-based care coordination programs revealed little to no benefit in utilization outcomes (Marek et al., 2014). Similarly, McWilliams and Schwartz (2017) indicated that care coordination programs did not influence cost savings for health care organizations based on the need to expand resources and to increase the use of services. In contrast, Marek et al. (2014) posited that transitional care was an effective care coordination program feature to reduce inpatient utilization costs. Murphy and Neven (2014) indicated that care coordination program assessments lacked a standardized method of evaluating cost. Moreover, Murphy and Neven indicated that cost-effectiveness was a fundamental element for leaders to determine an efficient allocation of resources. The measure of success across programs was the ability to reduce inpatient utilization outcomes. Kates, Shield, Behrend, and Noyes (2015) indicated that inpatient cost would increase from $129.1 billion in 2008 to $234.9 billion in 2019.

Dual-Eligible Population

According to Whittington et al. (2015), choosing a population to implement the three dimensions of the Triple Aim is a core competency for health care transformation. Rittenhouse et al. (2015) indicated that the older adult population would account for 19% of the total population by 2030. Moreover, the dual population requires coordination to integrate the financial and medical components of the federal and state health care

programs (Prindiville, 2013). The Duals Office ensures the dual-eligible beneficiary receives integrated benefits (Justice & Holladay, 2013). In addition, the provisions of the ACA created regulatory groups to monitor activities for the dual-eligible population savings (Brown et al., 2012). Eggbeer et al. (2013) pointed out that the dual-eligible population is increasing at a rate double that of single-program beneficiaries. In addition, the dual population has a higher incidence of social issues influencing the ability to access health benefits (Ortega, 2016). Zainulbhai et al. (2014) added that medical and behavioral complexities complicate care for the dual-eligible. Joynt, Gawande, Orav, and Jha (2013) indicated that 10% of the older adult population consumes 50% of the federal health care resources. Moreover, Powers, Chaguturu, and Ferris (2015) revealed that care coordination programs could improve quality of life and reduce health care expenditures. Eggbeer et al. indicated the system of managed care is appropriate for dual-eligible beneficiaries because of the following: 40% of the population is younger than 65, 75% of the dual-eligible population has not experienced a hospital admission, and 87% of the dual-eligible reside at home. However, the dual-eligible population presents a challenge when coordinating care amongst multiple providers and services (Eggbeer et al., 2013). Kennedy (2013) indicated the dual-eligible population is at risk for fragmented care due to the coordination required between multiple programs with varied benefits, ID cards, appeal and grievance processes, and documentation.

Jung, Trivedi, Grabowski, and Mor (2015) indicated the dual-eligible population account for 15% of state-sponsored health care enrollment and 39% of the expenses. Eggbeer et al. (2013) posited that care coordination programs for dual-eligible

beneficiaries cost between $150 and $195 per enrollee. However, Brown et al. (2012) concluded that programs could cost no more than $125 to $150 to realize savings. MCOOA must reduce hospitalizations for the dual-eligible beneficiary by 15 per 100 enrollees to realize net savings (Brown et al., 2012). Additionally, the dual-eligible population has 25% more chronic conditions than single-program recipients (Segal, Rollins, Hodges, & Roozeboom, 2014). Cleave et al. (2013) indicated multiple chronic conditions cause 98% of the federal health care expense. Moreover, the high incidence of medical, social, and mental health needs complicates care coordination for the dual eligible population. (Zainulbhai et al., 2014). Eggbeer et al. proposed that coordinating and integrating care for the dual-eligible could improve the quality of care and save $20 billion in expenditures.

The Coordinated Care Initiative (CCI) in California consists of participation from 8 counties: Alameda, Los Angeles, Riverside, San Bernardino, Orange, Santa Clara, San Diego and San Mateo (Cutler et al., 2013). Cutler et al. (2013) indicated that the CCI is limited to a 3-year demonstration project to determine the statewide implementation of unified state and federal health care benefits. Statistics reflects that 76% of dual-eligible beneficiaries are 65 and older, and 37% are people with disabilities (Cutler et al., 2013). The total dual population is approximately 1 million in California, of which, 223,084 are in the eastern county of Southern California (Cutler et al., 2013). There is a 200,000 cap on enrollment in the county (Cuter et al., 2013).

Fifteen states received a $1 million grant for the development of care management programs for beneficiaries enrolled in federal and state-sponsored health care programs

(Lindeblad, 2013). The purpose of a care management program is to reduce expenditures for the federal government and improve health outcomes for the dual population (Lindeblad, 2013). The dual-eligible rate of hospitalization is 26% compared to 20% for the single-program beneficiaries (Segal et al., 2014). Although hospitalizations are necessary to regain optimal functions, hospitalizations for conditions identified as an outpatient service are potentially avoidable hospitalizations (Wysocki et al., 2014). Zainulbhai et al. (2014) determined that 44% of the dual-eligible population require long term support services to address co-occurring conditions and social issues. Wysocki et al. (2014) indicated improved transitions and community services can reduce avoidable hospitalizations for the duals. Wysocki et al. explained the interconnectivity of medical and long-term care services requires payment reform to encourage providers to improve coordination of care and transition of care. Nevertheless, Segal et al. (2014) indicated 26% of the hospitalizations for the dual population were potentially preventable. Zainulbhai et al. (2014) indicated that new strategies developed through the federal demonstration projects are necessary to improve the quality of care, enhance access, and reduce administrative barriers for the dual-eligible population. However, Prindiville (2013) voiced a concern related to consumer protections to avoid new strategies that limit care for the vulnerable dual-eligible population.

Readmissions

Ouslander and Maslow (2012) indicated reducing preventable hospitalizations is a key initiative in achieving the objectives of TAM. Similarly, Hitch et al. (2016) stated that the capacity to control high readmission rates is where health care systems are

deficient in meeting TAM objectives. However, care coordination is a consistent theme in reducing the costs associated with readmissions (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014). Gohil et al. (2015) indicated that readmissions occur within one year for approximately 30% of hospitalized patients. Moreover, Hitch et al. noted that 1 in 5 beneficiaries enrolled in the traditional federal health care program readmit to an inpatient level of care, costing the federal program 26 billion dollars annually. Readmission is one of the key indicators of quality health care delivery (Hao et al., 2016). Hao et al. (2016) indicated that preventative measures for readmission include focusing on high-risk factors, strategic prevention strategies, and timely interventions for vulnerable populations. The readmission rate for beneficiaries enrolled in the traditional federal health care program is 20% and cost an estimated $17 billion (Fischer et al., 2014).

According to Vipperla et al. (2014), identifying the risk and reason for readmissions can reduce health care costs. Jiang et al. (2016) posited that readmissions are the result of lack of primary care incentive to reduce readmissions, fragmented health care, and poor access to care. Gohil et al. (2015) indicated that social determinants such as education and income level have a direct impact on the probability of readmission. Moreover, Dharmarajan et al. (2013) indicated that readmissions occur from generalized vulnerabilities post hospitalization that include new disabilities, nutritional deficits, sleep disturbance, and new medications. According to Picker et al. (2015), there is not a standard preventative method to deter readmission due to the complexity of identifying patients with a high risk of readmission. Likewise, Kahlon et al. (2015) indicated that

researchers and clinicians are unsuccessful in developing an algorithm to predict readmissions. However, Mittler et al. (2013) noted that improved care coordination during the transition from the hospital to an alternative level of care can prevent readmissions.

There is limited evidence-based literature to determine a particular methodology for transitional care interventions or identification of populations at greatest risk of readmission (Kripalani, Theobald, Anctil, & Vasilevskis, 2014). However, poor communication at the point of transition endangers the lives of older adults (King et al., 2013). The older adult is at greater risk for medication discrepancies at the point of care transition related to chronic conditions, comorbidities, functional impairments, and complex medication regimens (Coughlin, Waidmann, & Phadera, 2012). Kripalani et al. revealed there are various complexities to identifying specific interventions that affect readmission. Similarly, Johnson et al. (2013) reported the transitional care program elements include scheduling follow-up care, educating on the disease condition, and training on warning signs that could result in readmission. Feltner et al. (2014) indicated the focus on transitional care interventions improve readmissions by preventing adverse events related to poor care coordination. Moreover, McWilliams and Schwartz (2017) proposed that transitional care strategies include information technology, staff trained for transitional care, interventions delivered in a home environment, and action planning for inpatient and outpatient settings.

Although readmission is a significant portion of health care costs, health care leaders may debate the value of readmissions as an indicator of health care quality.

Additionally, Fischer et al. (2014) indicated there is a lack of evidence to support using readmission rates to measure the quality of hospital care. With the same vein, Parina, Chang, Rose, and Talamini (2015) indicated readmission is not an independent measure of quality based on the weak correlation to mortality rates. Gulati (2013) discovered 28% of readmission are based on individual behavioral factors; therefore, negating the use of readmissions as an indicator of hospital performance. Gu et al. (2014) determined the dual-eligible status of patients has an adverse impact on the readmission rates. Therefore, hospitals with high dual populations will receive a disproportionate share of readmission penalties (Gu et al., 2014).

Relationship to Previous Leadership Research

Leaders require education in cost-benefit analysis and developing models that can measure quality and cost (George & Shocksnider, 2014). In addition, leaders strategically plan the development of a business case to influence stakeholders to invest in new initiatives (Harvard Business Press, 2011). In the health care environment, a business case manages clinical and financial performance expectations and provides an analysis of the resources required for implementation (Song, McAlearney, Robbins, & McCullough, 2011). Health care leaders struggle with creating a business case for care coordination because the standard business model does not apply (Perry & Stevens, 2013). According to Wilf-Miron et al. (2014), health care leaders have difficulty determining the cost and savings associated with health care interventions to improve the quality of care. Perry and Stevens (2013) stated the organization's mission and drivers of profit margin are considerations when creating a business case. Creating the business case is necessary to

establish the value add for the proposed new initiative or for requesting resources for existing projects (Perry & Stevens, 2013). A business case provides documentation of the cost and benefits of potential investments (Maes, van Grembergen, & de Haes, 2013). The business case provides a critical, formalized document for evaluating the allocation of resources. The content of the business case can include an investment description, investment objectives, investment requirements, investment impact, investment risk, investment assumptions, and investment governance.

Health care leaders may lack strategies to garner support for care coordination programs for the dual-eligible population. In addition, leaders may lack strategies to reflect the effectiveness of care coordination programs. Kripalani et al. (2014) concluded there is a lack of evidence-based literature to support a particular method for leaders to reflect the benefits of implementing care coordination interventions. In addition, Wilf-Miron et al. (2014) indicated that there is a variation in the delivery of care coordination programs limiting the ability to do a cost analysis of the effectiveness. Similarly, Schuller, Kash, Edwardson, and Gamm (2013) indicated there is a gap in the literature defining how health care leaders enact organizational change. According to Wilf-Miron et al. , there is an abundance of research to support implementing quality initiatives based on performance indicators; however, there is a gap in the literature for leaders to use when reflecting the associated financial implications. Similarly, Marek et al. (2014) revealed a deficiency in the literature to defining how leaders reflect the cost-effectiveness of care coordination programs. Likewise, Wilf-Miron et al. pointed out the need for additional research on how leaders present a business case for implementation of

programs designed to address care for the complex population. Hong et al. (2014) noted that there is little evidence of the ability of care coordination programs to reduce net costs and demonstrate cost savings. According to Teut and Linde (2013), case study design is an effective approach to study a field where there is a deficiency of existing research.

Researchers may use qualitative strategies to extract information from leaders as key informants. Kash, Spaulding, Johnson, and Gamm (2014) employed qualitative strategies to research success factors used by health care leaders to implement change initiatives. Kash et al. used an open-ended interview process to engage participants in describing critical success factors and offered insight into the process of successful change implementation. In addition, Schuller et al. (2013) used qualitative strategies to explore factors that can enable or disable implementation of change initiatives amongst health care leaders and managers. Schuller et al. identified the use of a case study design to provide a deeper understanding of the factors for leaders to implement change successfully. Additionally, Brown et al. (2012) gave an analysis of four care coordination programs that produced neutral cost results for the federal health care program for the older adult. Brown et al. pointed out the need for health care leaders to control the cost of interventions to realize savings when developing new care coordination programs. According to de Waal et al. (2013), health care executives require evidenced based business strategies to support the use of scarce resources for quality improvement in health care.

Health care leaders in the position of manager, director, or vice president may use TAM framework to define transformational changes within the organizational structure.

Findley, Matos, Hicks, Chang, and Reich (2014) suggested TAM framework as a measure for leaders to determine the successful integration of community health workers into the care coordination team. Likewise, Ory et al. (2013) used TAM objectives for leaders to define the success of implementation of a care coordination program designed to support self-management of chronic conditions. Lucatorto, Watts, Kresevic, Burant, and Carney (2016) used TAM as the framework to determine the impact of the advanced practice registered nurses in the care coordination program. In this study, TAM is the conceptual framework to explore the strategies health care leaders positioned in the role of manager, director, or vice president use to increase the resource allocation for care coordination programs within a managed care setting.

I used a systematic approach to reviewing relevant journal articles and scholarly books to guide the literature review process. Moreover, I provided a comprehensive review of the literature on TAM, MCOOA, the Affordable Care Act, dual-eligible population, care coordination programs, and readmissions. The literature review supports the use of the qualitative research method to explore the strategies health care leaders use to improve corporate financial investment in care coordination programs that include TAM objectives.

Transition

In Section 1, I provided the foundation of the study to support the exploratory, single case study design. Additionally, the section included (a) the background of the problem, (b) the problem statement, (c) the purpose statement, (d) nature of the study, (e) research question, (f) interview questions, (g) conceptual framework, (h) operational

definitions, (i) assumptions, limitations, and delimitations, (j) significance of the study, and (k) the literature review. Section 2 is the detailed underpinnings of the qualitative, case study. The objective was to provide the reader with the case study protocol driving the research process. Section 2 contains a detailed account of the research process and includes (a) purpose of the research, (b) the role of the researcher, (c) eligibility criteria for participants, (d) research methodology, (e) research design, (f) population and sampling, (g) ethical research, (h) data collection instruments and technique, (i)data organization and analysis, and (j) reliability and validity. To conclude in Section 3, I discussed the research findings, recommendations, and reflections.

Section 2: The Project

Policymakers increased efforts to reduce state and federal health care expenditures by improving care coordination for the dual-eligible population (Gimm et al., 2016). The provisions of the ACA included opportunities to refine the delivery of services for the dually eligible. The challenge is in the ability of health care leaders to define the business strategies for new service models aimed at cost reduction (Song et al., 2011). Wilf-Miron et al. (2014) indicated the health care industry is inept in the development of strategies to support business initiatives. In Section 2, I describe the research purpose and provide a detailed account of the processes governing the framework of the study.

Purpose Statement

The purpose of this qualitative single-case study was to explore the strategies that health care leaders use to improve corporate financial investment in care coordination programs that include TAM objectives. The target population was health care leaders in the role of vice president or higher from one health care organization with experience implementing strategies to improve corporate financial investment for care coordination programs that included TAM objectives. The geographical region was Southern California. Health care executives may consider the data from this study as a contribution to social change if recommendations improve the quality of care for the dual-eligible population.

Role of the Researcher

As the researcher, my role was as the primary instrument for data collection. According to Hanson et al. (2011), the qualitative researcher is the primary instrument of study when collecting interview data. My relationship with the topic, participants, and area of study was that of an inside researcher. The inside researcher is a member of the organization of study (Greene, 2014). I chose the inside researcher role to have direct participant access and for a comprehensive understanding of the case study site. Greene (2014) noted that inside researchers benefit from knowledge of the environment, familiarity with participants, and access.

As the vice president of medical management, I possessed the knowledge of TAM principles, care coordination, and the managed care environment. In addition, I had an increased understanding of the business problem guiding the central research question and a direct, established working relationship with the participants. However, the participants were not subordinates. I interviewed leaders with accountability for work processes and allocation of resources. According to McDermid, Peters, Jackson, and Daly (2014), the advantage of a researcher employed by the research site is the understanding of the organization and preexisting relationship with the participants. Similarly, Blythe, Wikles, Jackson, and Halcomb (2013) indicated that inside researchers have an increased depth of understanding, access, and rapport.

The three guiding principles of ethical research identified in the Belmont Report provided the ethical foundation for the study. The role of the researcher is to ensure respect for persons, beneficence, and justice (McDermid et al., 2014). Researchers

preserve the respect of persons by communicating the voluntary nature of the study and providing information for informed decision-making (McDermid et al., 2014). The ethical considerations include obtaining informed consent, providing honest dialog regarding the study, and ensuring privacy and confidentiality (McDermid et al., 2014; Yin, 2014). In addition, researchers maintain beneficence by maximizing benefits and reducing harm (McDermid et al., 2014). Seidman (2012) indicated informed consent minimizes participant risks. I used the informed consent process to guide ethical research practices. To protect the confidentiality of the participants and reduce harm, I provided them with unique identifiers rather than using their names or initials.

As an inside researcher, my role in this study was to mitigate bias through the preservation of reflexivity. I mitigated bias and preserved reflexivity by using an interview protocol and avoiding leading questions in the interview process. Collins and Cooper (2014) indicated reflexivity is the initial process to determine how the view of the researcher may influence the research process and findings. Similarly, Blythe et al. (2013) indicated reflexivity is essential for inside researchers to reduce subjectivity and bias. I used an interview protocol to establish uniformity and avoid deviation in the line of questioning between participants (Appendix A). According to Jacob and Furgerson (2012), an interview protocol preserves the focus of the study and ensures consistency in the verbal exchange of information.

Participants

According to Barratt, Choi, and Li (2011), the experience of participants is critical in determining the practicality of the research findings. Song et al. (2011) used a case

study design with organizational leaders as the key informants to extract qualitative data. Likewise, Nicol, Mohanna, and Cowpe (2014) extracted information from senior health care leaders to determine their views on the skills of clinical leaders. Cohen et al. (2014) interviewed health care leaders to explore their understanding of the subject. In the current study, the participant selection criteria included health care leaders at the level of a vice president or above who used strategies to improve corporate financial investment in care coordination programs that included TAM objectives.

According to Greene (2014), an inside researcher has direct access to the organization of study as a member of the organization. Likewise, McDermid et al. (2014) indicated the inside researcher has access to the organization and an understanding of the site. Blythe et al. (2013) added that an advantage of inside research is the ability to gain access as a member of the community of study. I gained access to the organization as an inside researcher. I sent the letter of cooperation (Appendix B) that included a brief description of the study to the chief medical officer via e-mail and scheduled a meeting to obtain the signed letter of cooperation. After gaining the support of the chief medical officer, I e-mailed the potential participants the informed consent with a voting option to signify an agreement or disagreement with participation. The e-mail contained my direct e-mail and telephone contact for potential participant questions prior to giving consent. The informed consent included a description of the study and the disclosure information identified in the Belmont report.

The participants did not have a reporting relationship with me or any employee who reports to me. The participants were health care leaders in the position of vice

president or above who make or influence decisions about work practices and resource allocation within the organization. According to McDermid et al. (2014), a researcher employed by the research site develops an understanding of the organization and establishes a preexisting relationship with the participants. In addition, Greene (2014) noted that inside researchers benefit from the familiarity with participants and access. Likewise, Blythe et al. (2013) added that inside researchers take advantage of access, rapport, and depth of understanding.

Research Method and Design

I used the qualitative case study design to explore strategies for health care leaders to improve corporate financial investment in care coordination programs that included the TAM. According Bradley, Curry, and Devers (2007), qualitative researchers provide an understanding of the complexity and breadth of a phenomenon. The organizational phenomenon was the strategic processes health care leaders engage in to procure funding for care coordination programs for the dual-eligible population. Yin (2014) posited that a case study design can expand knowledge of organizational phenomena.

Research Method

Researchers apply a qualitative, quantitative, or mixed-methods approach based on the line of inquiry grounding the study. Moustakas (1994) indicated qualitative researchers seek to obtain meaning from the core of the human experience. Likewise, Denzin and Lincoln (2011) indicated qualitative researchers take an account of the participant's perspective through observations and interviews. Qualitative research

methods are ideal for identifying concepts and understanding phenomena (Bradley et al., 2007). According to Myers (2013), qualitative research methods are appropriate for exploratory, in-depth research on a topic that has limited existing research. Moreover, Myers indicated the qualitative method allows the researcher to reveal the context in which leaders generate decisions. I chose the qualitative method to explore strategies for health care leaders in the position of manager, director, or vice president to improve corporate financial investment for care coordination programs that included TAM objectives. I conducted face-to-face interviews at the case study site, free of experimental controls. The purpose of conducting the semi-structured interviews was to gauge the participants' experience and perspectives related to increasing resource allocation. Qualitative strategies were appropriate for this study because the method allowed for exploration of the decision-making process of health care leaders from the perspective of the participants.

Quantitative researchers use numerical data to test hypotheses (Yilmaz, 2013). Hanson et al. (2011) indicated quantitative researchers count occurrences and test hypotheses. Quantitative researchers disregard context to focus on statistical techniques to generalize findings (Myers, 2013). Because I focused on contextual content rather than statistical numbers to test hypotheses, the quantitative method was not appropriate. Investigators use mixed methods when the complexity of the research renders one method insufficient (Wisdom et al., 2012). According to Yin (2014), researchers employ mixed methods to address diverse research questions and to strengthen the data collected. Likewise, Palinkas et al. (2015) indicated researchers use mixed methods to explore a

research topic using qualitative methods and to test a hypothesis using quantitative methods. The qualitative method was appropriate for this study to extract the participant's insights and answer the central research question.

Research Design

The research designs prevalent in the literature include ethnography, phenomenology, and case study (Hays & Wood, 2011). Additionally, Barratt et al. (2011) indicated that researchers using the case study design to explore a phenomenon within the bounds of the case. Moreover, the researcher using a case study design outlines the questions and problems before conducting the study (Halaweh, 2012). Yin (2014) described three conditions for choosing case study methods: research questions that use *how* or *why* questions to explore operational connections, an environment free of behavioral control, and the use of current events. I constructed the research question to address an operational understanding of how health care leaders in the position of manager, director, or vice president within a managed care environment gain funding for care coordination programs. Research within a real-world context bounded by the managed care site supported the application of a case study design. Researchers using an ethnographic design focus on the culture of a group (Wolcott, 1999). Additionally, Hanson et al. (2011) indicated ethnography requires the researcher to interact with participants over an extended period in a setting where participants live. Moreover, in ethnography the researcher uses participant observations and develops ongoing relationships with the participants within a cultural framework (Watson, 2012). The ethnographic design was not suitable because the study did not occur over an extended

period to gain knowledge of a culture. I did not employ extended periods of participant observations as a data collection method, and I did not seek to develop continuous relationships with the participants.

Phenomenological researchers aim to understand the lived or perceived experiences of research participants (Tuohy, Cooney, Dowling, Murphy, & Sixsmith, 2013). Hays and Woods (2011) indicated phenomenological researchers aim to extract meaning from understanding the individual's conscious thoughts about a phenomenon. Moreover, Moustakas (1994) reported that phenomenological researchers approach the study of a phenomenon naively and without supposition. In this study, the focus was on the strategies employed by health care leaders to gain financial support rather than the subjective lived experiences of the participants. Therefore, the phenomenological design was not appropriate.

Hanson et al. (2011) indicated qualitative researchers collect and analyze data simultaneously to determine the point of saturation. According to Marshall, Cardon, Poddar, and Fontenot, (2013), saturation occurs when there is a lack of new information from the analysis of the interview data. Researchers achieve data saturation when there are consistent themes noted in the data analysis process (Burda, van den Akker, van der Horst, Lemmens, & Knottnerus, 2016). I achieved data saturation by interviewing participants until there were no new themes identified in the analysis.

Population and Sampling

The purposeful sampling method supports the selection of information-rich cases (Palinkas et al., 2015). Duan, Bhaumik, Palinkas, and Hoagwood (2015) indicated that

purposeful sampling is beneficial in capitalizing on scarce resources by identifying participants who can provide information to support the purpose of the study. Nicol et al. (2014) used purposeful sampling to gain insight from leaders involved in the key leadership agenda. Kash et al. (2014) conducted a qualitative single case study using purposeful sampling to extract the perceptions of health care leaders on evidence-based leadership. Likewise, Cohen et al. (2014) implemented purposeful sampling to gain information from health care leaders implementing population health strategies. I used purposeful sampling to identify the participants in this study. The participant selection criteria included health care leaders at the level of vice president or above who used strategies to improve corporate financial investment in care coordination programs. The sample size for the study was a minimum of six participants. Kelly (2010) noted that a sample size of six to 10 participants could be appropriate for qualitative research. Similarly, Barratt et al. (2011) indicated a sample of four to 10 is appropriate to capture the essence of the phenomenon. Robinson (2013) indicated an estimated three to 16 interviews is appropriate in qualitative research. However, there is no predetermined sample size for qualitative research methods (O'Reilly & Parker, 2013). Kelly posited that the depth of information determines the sample size for a qualitative study as opposed to a number based on a statistical calculation. Holloway and Wheeler (2013) indicated a large sample size is uncommon and can jeopardize the depth and specificity of qualitative research. Furthermore, the lack of new data determine the sample size (Marshall et al., 2013). I selected a sample size of six participants to gain the depth of information within a defined case study site. Data saturation occurs when no new

information emerges from the data analysis (O'Reilly & Parker, 2013). Marshall et al. (2013) indicated data saturation is the point when the data extracted become redundant. According to Burda et al. (2016), data saturation occurs when no new data emerge during data collection and analysis. I completed parallel processes of conducting interviews and analyzing the interview data to determine the point of saturation.

The participant selection criteria included health care leaders at the level of a vice president or above who used strategies to improve corporate financial investment in care coordination programs that included TAM objectives. The individual participant interviews occurred in a closed environment to reduce interruptions, ensure privacy, confidentiality, and accuracy of recordings. Moreover, I conducted the interview in a closed environment onsite based on the preference of the participant. Consideration of the actual setting is an essential step in the process of conducting interviews (Rabionet, 2011). According to Doody and Noonan (2013), an interview site without interruptions is integral to the data collection process. Furthermore, Kelly (2010) indicated the interview setting should be a mutually agreed upon location that is convenient for the participant.

Ethical Research

According to Seidman (2012), informed consent is the grounding principle of ethically based research practices. The participants received and return the informed consent form via email. I emailed the potential participants the informed consent with the voting option to elect either an agreement or disagreement with participation in the study. The email contained my direct email and telephone contact for participant questions prior to the giving consent. Schrems (2014) indicated that researchers use the informed consent

process to provide the participant information to make a determination on involvement (Schrems, 2014). Likewise, Wright (2012) indicated informed consent protects the rights of the participant and provides information on the research project. Seidman outlined the components of informed consent: (a) the invitation and explanation of the research study, (b) potential risks and benefits involved with participation, (c) rights of the participants, (d) confidentiality and privacy protections, and (e) Institutional Review Board (IRB) and researcher contact information.

To ensure compliance with ethical standards and principles, I aligned the informed consent with the components identified by Seidman (2012). The first element of the informed consent for this study included the invitation and details of the research study to provide participants material to make an informed determination on participation. There were no incentives offered to research participants. The next component contained verbiage to indicate potential risks and benefits to participation in the research study. The third component of the informed consent for this study included the rights of the participants and the voluntary nature of the study, including the right to withdraw at any point in the research process. Participants could withdraw via email at any point in the study. In the privacy and confidentiality section, I documented the process of de-identifying the organization, providing unique identifiers for participants, storing research documents in a steel, fire resistant locked lateral file cabinet for 5 years and storing electronic data in a password protected electronic database. The final section of the informed consent included my contact information.

The primary tools for establishing ethical research practices are the values and ethics of the researcher (Merriam, 2014). To ensure the ethical protection of participants, I adhered to the principles guiding ethical research practices and obtained approval from Walden University's IRB before conducting the research study. Furthermore, Morse and Coulehan (2015) indicated researchers protect participants by limiting information and avoiding demographic data. Therefore, I did not use participants' name, but a unique identifier that consisted of an alphanumeric combination. The participant data excluded the demographic data, department, and title of participants to maintain confidentiality.

Data Collection Instruments

I was the primary data collection instrument in the research study. Peredaryenko and Krauss (2013) indicated that the researcher is the primary data collection instrument in qualitative research. Likewise, Chan, Fung, and Chien (2013) noted qualitative researchers are the primary instrument in data collection, data analysis, and the interpretation of findings. Hanson et al. (2011) noted that qualitative researchers are the primary instrument of the study, in that, the researcher takes note of verbal and nonverbal communication during the interview process and explores emerging thoughts.

The semistructured interviews and company documents were the data collection instruments for this study. The semistructured interview allows for flexibility in the order of questions to ensure sufficient exploration of the research question (Rowley, 2012). The flexibility applied to semistructured interviews enables the researcher to engage the participant to elicit a complete response (Saleem et al., 2014). Furthermore, researchers using semistructured interviews can guide the participant through the participant's

experience (Kelly, 2010). The next data collection instrument was company documents. The documentary evidence will consist of minutes from managed care meetings, financial performance meetings, business operations meetings, utilization management meetings, and strategic planning meetings. Yin (2014) indicated document evidence can substantiate or expand on other lines of evidence in the case study design. Myer (2013) indicated meeting minutes from the organization of study provides documents relevant to the research topic. Moreover, Ritchie, Lewis, Nicholls, and Ormston (2013) noted that meeting minutes are pre-existing documentary evidence that will have pre-established topic-based sorting to support data analysis.

I used an interview protocol as a guide to provide uniformity when conducting the interview (Appendix A). Jacob and Furgerson (2012) indicated the interview protocol describes the pre-interview statements, post-interview statements, and provides written cues and prompts to remain on topic and ensure participants clearly define abbreviated terms. According to Rowley (2012), the interview questions within the interview protocol may contain 2 to 4 prompts to ensure sufficient response. Prompting within the interview protocol allows the participant to expound on answers and provide the researcher with an increased understanding (Doody & Noonan, 2013).

I included the interview protocol elements identified by Jacob and Furgerson (2012). The pre-interview section of my interview protocol contained prompts for establishing the appropriate setting for the interview, rapport building, informed consent, and recording devices. The interview section of the protocol included scripting prompts for an introduction to the research study. Moreover, the interview section included the

interview questions. I entered prompts to document verbal and non-verbal notes within the interview protocol. Next, the interview protocol for this study included a post-interview section to ensure participants received an explanation of subsequent communication and my email contact information. The final section of the interview protocol was the member check process. According to Jacob and Furgerson, researchers use the interview protocol as a procedural guide when conducting the interview.

The interview protocol contained the member check section, which included the interview questions, synthesized responses, verification of the accuracy of responses, additional information from the participant, and a section for follow-up questions (Appendix A). I used the member checking process to increase the reliability and validity of the interview data. According to Burda et al. (2016), member checking can increase the trustworthiness of the research by allowing participants to check for accuracy of the researcher's interpretations. Similarly, Harper and Cole (2012) pointed out that the member checking process reduces errors in the data and the interpretation of the data. According to Caretta (2015), member checking promotes mutual respect with participants and preserves the authenticity of the research. After conducting the initial interviews, I conducted the member check process by completing my transcript interpretations and conducting second interviews to validate the responses. In addition, the participants will receive a printed copy of the interview questions and my synthesized responses.

Data Collection Technique

I used a paper-based interview protocol to collect the interview data (Appendix A). According to Jacob and Furgerson (2012), researchers use the interview protocol as a

procedural guide to collect interview data. Likewise, Rowley (2012) indicated that the prompts within the interview protocol guide the researchers through the data collection process. Doody and Noonan (2013) noted that the interview protocol supports the depth of understanding by providing prompting to expand on interview questions. The interview protocol contained the pre-interview, interview, post-interview, and member checking sections (Appendix A).

The interviews occurred in a closed environment to promote privacy and confidentiality. In addition, the participant received a unique identifier to maintain confidentiality. I recorded each interview using a digital voice-recording device. The participant received a written copy of the interview questions to provide a visual review of the questions. I allowed a minimum of one hour for the interview and ample time for the participant to answer each interview question, adhering to the protocol prompts and time management. During the interview, I documented nonverbal cues on the interview protocol and recorded post-interview thoughts for reflexive journaling. Additionally, the participant received an explanation of subsequent interview requirements and my contact information following the interview.

Yin (2014) indicates using multiple sources of evidence is an advantage of the case study design. The main advantage of interview data is that interviewing allows the participant to vocalize experiences (Rowley, 2012). Moreover, interviews allow the researcher to increase the complexity of questions, probe for details, provide clarification of questions, and ask open-ended questions about the emergence of data (Doody & Noonan, 2013). Doody and Noonan (2013) indicated the disadvantage of collecting

interview data is that interviews are time-consuming and susceptible to bias due to the participant's desire to answer questions to appease the researcher. Similarly, Rowley (2012) indicated the time constraints require researchers to collect data from a small participant base reducing the generalization of the research findings.

The next data source included the collection of company documents. The documents consisted of minutes from meetings relevant to the research topic. I developed a list of meetings pertinent to the study based on past meeting minutes. In addition, I reviewed relevant data extracted from meeting minutes during the interview to allow participants the opportunity to expand on the company documents. The document data consisted of paper documents and online documents.

Documents as an additional source of data are advantageous and allow for an economical and accessible means of discovering emerging themes (Merriam, 2014). In addition, documentary evidence serves as a means of validating data retrieved from other sources (Yin, 2014). Ritchie et al. (2013) indicated documentary evidence allows for ease of sorting by topic. However, Merriam (2014) indicated a limitation of documents is the potential for misalignment and difficulty in authentication. Ritchie et al. noted documentary evidence potentially limit the application to research due to preexisting purposes. Yin (2014) added that although documentary evidence is pertinent to the case study design, author bias is a potential disadvantage.

Burda et al. (2016) noted that researchers use member checking to provide an accurate account of the participant's meaning. Likewise, Harper and Cole (2012) indicated member checking is a means to reduce the probability of inaccurate data

interpretations. Moreover, member checking increases the credibility of the data by having the participant validate the accuracy of the researcher's interpretation (Caretta, 2015). I conducted an additional interview for the member checking process. The participants received the interview questions and my synthesized responses to validate the accuracy of the data interpretation. I audio recorded the interview and asked that the participant clearly state if the interpretation is correct. In addition, the participant had approximately one hour to provide additional information and to ask follow-up questions. I clarified discrepancies identified and validated the accuracy of the changes during the member check interview.

Data Organization Technique

In this study, the principal organization tool is the interview protocol. According to Doody and Noonan (2013), researchers use the interview protocol to organize data for the interview process to assist in extracting pertinent information from participants (Doody & Noonan, 2013). Likewise, Jacob and Furgerson (2012) indicated that the interview protocol is a procedural document that organizes the interview process and data collected. In addition, researchers use an interview protocol to organize data in preparation for the analytical phase of the research process (Rabionet, 2011).

As the primary instrument of the research study, the additional data organization processes included reflexive journaling and a research log. Researchers use a reflexive journaling to document preconceptions that may influence the research process (Tufford & Newman, 2012). Furthermore, reflexive journaling documents the personal experiences and beliefs of the researcher (Berger, 2015). According to Ward, Furber,

Tierney, and Swallow (2013), researchers use reflexive journaling to record ideas and decision-making. I employed the use of reflexive journaling to document thoughts and perceptions prior to and during the research process. According to Merriam (2014), qualitative researchers use research logs to make note of obstacles and ideas stemming from the data collected. Likewise, Yin (2014) indicated that researchers use notes to document preliminary data interpretations. Ritchie et al. (2013) indicated that researchers use a log to keep track of emerging analytical thoughts. I used a research log to document emerging conclusions from the data. In addition, I labeled and categorize the research log entries based on notes documented from interview and company documents. I stored the data in a steel, fire resistant locked lateral file cabinet for 5 years.

Data Analysis

Yin (2014) identified multiple sources of evidence as a core principle of data collection in the case study design. Therefore, I used methodological triangulation to analyze data using multiple data collection methods. According to Hussein (2015), triangulation entails analyzing the research question from multiple vantage points to establish research validity. Moreover, triangulation is a strength in the application of a case study design (Houghton, Casey, Shaw & Murphy, 2013). According to Carter et al. (2014), researchers establish methodological triangulation by using multiple data collection methods to research a phenomenon. Furthermore, Bekhet and Zauszniewski (2012) indicated that methodological triangulation allows the researcher to explore the phenomenon by using multiple qualitative strategies or multiple quantitative strategies, not a combination of the two. The data collection techniques for methodological

triangulation included interview data and company documents. The documentary evidence consisted of minutes from managed care meetings, financial performance meetings, business operations meetings, utilization management meetings, and strategic planning meetings.

Data analysis is the process of transforming data from the descriptive process to a level of interpretation (Vaismoradi, Turunen, & Bondas, 2013). Moreover, researchers separate text data and make logical connections to make inferences from raw data during the data analysis phase (Wahyuni, 2012). Thematic analysis requires the researcher to become familiar with data by transcribing, reviewing data multiple times, and noting ideas (Vaismoradi et al., 2013). In addition, Bradley et al. (2007) indicated reviewing the overall data without coding is the initial step in comprehending data. First, I reviewed the data multiple times to familiarize myself with the information. Following the data review, I employed the use of NVivo11 memo links to journal my thoughts and ideas.

I used NVivo11 as the software to guide the sequential process for data analysis using coding, mind-mapping, and identification of themes. NVivo11 is the most recognized Computer-Assisted Qualitative Data Analysis Software tool (Zamawe, 2015). Houghton et al. (2013) supported the use of NVivo11 to analyze observation, interview, and documentary evidence in a case study research design. In addition, Bernauer, Lichtman, Jacobs and Robinson (2013) indicated that researchers could use NVivo11 to support the critical thought processes involved in analyzing data. In addition, I used NVivo11 to determine commonalities by linking the key themes from the data with the conceptual framework, existing literature, and literature published after the proposal

approval date. According to Zamawe (2015), NVivo software can organize data based on the purpose. In addition, Bernauer et al. (2013) indicated NVivo software aids in the analysis process by organizing data based on themes and relationships. Moreover, Houghton et al. noted NVivo is a data management tool that researchers use to provide a comprehensive audit trail. First, I imported the text from the reflexive journal to the source folder. Then, I organized the reflexive journaling according to the assigned participant or assigned company document. I imported the company document files into the source folder titled Company Documents. I labeled the company documents based on the type of meeting. The meeting types included managed care meetings, financial performance meetings, business operations meetings, utilization management meetings, and strategic planning meetings. Next, I imported the audio files from the initial interviews into the source folder titled Interviews. I listened to audio files and transcribed the data within NVivo11. I added a node to assign the unique identifier to the participant interview to capture the response by participant. I reviewed the transcriptions three times prior to coding.

Yin (2014) indicated that the coding process is an essential phase of data interpretation for qualitative research. Moreover, Elo et al. (2014) indicated that qualitative researchers must code and interpret data using a structured approach. Thematic analysis is a structured data analysis strategy of using codes, themes, and theory (Bradley et al, 2007). I queried the data based on the 100 most frequent words with four characters or more for open coding and thematic analysis. Bohren et al. (2014) indicated that researchers use open coding to establish broad codes from the research

data. Likewise, Wolfswinkel, Furtsmueller, and Wilderom (2013) noted that researchers apply open coding strategies to extract concepts from the data. Kolb (2012) posited that researchers use open coding to identify different categories within the data. The analysis process included the use of the NVivo11 coding stripes to provide documentation of the coded sections of the interview and document data. The next process included the NVivo11 tag cloud visual diagram feature to illustrate the themes based on the word frequency for axial coding. Axial coding is the process of using the categories identified in open coding to identify the main themes of a research study (Wolfswinkel, et al., 2013). Kolb indicated that researchers use axial coding to establish connections between the codes revealed during the open coding phase. Similarly, Bohren et al. (2014) indicated that qualitative researchers use axial coding to separate data into themes. The final step was to use the interview data and document data to create a visual chart of the themes identified for methodological triangulation and selective coding. According to Wolfswinkel et al. (2013), selective coding is the process of refining themes identified in the axial coding phase. Likewise, Kolb indicated that researchers use selective coding to further identify, connect, and validate core themes. King et al. (2013) noted that researchers validate conclusions using selective coding to verify patterns. The data collection and data analysis process occurred simultaneously to establish the point of data saturation.

Reliability and Validity

Reliability

Dependability is the quality indicator used to establish reliability (Houghton et al., 2013). The measure of quality in qualitative research depends on the documentation of research processes, the analytical procedures, and the thought processes of the researcher (Mertens, 2014). Dependability reflects the stability and accuracy of the research data (Houghton et al., 2013). Furthermore, Thomas and Magilvy (2011) noted dependability as the extent to which other researchers can follow the decision-making processes.

According to Houghton et al. (2013), NVivo11 software reflects the thematic analysis process and provides an internal audit of findings. Although changes can occur in the qualitative research method, researchers establish dependability by documenting the changes for public auditing (Mertens, 2014). Moreover, researchers use a structured audit trail to create dependability (Houghton et al., 2013). I provided a detailed account of the research purpose, participants, research method, research design, population and sampling, consents, data collection, data organization, and data analysis to establish dependability and provide an audit trail. I used NVivo11 software to reflect the data analysis and path of decisions used to reveal themes. Additionally, I documented in the member checking section of the interview protocol the changes to participant responses to provide an audit trail of the response verification process and establish dependability.

Validity

The specific quality indicators used to establish validity include creditability, transferability, and confirmability (Wahyuni, 2012). Establishing credibility involves

processes that supports the researchers in ensuring interpretations are accurate and easily recognized by those within the industry of study (Lohle & Terrell, 2014). I used member checking of the interview responses to establish credibility. Member checking increases credibility by allowing the participant to verify the accuracy of the researcher's interpretations of the interview data (Caretta, 2015). Likewise, Burda et al. (2016) indicated researchers use member checking to ensure accurate conveyance of the participant's meaning. Additionally, Harper and Cole (2012) indicated member checking is a means to reduce the likelihood of inaccurate data or erroneous data interpretations. The member checking section of the interview protocol included the participant's validation of my synthesized responses. To further establish credibility, I used interviews and company documents for methodological triangulation. The advantage of using methodological triangulation is in the confirmation of research findings, the expansion of data available for analysis, and the increased validity of the study (Bekhet & Zauszniewski, 2012). Carter et al. (2014) indicated that researchers use methodological triangulation to establish the credibility of findings by confirming findings between sources of evidence. Likewise, Bekhet and Zauszniewski (2012) noted that methodological triangulation augments validity and supports the confirmation of findings. According to Hussein (2015), researchers use methodological triangulation to improve credibility. I compared themes identified in the documentary data and the interview data collected to discern methodological triangulation.

Black, Palombaro, and Dole (2013) indicated that investigators use transferability to establish the trustworthiness of research. Moreover, transferability is the extent to

which the research findings of a research study can apply to different settings (Elo et al., 2014). Houghton et al. (2013) indicated the overarching aim of establishing transferability is for the reader to determine the applicability of research findings and methods to different settings (Houghton et al., 2013). Moreover, Wahyuni (2012) noted that researchers use detailed descriptions of the case study site to improve transferability of research processes to other settings. Thomas and Magilvy (2011) specified that researchers establish transferability by providing rich descriptions of the population. To achieve transferability, I used a research log and provided thick descriptions of the phenomenon, case study site, participant criteria, research processes, and findings to allow readers to determine the applicability to different settings. In addition, I used an interview protocol and ensured adherence to the data collection and data analysis techniques for the case study design.

The predominant role of creating confirmability is to establish the reliability of the findings by ensuring the findings do not represent the views of the researcher (Tong & Dew, 2016). The confirmability process reduces bias by providing transparency through reflexivity (Thomas & Magilvy, 2011). Furthermore, Wayhuni (2012) indicated that confirmability allows others to confirm that research findings are an accurate conveyance of participant views versus the opinion of the researcher. I used NVivo11 software to demonstrate confirmability through query searches to demonstrate findings are beyond the investigator's determination. According to Collins and Cooper (2014), researchers use emotional reflexivity to reveal the predispositions of the researcher and to reflect self-awareness. I documented preconceived thoughts using reflexive journaling.

Moreover, Thomas and Magilvy (2011) added that self-awareness of potential bias and documenting preconceptions establishes trust and confirmability. Likewise, Houghton et al. (2013) indicated documenting any personal thoughts or insights establishes reflexivity. I used reflexive journaling following each interview to document personal thoughts or feelings.

Data saturation occurs when no new concepts emerge from data analysis (Marshall et al., 2013). According to O'Reilly and Parker (2013), data saturation determines the adequacy of the sample selected. Data saturation is the point where researchers note uniformity in codes and themes (Burda et al., 2016). Data saturation occurred following the fifth interview. There was no new information emerging from the interviews and company documents.

Transition and Summary

In Section 2, I presented the rich description of the research purpose and processes. The section includes the role of the researcher, the participant selection process, and justification for the population and sampling. Section 2 included a detailed account of the ethical principles guiding the research. There is an expansion of the rationale and scholarly justification for using the qualitative research method and case study design. I included thick descriptions of the data collection instruments, data collection techniques, data organization, and data analysis to support the external auditing of processes. The final components of Section 2 consisted of the methods to achieve reliability and validity through establishing dependability, creditability, transferability,

and confirmability. In Section 3, I included the research findings, recommendation for action, and future research considerations.

Section 3: Application to Professional Practice and Implications for Change

Introduction

The purpose of this qualitative single case study was to explore the strategies that health care leaders use to improve corporate financial investment in care coordination programs that include TAM objectives. Section 3 consists of the (a) presentation of findings, (b) application to professional practice, (c) implications for social change, (d) recommendations for action, (e) recommendations for future research, and (f) reflections. The data extracted from the semistructured interviews revealed the overall strategies to garner support for care coordination programs. According to Wilf-Miron et al. (2014), decision-makers expect leaders to present a return on investment for improvement in health care. The health care leaders interviewed noted the importance of using data to demonstrate a decrease in health care costs of care coordination programs. Health care leaders also indicated that the structure of the care coordination program must align with the organization's strategic mission. Whittington et al. (2015) indicated that the success of deploying the TAM depends on the integration of the key tenets with the organizational structure. Participants in the current study also indicated that leaders must focus on the high-needs, high-cost populations. Whittington et al. pointed out that health care leaders must complete a population assessment to select populations in which the three objectives of TAM apply. Finally, participants in the current study indicated that leaders must work in partnership with primary care practices for interprofessional collaborative practice.

Presentation of the Findings

The central research question for this study was as follows: What strategies can health care leaders use to improve corporate financial investment in care coordination programs that include the TAM objectives? I used semistructured interviews and archival documents to collect data for this study. I analyzed the data using NVivo 11. The four themes that emerged from my analysis included (a) reflecting a reduction in health care cost, (b) focusing on high-need, high-cost populations, (c) partnering with primary care practices, and (d) patient-centered care.

Theme 1: Reducing Health Care Costs

The key tenets of the TAM include reducing per capita health care costs, improving patient experience, and providing population health (Bodenheimer & Sinsky, 2014). Although there are evidence-based care coordination methods that provide high value, health care leaders lack the funding source for implementation (Rowe, Fulmer, & Fried, 2016). The most common strategy to obtain financial support was indicating how investing in care coordination programs can reduce the overall costs for the organization. Six (100%) participants indicated that cost reduction is a critical strategy to improve investment in care coordination programs. However, the specific cost reduction strategy differed among participants. As depicted in Figure 1, participants with more than 20 years of experience recommended specific measures for cost reduction at a higher frequency than participants with less experience. The data indicated that participants with less than 20 years of experience referenced generalized cost savings with greater frequency than participants with more than 20 years.

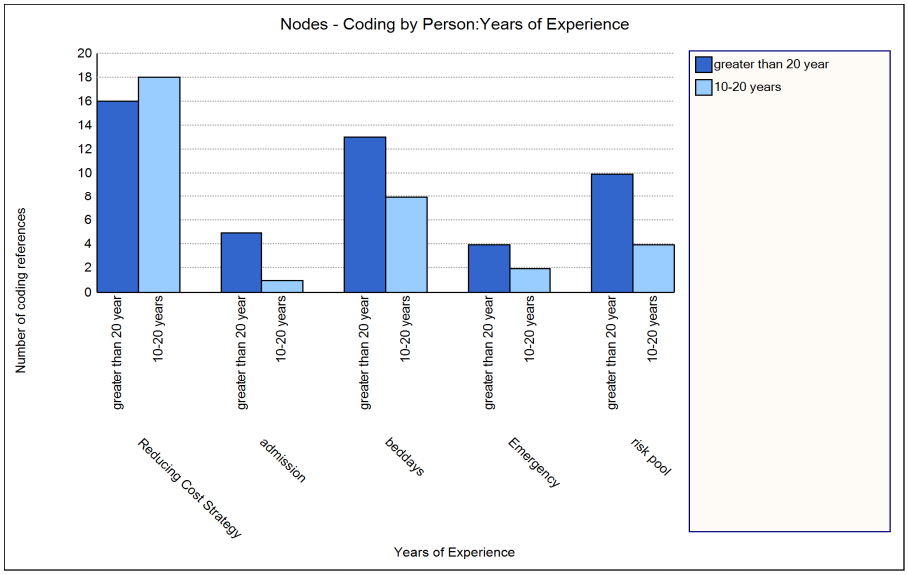

Figure 1. Cost reduction strategy coding by participant.

All participants indicated the capacity of the care coordination program to reflect a cost saving is a critical strategy. Six (100%) participants identified hospital utilization as a cost driver that warrants data analysis and strategic planning for the structure of care coordination programs. According to Brown et al. (2012), MCOOA must reduce hospitalizations by 15 per 100 participants to realize net savings. Likewise, Ouslander and Maslow (2012) noted that reducing hospitalization is a key initiative in achieving the TAM. One participant in the current study pointed out that leaders should resist the urge to cite the TAM, but should clearly define the organizational measures that will affect the TAM objectives. The specific hospital utilization data identified were bed days, admissions, readmissions, emergency visits, and inpatient risk pool performance. All participants in this study referenced bed days as a measure for consideration when developing strategies for care coordination supports. Five (83%) participants referenced

inpatient risk pool data as an element to reflect the performance of a care coordination program. Hitch et al. (2016) stated that controlling readmissions is a key element of achieving the TAM objectives. Similarly, 67% of the participants in the current study referenced readmissions as a key cost consideration. In the table below, I indicate the frequency of principle metrics and the weighted percentages.

Table 2

Principle Metric Reference

Metric	Total number of references	Weighted percentage
Risk pool performance	15	.95
Bed days	20	.90
Readmission	11	.50
Emergency visit	6	.27
Admissions	6	.27

Song et al. (2011) indicated that the business case for care coordination defines the clinical and financial performance expectations for program implementation. Five (83%) of the participants indicated that leaders should understand financial data from health plan risk pools to use as a strategy to garner fiscal support. According to 33% of the participants, leaders seeking to present a strong case for monetary support must use financial trends to reflect gains versus depending solely on clinical benchmark metrics. However, de Waal et al. (2013) revealed that health care leaders might not have the competencies to develop a business case presentation to support the implementation of new strategies. The participants in the current study revealed two strategies to address gaps in competency. Four (67%) of the participants indicated that leaders could use external consultants as a strategy to garner support and capture data on care coordination

practices within the industry. One (17%) of the participants noted that leaders could capitalize on internal business units that focus on workforce strategic planning to provide data on cost considerations and return on investment for program implementation.

McGinley and Gabbay (2016) identified the total cost per member per month as a measure used to determine cost savings when transforming health care delivery models. McWilliams and Schwartz (2017) pointed out that services and cost of care increase with care coordination programs. Four (67%) of the participants in the current study identified per member per month costs as a relative indicator to determine cost savings. One participant indicated that per member per month data should be reflective of the financial risk model of the MCOOA. According to 33% of the participants, executive leadership understands the per member per month payment methodology, and health care leaders should present cost analysis in a format familiar to the intended audience. Four (67%) of the participants indicated that ensuring senior leadership understands the key metrics and the managed care environment is a key strategy to garner financial support.

Theme 2: High-Need, High-Cost Population Focus

Blumenthal, Chernof, Fulmer, Lumpkin, and Selberg (2016) indicated that health care leaders improve the system of health care by concentrating on the high-need, high-cost (HNHC) population. Four participants (67%) in the current study noted that strategies to garner support should include how health care leaders intend to influence the HNHC population and reduce cost. Blumenthal et al. posited that the HNHC individuals are 5% of the population and account for 50% of the expenditures. Four (67%) of my participants concurred that there is a disproportionate share of the cost attributed to a

small population. In addition, the participants revealed that a focus on the HNHC patients allows leaders to track and trend data to present the return on investment for a small population. Care coordination programs that focus on the HNHC populations have the capacity to meet the TAM objectives (Larson, Hoffman, & Artman, 2017). Four (66%) of the current study participants reported that a successful business practice to garner financial support and to address the overall TAM is to present strategies to address the HNHC population, further confirming findings from the existing literature on HNHC populations.

As shown in Figure 2, participants at the level of vice president with fewer than 20 years of experience referenced HNHC at a greater frequency than other participants. All participants considered the dual-eligible population as a HNHC population. I confirmed the findings related to the dual-eligible population reflecting a HNHC population through recent literature. According to Ortega (2016), the dual-eligible population has a higher incidence of chronic illness and higher costs. Similarly, Doyle, Emmett, Crist, Robinson, and Grome (2016) indicated that the dual-eligible population has a greater frequency of being poor, disabled, sick, and mentally ill compared to beneficiaries of a single health care program.

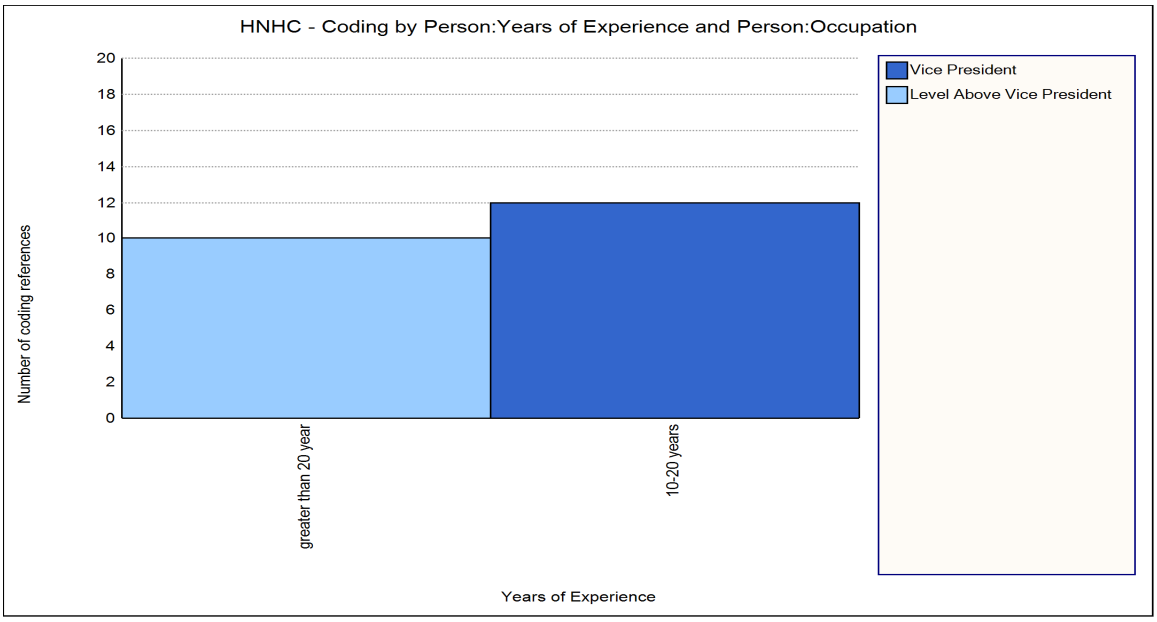

Figure 2. High-needs, high-cost frequency by participant.

The care delivery model for the HNHC population should include a multidisciplinary approach to providing services (Hochman & Asch, 2016), confirming the finding for 83% of the participants in the current study. Specifically, 5 (83%) of the participants stated that health care leaders should specify that the HNHC population requires interprofessional collaboration to impact cost. Jette (2016) indicated that the characteristics of the HNHC population include three or more chronic conditions and functional deficits. Moreover, Jiang et al. (2016) posited that the economically disadvantaged populations have multiple factors beyond medical conditions that influence health. Factors such as housing, access to food, transportation, and health literacy affect readmission rates (Alvarez, Ginsberg, Grabowski, Post, & Rosenberg, 2016). Aligned with the TAM objectives, Taylor et al. (2016) noted that social determinants of health are integral in influencing population health and improving quality

outcomes. Five (83%) of the participants in the current study identified a partnership with primary care as a strategy for fostering support for care coordination programs aimed at the HNHC population.

Theme 3: Partnership With Primary Care

Capital spending has an impact on the operating budget of health care organizations, requiring health care leaders to make investments that reflect value and improve population outcomes (Klein, Brown, & Detsky, 2016). Transforming the health care delivery system to focus on cost and quality requires concentration on the role of primary care providers (Miller et al., 2017). A strategy shared by 83% of the participants in the current study included a partnership with primary care practices due to the ability of primary care to lead cost containment strategies. Mostashari (2016) confirmed this strategy by indicating that the decisions of the primary care physician impact 85% of the cost of care; however, independent primary care providers may lack the financial resources to invest in the technological advances, analytics, and human resources required to provide value-based care. When reviewing the recent literature, I was able to confirm that there is an opportunity to garner financial support for care coordination programs through the partnership with primary care. Three (50%) of the participants in the current study indicated that health care leaders should use innovative strategies to integrate with primary care to meet the TAM objectives. Maciosek (2017) indicated that primary care providers could align with value-based preventative measures to meet the TAM objectives.

Theme 4: Patient-Centered Care

According to McWilliams and Schwartz (2017), care coordination programs have a positive impact on patient experience. Farmanova et al. (2016) noted that care coordination is a critical factor in providing patient-centered care. Likewise, Rowe et al. (2016) posited that outcomes-based performance metrics centered on the patient and family are necessary to define effective care management programs. When reviewing the literature, I confirmed the findings that patient experience is a defining strategy when garnering financial support for care coordination programs. Five (83%) participants in the current study agreed that the perception of the patient population is a critical factor when gaining support for care coordination programs. However, Farmanova et al. noted that presenting patient experience data for a population is more difficult that collecting data at a project level. According to one participant in the current study, patient-centered care requires a comprehensive training process to develop care coordination practices among team members.

Findings Related to the Triple Aim Model

The research findings were consistent with the TAM. The TAM objectives include reducing per capita costs, achieving population health, and improving the patient experience (Bodenheimer & Sinsky, 2014). According to Ryan, Brown, Glazier, and Hutchison (2016), the predominant goal of the TAM is to accomplish the three objectives simultaneously. The themes identified in the current study indicated successful approaches used to populate the TAM framework. The findings reflect that the tenets of

the TAM are key in presenting strategies to garner support for care coordination programs.

The TAM is essential in identifying strategies to reduce health care waste and decrease costs (Coyne et al., 2016). Although medical care accounts for 10% to 20% of the factors driving heath status, health care leaders attribute 88% of health care spending to providing medical care (Zangerle, Harris, Rimmasch, & Randazzo, 2016). All participants in the current study identified a reduction in health care cost as the most successful strategy used to foster support for care coordination resources. Also, the participants in this study identified medical care based measures to populate the TAM objective of reducing health care cost. Therefore, based on the research findings, successful strategies for garnering support for care coordination programs address the component of health care that accounts for the largest percent of spending. On the other hand, Zangerle et al. (2016) indicated that effective programs must address the upstream social factors that have the greatest impact on health outcomes.

Defining the needs of the population is a core requirement for achieving the TAM objectives (Farmanova et. al, 2016). According to Farmanova et al., health care leaders define the population by a common need within a geographical region or by a distinct population driven by business requirements. Whittington et al. (2015) noted that health care leaders must choose populations whereby the three objectives of TAM apply. The participants in the current study revealed the HNHC population as the population health care leaders should address when appealing for financial support. Also, Kindig and Isham (2014) posited that population health requires the collaboration of numerous

organizations to influence the social and physical determinants of health. Farmanova et al. posited that organizational leaders must form cross-sector partnerships to implement programs designed at meeting the TAM objectives. The research findings included the partnership with primary care practice as a successful strategy to gain resource allocation for care coordination program. The participants confirmed that health care leaders should seek alliances with organizations to impact the TAM objectives.

According to Harder et al. (2016), measuring the TAM objective of patient experience is a critical component in efforts to change the delivery of health care. Cook et al. (2015) revealed that efforts to improve health outcomes must take account of patient experience feedback to guide quality initiatives. Moreover, Ryan et al. (2016) indicated that health care leaders could use patient surveys to establish a quantitative measure of the patient experience TAM objective. The participants revealed an opportunity to use patient experience surveys to provide feedback to senior executives regarding the effectiveness of care coordination programs. The participants indicated that a strong alignment with the patient-centered mission of the organization is

Applications to Professional Practice

The most prevalent finding relevant to the professional practice of business was defining the ability of care coordination programs to reduce health care cost. The finding is important to the practice of business because it provides a mechanism to garner financial support for care coordination grounded in cost control strategies. In review of recent literature, cost control was a critical factor in the development of care coordination programs and aligns with the TAM. Miller et al. (2017) indicated that reducing cost and

improving the quality of care require health care leaders to invest in the transformation of the health care delivery system.

Ellner and Phillips (2017) noted that health care leaders have the capacity to lead the effort to transform the health care industry to provide high quality care at a sustainable cost by focusing on the transformation of primary care practices. Similarly, Cross, Cohen, Lemak, Adler-Mil-Stein (2017) indicated that policy leaders focused on primary care to impact the cost and quality of health care. However, transitioning the primary care model requires human resource investment and defined interprofessional practices to reduce fragmentation and influence cost (Zink, Kralewski, & Dowd, 2017). Mostashari (2016) added that primary care providers may lack the resources to invest in value based care. Moreover, Whittington et al. (2015) posited that provider payments lack incentives for providers to decrease the cost of health care. The findings are relevant to the professional business practices, in that, the participants revealed that a strategic alliance with primary care has the capacity influence investment in care coordination and impact health care costs. Moreover, the research participants revealed an opportunity to align with primary care practices and support incentives that encourage primary care physicians to reduce costs associated with hospitalizations and emergency room utilization.

Reinhard (2013) posited that managed care leaders with the capacity to coordinate care for high-risk populations would increase profitability and market share. Therefore, health care leaders could develop strategies to garner support for care coordination based on methods to improve profitability. Cross et al. (2017) indicated that health care leaders

focus on improving health care cost by targeting the HNHC population that consume a disproportionate share of health care services. Similarly, Jette (2016) indicated that the HNHC population account for an approximate 50% of the total health care cost. In relation to the applicability to the professional practice of business, the research participants revealed that health care leaders should focus on the HNHC population when presenting strategies for care coordination. In addition, the participants revealed that a focus on the HNHC population provides a targeted approach to reveal a return on investment for care coordination for a high cost group. Also, the research participants indicated that the cost control data varies based on the maturity of the organization. Less mature organizations might require health care consultants to conduct an environmental scan to provide cost-effective strategies for care coordination. Health care leaders may consider this finding critical to the professional practice of business because the maturity of the managed care organization may influence the strategies required to garner financial support. According to recent literature, the strategies health care leaders deploy are highly dependent upon the organizational structures and processes (Aveling, Martin, Herbert, & Armstrong, 2017).

According to Miller et al. (2017), the United States health care costs are approximately $2.9 trillion and are not tantamount to an increase in quality. Health care leaders use TAM to describe the health care agenda for systematic changes for cost control (Bodenheimer & Sinsky, 2014). However, recent literature reflects that health care leaders struggle with the practical application of the TAM objectives due to the diverse comprehension of the relationship between quality and cost (Storkholm,

Mazzocato, Savage, & Savage, 2017). The findings are relevant to the professional practice of business, in that, the participants in the current study provided health care leaders a method to align the request for resource allocation with the TAM objective of reducing cost.

Implications for Social Change

Health care leaders define population health as the clinical outcomes of a defined group of individuals (Kindig & Isham, 2014). Population health is one of the three goals of the TAM (Bodenheimer & Sinsky, 2014). In addition, a driver of population health is transforming the medical culture from providing sick care to the provision of wellness services to prevent illness (McGough, Kline, & Simpson, 2017). According to Shrank (2017), the mission of primary care practices is to improve population health through the provision of high-quality care. Health care leaders may consider the findings of this study important to impact social change because garnering support for care coordination programs grounded in the TAM objective of population health allows leaders to impact the health of communities.

According to Zangerle et al. (2016), social determinants of health influence 80% to 90% of the population's health outcomes. Bridger, Smith, and Saunders (2017) posited that the drivers of health status include social components that require a collective approach to population health. Moreover, Taylor et al. (2016) indicated that policymakers should take note of care coordination strategies that focus on social determinants that impact overall population health and impact cost. Therefore, health care

leaders seeking to influence social change could use the results of this study to affect the quality of care for the HNHC populations through care coordination programs.

MCOOA accounts for 25% of the enrollment for beneficiaries with federal and state sponsored health care benefits (Reid et al., 2013). In addition, the dual-eligible population is increasing at a rate that is double the beneficiaries of a single program (Eggbeer et al., 2013). Moreover, the dual-eligible population is at greater risk for fragmented care related to the need to coordinate between multiple programs with varied benefits (Kennedy, 2013). Ortega (2016) posited that the dual-eligible have complex social issues influencing access to health benefits. Powers et al. (2015) revealed that care coordination programs could improve the quality of life and reduce health care expenditures. The data from this study may affect social change by providing an avenue through care coordination programs to reduce care fragmentation and address the social determinants of health for a targeted high needs population.

Recommendations for Action

Rowe et al. (2016) indicated that evidence-based literature supports the need for care coordination programs; however, health care leaders may lack the budget for program implementation. The research findings provide strategies to garner support for programs grounded in the TAM objectives. Based on the research findings, I recommend the following actions:

- Leaders should define the measures used to populate the tenets of the TAM.

- Health care leaders should understand the mission of the organization and focus on the patient driven elements when developing strategies for financial support.
- Health care leaders should identify the hospital-based utilization measures that support the mission of the organization.
- Leaders should focus on the high-need, high-cost population and consider the dual-eligible as a priority population.
- Health care leaders should identify stakeholders within primary care to create an interprofessional practice environment to support medical and social determinants of health.
- Health care leaders should gauge the maturity of the organization and shape discussions to ensure a comprehensive understanding of managed care and care coordination.

The findings are broadly applicable to health care organizations that are accountable for care coordination programs. I will seek to disseminate findings through academic journals and professional conferences. Moreover, health care leaders could use the results of the study to provide leadership development training for leaders responsible for care coordination programs.

Recommendations for Further Research

There is a limit in literature defining a specific methodology to communicate the financial benefits of care coordination program (Kripalani et al., 2014). The findings from my study may contribute to limitations in research on business practices that health

care leaders can use to support financial allocations to care coordination programs. Variability exists amongst program infrastructure and maturity of the organization. Therefore, the recommendation for future research is to determine if there is a correlation between the maturity of the managed care organization and the strategies used to garner support. I utilized a single-case study design, which limits the research. I would recommend that future research includes a multiple-case study design to increase the sample size and improve generalizability. Also, I would recommend further research on the care coordination program infrastructure and the impact on investment potential.

Reflections

I explored the strategies health care leaders use to garner financial support for care coordination programs. I used reflexive journaling to document preconceptions and personal bias. As an inside researcher, I was aware of my obligation to mitigate bias through the preservation of reflexivity. I maintained the use of the interview protocol and wad careful not to lead the participant during interview process. There were four preconceived ideas discovered in the journaling process. Through the journaling process, I revealed a preconceived idea that using external consultants reflected a lack of trust in the experience of the internal leadership. After completing the study, my thoughts on the value of external consultants changed to view the use of external consultants as a reflection of the maturity of the organization and the commitment to identify best practices beyond the walls of the organization. Second, I had a preconceived idea that the strategies used in an integrated delivery system for the older adult with less than 2,000 members would differ from those used in a managed care environment with greater than

200,000 members. The health care leaders (50%) provided confirmation that the capacity to provide care in an integrated model is significantly different. However, developing programs with similar infrastructure and management strategies can prove beneficial and applicable in settings focused on the HNHC population. Therefore, my thoughts expanded to realizing the value of an analysis of best practices and the capacity to replicate. The next preconceived idea was that primary care practice is a customer of the managed care organization's care coordination program. The study participants revealed a partnership that required sharing goals, shared strategies, and shared knowledge to achieve the TAM versus a customer-based relationship. The final preconceived idea was that strategies for investment in care coordination programs required changing patient behaviors; therefore, requiring a long-term commitment to realize savings. The study participants revealed that strategies should focus on short-term savings realized through risk pool savings and hospital utilization for the high cost population.

Summary and Study Conclusions

The purpose of this qualitative single-case study was to explore the strategies that health care leaders use to improve corporate financial investment in care coordination programs that include TAM objectives. The target population was health care leaders in the role of vice president or higher who have implemented strategies to improve corporate financial investment for care coordination programs. I conducted semi-structured interviews and used open-ended questions to extract interview data. In addition, I used archival documents (meeting minutes) for triangulation of the data to address the research question. The five themes that emerged included (a) reflecting a

reduction in health care cost, (b) focusing on high-need, high-cost populations, (c) partnering with primary care practices, and (d) providing patient satisfaction data. The research participants revealed that defining the measures used to populate the key tenets of the TAM objectives is of greater importance than citing the TAM. As a priority, health care leaders seeking investment in care coordination must have a concise presentation that reflects the cost considerations based on the level of risk assumed by the managed care organization. Next, leaders should seek out alliances with primary care practices to influence the population with the highest needs and highest cost. Finally, the research reflected that there should be clear patient experience data to reflect the impact on the population.

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Appendix A: Interview Protocol

Pre-Interview

1. Selecting respondents: Initial contact in-person, phone, or email. Information on research emailed. Respondent Identifier

2. Setting interview time and place: Closed environment selected by participant. Interview time at approximately one hour

3. Building Rapport: Explain purpose of the study and voluntary nature of the study. Inform the participant to stop the interview if any discussion becomes offensive, threatening, sensitive, or degrading.

4. Inform the participant to enhance industry knowledge and establish best practice the participant should avoid providing a response based on perceptions of what the researcher may want to hear, ensure all responses are honest without concern of negative or positive connotations, and exclude any personal agendas.

5. All responses are confidential.

6. Explaining the study and consent: Written Consent.

7. Limits of Confidentiality by the duty to report criminal activity, child abuse, or elder abuse.

8. Recording the Interview

Interview

Introduction: Thank you for agreeing to participate in this research study. For the past three years. I have studied the literature and identified some of the most successful practices to foster financial investment for care coordination programs. The open-ended interview questions allow you to elaborate on how you, as an organizational leader, have improved financial investment for care coordination programs that include the TAM.

Interview Questions

1. What successful strategies did you use to improve corporate financial investment in care coordination programs?
    a. Notes
    b. Nonverbal Notes
2. What strategies did you find worked best to improve corporate financial investment in care coordination programs?
    a. Notes
    b. Non-verbal notes
3. How did the executive leaders respond to your strategies?
    a. Notes

   b. Non-verbal notes

4. How did you evaluate the cost effectiveness of care coordination programs?

   a. Notes

   b. Non-verbal notes

5. What are your recommendations to healthcare leaders pursuing care coordination investments?

   a. Notes

   b. Non-verbal notes

6. What other information, not asked, can you share regarding this study?

   a. Notes

   b. Non-verbal notes

Post-Interview

Thank the participant: I appreciate you taking time out of your busy schedule to complete this interview. Your practices are important to the healthcare industry. I will do my due diligence to ensure I have conveyed the meaning of your responses. I will transcribe the interview and synthesize the responses for your review and approval. I will outreach to

you to schedule a follow-up lunch meeting to ensure my transcription is accurate. This is called the member checking.

Recording: Recorded thoughts after each interview

Next Phase: Next Interview. Approximately one hour. Provide email and telephonic contact. Transcription with Interpretation for member checking

Member Checking

Member Check Introduction: Thank you for taking time out of your busy schedule to validate the responses from our initial interview. Your practices are important to the industry and I would like to ensure I accurately convey your meaning through the member check process. We will review each question and your synthesized response for accuracy. I may have additional clarifying questions based on the initial analysis of the interview data.

1. What successful strategies did you use to improve corporate financial investment in care coordination programs?
    a. Synthesis of Response
    b. Accuracy
    c. Additional Information (Did I miss anything)
    d. Additional Information (Anything you would like to add)

2. What strategies did you find worked best to improve corporate financial investment in care coordination programs?
    a. Synthesis of Response
    b. Accuracy
    c. Additional Information (Did I miss anything)
    d. Additional Information (Anything you would like to add)
3. How did the executive leaders respond to your strategies?
    a. Synthesis of Response
    b. Accuracy
    c. Additional Information (Did I miss anything)
    d. Additional Information (Anything you would like to add)
4. How did you evaluate the cost effectiveness of care coordination programs?
    a. Synthesis of Response
    b. Accuracy
    c. Additional Information (Did I miss anything)
    d. Additional Information (Anything you would like to add)

5. What are your recommendations to healthcare leaders pursuing care coordination investments?

    a. Synthesis of Response

    b. Accuracy

    c. Additional Information (Did I miss anything)

    d. Additional Information (Anything you would like to add)

6. What other information, not asked, can you share regarding this study?

    a. Synthesis of Response

    b. Accuracy

    c. Additional Information (Did I miss anything)

    d. Additional Information (Anything you would like to add)

Appendix B: Letter of Cooperation

Letter of Cooperation from a Research Partner

Altamed Health Services Corporation
20140 Camfield Ave
Los Angeles, CA 90040

7/28/2016

Dear Shameka Coles,

Based on my review of your research proposal, I give permission for you to conduct the study entitled Strategies for Health Care Leaders to Increase Resource Allocation for Care Coordination Programs within Altamed Health Services. As part of this study, I authorize you to contact health care leaders within the organization who used strategies to improve corporate financial investment in care coordination programs that include TAM objectives. In addition, I authorize you to collect participant viewpoints through interviews. I give permission for you to access relevant documentary evidence through meeting minutes. Also, I authorize for you to conduct member checking by completing the transcript interpretations and second interviews to validate the participant responses. Based on your determination, I grant permission for dissemination of research findings within the organization, at professional conferences, and within professional journals. Individuals' participation will be voluntary and at their own discretion.

We understand that our organization's responsibilities include allowing personnel to participate in the study, allowing access to meeting minutes, and providing office space to conduct the interviews. We reserve the right to withdraw from the study at any time if our circumstances change.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,
Martin Serota
Chief Medical Officer
(323) 725-8751

Walden University policy on electronic signatures: An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction

electronically. Electronic signatures are regulated by the Uniform Electronic Transactions Act. Electronic signatures are only valid when the signer is either (a) the sender of the email, or (b) copied on the email containing the signed document. Legally an "electronic signature" can be the person's typed name, their email address, or any other identifying marker. Walden University staff verify any electronic signatures that do not originate from a password-protected source (i.e., an email address officially on file with Walden).