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The Center for Total Health: Healthcare Reform in Cook County, Illinois

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Walden University
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Abstract

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by

James L. Miles, Sr.

DMin, Virginia Union University, 2002

MDiv, Virginia Union University, 1996

BS, Park University, 1989

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

The Patient Protection and Affordable Care Act (PPACA) of 2010 requires hospital systems in the United States to shift the culture of patient care from a focus on sick-care to a focus on prevention and wellness care. Little is known about how hospital systems will make this culture shift while retaining quality patient care. The purpose of this case study of a pioneering hospital-based PPACA-compliant initiative was to answer the research question of how Wallace's revitalization movement theory (RMT)—a rapid culture change model—could serve as a transferable evaluation framework for PPACA prevention and wellness care compliance in hospital-based programs. Kingdon's policy streams theory provided a conceptual framework. Data analysis included iterative, thematic coding of interviews with 3 primary stakeholders responsible for developing the policy, planning, and program implementation strategies of the Center for Total Health (CTH). Nineteen extensive primary source documents were included in the analysis as well. Findings supported the utility of the RMT structure and definitions in the identification of culture change dynamics in CTH. Additionally, this structure served as a scaffolding for grouping individual and institutional rapid culture change dynamics into stages that could be evaluated in terms of PPACA compliance. These stages effectively identified a Kingdon policy window in which PPACA mandates could be expected to result in culture change in multiple streams of public policy development, not only in wellness and sickness prevention, but also in local, state, and national health cost-saving initiatives in food-as-medicine, community identity, public health support networks. It could also reduce chronic disease and the rising institutional care delivery costs.

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Dedication

With a grateful heart, I dedicate this dissertation to my parents, Harold and Evelyn, and to my children, Princess and JL.

Acknowledgments

First and foremost I thank Dr. Bethe Hagens, my dissertation Chair, for her amazing guidance, corrections, and support without which I would not have reached this academic milestone. A special thanks to Dr. Eliesh Lane who presented finely tuned public policy perspectives that strengthened my dissertation research and writing. To Dr. Terry Mason, I am eternally grateful for the, life transforming, invitation to participate in his vision for a revitalized 21st century food is medicine movement. There were others among Walden University faculty leadership, my family, friends, students, and colleagues who shared just the right encouragement, at the right times, solidifying my resolve to complete this academic goal. To all, I say thank you for believing in me and my potential to make a difference with this scholarship.

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Chapter 1: Introduction to the Study

Background

The Patient Protection and Affordable Care Act (PPACA) of 2010 made prevention and wellness care a national priority (Fielding, Teutsch, & Koh, 2012; T. D. Johnson, 2011; Marvasti & Stafford, 2012). Healthcare leaders across the United States, in compliance with PPACA, were faced with shifting their institutions from a sick-care-centered approach to a prevention-and-wellness-care-centered approach (T. D. Johnson, 2011). For many hospital systems, changing from a sick-care system to a prevention and wellness care system requires more than instituting process and program improvements; it requires a change in the healthcare delivery culture at the system and human levels (Marvasti & Stafford, 2012).

I explored revitalization movement theory (RMT; Wallace, 1956) as an evaluation framework with the potential to provide critical feedback to healthcare leaders regarding the design of a prevention and wellness care initiative oriented toward facilitating the shift from a sick-care culture to a prevention and wellness care culture that is in compliance with the PPACA. Providing this evaluation in the design stage of development of a prevention and wellness care program might provide leaders with early opportunities to make adjustments and optimize implementation plans prior to incurring program implementation costs. In this case study, the RMT evaluation framework was tested against the design of a Cook County (Illinois) Health and Hospital System

(CCHHS) PPACA-compliant prevention and wellness care initiative called the *Center for Total Health* (CTH).

PPACA is projected to insure 32 million previously uninsured persons (Fiscella, 2011), lower the annual expenses of Medicaid from $400 billion (Iglehart, 2012), and improve access to services (Kellis, Rumberger, & Bartels, 2010), all while improving the health of Americans overall, which is also referred to as *population health* (Hokanson Hawks, 2012a). The focus of PPACA on prevention and wellness as an integral part of the healthcare reform law is one of the ways in which the law was designed to achieve these population health goals (Cogan, 2011). Making prevention and wellness integral components of healthcare reform has also made prevention and wellness national priorities to match compliance requirements of the PPACA (Benjamin, 2011; Currie, 2013; Fielding et al., 2012; Majette, 2011). Since passage of the PPACA, all healthcare systems receiving payments from the federal government have been required to integrate prevention and wellness services into their healthcare delivery process (Cykert, 2012; Majette, 2011).

The significance of this study is its potential to help healthcare leaders improve their capacity to implement health care delivery initiatives in compliance with the PPACA prevention and wellness standards. Increased successes in prevention and wellness care program implementations raise the potential that more communities across America will have access to healthcare services designed to improve their health outcomes, lower the cost of care delivery, and enhance population health (Kovner &

Knickman, 2008; Marvasti & Stafford, 2012). Compliance with PPACA required healthcare industry leaders and stakeholders to go through a rapid culture change. This rapid culture change included learning to handle larger groups of patients while simultaneously making prevention and wellness a priority standard of care (Afsar-Manesh & Martin, 2012; Carter, 2013; Rooney & Arbaje, 2012).

Overview

There is extensive literature covering various evaluation frameworks for care delivery programs within healthcare. The most common of these evaluation approaches are random controlled trials, observational studies, and participatory studies (Baldi & Gregori, 2012; Cook et al., 2010; Cook, 2009). Using these common evaluation approaches (Adirim, Chafranskaia, & Nyhof-Young, 2012; Ahmed & Rak, 2010; Andrews, Twigg, Minami, & Johnson, 2011), the program being evaluated is in operation, and the effectiveness of the operating unit and its procedures, protocols, and realized outcomes are reviewed in real time or through collected performance data (Arbab Kash, Spaulding, Johnson, & Gamm, 2014; Hartmann et al., 2013; McHugh et al., 2012; Rooney & Arbaje, 2012).

The literature also revealed predictive models for evaluating program outcomes (Chang, Weiner, Richards, Bleich, & Segal, 2012). The predictive approach to program evaluation in healthcare involves existing data or a conceptual framework that is relevant to the program or proposed program being evaluated; the data or framework are used to predict outcomes that can reasonably be expected based on program design inputs and

planned implementation (Best et al., 2012; Chang et al., 2012). Informed by this predictive approach, this case study focused on the design of a prevention and wellness care initiative and its aim to serve as a catalyst for culture change within the CCHHS in Cook County, Illinois.

Chapter 1 proceeds with a discussion of the background, problem statement, and purpose of this case study. The chapter then covers the research question, the conceptual/theoretical framework through which this question was explored, and the methodological approach informing the research design. Chapter 1 ends with an explanation of the limits to the study, its significance to the research literature, expected positive social change implications, and a summary of the chapter.

Background of the Study

There have been many calls for behavior change within the healthcare industry. On a systems level, there have been calls for a shift from a culture of entitlement and sick care to a culture of accountability (Kaufman, 2011b; Lewin, 2012; Rooney & Arbaje, 2012). The existing culture, according to this view, is exemplified by the patient who wants improved health without accepting the need to change his or her behavior in the areas of diet, smoking, and exercise, or the health care practitioner and hospital that seek maximum pay and reimbursement with minimal responsibility for the health outcomes of patients (Kaufman, 2011b). Gruber (2009) discussed people's willingness to pay hundreds and even thousands of dollars to look good while resisting medical care that could reduce their morbidity and mortality. These behaviors are pervasive enough within

the healthcare enterprise that Knickman and Kovner (2008) suggested that people pay out of pocket for healthcare problems resulting from their own negligence and behavior choices.

Behavior change studies have highlighted more complex issues suggesting that cognitive, social, and biological functions can complicate or even prevent patient and practitioner alike from making what may appear to be simple, even logical behavior changes that promote wellness (Aballay, Eynard, Díaz, Navarro, & Muñoz, 2013; August & Sorkin, 2011; Church et al., 2011; "Why Behavior Change Is Hard," 2012). Behavior, often referred to as a *lifestyle*, is central to the success of prevention and wellness programs. Where the lifestyle behavior promotes positive health outcomes, the patient and healthcare practitioner are seen as practicing wellness and prevention (Domaszewicz, Havlin, & Connolly, 2010; Senzon, 2011; Sprange et al., 2013).

Under PPACA, healthcare delivery systems are tasked with shifting from a fee-for-service, transaction-based, professionally segmented healthcare delivery culture to a centralized, coordination of care operation, with payment for services rendered tied to patient health outcome measurements (Bennett, 2012; Hacker & Walker, 2013; Nugent, 2010). This call for organizational/operational behavior change extends beyond process improvements into a change in the culture of healthcare and healthcare services delivery.

National Healthcare Delivery Challenges

One of the biggest challenges to the effort to achieve the national healthcare and population health outcomes targeted by the PPACA is the prevalence of chronic disease

(Kovner & Knickman, 2008; Siu, Spragens, Inouye, Morrison, & Leff, 2009). The number of patients covered under Medicare is projected to increase from 46.3 million in 2009, to 77 million in 2031 (Akushevich et al., 2011). This increase in Medicare-covered patients will come at the same time that the number of Americans diagnosed with chronic disease is estimated to exceed 45% of the entire population (Akushevich et al., 2011; Kovner & Knickman, 2008). These trends drive rising healthcare costs nationally while challenging existing models of care delivery locally (Ameringer, 2012; Kovner & Knickman, 2008; Siu et al., 2009; Yang & Hall, 2008).

Cook County, Illinois Healthcare Delivery Challenges

Cook County, Illinois, the second largest county in the United States, is composed of 130 municipalities. The county includes the City of Chicago, contains 5.2 million people, and is home to 40% of all Illinois residents (Foundation, 2014; Preckwinkle, 2014). Between the year 2000 and the year 2010, Cook County experienced demographic shifts represented by a 31% increase in total minority population and a 12% increase in the number of residents between 45 and 64 years of age ("Community Health Status Assessments," 2010). In the southern and western districts of Cook County, median unemployment in 2010 approximated 12%, with 30% of the population living under 200% of the federal poverty level (Health, 2010). In 2010, the Cook County Department of Public Health (CCDPH) reported that suburban Cook County minority mortality rates were higher than those of Illinois and the United States as a whole. These statistics contributed toward CCHHS providing approximately $500 million in uncompensated

medical services annually prior to 2013 ("CCHHS Announces 115,000 Apply for CountyCare," 2013).

Raju, the CCHHS CEO at the time this study was conducted, saw an opportunity in the Medicaid expansion component of the PPACA to reduce the cost of uncompensated medical services in Cook County. The first step in Raju's plan was to apply for permission through a 1115 demonstration waiver from the federal government to start enrolling adults in the Cook County Medicaid expansion plan called CountyCare prior to the 2014 PPACA designated start date (Illinois Department of Healthcare and Family Services & CCHHS, 2012; Foundation, 2014). In October 2012, the state of Illinois and CCHHS were granted the 1115 demonstration waiver. Shortly thereafter, the CCHHS began the enrollment process for an estimated 618,000 uninsured adults deemed eligible for CountyCare (Foundation, 2014).

CountyCare, under the 1115 demonstration waiver, allowed Cook County, Illinois, to extend medical care coverage to adult residents between the ages of 19 and 64 with income at or below 133% of the federal poverty level (Foundation, 2014). Staff of CountyCare reviewed more than 113,000 applications and approved 82,000 applicants over a 12-month period beginning in February 2013 (Foundation, 2014). Since that time, CountyCare has represented approximately 50% of all Illinois adult residents enrolled in a Medicaid expansion program.

With this influx of new and medically insured patients, Raju and the CCHHS staff faced the challenge of managing the increase in patient population, closing revenue over

expense shortfalls, and achieving the PPACA prevention and patient health outcome standards. This challenge presented Raju with a call for two types of changes. The first change needed was to improve patient management processes while resolving operational and financial shortfalls. The second change needed was to implement a cultural shift from sick care to prevention and wellness care (Arbab Kash et al., 2014) for CCHHS staff and patients using a method that would comply with PPACA-mandated patient outcomes.

Participation in the Research Project

I was contracted to serve as project lead. Initially, the scope of my work was as follows:

1. Develop a program that prescriptively uses food as medicine to decrease or eliminate a patient's use of medications for lifestyle-related diseases.
2. Design program elements to help program participants become empowered to actively participate in preventing disease while promoting wellness at home, as well as in partnership with medical and public health service personnel.
3. Develop a regional food hub and nutrition training center to provide fresh and prepared fruits and vegetables (*Farm-Med; Center for Chronic Disease development contract*, 2012).

The food-as-medicine program became the dominant focus of the project. Mason, as the chief medical officer of CCHHS and the executive providing oversight for the food-as-medicine program, established this aspect of the project as the first priority. The first objective became the bridge between the Farm-Med prototype, started by Mason's

CCHHS staff, and what came to be called the CTH, the basis for this case study. The regional food hub was discussed as a support function. Based on my background in economic development, I saw this project as an opportunity to design a self-funding support operation within CTH. The CTH design called for teaching patients and program participants how to grow nutrient-rich vegetables that they could consume as part of their prevention and wellness care treatment plan.

An analysis of food hub distribution models within Cook County, Illinois, and the surrounding region led to a decision by Mason to delay the development of a CTH regional full-service food hub and leverage an existing food services contract structured to provide nutrient-rich food items for patients' prevention and wellness care treatment plans. The intent was to lower the complexity and cost in the early stages of CTH implementation while keeping a primary focus on prevention and wellness care treatment protocols and outcomes. The demonstration vegetable and herb gardens used for the Farm-Med project would continue to be used for education and training during the early stages of implementing the CTH design.

Within 5 months, the food-is-medicine component of the project became the primary focus of all project design efforts. With this refined project design focus, the CTH name became the official title of the prevention and wellness care design initiative. The design elements incorporated a prevention and wellness care delivery model consisting of a patient-centered care delivery and diagnostic unit supported by four operating functions: (a) applied research, (b) natural foods sourcing and distribution, (c)

general education and professional training, and (d) operations. See Appendix A for a description of the CTH initiative.

Initial implementation of the CTH initiative was scheduled for Spring 2014. Terms of the CTH design contract were satisfied, and all contract work products were turned over to Mason in August 2013. Cook County released a request for proposals (RFP) focused on implementing the CTH plan in Fall 2013. Changes in leadership and related shifts in funding priorities led to the CTH implementation contract not being awarded (Dardick, 2013; Schorsch, 2014; Wang & Schorsch, 2014).

The CTH project remained an active, unfunded project, with the implementation phase of the project progressing no further than the Cook County CTH RFP process. An implementation contract was not executed as part of the CTH RFP process. My contract terms with CCHHS, as project lead on the CTH project, were fulfilled as of August 2013, thus ending my duties as CTH project lead. With the conclusion of all my CTH project contractual duties and operational assignments, my interest and attention were redirected to the role of researcher analyzing the CTH design. Mason, who was at that time the senior executive of the Cook County Department of Public Health, agreed to support my interest in researching his work and vision.

Healthcare Reform as Process Improvement and Culture Change

Healthcare reform as process improvement (Best et al., 2012; de Mast, Kemper, Does, Mandjes, & van der Bijl, 2011; Friesner, Neufelder, Raisor, & Bozman, 2009; Guo & Hariharan, 2012) has been covered extensively in the literature, whereas healthcare

reform as culture change (Afsar-Manesh & Martin, 2012; Barbara & Las Casas, 2013) is much less represented. Mandates of the PPACA call for healthcare systems such as CCHHS to include a change in their organizational culture that extends beyond the clinic and healthcare practitioners to the lifestyle habits of the patient, as well as the behavior of practitioners toward prevention care as a healthcare practice (Cykert, 2012; Morley, Bogasky, Gage, Flood, & Ingber, 2014; Rotter, 2010). Healthcare system programs designed to address PPACA mandates are best evaluated through a framework that can engage this broader scope of behavior and culture change.

The present research addresses this gap in the literature by exploring the application of revitalization movement theory (RMT) as a framework that healthcare leaders can use to evaluate prevention and wellness care initiatives designed to facilitate cultural change within a healthcare system. This evaluation framework has the potential to promote healthcare delivery efficiencies that can improve health outcomes for patients during the CTH program implementation period while lowering the cost of care delivery for CCHHS as a health system. From a public policy perspective, this framework helps to highlight the connection between the policy entrepreneur and subsequent policy implementations.

Problem Statement

The research problem addressed in this study was the need to explore the potential of RMT, a short-cycle culture change process, as an evaluation framework capable of providing critical program design and compliance feedback to healthcare leaders early in

the program design process. The PPACA identified prevention and wellness as a national priority (Cogan, 2011; Majette, 2011). Programs must be created, enhanced, and implemented on an unprecedented scale to support this prioritization. One of the challenges facing healthcare leaders under PPACA is the ability to address healthcare reform as culture change at the system and human levels within a single evaluation framework.

This notion of healthcare reform as culture change comes from understanding the purpose behind many of the emerging prevention and wellness care initiatives. The purpose of these initiatives is to help healthcare systems achieve PPACA prevention and wellness outcomes, which generally translates into these programs serving as catalysts aiding in the shift from a sick-care culture to a prevention and wellness care culture (Barksdale, Newhouse, & Miller, 2014). These initiatives may be operationalized as changed behavior (Weiner et al., 2013) and revitalized identities (Bellieni & Buonocore, 2009; Boufoy-Bastick, 2014), anchored in the collaborative and active pursuit of being and staying well on the part of the patient and practitioner (Fontenot, 2013a, 2013b; Mango & Riefberg, 2009; Marvasti & Stafford, 2012).

Purpose of the Study

The purpose of this research study was to explore the effectiveness of RMT as a framework for evaluating emerging prevention and wellness care initiatives early in the design and development process for their capacity to facilitate the shift from a sick-care culture to a prevention and wellness care culture. The CTH is a prevention and wellness

care delivery model designed to operate within the CCHHS. Ability to evaluate CTH during the design stage has the potential to drive program efficiencies and cost savings in the early stages of implementation. CTH program efficiencies raise the capacity of CTH to achieve prevention and wellness goals among its patient population, thus meeting the performance goals set by the PPACA (Koh & Sebelius, 2010; Majette, 2011).

Research Question

The present study was driven by a single research question: How can revitalization movement theory serve as an evaluation framework for prevention and wellness care programs under the PPACA?

The Conceptual Framework for the Study

Revitalization Movement Theory (RMT)

Wallace (2009), an American anthropologist, wrote about the need to celebrate the diversity of individuals within cultures. His message was a call for an appreciation of culture being more than groups or people with similar traits and behaviors (Wallace, 2009). This more nuanced approach to the study of culture is evident in Wallace's (1956) seminal work on revitalization movements, which are deliberate, organized, conscious efforts to construct a more satisfying culture. Wallace (2003) described cultural revitalization as a "special kind of culture change phenomenon" (p. 10) incorporating the following elements: (a) persons involved in the revitalization process must perceive their culture as a system, (b) these persons consider this system to be unsatisfactory, and (c) they must create a new cultural system. This transition from the old cultural system to the

new one must be completed within a compressed period of time, as short as a few years, in order to be considered a revitalization movement (Wallace, 1956). In a revitalization movement, change happens abruptly and simultaneously through intentional action on the part of those going through the culture change process (Wallace, 1956). Revitalization movements are characterized by a five-stage process.

- Stage 1: the original steady state, at which individuals are able to manage their daily activities and stressors.
- Stage 2: the period of increased individual stress, during which the daily stressors have increased and individuals' efforts at stress reduction are ineffective and viewed with suspicion within the larger culture.
- Stage 3: the period of cultural distortion, during which chronic stress provokes outward behavior that can manifest in destructive ways, individually and within community networks.
- Stage 4: the period of revitalization, during which individuals take demonstrative steps to change the culture now perceived as inadequate for their desired lifestyle or, in many cases, survival.
- Stage 5: the new steady state, at which emergent cultural substitutions have transformed lives and are accepted as normative within the larger society.

This five-stage process of intentional personal action and identifying with the emergent cultural substitutions is what drives the compressed schedule under which these culture changes take place in the lives of the people involved. A compressed schedule culture

change is a change that takes place in as little as a few years, in contrast to a more traditional view of culture change as gradual action-reaction cycles taking place over multiple generations and even millennia (Wallace, 1956).

Wallace (2003) highlighted the importance of leadership in the revitalization process during the period of revitalization. The leader is a visionary who is "supremely powerful and potentially benevolent" (Wallace, 2003, p. 22), has a high degree of charisma, and is able to communicate the culture change with "emotional appeal" (Wallace, 2003, p. 21). This description of the revitalization movement leader is compatible with the religious nature of the culture change movements Wallace studied. Wallace rejected the perception that this revitalization movement leadership model is not compatible with secular culture change movements. Phelan's (2005) discussion comparing cultural revitalization movements to organizational change management literature presents the corporate leader, tasked with executing change in the corporate culture, as compared to Wallace's description of the leader of a revitalization movement. Phelan (2005) referred to the corporate leader as being "charismatic" (p. 48) with a priority skillset of being able to communicate the vision of change. This corporate leader is highly visible, "frequently reinforcing the plan through word and deed" (Phelan, 2005, p. 49).

Wallace (2003) reserved the use of the term *revitalization movement* for a culture change process in which "the whole society is explicitly intended as the target" (p. 7).

Wallace's (1956) whole society qualification is met as a result of PPACA making prevention and wellness healthcare reforms a national priority (Koh & Sebelius, 2010).

Revitalization Movement Theory as an Evaluation Tool

Using the framework of RMT as an evaluation tool for the CTH model design provides for multiple points of investigation. First, a distinguishing quality of the revitalization movement is the compressed schedule under which the revitalization process must take place. In Wallace's (1956) work, this time period is as short as a few years, as compared to the generations required by more traditional social science definitions of culture change as a process. CTH was designed to achieve its culture change goals with patients and practitioners within two to five 12-month budget cycles. RMT as a framework considers human and nonhuman systems as extensions of each other. If there is a breakdown or stressor in one component, the whole system experiences the impact. The oneness of all moving parts or, from a RMT cultural lens, the interconnectedness of the various participants' worldviews (mazeways) could be instructional for evaluating a health and wellness delivery program designed to address PPACA mandates for a transformed health care delivery system and patient wellness outcomes (Giordano, Hutchison, & Benedikter, 2010; Habersack & Luschin, 2013; Halpin, Morales-Suárez-Varela, & Martin-Moreno, 2010; Hardcastle, Record, Jacobson, & Gostin, 2011; Wahlqvist, 2014).

The approach taken by CTH relative to prevention and wellness care delivery requires a total systems view of health and wellness that removes traditional barriers of

responsibility between what takes place in the medical clinic and what takes place in the patient's home or community. It also removes the traditional barriers of accountability for outcomes and behaviors. Throughout Wallace's (1956) explication of RMT are direct or indirect references to personal identity and the role personal identity plays in the culture change process. Wallace pointed out that in Stage 5, the new steady state, some people resist culture change by holding rigidly to the existing culture. This resistance occurs even when the existing culture has proven to be inadequate in promoting a satisfying lifestyle. Wallace remarked that these resistors of culture change choose to die under chronic stress rather than embrace emergent culture changes and systems. In similar fashion, there are differing identity possibilities within a revitalization movement. One identity may call for radical actions against a dominant culture, another may be more conciliatory, and a third may seek separation and avoidance. Each revitalization movement and identity within the movement evokes a corresponding reaction from the larger culture or from individuals within the same revitalization movement.

In RMT, the identification of an individual's personal worldview (belief system) is called a *mazeway*. Any change to this personal worldview that results from the revitalization movement is called a *mazeway reformulation* (Wallace, 1956). Personal identity, as shaped by an individual's mazeway, is a central construct in the use of RMT as an evaluation framework for prevention and wellness programs. In this case study, the RMT framework was applied to CTH with the goal of exploring the presence of identity transformation themes and opportunities within the design documents. CTH as a

subculture, or mazeway system within the larger CCHHS culture, emphasizes prevention and wellness rather than medical procedures and prescription medicines. The patient initially experiences both.

For CTH to produce its prevention and wellness patient health outcomes, it must help the CTH patient and CCHHS CTH practitioner identify with wellness and prevention treatment protocols as the priority option, as compared to prioritizing more traditional CCHHS medical procedures, treatments, and pharmacological prescriptions. Using RMT, the CTH patient treatment and services process can be evaluated based on how each stage of the patient engagement strategy identifies, engages, and promotes the development of a prevention and wellness identity, which in turn has been shown to produce improved patient outcomes (Aronson, Burgess, Phelan, & Juarez, 2013; Fontaine, 2013; Haack, 2014; Lamiani et al., 2008; Remmers, 2008; Wahlqvist, 2014).

Nature of the Study

Passage of the PPACA (2010) has prompted healthcare leaders across the nation to evaluate the degree to which the operations and organizational culture of their health systems promote being in compliance with this healthcare reform law (Stephens & Ledlow, 2010; Verhezen, 2010). I proposed the use of RMT (Wallace, 1956) as an evaluation framework through which the design of a PPACA-compliant prevention and wellness patient care delivery initiative, the CTH, can be evaluated on whether the initiative is likely on track to meeting PPACA prevention and wellness objectives. I focused on the program design documents of CTH. A focus on the design of the initiative

has the potential to add value to other forms of implementation-oriented evaluations by introducing cost and process efficiencies early in the prevention and wellness care delivery program development process. The earlier that cost and process efficiencies can be realized (Kumar, 2011), the greater the benefit to patients and the health systems.

Study Time Frame

This case study focused on CTH design materials developed and presented between March 2012 and October 2013. During this period, I maintained an active presence in meetings and project development-related activities. From March 2012 through July 2012, and again from August 2013 through October 2013, my participation was that of a passive observer and guest of Mason in CTH-related development activities. I served as the project lead, according to which I was tasked with the development of a measurable and executable prevention and wellness care delivery model design under a 12-month services contract that began in August 2012. During this time, CTH programs, patient care processes, and practitioner service delivery standards were developed based on parameters set by Mason and in compliance with CCHHS and PPACA program implementation goals.

Data Collection

Primary data collection included interviews, contract work, observation notes, published government proceedings, and CTH project-related documents. I interviewed Mason, the project principal, and Schneider, the CCHHS chief operating officer at the time the CTH design contract was being approved by the CCHHS municipal board of

directors, using a qualitative interviewing approach (Yin, 2011). Based on qualitative interviewing techniques (Creswell, 2013), the central focus of the interview questions was threefold. First, I sought to capture the interviewees' general perception of the CTH model. Second, I sought to capture the interviewees' understanding of the role that the CTH model, when implemented, could have in healthcare delivery within CCHHS. Third, I sought to present the interviewees with a brief description of culture change versus process improvement within healthcare, and I asked the interviewees to discuss how the CTH design incorporates process improvement and culture change within the context of CCHHS healthcare service delivery. Use of this qualitative interview approach kept the interview and thus the data focused on the primary interest of this case study in rapid culture change as a design component of a PPACA-compliant prevention and wellness care initiative.

Data Analysis

Using MAXQDA data analysis software, I conducted primary and secondary data analysis in three phases. During the first stage of data analysis, I categorized all data inputs according to the source of the data. Data sources included primary source interviews, primary source observations and contract notes, as well as secondary source newspaper articles. Primary data coding took place within the source categories. The emerging intrasource metathemes were tagged for Stage 2 intersource coding and theme analysis (Yin, 2011). I repeated the Phase 2 data coding process of Stage 1 using intersource metathemes between source categories. Phase 3 involved comparing these

emergent themes with the five-stage revitalization movement. By conducting the comparison in Stage 3, I sought to identify common themes between the five-stage revitalization movement process and the CTH design.

Definition of Terms

Terms used throughout this study are defined as follows:

Behavior change: When the actions of an individual or group of individuals go from one state of expression to another (Choi, Choi, & Rifon, 2010; "Why Behavior Change Is Hard," 2012).

Center for Total Health (CTH): A prevention and wellness care delivery model designed to serve the residents of Cook County, Illinois (Mason, 2013c).

Chronic disease: A long-lasting health condition that can be controlled but not cured (Ameringer, 2012).

Cook County Health and Hospitals System (CCHHS): The Cook County, Illinois, municipal healthcare system (CCHHS, 2015a).

Cost efficiencies: The goal of achieving optimal program operating results at the lowest cost (Brealey, Myers, & Marcus, 2009).

Culture change: An alteration in the way individuals within social systems have historically come to behave and institutionalize approaches to coping with individual diversity (Alchin, 2010; Guan, Lee, & Cole, 2012; Wallace, 1962).

Farm-Med: The name of Mason's first food-as-medicine prevention and wellness care prototype in the CCHHS (Mason & Campbell, 2011).

Mazeway: The mental image an individual develops and maintains of how the world around and within him or her works (Wallace, 1956).

Medical home: The patient-centered model according to which the hospital or medical services clinic provides a central point of patient care coordination within a hospital system or community of medical care practitioners/providers (Epperly, 2011).

Oak Forest Health Center (OFHC): A 300+ acre healthcare facility under the management of the CCHHS (CCHHS, 2015b).

Patient Protection and Affordable Care Act (PPACA): The healthcare reform law enacted under the Obama administration ("Patient Protection and Affordable Care Act," 2009).

Personal identity: A set of conscious or unconscious images that individuals have of themselves (Wallace, 2003).

Population health: Traditionally in the domain of public health professionals, the focus and management of health outcomes in the general public (*Population Health Implications of the Affordable Care Act: Workshop Summary*, 2013).

Prevention and wellness care: Healthcare services focused on helping the patient avoid health problems such as illness and chronic disease (Berman, 2011a).

Process efficiencies: An organized approach for replacing program processes deemed to be underperforming with higher performing processes (Kumar, 2011).

Process improvement: An organized approach to making changes in a process or program with the goal of improving a targeted outcome (Arar et al., 2011).

Regional food hub: An organization created to source and redistribute food, generally from local farmers and natural foods producers, for the benefit of local and regional residents (Matson, Shaw, & Thayer, 2014).

Assumptions

I made the following assumptions about the present study:

1. Healthcare leaders would see the evaluation of the design of a prevention and wellness care initiative using the revitalization movement framework as beneficial and worth the time and cost to execute.
2. The documented CTH design and design process were unique to this particular case study and therefore provided the primary source data to be analyzed within this research design.
3. Healthcare reform-inspired culture change initiatives will be an ongoing phenomenon within the healthcare industry.

Scope, Delimitations, and Limitations

This instrumental, participatory case study focused on healthcare reform as culture change (Alchin, 2010; Guan et al., 2012), which extends the healthcare reform discussion beyond the more traditional focus on process and program improvement (Arar et al., 2011).

Scope

The central focus throughout this case study was identifying and exploring the presence of culture change from a RMT perspective within the CTH model design.

Within the culture change construct, this case study also used Kingdon's (2011) three streams policy development theory to identify the emerging culture change taking place nationally, as reflected in the development of the PPACA. This emerging national shift in the culture of healthcare became a catalyst for culture change in PPACA compliance-focused initiatives at the local, municipal level. Against this backdrop, the CTH model design was analyzed as an archetype of healthcare reform culture change as well as healthcare reform process and program improvement changes in CCHHS. This distinction between culture change and process improvements is a lens of inquiry revealing links between national policy development and emergent culture change to be realized at the local municipal government level through program designs, implementation, and compliance-oriented initiatives.

Delimitations

The design of CTH was the focus of inquiry in this case study. This focus provided a discrete and bounded research subject that also limits the broader applicability of the research findings. Creswell (2013) discussed having a balance of views as a way to improve the validity of research findings. The CTH concept and design process was launched out of Mason's office when he served as chief medical officer of CCHHS. Raju, the CCHHS CEO, and Schneider, the CCHHS chief operating officer, worked with Mason to translate the CTH concept into a design and development contract within the structure of CCHHS.

Limitations

Because of the limited scope and cost of the CTH design and development contract, a CCHHS board of directors vote was not required to execute the contract. This exception translated into a small, three-person decision-making stakeholder group. Of the three persons, Mason and Schneider were still in the Chicago market at the time this report was prepared. Raju is no longer in the Chicago market. Mason, as of July 2014, was the only one of these three executives still serving in CCHHS executive leadership as the senior executive over the Cook County Department of Public Health. Mason remains the originating, principal visionary and executive stakeholder supervising the development of the CTH model and is the primary person able to explain the origins and intent behind the CTH model design. While the presence and accessibility of this leader were important to this research, these elements also present limitations to the generalizability of the research findings.

This research design was created to offset biases that arose as a result of my participation, which switched between that of a passive observer (February 2012–May 2012 and August 2013–November 2013) and an active facilitator (June 2012–July 2013) relative to CTH design development activities. My role as an active facilitator was narrowly defined as a nonsupervisory role with direct reporting to Mason only. The interview data from Mason and Schneider served as primary data from which to interpret the CTH design and development process. As an active facilitator, I functioned as a contractor with contractually defined roles, responsibilities, and work deliverable

guidelines to meet. I suspended my role as researcher during this contractual period from June 2012 to July 2013. Government documents and personal meeting notes that I maintained throughout the study served as guidance and directives governing my role as an active facilitator and helped in minimizing the potential for excessive researcher bias influencing research outcomes.

Significance

The PPACA has made prevention and wellness a national priority (Fielding et al., 2012), reinforced through changes in the federal healthcare services payment system linking payment reimbursements with patient and population health outcomes (Kaufman, 2011a; Morley et al., 2014). The PPACA has also increased access to healthcare services by previously uninsured citizens. In Cook County, Illinois, 82,0000 previously uninsured citizens enrolled for coverage during a 12-month period ending in 2013, crediting the PPACA for making the coverage possible (Foundation, 2014). Prioritizing prevention and wellness, along with significant increases in patient populations, requires healthcare leaders to have prevention and wellness programs in place that deliver immediate patient health outcome results.

Some healthcare systems will need to change their delivery of healthcare from a culture of sick care to one focused on prevention and wellness. Effective prevention and wellness programs, coupled with equally effective, PPACA-aligned evaluation frameworks, are valuable assets in the PPACA healthcare reform era. This case study was designed to address the need for a PPACA-aligned evaluation framework.

As an evaluation framework, RMT can give healthcare leaders assessment feedback on their prevention and wellness initiatives early in the design and development process. This application of RMT focused on the capacity of healthcare providers' prevention and wellness care programs to facilitate the transition from a culture of sick care to one of prevention and wellness by assessing design features that drive identity change and are correlated to PPACA prevention and wellness mandates. The earlier this evaluation feedback can be collected and analyzed, the more quickly process efficiencies and program adjustments can be executed. These early-stage adjustments provide increased opportunities for program cost savings while improving program capacity to meet projected performance outcomes early in implementation. Meeting and exceeding PPACA prevention and wellness performance outcomes secures a hospital system's federal payments and reimbursements, and thus its fiscal strength and ability to serve.

This case study highlighted the relationship between personal identity and culture change within a healthcare delivery program. The more quickly healthcare systems can make the transition from a culture of sick care to one of prevention and wellness, the more quickly patients and healthcare practitioners will identify with prevention and wellness in their everyday lives. In Cook County, Illinois, this culture shift triggered the opportunity to collaborate with previously uninsured citizens, helping them learn how to prevent illness and promote health beyond what transpires at the doctor's office. This approach has the potential to transform quality of life by promoting a change in the way healthcare practitioners and patients identify with behaviors that promote wellness and

prevention. Improvements in facilitating this transformation may reduce health disparities, improve population health, and raise quality of life for persons previously shut out of the health care system.

Summary

The PPACA has made prevention and wellness a priority performance measurement. Federal payments to hospital systems are tied to patient outcome measures defined by this new priority. For this case study, I explored the use of revitalization movement theory (Wallace, 1956) as a potential evaluation framework suitable for healthcare leaders to use to identify opportunities for design improvements in prevention and wellness care delivery program performance. Applying this framework in the early design and development stages of a prevention and wellness care initiative may yield greater opportunity to improve capacity of the initiative to meet and exceed PPACA policy performance mandates. Doing so could enhance capacity of the hospital system to deliver prevention and wellness care services to previously uninsured patient populations within their jurisdictions.

Chapter 2 is a review the literature relevant to this topic of early stage evaluations of PPACA-compliant prevention and wellness care initiatives. The literature review explores healthcare reform policy development as culture change along with the policy itself being a catalyst for culture change within the healthcare industry. Limited scholarly research is available on evaluation frameworks suitable for assessing emerging PPACA-oriented prevention and wellness programs. There is a particular lack of published

scholarly research addressing rapid culture change in terms of moving a health system from a traditional sick care culture to a prevention-and-wellness care culture. This case study addresses this gap in the extant literature.

Chapter 2: Literature Review

Introduction

The Patient Protection and Affordable Care Act (PPACA) of 2010 made prevention and wellness a national policy priority (Cogan, 2011; Majette, 2011). Programs have to be created, enhanced, and implemented on an unprecedented scale to support this prioritization. A challenge healthcare and public health leaders must address is the need for a policy implementation evaluation approach or tool that can assess the capacity of emerging prevention and wellness programs to help healthcare and public health systems achieve patient and community prevention and wellness outcomes. This new focus translates into calls for behavior change by both patients and practitioners, as highlighted in PPACA (Fontenot, 2013a, 2013b; Mango & Riefberg, 2009)

The purpose of this research was to explore the use of revitalization movement theory (RMT) as a framework for evaluating prevention and wellness care initiatives designed to meet PPACA patient and population health outcomes. In many health systems, PPACA patient and population health outcomes require a change in the culture of the healthcare delivery system as well as the behavior of patients and healthcare practitioners. For example, PPACA requires a shift from a culture of entitlement to one of accountability (Kaufman, 2011b).

The CTH is a PPACA-oriented prevention and wellness care delivery model designed to operate within the CCHHS. Evaluating the CTH during the design stage might drive program efficiencies and cost savings in the early stages of PPACA

prevention-oriented program implementation. CTH program efficiencies raise the capacity of CTH to achieve prevention and wellness goals among the patient population, thus meeting the PPACA performance goals (Koh & Sebelius, 2010; Majette, 2011).

Chapter 2 proceeds with a description of the literature search strategy, followed by a review of the literature in support of this study. The chapter closes with a summary of the literature, positioning the goals of this research relative to the literature.

Literature Search Strategy

This literature search was centered on understanding prevention and wellness within the context of PPACA policy development, implementation, and program evaluation. I used Google to identify federal, state, and local municipal government documents addressing PPACA policy development and implementation. I also searched the following library databases: Thoreau, MEDLINE, CINAHL, PubMed, Science Direct, Health Technology Assessments, NHS Economic Evaluation Database, ProQuest, Political Science Complete, Business Source Premier, SocINDEX, and Google Scholar. Key search terms included *Affordable Care Act*, *accountable care organizations*, *primary medical home*, *health care reform*, *Prevention and Public Health Fund*, *public health*, *healthcare delivery*, *social determinants of health*, *population health trends*, *RMT*, *wellness*, *culture change*, *process improvement*, *chronic disease*, *adherence*, *social change theory*, *healthcare cost*, *healthcare delivery*, *health disparities*, *obesity*, *wellness identity*, *food is medicine*, *behavior change*, *lifestyle diseases*, *healthcare workforce*, *primary care*, and *prevention*.

I followed a four-stage iterative process for this literature search. For the first stage, I searched for the term *PPACA* using Thoreau and MEDLINE databases, which provided the initial set of documents. In the second stage, I refined the search terms to include the research foci (e.g., *prevention*, *cost*, *wellness*, *population health*, *healthcare delivery*, and so on). In the second stage, I also cross-referenced concepts and data from various stakeholders' perspectives. For example, I defined health outcomes from a hospital services perspective as opposed to a public health perspective.

In the third stage, the focus was on the theoretical evaluative framework in a healthcare reform policy context. For the search string in Stage 3, I used an anchor term, such as *healthcare reform*, and added a secondary term such as *culture*, *process improvement*, *revitalization*, *patient care*, *behavior*, *adherence*, *reform*, *prevention*, or *wellness*. For the Stage 3 search, I searched databases such as Google Scholar, Business Source Premier, Science Direct, Health Sciences, Nursing, and PubMed. The goal of Stage 3 was to capture a broader interdisciplinary and total systems perspective on prevention and wellness in the healthcare reform policy context.

For the fourth stage of the literature search, I conducted general Internet searches on themes and references identified in the articles, books, and government documents retrieved during the previous three stages. The goal in the fourth stage was to identify source content missed in the formal databases that could be verified through peer-reviewed journals. I also sought greater clarity of content, context, or intent behind the source documents. With few exceptions, the literature search was focused on articles

published after 2008. When a literature search produced few or no relevant documents in Stage 1, Stages 2 through 4 provided alternate search paths to discoveries of relevant scholarship indexed under terms from a related industry, profession, or school of thought.

Policy as Culture Change

Researchers have made a distinction between the healthcare reform policy development process (Beaussier, 2012; Brownson, Chriqui, & Stamatakis, 2009; Evans, Snooks, Howson, & Davies, 2013) and policy serving as a catalyst for behavior or culture change in healthcare (Brownell & Warner, 2009; Carson, 2007; Everette, 2011). Majette (2011) described the process and people involved in shaping the language of prevention and wellness in the PPACA that suggests that cultural changes, at the societal level, were instrumental in the passage of PPACA. The PPACA policy-making process elevated the importance of prevention and wellness over previous legislation such as the Healthy Lifestyles and Prevention America Act and the Healthy Workforce Act, both of 2007 (Majette, 2011). This increased importance of prevention is a glimpse at how previous policy can influence behavior and culture change while modeling the emerging behavior and culture change during the formulation process. Kingdon (2011) framed the PPACA policy development process as demonstrations of behavior and culture change. Once the PPACA became law, its potential to serve as a catalyst for behavior and culture change in the broader healthcare industry became the focus of healthcare leaders and policy implementers across the United States.

Kingdon (2011) commented on how the complexity of the healthcare system as an interest group served to block healthcare reform prior to PPACA. When the Obama administration took office, Kingdon remarked, members of this interest group agreed on tenets of the PPACA policy language. Globalization and the rising cost of healthcare contributed to changes in this healthcare interest group's culture. In the larger societal context, the PPACA policy-making process was both a symbol of and catalyst for behavioral and culture change. These changes in culture opened a policy window through which PPACA became the new healthcare reform law of the land (Kingdon, 2011).

PPACA as law meant that local municipal healthcare systems were legally required to achieve patient health outcomes that reflected the prevention and wellness mandates of PPACA. For many municipal healthcare systems, this mandate also meant implementing change, shifting from a sick-care culture to one of prevention and wellness care. In Cook County, CCHHS is one of these municipal healthcare systems implementing culture change initiatives to comply with the PPACA. One of the prevention and wellness care culture change initiatives of CCHHS was CTH.

Importance of Prevention and Wellness

Sebelius, former Secretary of Health and Human Services during the Obama presidency, deemed prevention and wellness a national priority (Koh & Sebelius, 2010). Passage of the PPACA led to the creation of the Prevention and Public Health Fund (Grogan, 2012) to reinforce the importance of prevention and wellness in achieving patient and community health outcome goals mandated by the law. Local municipalities

and hospital systems faced three primary challenges in addressing this new national priority: (a) funding is limited and under constant political attack (Feldman, 2011; Tataw, 2011); (b) the law focuses on health and wellness screening (e.g., mammograms and wellness checkups) for prevention and wellness rather than reflecting a broader public health view that targets the social and environmental causes of illness (Hokanson Hawks, 2012b); and (c) a prevention and wellness program under the PPACA must demonstrate multiorganizational collaboration, which, in many cases, extends beyond process or program improvement into complex culture change among all stakeholders involved (Kaufman, 2011b; *Population Health Implications of the Affordable Care Act: Workshop Summary*, 2013; Rooney & Arbaje, 2012).

The RMT framework might help leaders with PPACA policy implementation, especially in assessing the capacity of a program to address challenges early in the program lifecycle. Early resolution of challenges would be of great benefit to goal attainment for PPACA-oriented policy program implementations overall. Of particular importance to this study was determining whether RMT could function as a policy evaluation tool to help leaders distinguish between healthcare reform as process improvement and healthcare reform as culture change (Kash et al., 2014). A prevention and wellness program that meets the PPACA goals must address both types of healthcare reform. A policy evaluation tool that helps leaders know when and whether a PPACA prevention and wellness initiative addresses process-improvement needs versus rapid-culture-change needs might enhance performance outcomes and policy compliance.

Calls for revitalization in healthcare have focused on one or more aspects of the healthcare enterprise, such as primary care, the payment system, care coordination, health records management, and population health (Bhatia & Rifkin, 2010; Fiscella, 2011; Kovner & Knickman, 2008; Lee, 2008). This industry function-focused approach to revitalization reflects a common use of the term in the literature. I have proposed an expanded perspective offered by RMT. This expanded perspective incorporates system changes, process improvements, and organizational culture and operational changes. RMT also extends beyond system changes and process improvements to individuals' beliefs and behaviors relative to the revitalization effort. This type of change at the patient level has been referred to as a transformational change where a life-defining experience or commitment represents a transition from one way of acting and believing to another in the healthcare process (White, 2004).

RMT addresses these transformations at the individual and system levels simultaneously, which is what prevention and wellness programs are challenged to do through the PPACA mandates (Arend, Tsang-Quinn, Levine, & Thomas, 2012; Baird, 2013; Clancy & Newell, 2011; Fiscella, 2011; Majette, 2011; Marien, 2009).

PPACA Prevention and Wellness Policy Formation

Title IV, the prevention and wellness section of PPACA, is an example of how the national health and healthcare cost debates gave rise to the formulation of policy addressing debated issues and to a policy formulation process designed to secure stakeholder support (Majette, 2011). The difference between the broader context and the

more narrow policy focus provides insight into stakeholder interest and intent during the policy development process. Kingdon's (Kingdon, 2011) three streams framework for policy development informed this discussion of the development of Title IV.

Kingdon's Three Streams and Title IV Development

The process of policy formulation yields desirable outcomes through undesirable processes (Project, 2007). Title IV incorporated a broad range of stakeholder inputs, each seeking to influence the way the PPACA addressed prevention and wellness. Policy development, like organizational decision making (Robinson & Eller, 2010), has been compared to a garbage can into which competing and conflicting variables get thrown (Robinson & Eller, 2010). From this perspective of policy development, stakeholder participation and interest are decentralized and driven by self-interest rather than an orchestrated and agreed-upon desirable outcome (Kingdon, 2011). Using this system, Kingdon (2011) identified two system structures: the flow of separate streams of actors and processes, and the coupling of these separate streams to form and inform outcomes that shape the resulting policy. By identifying separate streams of actors and processes, this system model labels some of the actors as policy entrepreneurs when their self-interest seeking behavior can be compared to the entrepreneur striving to influence outcomes in support of a personal agenda (Kingdon, 2011).

Applying this organizational decision-making model to federal policy development, Kingdon (2011) identified three major process streams in the policy development system: (a) problem recognition, (b) the forming and refining of policy

proposals, and (c) politics. In Kingdon's model, each stream can operate independently of the others. When coupled with their corresponding actors, these streams promote or restrict outcomes across the policy development process (Kingdon, 2011; Robinson & Eller, 2010). Figure 1 reflects these three streams.

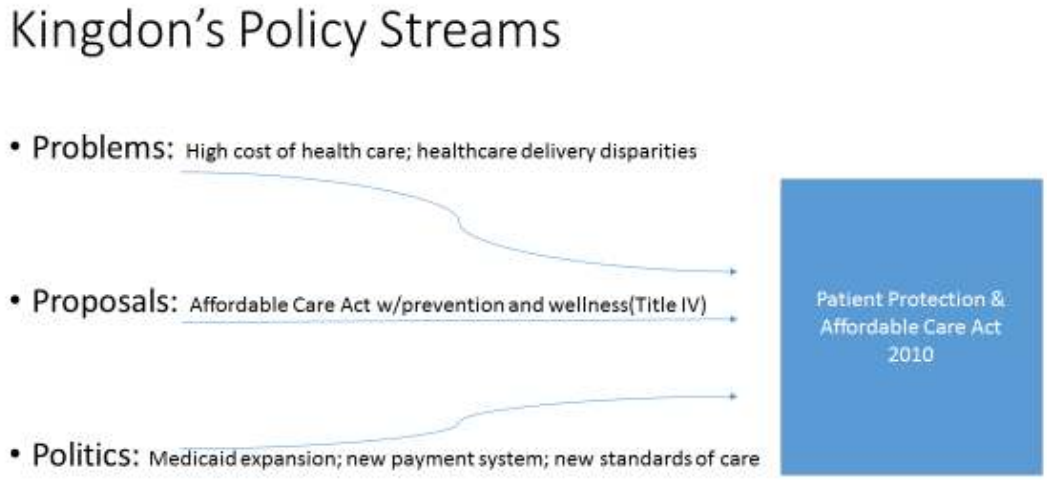

Figure 1. Kingdon's policy streams.

The problem stream. The problem stream is the escalating expense of healthcare delivery (Akushevich et al., 2011; Bodenheimer, Chen, & Bennett, 2009; Grogan, 2012; Yang & Hall, 2008) and the comparatively poor patient and population health outcomes these high costs yield (Click, 2012; Gruber, 2009; Hokanson Hawks, 2013; Kovner & Knickman, 2008; Moore, Eyestone, & Coddington, 2013; O'Connor et al., 2013; Smith, 2012). From an economic perspective, these escalating healthcare costs threaten to exceed federal and state budget allocations, as well as the financial health of employers and employees (Bergner & Thompson, 2013; Carreras, Ibern, Coderch, Sánchez, &

Inoriza, 2013; Kaufman, 2011a; Mango & Riefberg, 2009). In this problem stream, actors come from those areas and agencies in the marketplace affected by this problem of escalating healthcare cost, poor health outcomes, and constricting budgets in the federal, state, local, and private market sectors. Cost played a role in securing broad-based stakeholder support, driving passage of the PPACA into law (Gorin, 2011; Kingdon, 2011).

The proposal stream. The proposal formulation stream for Title IV presented unprecedented opportunities and challenges. Opportunities included the chance to address imbalances in funding for prevention versus medical treatment. Prevention has traditionally received less than 5% of federal and state healthcare budget funding, while medical treatment gets in excess of 85% (Grogan, 2012; Kovner & Knickman, 2008; O'Connor et al., 2013). This budget allocation does not reflect the potential role prevention can play in reducing the need for medical treatments (Benjamin, 2011). The biggest increase in healthcare spending has been attributed to chronic diseases that are also largely preventable lifestyle diseases (Bodenheimer et al., 2009; Hokanson Hawks, 2013; Koh & Sebelius, 2010; Kumar & Nigmatullin, 2010; O'Connor et al., 2013).

Title IV shifted this funding focus while helping key stakeholders of both prevention and treatment components to address negative budgetary impacts of preventable lifestyle diseases. Stakeholders in the proposal formulation stream leveraged a broad-based coalition of industry experts such as healthcare, public health, and policy leaders to craft the prevention language specifically addressing these funding imbalances

(Majette, 2011). In 2008, actors in the proposal formulation stream agreed on policy language that created a national prevention strategy (Benjamin, 2011) and the Prevention and Public Health Fund (Koh & Sebelius, 2010; Majette, 2011).

The political stream. The third and final stream in Kingdon's (2011) model is the political stream. The economic climate of 2008 allowed the Obama administration to secure enough political support to pass the PPACA (Carreras et al., 2013). Comprehensive healthcare reform legislation had been attempted as far back as President Theodore Roosevelt's administration (Kingdon, 2011). The difficulty in passing comprehensive legislation as recently as the Clinton administration has been attributed to the complex network of groups protecting their interests, and the impact of healthcare as an industry sector being one-sixth of the national economy (Kingdon, 2011).

The Obama administration had one benefit previous administrations did not: filibuster-proof control of the Senate in 2008 (Kingdon, 2011). The Obama administration leveraged unprecedented support from citizens and stakeholder groups that previously blocked or did not participate in the healthcare reform legislative process (Kingdon, 2011; Pollack, 2011; Rowland, 2011). Having a political majority in the House and the Senate, and an economic climate serving as a catalyst for stakeholders to jointly seek relief through healthcare reform, the Obama administration overcame opposing campaigns seeking to block passage of the PPACA (Cogan, 2011; Kingdon, 2011; Majette, 2011).

Prevention, Wellness, and Public Health in PPACA

PPACA and Title IV

PPACA (2010) Title IV targets prevention of chronic disease and improving public health. This section of the law contains the largest concentration of language pertaining to prevention, wellness, and population health. Sebelius called prevention and wellness a national priority (Koh & Sebelius, 2010; Majette, 2011). Title IV, Section 4002, established a federal funding instrument for this new national prevention strategy (Benjamin, 2011), the Prevention and Public Health fund. Title IV also calls for modernizing disease prevention, increasing access to preventive services, creating healthier communities, and innovation within the prevention and public health arenas ("Patient Protection and Affordable Care Act," 2009).

Prevention is a key strategy of reaching the population health goals of PPACA (Benjamin, 2011; Koh & Sebelius, 2010; Majette, 2011). Stakeholders supported the crafting of policy language approved through the Health Education Labor and Pension Committee and Health Subcommittee of the Senate Finance Committee (Majette, 2011). There is a difference between what was signed into law by President Obama and the policy language collaboratively developed through congressional committees (Pollack, 2011). Many of these differences referenced included removing investments targeted for funding prevention services such as reproductive health, HIV prevention, and smoking cessation. Pollack (2011) highlighted four positive elements incorporated into the law: (a) expanded medical coverage to support a reduction in racial and ethnic health disparities,

(b) the ability to fund critical public health services through Medicaid eligibility being extended to all American households below 133% of the poverty line, (c) mandates for insurers to cover prevention services, and (d) the creation of the Prevention and Public Health Fund. The challenge for PPACA policy stakeholders is to translate the law into a daily operational reality in healthcare and public health systems.

PPACA: New Guidelines for Practitioners

Healthcare and public health practitioners represent the front line in a battle to defeat chronic disease and illness. This front line is often seen as having two primary objectives: keeping people healthy and restoring health after injury or disease diagnosis (Kovner & Knickman, 2008). This dichotomy is an oversimplification of a much more complex system of actors driving service delivery and health outcomes (Kovner & Knickman, 2008).

The U.S. healthcare system has three primary channels of actors: the government, nonprofit community-based providers, and private sector providers (Wendt, Frisina, & Rothgang, 2009). Any individual hospital system can have a combination of actors and interests from each of these three groups. For the purposes of this present research, a broad-based two-category approach involving healthcare and public health was sufficient for a general understanding of the new service delivery and outcome guidelines of the PPACA. Healthcare practitioners are generally responsible for restoring a person to health after an injury or disease diagnosis, and public health practitioners are generally responsible for keeping people healthy, also referred to as *prevention.*

Restoring health. In the two-category PPACA service delivery system, restoring health is focused on primary care medical service providers positioned to help patients navigate the complex system of general and specialty care options while also helping the patient experience a protective, single-point coordination of care (Davis, Abrams, & Stremikis, 2011). This primary point of contact for medical services is the cornerstone of the patient-centered medical home model (PCMH) (Arend et al., 2012), one of two primary approaches to healthcare delivery under the PPACA.

PCMH creates a collaborative relationship between the patient and healthcare delivery team based on seven key principles: (a) enhanced access to care, (b) continuity of care, (c) comprehensiveness, (d) a team-based approach to care, (e) care coordination and management, (f) a systems-based approach to safety, and (g) a PCMH functions-linked reimbursement structure (Arend et al., 2012; Epperly, 2011). These seven principles make PCMH a highly compatible tool for coordinating healthcare delivery in accordance with PPACA guidelines for increased access and improved patient outcomes at a lower cost of delivery. The second primary approach to healthcare delivery, the accountable care organization (ACO) (Bennett, 2012; Weil, 2012) is akin to the more familiar health maintenance organization (Weil, 2012). This comparison highlights a distinction between the PCMH and ACO approaches. The ACO is a larger system, which must maintain a minimum of 5,000 Medicare patients, that assumes total cost of patient care (Schultz et al., 2013). The PCMH can be as small as a single-doctor primary care office or a network of providers who deliver direct care and coordinate the delivery of

care from other specialist and system services. A PCMH does not assume full responsibility for all patient care cost, whereas an ACO does.

The PPACA established the Medicare Shared Savings Program (MSSP) (Yeung, Burns, & Loiacono, 2011), a mechanism through which the federal government makes payments to healthcare providers serving Medicare patients. Under the MSSP, healthcare providers to provide comprehensive care to the Medicare patient within preset cost guidelines, also known as a bundled payment (Morrissette, 2012). This bundled payment approach led to federal government calls for the formation of ACOs (Rosenbaum, 2011) and encouraged the development of patient care coordination practices that are driven by care outcomes rather than by transaction fees, regardless of the care outcome (*Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, 2013). Those ACOs that develop PCMH patient-centered practices (Bennett, 2012) and deliver cost-effective patient health outcomes at a savings will receive a portion of those savings in additional payments from MSSP (Weil, 2012; Yeung et al., 2011). These two primary models are required to incorporate elements of prevention to meet the cost containment goals and improved PPACA health outcome mandates (Grant & Greene, 2012; Hacker & Walker, 2013; Johnson, 2013).

Public health. Public health, in this two-category system for service delivery under the PPACA, is responsible for keeping people healthy, as it has traditionally done. The public health system meets its responsibility by monitoring food and water safety, addressing disease outbreaks, identifying social and environmental causes for illness and

disease, and providing community-oriented health education services (Hacker & Walker, 2013). Title IV of the PPACA provides new opportunities for public health departments to access funding for their expanded scope of responsibility. Putting this role in perspective, the services provided by public health practitioners historically represented 1–2% of federal and state healthcare budgets, although their services touched more than 50% of the lifestyle-related health behaviors, such as smoking and obesity, identified as major contributors to rising healthcare cost in the United States (Grogan, 2012). Prioritization of prevention and creation of the $15 billion Prevention and Public Health Fund (Pollack, 2011) are new drivers challenging public health departments to find innovative, cost-effective ways to improve population health under the new law.

PPACA, Chronic Disease, and Healthcare Delivery

A major challenge in achieving the healthcare and population health outcomes targeted in PPACA is chronic disease (Kovner & Knickman, 2008; Siu et al., 2009). The number of patients covered under Medicare has been estimated to increase from 46.3 million in 2009 to 77 million in 2031 (Akushevich et al., 2011). This increase in Medicare-covered patients comes at a time when the number of Americans diagnosed with chronic disease is estimated to exceed 45% of the entire population (Akushevich et al., 2011; Kovner & Knickman, 2008). These trends increase healthcare costs nationally and challenge existing models of care delivery locally (Ameringer, 2012; Kovner & Knickman, 2008; Siu et al., 2009; Yang & Hall, 2008).

Addressing Current Challenges in Healthcare Delivery

The U.S. healthcare delivery system has been geared toward effectively treating patients in need of short-term, episode-oriented care (Arend et al., 2012). This care is driven by a transaction-based, fee-for-service payment system with little incentive to efficiently match the care delivered with an accurate measure of the care needed to produce a particular health outcome (Riehle & Hyrkas, 2012). Increases in numbers of chronic disease diagnoses and the transaction-based payment system explain, in part, the rising cost of healthcare. Chronic diseases are long-term conditions that generally require ongoing medical care (Kovner & Knickman, 2008). An effective acute health care delivery system is designed for short-term and episodic trauma care. It is not designed to deliver the long-term care required by chronic illness, particularly in patients who have more than one chronic condition requiring concurrent treatment. Chronic diseases are often linked to a complex assortment of causal factors such as conditions in the home or work environment, mental state, or dietary and other lifestyle habits (Tacón, 2008).

By 2020, 81 million people will be diagnosed with multiple chronic illnesses (Bodenheimer et al., 2009). This trend of growing numbers of multiple chronic disease diagnoses exacerbates the difficulty of aligning the current acute care-oriented healthcare delivery system and the future rising prevalence of chronic disease. Effective treatment of chronic disease challenges more than the care delivery process of the current model. It calls for care delivery practitioners to collaborate under the PPACA bundled payment

system to meet national population health goals (Benjamin, 2011; Kovner & Knickman, 2008; Morrissette, 2012).

PPACA Healthcare Delivery and Population Health

The PPACA provides two primary population health care delivery mechanisms: ACO and a bundled payment system (Hacker & Walker, 2013). Under PPACA, responsibility of the ACO coordinated care team extends past delivery of treatment at a medical facility into the health outcomes experienced by the patient after initial treatment. Some argued this expanded scope of care did not require legislation (Rosenberg, 2012; Wilensky, 2012), while others attributed PPACA to driving the adoption of the ACO healthcare delivery model industry-wide (Rosenbaum, 2011; Schultz et al., 2013). The ACO care coordination team approach supports the second primary population health driver of bundled payments (Perlin & Baggett, 2010). The bundled payment system rewards ACOs for cost-effective medical treatment that reduces the overall cost of patient care (Hacker & Walker, 2013; Hokanson Hawks, 2012b). Under the bundled payment system, patients are referred to the more proficient specialty care practitioners whose services keep overall patient care costs down (Hokanson Hawks, 2012b).

Provider inefficiency, lack of care coordination, and preventable conditions in 2006 represented $375 billion to $525 billion of the $700 billion dollars in estimated healthcare system waste (Moore et al., 2013). A higher level of coordinated patient care services backed by a bundled federal payment system translates to reduced healthcare

system waste and improved patient health outcomes. This objective and result are a matter of legal compliance versus industry best practices deployed at the discretion of industry leaders.

The influence of the PPACA extends beyond providers and patients participating in the federal payment system. Delbanco, the executive director of Catalyst for Payment Reform, discussed how private sector purchasers of healthcare services align with federal payment policies to protect themselves from being used by the healthcare industry to offset lower payments by the federal government (Warren, 2011). The ACO coordination of care model needs more than payment incentives to be successful. Medical care only represents 10% of patient health outcomes; another 50% to 60% are attributed to an individual's health behaviors (Hacker & Walker, 2013). Medical care professionals under PPACA ACOs must expand their understanding of patient treatment outcome goals beyond the boundaries of their clinics and hospitals to maintain wellness where their patients live, work, and experience the causes of the chronic diseases that have challenged the care delivery capacity of the healthcare system (Hacker & Walker, 2013; Hokanson Hawks, 2012b; Rosenberg, 2012).

The Population in Population-Health

Under the PPACA, an ACO must control cost by coordinating total care of patients. Total care extends beyond the clinic and covers all activity related to the conditions for which patients sought medical treatment. This requirement has encouraged many ACOs to adopt the triple aim initiative advocated by the Institute for Healthcare

Improvement (Berwick, Nolan, & Whittington, 2008; Levine, Herbert, Mathews, Serra, & Rutledge, 2011). Under the triple aim approach, the ACO seeks to (a) improve patients' experience of care, (b) improve the health of a defined population, and (c) reduce the per capita cost of care for populations (Berwick et al., 2008; Levine et al., 2011).

While the triple aim approach aligns with the PPACA policy goal of improved patient health outcomes at a reduced cost of care delivery, it does not define what is meant by population (Berwick et al., 2008) or defined population (Levine et al., 2011). The ability to clearly define what is meant by population is a key consideration when evaluating the success or failure of an ACO. This definition of population is also a distinguishing factor for medical care and public health services. The medical care practitioner has traditionally defined population as a group of patients covered by a health plan (*Population Health Implications of the Affordable Care Act: Workshop Summary*, 2013).

Under the PPACA, medical care practitioners must incorporate prevention health strategies as part of their total care and cost control approach. Medical care practitioners must get involved in their patients' lifestyle habits at work and in the community (Hokanson Hawks, 2013). The more medical care practitioners incorporate prevention into their patient treatment protocols, the more those practitioners are reaching into the traditionally defined domain of public health practitioners, whose focus is primarily on prevention of disease and promotion of health to entire communities (Hardcastle et al.,

2011; Kovner & Knickman, 2008). The PPACA expanded the definition of population for medical care practitioners and ACOs. This expanded definition makes prevention an essential element of the care process; however, it does not incorporate the view of population health covering a geographic community in need of comprehensive health and prevention treatment services, as would be the case from a public health perspective (Grogan, 2012; Hardcastle et al., 2011; Mayes & Oliver, 2012).

While these definitions of population fall short of a broad public health scope, they do increase the reach of medical services and thus expand the area of overlap between healthcare and public health (Hardcastle et al., 2011). Hacker and Walker (2013) asserted that the evolving definition of population is influenced by the degree of collaboration between ACOs and community-based healthcare providers. These collaborations might extend the reach of the medical care coordination team, model public health best practices, and increase access to care for whole communities within the service areas of the participating organizations (Hacker & Walker, 2013).

PPACA in Cook County, Illinois

Cook County, Illinois, the second largest county in the United States, comprises 130 municipalities and includes the city of Chicago. In 2010, the county was home to 5.2 million people, which equaled 40% of all Illinois residents (Foundation, 2014; Preckwinkle, 2014). Between 2000 and 2010, Cook County, a large municipality, experienced demographic shifts represented by a 31% increase in total minority population, a median age increase from 37.2 to 38.7, and a 12% increase in the number of

residents between 45 and 64 years of age ("Community Health Status Assessments," 2010). In the southern and western districts of Cook County, median unemployment in 2010 was approximately 12%, with 30% of the population living under 200% of the federal poverty level (Health, 2010). In 2010, suburban Cook County minority mortality rates were higher than those of Illinois and the United States as a whole (Health, 2010).

The Cook County Board of Commissioners oversees the CCHHS, which, until 2012, provided approximately $500 million in uncompensated medical services annually ("CCHHS Announces 115,000 Apply for CountyCare," 2013). Raju, the CCHHS CEO at the time, saw an opportunity in the Medicaid expansion component of the PPACA to help reduce this uncompensated budget amount. The first component of Raju's plan was to apply for permission (1115 demonstration waiver) from the federal government to start enrolling adults in the Cook County PPACA Medicaid expansion plan, called CountyCare, prior to the 2014 designated start date (Illinois Department of Healthcare and Family Services & CCHHS, 2012; Foundation, 2014).

In October 2012, the state of Illinois and CCHHS were granted the 1115 demonstration waiver and began the enrollment process of an estimated 618,000 uninsured adults deemed eligible for CountyCare (Foundation, 2014). CountyCare, under the 1115 demonstration waiver, allowed Cook County to extend medical care coverage to adult residents, ages 19–64 with income at or below 133% of the federal poverty level (Foundation, 2014). Staff of CountyCare reviewed more than 113,000 applications and

approved 82,000 applicants over a 12-month period beginning in February 2013 (Foundation, 2014).

During this same period, CountyCare represented approximately 50% of all Illinois adult residents enrolled in a Medicaid expansion program. With this influx of new and medically insured patients, Raju and CCHHS staff faced another challenge. They were tasked with converting an overburdened, countywide medical care delivery system into a fully operating ACO able to manage the expanded patient population while closing revenue-over-expense shortfalls and achieving PPACA prevention and patient health outcome standards.

CCHHS Revenue Challenge

On October 25, 2013, at a Cook County Commissioners' budget hearing, Raju announced the results of his first 24 months on the job as the CCHHS CEO. As a result of PPACA, CCHHS generated $468 million in new revenue for services provided to patients newly insured under PPACA. PPACA provides payments for services rendered to patients whose health care cost were covered by Cook County tax dollars. In 2012, the annual cost for uncompensated care was $500 million dollars. Raju acknowledged there would be increased costs incurred by CCHHS to serve the increased patient population created by PPACA.

The increased PPACA payments helped reduce the $500 million in uncompensated care incurred annually by CCHHS. Positioning CCHHS to manage this influx of newly insured patients was the basis for Raju's claim of having improved the

financial stability and viability of the health care system that treated anyone who walked through its doors (*CCHHS Budget Hearing, Dr. Raju's Testimony*, 2013). This positive progress is in contrast to reports from 2011 that CCHHS had an $80 million revenue shortfall, was unsure of what direction to take concerning Medicaid reimbursements under PPACA, and anticipated taxpayer subsidy cuts from the county budget (Schorsch, 2011). A contributor to this turnaround was the revenue received through the federal 1115 demonstration waiver, which, in October 2013, was more than $23 million through the CountyCare program (*CCHHS Budget Hearing, Dr. Raju's Testimony*, 2013). This $23 million revenue stream was projected to double once the PPACA was fully implemented in 2014 (*CCHHS Budget Hearing, Dr. Raju's Testimony*, 2013).

The doubling of revenue assumed at least two operational outcomes. First, the patients already enrolled in CountyCare would remain with CountyCare after the 2014 PPACA start date, when they would be eligible to go to other providers for care. During the demonstration period, an adult who signed up with CountyCare was only covered for services provided through CCHHS. As of January 1, 2014, the official launch of PPACA, these same patients were free to seek medical treatment anywhere using their new medical insurance coverage. Raju's $468 million revenue projection assumed CCHHS would have an average of 56,000 CountyCare members on any given day in 2014 (*CCHHS Budget Hearing, Dr. Raju's Testimony*, 2013). This revenue projection accounted for patients' ability to leverage their coverage under PPACA to obtain health insurance and therefore health services from providers other than CountyCare.

Federal reimbursement for services rendered goes to where the patient obtains services. If a former CountyCare member gets healthcare services elsewhere, CountyCare must pay that provider for services rendered to the CountyCare member. CountyCare must therefore retain members, which serves as the basis for the federal reimbursement payment. Likewise, CountyCare must encourage its patient-members to seek their care from CountyCare medical providers. Maintaining an average membership count and direct service delivery rate was critical to CountyCare meeting the $468 million revenue projections made for 2014.

CountyCare patients represent a significant increase to the existing CCHHS patient population. The pre-PPACA patient care process had to be transformed so new and existing patients could obtain a level of care that made them want to keep coming to CCHHS for treatment. The CCHHS care team must now be concerned about a potential loss of patients, something that was not a concern in the past (*CCHHS Budget Hearing, Dr. Raju's Testimony*, 2013; Zwanziger, Khan, & Bamezai, 2010), while also ramping up their capacity to serve a much larger patient population. These operational changes are required at every level of CCHHS. Raju referred to this transformation as moving CCHHS from a patient's last resort to a patient's first choice as a destination for medical care (*CCHHS Budget Hearing, Dr. Raju's Testimony*, 2013).

The transformation made CCHHS an ACO under the PPACA. The second operational outcome assumed increased patient population and improved care coordination process could be accomplished within then-current federal Medicare-

Medicaid reimbursement guidelines (Field, 2011; Keough & Webster, 2013; Morley et al., 2014). To address this assumption, Raju worked to close the deficit gap by reducing the backlog of unpaid patient services. Assumptions withstanding, Raju advanced an organizational vision recasting CCHHS as a provider of choice for all county patients and a responsible investment of tax payer dollars (*CCHHS Announces 70,000 members in CountyCare*, 2014; *CCHHS Budget Hearing, Dr. Raju's Testimony*, 2013; Integrated Clinical Solutions, 2010).

Raju's 4 Ps

Raju's vision was captured in his 4 Ps program (*Minutes of Meeting - CCHHS Board of Directors*, 2013). Raju's 4 Ps program called for CCHHS to be a payer, provider, plan, and population health manager. In 2013, Cook County served as a payer by providing healthcare for employees, retirees, and the non-federal share of county patients' Medicaid (*Minutes of Meeting - CCHHS Board of Directors*, 2013). Cook County provided healthcare services through CCHHS. As a provider, Raju acknowledged CCHHS needed to improve its capacity to serve existing and new PPACA-covered patients (*CCHHS Budget Hearing, Dr. Raju's Testimony*, 2013). CCHHS needed to provide a patient experience that encouraged patients to continue to obtain services and support from the county rather than take their health insurance (and its funds) to a provider not affiliated with CCHHS. The CountyCare plan was composed of 138 primary care access points representing CCHHS-operated facilities and contracted services

through a CountyCare provider network (*CountyCare Member's Handbook*, 2013; *Q+A with Dr. Ram Raju*, 2013).

Raju's (2012) vision called for CountyCare to become a managed care community network (MCCN) (*Minutes of Meeting - CCHHS Board of Directors*, 2013). As a MCCN, CountyCare would seek an HMO license from the state of Illinois with the goal of launching an insurance product on the Illinois health exchange. This expansion of CountyCare positioned CCHHS to provide an affordable health care plan for county residents who did not meet CountyCare income guidelines, yet whose income presents a hardship when buying health insurance from other providers on the state exchange (*Minutes of Meeting - CCHHS Board of Directors*, 2013).

The final *P* in Raju's (2013) 4 Ps program was population health management. In Cook County, leadership of the CCPDH reports directly to the board of commissioners. The department functions fiscally under CCHHS. The CCDPH chief executive at this time was Chief Operating Officer Mason. Under Raju's 4 Ps program, CCDPH represented the population management arm and the fourth P (*Minutes of Meeting - CCHHS Board of Directors*, 2013).

Mason, at the February 28, 2013 meeting of the CCHHS Board of Directors, presented his population health management model, the CTH, although the model was presented as an agenda item as the Healthy Living Center at Oak Forest Health Center (*Minutes of the meeting, CCHHS Board of Directors, Cook Coutny Health and Hospitals Systems held Februrary 28, 2013*, 2013). The following section is an overview of the

CTH model based on materials used for this CCHHS Board of Directors presentation, as documented in the project lead's working notes (Miles, 2013). The project overview document and its accompanying PowerPoint deck are provided in Appendix A.

The Center for Total Health (CTH)

CTH Overview

CCHHS (2012c) waited for a response to the 1115 waiver request. Mason, who was, in 2012, CCHHS chief medical officer, strategized on a wellness center prototype: Farm-Med. Farm-Med was designed to help address negative chronic disease trends in Cook County, Illinois. The Farm-Med wellness model promoted the use of food, particularly vegetables, fruits, herbs, and natural supplements as a cost-effective method to treat individuals diagnosed with chronic conditions such as diabetes, high blood pressure, and obesity.

Mason and his team conducted a 6-month test of patient receptivity to the Farm-Med wellness model. This test incorporated garden planting, harvesting, and produce cooking as instructional content to supplement existing occupational therapy training for patients diagnosed with diabetes (Mason & Campbell, 2011). The enhanced occupational therapy training took place at the Oak Forest Health Center (OFHC) (n.d.), a 300+ acre campus and former long-term residential CCHHS hospital. Mason, the OFHC occupational therapy team, and master gardeners/program directors from the University of Illinois extension program considered Farm-Med a success (Mason, personal communication, July 25, 2012). Success was defined as the patients learning and

practicing new gardening, cooking, and preventive health lifestyle management skills. This positive feedback helped secure approval through the CCHHS municipal board of directors during the third quarter of 2012 to design a full-service prevention and wellness care delivery model based on Mason's work and the results of the Farm-Med initiative.

The intent of this proposed prevention and wellness care delivery model was to medically treat CCHHS patients' chronic health conditions related to food and lifestyle through protocols that prescriptively applied evidence-based food and lifestyle behavior change as part of a medical treatment program. The early stages of this design work produced a healthcare delivery model (CTH). The CTH model was designed to help advance the CCHHS healthcare reform agenda by serving patients in the south suburban region of Cook County and by providing additional patient care delivery support to enhance CountyCare (*CCHHS Prepares for Affordable Care Act*, 2013; Foundation, 2014). The CTH approach to prevention and wellness care was projected to improve the capacity of CCHHS to meet PPACA wellness and prevention mandates (Mason, personal communication, July 26, 2012).

The CTH was designed to be an evidence based prevention and wellness care delivery system (Mason, 2013c) that promotes living a positive and active life, which includes growing, consuming, and experiencing the natural foods, natural environments, and positive social experiences available within one's local or regional area as part of a daily regimen focused on optimizing physical, mental, and spiritual wellbeing (Ashcroft, 2011; Ferdjani, 2010; Ferkany, 2012; Morales, 2011).

CTH Challenges and Success Measurements

The CTH design requirements were shaped by a list of four healthcare reform challenges Mason wanted to address in support of PPACA compliance initiatives. Each challenge was presented as a question to be addressed by the CTH design.

- Challenge 1: How does a municipality achieve the health outcomes and performance mandates specified in the PPACA?
- Challenge 2: How will healthcare reform initiatives address healthcare delivery and health outcomes disparities, particularly in minority and impoverished communities?
- Challenge 3: Can the use of fruits, vegetables, and other measureable lifestyle habits be prescriptively applied at the community level to reduce chronic disease while also improving socioeconomic conditions for the community being served?
- Challenge 4: Can the PCMH approach to care coordination be expanded to cost-effectively and routinely deliver primary care in the patient's home versus a medical clinic?

These challenges helped shape the prevention and wellness care delivery agenda of the CTH model. In addition to these four challenges, the CTH design called for key measures of performance to be defined.

In the CTH design, performance is tracked based on five success measurements:

- Success Measurement 1: The reduction in patient obesity rates.

- Success Measurement 2: The reduction in the need and use of pharmacological prescription drugs by patients.
- Success Measurement 3: The increased consumption of plant-based, nutrient-dense foods by patients and staff.
- Success Measurement 4: The increased physical movement, measured through range of motion, strength, and endurance.
- Success Measurement 5: The number of healthcare delivery personnel trained in CTH wellness and prevention delivery protocols.

The CTH prevention and wellness care delivery model incorporated these four challenge considerations and five success measures. During a design review (see Appendix A, CTH Overview), Mason (2013a) wanted to evaluate the CTH design from a theoretical perspective. Mason expressed interest in having the CTH prevention and wellness design elements reviewed with the goal of identifying opportunities for design optimization and implementation of cost containment controls.

Evaluating the CTH Model Design

CTH was designed to perform as a specialty medical services clinic within CCHHS. As a specialty clinic, CTH obtained referrals from within the system and worked with other primary care and specialty care units, enhancing the ability of CCHHS to serve the increased patient enrollment created by the PPACA. As a specialty clinic, the CTH performance was designed to be rated on Mason's five success measurements. Collecting metrics in each of these five performance areas was a relatively

straightforward task. Also straightforward was the challenge of getting patients to adhere to CTH treatment protocols (Desroches et al., 2011; Greer, Brondolo, & Brown, 2013; Smith, 2012; Williamson et al., 2010).

The complexities in this discussion of adherence led the CTH design team to understand CTH as a culture change initiative for CCHHS, CTH patients, and the CTH care delivery team. With the PPACA performance outcomes established, CTH was intended to facilitate a culture change while achieving cost-effective patient wellness outcome measures in a 3- to 5-year window; the timeline set by Mason and communicated to the CCHHS board of directors (*Minutes of Meeting - CCHHS Board of Directors*, 2013).

Culture Change and CTH

Using a general definition of culture as norms, values, assumptions, and behaviors held by the vast majority within an organization, community, or social group (Alchin, 2010), the CTH design needed to take into account the CCHHS as an organizational culture, southern Cook County as a set of communities, and the patient or practitioner groups as social groups, each having a defined culture (Alchin, 2010; Kash et al., 2014; Seren & Baykal, 2007). Having this mixture of culture groups made the more traditional, single organizational culture change model (Recardo, 2011) less applicable as additional and varied culture groups were incorporated into the scope of service the CTH model was designed to serve. Researchers have linked culture with performance and leadership (Hartmann & Khademian, 2010) while paying little attention to the type of personal

transformation (Hartman & Zimberoff, 2009; White, 2004) the CTH model design sought to implement. The design team set out to find an evaluation framework for short-cycle, culture change initiatives taking place within a healthcare system. A search through the literature led to Wallace's (1956) RMT, a five-stage culture change model characterized by short time period culture change initiatives that focus on personal and systems transformation.

Revitalization Movement Theory

Wallace (2009) advocated for the need to celebrate the diversity in cultures, which was a call for an appreciation of culture as more than groups or people with similar traits and behaviors. This more nuanced approach to the study of culture is evident in Wallace's (1956) seminal work on revitalization movements, which are deliberate, organized, conscious efforts to rapidly construct a more satisfying culture. Wallace (1956) described cultural revitalization as a special culture change phenomenon incorporating (a) persons' perceptions of their culture as a system, (b) persons' belief this system was unsatisfactory, and (c) person's desire to create a new cultural system. An additional distinguishing trait of cultural revitalization is the compressed schedule, as short as a few years, under which the culture change takes place. Wallace (1956) observed the change happens abruptly and simultaneously through intentional action on the part of those going through the culture change process.

There are five stages of intentional action by those going through the culture change. In Stage 1, the original steady state, individuals manage their daily activities and

stressors by making adjustments in behavior to handle the challenges within established cultural practices (Wallace, 2003). In Stage 2, the period of increased individual stress, culturally sensitive behavior adjustments no longer yield relief from daily stressors. These daily stressors challenge an individual's ability to accept the cultural guidelines that allow, promote, or even create these stressors. This challenge is increased as an individual experiences additional anxiety when attempts to make lifestyle behavior changes to reduce stress are looked upon with suspicion or even as a threat to the culture's population (Wallace, 2003).

In Stage 3 of Wallace's (1956) culture change, the period of cultural distortion, is a time when chronic stress provokes outward behavior due to the growing ineffectiveness of personal efforts to release stress or be relieved of unacceptable cultural conditions. This emerging behavior can manifest in self-destructive or community-relationship disturbing ways. Substance abuse and interpersonal violence are examples. In this third stage, Wallace (1956) asserted that people will either rigidly hold to a personal existence defined by chronic stress or seek cultural substitutions for unacceptable conditions. Stage 4, the period of revitalization, is characterized by those persons seeking cultural substitutions taking action to make these substitutions normative and therefore actively engaged in changing the inadequate culture. Substituting undesirable cultural systems, ways of thinking and practices (also called mazeways) for more desirable ones is the primary thrust of this revitalization stage (Wallace, 2003). In Stage 5, the new steady state, culture changes have transformed the lives of those seeking relief and have

survived challenges from the larger society; these individuals are now accepted as normative within a culture context (Wallace, 2003).

This five-stage process of intentional personal action and behavior drives these culture changes. Abrupt change means change takes place in as little as a few years, in contrast to a more traditional view of culture change as gradual action-reaction cycles taking place over multiple generations and even millennia (Wallace, 1956). Driving this abrupt change in culture is people's intention to address life-threatening levels of stress and unsatisfactory culture or cultural system conditions, or mazeways (Wallace, 1956). Using the analogy of a living organism, Wallace (1956) described culture as having many elements and moving parts, ranging from nonhuman systems and structures on the micro end, to the varying cells and organs of people undergoing the culture change process on the macro end of the scale. This robust culture change framework positions Wallace's (1956) RMT as a fitting theoretical framework through which to evaluate CTH.

RMT and the CTH

CTH was designed to help CCHHS meet PPACA policy mandates of serving more people while improving patient health outcomes at a lower cost for delivery of care. This description of CTH as a specialty clinic within CCHHS to help CCHHS transform its delivery of healthcare while transforming health outcomes, thus a rapid cultural systems change for patients and practitioners alike, suggested RMT as a strong potential candidate for implementation in the evaluation of the CTH model. Evaluation of the model design focused on alignment between design elements of the model and projected

outcomes the model is expected to produce once fully operational. Capturing misalignments during the preimplementation time period might yield cost-saving efficiencies, a critical benefit for municipally funded, budget-constrained healthcare delivery operations.

The framework of RMT as an evaluation tool for the CTH model design provided multiple points of investigation aligned with PPACA policy implementation guidelines. First, a distinguishing quality of a revitalization movement is its compressed schedule during which the revitalization process must take place. Wallace (1956) believed this time period is as short as a few years, compared to generations for traditional definitions of culture change as a process. CTH was designed to achieve its culture change goals with patients and practitioners in two to five 12-month budget cycles, which are based on funding cycles linked to federal reimbursement rates and program evaluation standards.

In the RMT framework, human and nonhuman systems are extensions of each other. A breakdown or stressor in one element has an impact on the whole. This oneness of all moving parts—or from a cultural lens, the interconnectedness of the various mazeways—is instructional for evaluating a health and wellness delivery program designed to address calls for a transformed health care delivery system and patient wellness outcomes (Giordano et al., 2010; Habersack & Luschin, 2013; Halpin et al., 2010; Hardcastle et al., 2011; Wahlqvist, 2014). PPACA calls for prioritizing wellness and prevention to reduce the cost of healthcare delivery while increasing access to care and quality of life. To meet this new priority, healthcare systems must create seamless

patient care transitions between primary care services and the various specialty clinics in a health system. Primary care and specialty clinic care become integrated extensions of one another from the patient care and health care services delivery perspectives (Koh & Sebelius, 2010).

The approach to wellness and prevention care delivery of CTH is based on PPACA population health objectives. The model requires a total systems view of health and wellness that removes traditional barriers of responsibility between what takes place in the medical clinic and what takes place in the patient's home or community. CTH also removes the traditional barriers of accountability for outcomes and behaviors. The patient and practitioner must partner for success and treatment adherence (Branda et al., 2013; Clancy & Newell, 2011; Desroches et al., 2011; Smith, 2012).

Wallace's (1956) explication of RMT invokes both direct and indirect references to personal identity. A person's cultural systems, practices, and beliefs dictate his or her behavior and often the outcome of experience in relationship to the revitalization movement. In a new steady state, some people hold so rigidly to the existing culture, even after it has proven to be inadequate in promoting a satisfying lifestyle, that they die under chronic stress rather than embrace mazeway, or cultural systems reformulations (Wallace, 1956).

Various identities are possibly in a revitalization movement. If the participant's cultural system calls for radical actions against a dominant culture, this identity has one set of consequences; a person with a more conciliatory identity, or one that promotes

separation and noncontact has different consequences. The role of personal identity as shaped by an individual's mazeway provides a backdrop for evaluating CTH systems and how program participants engage personal identity as part of the transformation process. CTH is a subculture, or mazeway system, in the larger CCHHS culture. This subculture emphasizes wellness and prevention; the typical emphasis of a healthcare culture is on medical treatment and prescription medicines.

Under PPACA, the patient initially experiences both. For CTH to achieve the projected patient health outcomes, it must help the patient and CTH practitioner identify with wellness and prevention treatment protocols over the more traditional medical procedures and prescribed pharmacological treatments. Using RMT, the CTH patient treatment and services process can be evaluated based on each patient's stage of the patient engagement strategy and how the patient identifies with and engages a wellness and prevention identity. How the patient identifies with and engages his or her wellness and prevention identity has been shown to produce improved patient outcomes (Aronson et al., 2013; Fontaine, 2013; Haack, 2014; Lamiani et al., 2008; Remmers, 2008; Wahlqvist, 2014).

Wellness Identity

In the CTH model, wellness is the central theme and driver of the definition of total health. Total health is a state of regeneration that enhances an individual's ability to enjoy life, family, and community (Mason, 2013e). Wellness is directly related to an individual's experience of life and living on a daily basis (Sanders, Mullins, & Zetts,

2012). Wellness models help us measure and manage these life experiences, improving our capacity to promote desirable life experiences, such as wellness, over undesirable life experiences. Wellness is a measurement outcome objective of the CTH model.

Wellness models take on two primary approaches. The first approach is a multidimensional construct (Roscoe, 2009). The multidimensions of wellness are grouped into categories that reflect the individual's actions and experiences of, for example, a social, emotional, physical, intellectual, spiritual, psychological, occupational, and environmental nature (Roscoe, 2009; Sanders et al., 2012). The second approach is a broad continuum, ranging from experiences of wellness on one end to disease on the other (Harari, Waehler, & Rogers, 2005). In the CTH model design, these two general approaches inform the CTH definition of total health.

One model that demonstrates a merging of these two approaches to wellness is reorganizational healing (Epstein, Senzon, & Lemberger, 2009). ROH highlights the importance of an individual's perception of health and illness such that a disease can serve as a catalyst for growth that promotes self-healing (Epstein et al., 2009). From an ROH perspective, an individual has the power to leverage an experience from any point along the continuum of wellness and from within any dimension of wellness, and through perception, turn that experience into an opportunity for healing and improving his or her experience of life.

Assuming that perception is an individual choice, CTH focused on wellness as a personal identity to be expressed and developed, as the patient enters into a collaborative

journey to achieve improved experiences of wellness and multidimensional healing (Epstein et al., 2009). These individual perceptions are projected to shape or reshape individual identity and inform individual behavior (Epstein et al., 2009). Through the wellness identity motif, CTH engages the patient utilizing awareness-raising exercises designed to help the patient become more aware of wellness perceptions. The goal is to help the patient identify suitable options for shifting wellness perceptions, if undesirable, or leveraging them, if desirable, toward achieving improved wellness in life experience. This shifting or leveraging process might transcend a simple behavior change exercise and usher the patient into a personal and sometimes collective culture change.

The patient and practitioner explore the question of what wellness looks like as a daily experience (Mason, 2013c). This question may serve as an awareness-raising tool, ushering all parties to share their thoughts and explore their personal perspectives on wellness and the role of external factors contributing to perceptions of wellness. This activity makes the CTH patient treatment process a culture change model with an identity (perception) of wellness as the catalyst for change, even culture change (Esmiol, Knudson-Martin, & Delgado, 2012; Krohn, 2013; Page-Reeves et al., 2013), and therefore the focal point of a mazeway reformulation (Wallace, 1956).

Summary and Conclusions

The PPACA (2010) made prevention and wellness a priority for healthcare systems across the United States. Under the PPACA, patient outcome measures are centered on how well a hospital system can deliver healthcare services that reduce or

eliminate the patient's need for ongoing and/ or repeat medical attention, especially for the same ailment. This approach to care delivery requires many health systems to undergo a culture change within a short period of time while achieving patient health outcomes. This approach has also placed pressure on healthcare leaders to expeditiously execute culture change initiatives, moving healthcare delivery culture from one focused on sick care to one focused on keeping people well, a prevention and wellness care culture.

The literature covers healthcare reform as process and program improvements. There has been considerable discussion regarding healthcare becoming more humanizing and culturally sensitive in the face of shifting demographics and changes in the health care needs of the general American population. This literature mainly discusses process and program improvements within a sick care health delivery culture. There has been limited discussion in the literature on how to evaluate the PPACA reform initiatives necessary to successfully execute a comprehensive culture change quickly. I explored this evaluative approach with the goal of providing feedback healthcare leaders can use to improve the performance of prevention and wellness care initiatives in the early stages of PPACA-related program implementations. RMT may fill this gap in practice by serving as an evaluation framework that concurrently incorporates system- and human-level changes through a five-stage process that clarifies wellness as an identity in a new healthcare delivery culture.

The RMT evaluative framework was applied to the CTH at CCHHS. The evaluation feedback was presented to CCHHS and Illinois healthcare policy executives to explore the applicability and receptivity of the RMT evaluation framework. Chapter 3 is a description of the instrumental, participatory case study approach I used in this explorative study.

Chapter 3: Research Method

Introduction

This instrumental case study was an exploration of the application of RMT (Wallace, 1956) as an evaluation tool to provide healthcare leaders with feedback in the early design and development stages of prevention and wellness initiatives created in response to PPACA legislation. This unique application of RMT helped to distinguish between healthcare reform as process improvement and healthcare reform as culture change. PPACA prevention and wellness outcomes call for process improvements, which, for some hospital systems, require changes in their healthcare delivery culture (Ameringer, 2012; Bauer, 2010; "Seizing Opportunities for Reform," 2011). Under the PPACA, healthcare providers are legally and financially accountable for patient care outcomes (Boult et al., 2009; Fielding et al., 2012).

The ability to evaluate the capacity of a prevention and wellness initiative to facilitate the shift of culture in a healthcare institution from one of sick care to one of prevention and wellness care (Garrett, 2011; Marvasti & Stafford, 2012) is important in the PPACA healthcare reform era (Johnson, 2011). Under the PPACA, hospitals and healthcare service providers are paid based on patient treatment outcomes versus the previous payment system that paid for care delivery transactions without direct accountability for patient health outcomes (Barksdale et al., 2014). This change in the federal healthcare payment system reinforces PPACA mandates for improved health outcomes among patients for healthcare providers across the country.

The CTH design initiative was a clearly defined case created to fulfill three primary requirements: (a) be in compliance with PPACA, (b) support the healthcare reform agenda of CCHHS, and (c) serve as a catalyst prioritizing prevention and wellness care delivery practices and outcomes in CCHHS. These requirements represent support and facilitation of culture change in CCHHS as the institution makes the shift from a culture of sick care to a prevention and wellness care approach (Raju, 2013). Chapter 3 includes a discussion of the rationale for using an instrumental, participatory approach for this qualitative case study (Creswell, 2013; Yin, 2014). Next, the role of the researcher, methodology, and methods used to support the stated purpose of this case study are explained. The chapter concludes with a discussion of trustworthiness.

Research Design and Rationale

Research Question

The research question that drove this study was the following: How could revitalization movement theory (RMT) serve as an evaluation framework for prevention and wellness care initiatives under the PPACA?

Central Concept

The central concept informing this study was the need for a program evaluation framework that can assess PPACA-oriented prevention and wellness care initiatives requiring a culture change early in the design and development process of the initiative. Funding for prevention and wellness care pilot projects under the PPACA typically cover a period of between 2 and 5 years (Barksdale et al., 2014; Zigmond, 2012). These

funding cycles provide a timeline for evaluation of program outcomes. At the point of evaluation, the goal of the Centers for Medicare and Medicaid Services is for pilot projects(Medicaid, 2012) such as CTH to become prototypes for prevention, wellness, and patient care coordination standards across the United States. This goal translates into an expectation that healthcare systems across the country will accomplish changes in their care delivery and patient health outcomes that meet the PPACA prevention and wellness standards within these same 2- to 5-year funding periods. In hospital systems with a deeply ingrained approach to sick care, this refocus equals a call for culture change within a 2- to 5-year period.

A 2- to 5-year period for culture change is considered a short or compressed schedule (Wallace, 1956). Applying an evaluation framework to the preimplementation design of a prevention and wellness care demonstration project delivery model would help expedite process efficiencies and program improvements. Expediting process efficiencies and program improvements would directly support the goal of a health system to design, implement, and achieve PPACA population health wellness outcomes within 24-36 months. This need for an evaluation process to help healthcare leaders meet PPACA population health wellness and prevention guidelines highlights the significance of applying RMT to the CTH model design. The results of this application could prove significant to healthcare leaders across the country seeking to design and implement healthcare delivery programs compliant with PPACA.

The distinguishing quality of RMT (Wallace, 1956) is the compressed schedule under which culture change takes place. CTH was designed to achieve its culture change goals with patients and practitioners within two to five 12-month budget cycles. For RMT and CTH, culture change involves people and systems. In CCHHS, culture change involves patient treatment protocols as well as the behavior of patients and healthcare delivery practitioners. With RMT, the key to achieving a sustainable short-cycle change in culture is a mazeway (Wallace, 1956)—or worldview—shift. This mazeway shift has been likened to a shift in personal identity. For CTH, the culture change goal is for patients, practitioners, and system processes to shift their focus and thus identity from treating sickness to promoting wellness. This shift goal, when achieved, is what is considered under RMT a revitalized identity; in this case, the identity is centered on achieving and sustaining wellness.

The CTH preimplementation design called for this wellness identity to facilitate patients' shift from low to moderately active participation in their healing and wellness to being empowered, collaborative partners with healthcare practitioners, advancing their health and wellness. Preimplementation design addressed the need for a shift from a high dependency on medical pharmacology to a focus on learning and using lifestyle, behavior, nutrition, and physical movement as the first line of prevention and wellness in response to the threat or presence of chronic disease and illness. These shifts required the healthcare practitioner and patient to identify with a wellness care mindset as their new identity, thus abandoning the previous sick care mindset (Berman, 2011b; Garrett, 2011).

These shifts in mazeways at the patient/practitioner level and in systems at the hospital/clinic level, for CTH, represented a call for PPACA-compliant culture change within a short period of time.

Research Tradition and Rationale

The qualitative participatory framework best supported the need for this study to capture data from multiple sources, including observation, interviewing using open-ended questions, and document analysis (Yin, 2011). The single case, instrumental research design approach is anchored in an understanding that healthcare leaders across this country, as a result of PPACA legislation, are challenged to achieve improved patient health outcomes by integrating prevention and wellness practices into their regular healthcare delivery operation (Lee, 2012; Myers, 2013). While CTH is a single case, it is representative of challenges faced by healthcare leaders across the United States.

This single case study has both intrinsic and instrumental value (Creswell, 2013;Yin, 2011) in that it represents the application of a social science culture change model as an evaluation tool in the healthcare reform arena. The present case study is instrumental in that it explored the use of this social science evaluation tool with a particular lens on its effectiveness in helping healthcare leadership develop and implement prevention and wellness initiatives in compliance with PPACA that have the capacity to serve as catalysts for the shift in a healthcare delivery culture from a sick-care orientation to a prevention-and-wellness-care orientation. One example in the literature of a single case study in PPACA healthcare reform research used instrumentally is the

Silver Cross Hospital study (Morrissette, 2012). Morrissette (2012) studied governance issues related to the hospital making the transition to becoming an ACO in compliance with PPACA. The Silver Cross Hospital case study highlighted the connection between this transition in Silver Cross Hospital with equivalent transitions being embarked upon by hospitals across the country (Morrissette, 2012). I explored healthcare reform as culture change, not just a management system-process change, as was the case with Silver Cross Hospital. In applying the RMT evaluation framework to the CTH model design, I have aimed toward healthcare leaders across the United States who are embarking on culture change initiatives involving prevention and wellness initiatives finding common points of applicability within the single case study.

Role of the Researcher

My involvement in the CTH project was that of an active participant and a passive observer. As an active participant, I worked on the CTH design project for 1 year with the task of converting Mason's CTH vision into an implemental CCHHS specialty care clinic. As passive observer, I secured permission to analyze the CTH design and interview Dr. Mason as part of this participatory, instrumental single case study.

The goal of this participatory case study was to analyze the use of RMT as a policy evaluation framework for PPACA prevention and wellness policy implementation programs. Using publicly available CCHHS and Cook County Council meeting documents along with interviews of CCHHS executives, I intended to apply all collected data, including transcribed interviews and personal work notes, toward analyzing the

efficacy of using RMT as a policy evaluation tool. For this study, the perspectives of CCHHS senior executive leadership were secured via personal interviewing and primary source documentation, such as minutes of meetings and official public proceedings. These primary source data were beyond my personal and professional control at all times, thus serving to minimize the potential impact of personal researcher bias due to my contracted service to design the CTH model.

Methodology

This participatory, instrumental case study, institutional review board approval 05-01-15-0131070, was focused on the design of the CTH prevention and wellness care delivery model. Interviewing, collecting, and examining were three of the four types of data collection methods (Yin, 2011) used in this research. The primary interview subject for this study was Mason, the principal who introduced the CTH approach to prevention and wellness in CCHHS. The interview was designed to capture the original intent behind the decision to design the CTH prevention and wellness care delivery model in CCHHS. Mason was the sole principal aware of the original intent behind the CTH model. Raju and Schneider offered additional perspectives on perceived benefits that CTH implementation would bring to healthcare reform efforts at other healthcare systems in Illinois and across the United States.

Documented proceedings from public meetings were used to provide primary source data regarding leadership perspectives on the CTH model design and implementation. Interview data served two primary purposes. The first purpose was to

help interpret the intended outcomes and design approach chosen by Mason, as reflected in the CTH model design and as presented to the CCHHS Board of Directors (CCHHS, 2013g; see Appendix A). The second purpose of the interview data was to minimize researcher bias by giving the interviewee the opportunity to review and amend a copy of the transcribed interview to ensure that the interview content was accurately represented. Each interviewee was offered a copy of the completed dissertation as part of the consent form and process.

Collecting and examining constituted the second data collection approach (Yin, 2011) used in this research. The CTH design process was reflected in many documents that were publicly available. These documents included online versions of CCHHS board meeting minutes; Cook County, Illinois contracts; RFPs; and newspaper articles. Additional documents that were accessed included relevant sections from my personal project progress reports and other project development or design-relevant reports that were presented at public forums by me as a professional or at the direction of Mason. These documents, some of which were official Cook County municipal documents, represented primary source data capturing the CTH design process, as well as political and organizational context. There were no other known primary source documents related to the CTH design process.

Interview Protocol

Following Creswell (2013a), I used the following interview protocol:

1. Interview research questions were based on the case study research focus and written to be open ended. The focus was twofold: capturing the intent behind the design of CTH first and subsequently applying RMT as an evaluation framework. I asked the following open-ended questions:
    - What was the original intent behind the design of CTH?
    - Based on the original intent, how would CTH help CCHHS meet the PPACA standards?
    - What impact, from an administrator's perspective, would the implementation of CTH in CCHHS, if ultimately funded, have on patients? on medical staff? on administration?
    - How would you propose evaluating the performance of a prevention and wellness care delivery model like CTH?
2. An onsite, in-person interview was arranged, scheduled to last between 30 and 60 minutes. A general overview of the case study using CTH program design language presented at the CCHHS Board of Directors meeting was e-mailed to the interviewee and then followed up by a phone call requesting the interviewee's participation. Using this language, with a stated understanding that the goal of the study was to explore evaluating the design of the CTH model, reduced the potential for interviewee response bias. The interview was expected to take place at the interviewee's office or a mutually agreeable alternative location conducive to conducting and recording the interview.

Once the interviewee agreed to the interview, a copy of the interview consent form and interview questions were forwarded to the interviewee for review.

3. The interview was digitally recorded using a Livescribe pen and digitized notebook. I made handwritten notes to augment the digital recording. I notified the interviewee when the audio portion of the interview was being recorded and when the audio recording function was turned off.
4. I provided the interview questions and a research participant consent form to the research participant prior to starting the interview. I requested that the interviewee sign the consent form and provided an opportunity for the interviewee to ask any clarifying questions prior to starting. Any questions from the interviewee, at this stage, were noted in writing but not recorded digitally. I reviewed follow-up steps described in the consent form with the interviewee. The first follow-up step was an opportunity to review the transcribed interview for accuracy. The second follow-up step was the option to receive a copy of the completed dissertation.
5. The interview commenced using open-ended questions with clarifying follow-up questions used when appropriate to better understand the interviewee's response.
6. The interview session closed with a statement of appreciation and a reminder of the two-step follow-up process and option. The interviewee was not

required to take any additional action after this interview session's two-step follow-up process.

7. The interview session was transcribed and sent to the interviewee for review. A follow-up phone call verified requested changes and/or the accuracy of the interview transcription.
8. The interview data were coded using the interviewee's words and themes first, followed by thematic code names represented in the literature relevant to this case study (Creswell, 2013).

Data Analysis

Interview data along with relevant primary source documents were analyzed follow the coding approach described above. For this data coding process, I used MAXQDA data analysis software to uncover primary source document themes to identify the presence of revitalization movement theory principles (see RMT five stages in Appendix B) in the primary source data. The analysis focused on the activities and targeted outcomes reflected in the source data. CTH designed activities and projected outcomes formed a basis through which a three-tiered evaluation could take place. For the first tier, I looked for alignment between CTH-designed activities and CTH program projected outcomes. If the goal was to have patients eating more vegetables and fruits, a Tier 1 analysis sought to identify statements in the design document linking that outcome with a documented activity in the CTH design.

For the second tier, I compared the themes connected to these activities and outcomes with the principles of the five-stage revitalization movement process. The first- and second-tier data analysis connected directly with the primary focus of the research question, applying RMT principles to the CTH design document to evaluate the claim by that the model could be a catalyst for culture change in CCHHS. The third tier expanded the scope of the analysis to source documents beyond the final CTH design document. This third tier was used to capture background information such as organizational context and influences external to the immediate CTH design process. The background information in the third tier data analysis was intended to capture data related to culture and identity change references within the larger CCHHS network. The references were analyzed using the RMT mazeway reformulation process descriptions to identify possibilities for CTH to have design features that reflect RMT culture transformation at the individual and system level.

This coding and analysis allowed for the disassembly and reassembly of the collected data (Yin, 2011) from varying viewpoints, as documented in the source data. This approach to data analysis allowed me to identify interactions between themes and more thoroughly assess the presence or absence of RMT principles in the CTH design document and design process, as reflected in the source data.

Trustworthiness

Credibility, dependability, and confirmability are three of the four issues addressed under trustworthiness (Creswell, 2013; Yin, 2011). Credibility in this case

study was addressed by using triangulation and member checking as validation strategies. Triangulation was represented by the use of primary source documents that are publicly accessible by law and reflective of the CTH design process. An additional form of triangulation is reflected in the coding and analysis process, which I used to identify themes across all primary source data and then analyzed links between these themes from different perspectives using the disassembly-reassembly approach (Yin, 2011). As part of the data coding and analysis process, triangulation addressed dependability within the context of the trustworthiness discussion. I sent the transcribed interview to the interviewee to ensure accuracy, thus leveraging member checking to enhance research validity.

All primary source data were identified with bibliographic citations, Internet links, or copies of source data content in the appendices. My role as researcher-participant and researcher-observer was fully disclosed to address potential biases resulting from my participant role and relationships. This role as participant ended in August 2013. My work as project lead on the CTH design project was thoroughly disclosed in Chapter 1. This work was guided by contractual agreements and supervised by Dr. Terry Mason. Language from the work contract and publicly presented representations of the CTH design provided authentication of the official CTH design document, thus minimizing potential biases in the representation of the CTH model design.

Any gaps between my work notes, participant observations, and these official representations of the CTH model design were disclosed in the analysis with priority given to official CTH model design documentation. Creating this data management and prioritization protocol should facilitate increased awareness of my location in each tier of data analysis, and promote greater reflexivity in the overall research design. The data management prioritization protocol served as confirmation of the rigor applied to the data collection and analysis approach I followed in conducting this case study.

Generalizability is the second trustworthiness issue. The CTH model design applies to a prevention and wellness care delivery unit designed to operate within the healthcare system of a local municipal government, in compliance with the PPACA. With the passage of the PPACA, other local municipal governments with healthcare systems are addressing PPACA compliance matters, such as the prevention and wellness mandates in Title IV. Private hospital systems receiving federal payments for healthcare services are also required to meet the Title IV prevention and wellness care mandates.

Findings and conclusions based on this case study will provide healthcare leaders with a unique approach to evaluating PPACA-oriented prevention and wellness care models in the design stage. An effective early stage evaluation of a prevention and wellness care delivery model can present measureable cost savings while promoting efficiencies in patient care and improved patient care outcomes. Cost savings, process efficiencies, and improved patient care outcomes are PPACA goals. The CTH model design was a specific case study that, by itself, is not directly generalizable. The lessons

learned from the case study can provide insight to healthcare leaders across the country that are challenged to consistently meet or exceed PPACA outcome goals.

Ethical Considerations

All documents and names of persons included in this case study came from public records, published minutes of official meetings, or project progress reports that are part of the public record for the CTH project or a related CCHHS, or Cook County, Illinois, government proceeding. The case study represents an analysis of the CTH model design and, therefore, does not include the names or accounts of any CCHHS patients. There are no references to healthcare providers or CCHHS staff that are not part of an official, accessible public record. The healthcare providers referenced are Dr. Raju, the former CEO of CCHHS; Dr. Mason, the chief executive of the CCDPH and visionary for the CTH model; and Mrs. Schneider, the former COO for CCHHS. Dr. Mason, as the principal visionary and champion for CTH, was the only CCHHS leader whose participation in this case study interview process had a direct impact on the ability to address the research question or the open-ended questions posed to help answer that research question.

I reviewed my contracts and my personal work notes before inclusion in the formal research document. As part of this review, I removed identifying data not pertinent to the CTH model design. Examples of language I removed include addresses, phone numbers, names of staff members, contract price, terms, conditions, and references to personnel assignments. Primary source data that included descriptive language that

directly dealt with the CTH design, the CTH design process, and CTH related information that are publicly reported and relevant to this case study were used.

Appendix A contains an example of extracted language from these source documents. This level of primary source document redaction eliminated any inadvertent disclosure of sensitive personal or organizational information outside of formal organizational protocols for public information requests. This redaction helped maintain a primary focus on the case study analysis of the CTH model design.

The CTH design primary source data were provided to me as part of my professional services confidential client portfolio. As such, the source data were managed according to existing professional client services policies and practices. The redacted documents and research specific source data are included in my academic records and personal filing system. All data were kept in password-protected files on external data drives kept in a locked office cabinet in my private office. These records will be maintained in this form for three years, after which, they will be destroyed.

All prospective interviewees were senior executive leaders, established in their respective professions. There were no known additional ethical considerations, undisclosed relationships, or potential conflicts of interest. If unforeseen ethical concerns had arisen, I would have immediately notified my dissertation committee chair and sought additional guidance from appropriate school officials or resources.

Summary

I explored RMT as an evaluation framework for PPACA prevention and wellness care programs. The intent was to provide healthcare leaders a potential model they could use to evaluate the capacity of their PPACA prevention and wellness care programs to facilitate culture and identity changes from a focus of sick care to one of prevention and wellness care. In this instrumental, participatory case study, I used interviewing along with locating and examining primary data as collection tools. Through a three-tiered data analysis process, I used triangulation to promote credibility. Primary data source documents were used to mitigate researcher bias, and data coding was done to identify culture and identity change themes across all case study data.

Chapter 4: Results

Introduction

The purpose of this study was to explore the effectiveness of RMT (Wallace, 2003) as a framework for evaluating emerging PPACA-oriented prevention and wellness care initiatives early in the design and development process. This evaluation framework has the potential to provide healthcare system leaders with critical feedback they can use to facilitate federally mandated (Koh & Sebelius, 2010) shifts from a healthcare system culture focused predominantly on sick care to one focused on prevention and wellness care. The CTH established by the CCHHS is a PPACA-compliant prevention and wellness care delivery model designed to operate in the Cook County, Illinois, municipal health and hospital system network. As an example of a PPACA prevention and wellness policy implementation, CTH was an appropriate case to use in this study. The results of this study have the potential to enhance prevention and wellness care program operating efficiencies and delivery of care cost savings in the early stages of implementation of an initiative. This study focused on three principal healthcare system executives responsible for the creation of the CTH concept and its organizational approval to be designed and developed. A CTH program that is implemented efficiently improves the ability to realize primary prevention and wellness patient outcome service goals while also meeting cost of service delivery containment guidelines, both of which are established in the PPACA (Koh & Sebelius, 2010; Majette, 2011).

The following research question supported the focus of this study on RMT as the evaluation framework: How could revitalization movement theory serve as an evaluation framework for prevention and wellness care programs under the PPACA? In addition to a review of documents, most of which were in the public domain, this study incorporated interviews of three senior healthcare executives and analysis of their responses to the following interview questions:

1. What was the original intent behind the design of CTH?
2. Based on the original intent, how would CTH help CCHHS meet the PPACA standards?
3. What impact, from an administrator's perspective, would the implementation of CTH in CCHHS, if ultimately funded, have on patients? on medical staff? on administration?
4. How would you propose evaluating the performance of a prevention and wellness care delivery model like CTH?

This chapter presents a summary of the interviews I conducted as part of this study. In this chapter, I also describe the setting, demographics, data collection process, data analysis process, and evidence of trustworthiness. The chapter concludes with study results and a summary of the answers to the interview questions.

Setting

All interviews took place at either the interviewee's primary office or virtually, using an online teleconferencing system. Being flexible as to the setting, allowed each

interviewee to choose an interview time and location that was most convenient. All interviews were completed within a single session. Two of the interviews were interrupted by telephone calls or staff requests. The interruptions were minor and the interview was completed as planned.

Demographics and Data Collection

A group of 25 source documents and interviews with three key leaders of CCHHS and the CTH served as primary sources of data. Source data were grouped into three general categories: respondents' interviews, CTH presentations, and CTH progress reports. These general categories provided a structured approach for my review of data and identification of steps taken in the conception and design phases of the CTH model. The focus of the study on early design activities for a prevention and wellness initiative called for a logical starting point that optimized identification of the design elements in the overall CTH development process. This collection and grouping of source documents provided a contextual lens through which I analyzed leadership-action and leadership-intent. In addition to highlighting the leaders' actions and intent in the source data, intercategory and intracategory source data analysis provided the basis for identifying thematic connections. These thematic connections helped in linking identified healthcare leadership actions and intent with the presence or absence of principles characteristic of a revitalization movement that paralleled the RMT model.

The participant population for this single case study was made up of the three senior municipal healthcare executives responsible for creation and approval of the CTH

design project at CCHHS. These three senior healthcare executives represented the intent and actions of CCHHS leadership. RMT is a charismatic leadership-driven culture change model that requires an understanding of the actions and intent of principal leadership. Collecting and analyzing data from interviews with these three leaders yielded insights helpful in addressing the research questions regarding the application of RMT as an evaluation tool for PPACA prevention and wellness programs. Additional data collection source material included primary source documents, such as documented public proceedings, public testimony, or secondary source documents such as organizational reports and newspaper articles. These additional data sources helped confirm links between content from the leadership interviews and the larger CCHHS as a culture under stress and in transition.

Each interview in the data collection process followed a standard format. I used the same set of questions for each interview and asked additional clarifying questions as needed. The four open-ended interview questions I posed were designed for a 30- to 60-minute interview session. The actual interview session times varied from 30 minutes to 105 minutes. The lengthier interview periods were necessary to accommodate staff or phone call interruptions. In one case, the extended time was necessary to allow the interviewee to provide more extensive responses to the standard interview questions. All three interviewees appeared comfortable, engaged, and expressed agreement for the importance of the study topic. Each interview was audiotaped and transcribed. Each

interview transcript was subsequently reviewed by the respective interviewee and, in some cases, edited to reflect the specific intentions of the interviewees.

The goal of my preliminary analysis was to incorporate interview transcripts and other primary source documents into a process I would use to identify key themes from which an initial coding structure could be created. I used MaxQData11 software to compare this initial manual coding structure and to conduct a word search analysis across primary and secondary source data documents, as well as to facilitate intersource data analysis.

Data Analysis

This study followed a multistage approach to data analysis. For this process, I categorized source documents, conducted preliminary manual data coding, created and evaluated metathemes within the data, and compared these metathemes to Wallace's (2003) RMT five-stage framework. The RMT five-stage framework includes the following stages:

- Stage 1: steady state, a period of generally satisfactory adaptation to the social and natural environment of a group.
- Stage 2: a period of increased individual stress, when changes in the social or natural environment impede individuals' efforts to obtain and sustain normal satisfaction of their needs, although the group, as a whole, is still able to survive using cultural behavior norms.

- Stage 3: a period of cultural distortion, in which the majority of group members find changes in their social or natural environment to drastically reduce their capacity to satisfy physical and emotional needs through accustomed cultural behavior norms.
- Stage 4: a period of revitalization, when a charismatic leader-driven process takes place that identifies and communicates alternative cultural norms and mindsets designed to offset existing cultural distortions and the related stressors being experienced by the group. The group then develops and deploys these alternative cultural norms and mindsets into a new shared lifestyle, which is seen as better able to address the physical and emotional needs of the group as a whole.
- Stage 5: a new steady state; a generally satisfactory adaptation to the group's changed social and/or natural environment.

For the next stage of source data analysis, I integrated secondary documents and organized them into three groups. In Group 1, I placed all the interview data. In Group 2, I placed the CTH project presentation and project progress reports. In Group 3, I placed CTH-related and supporting secondary documents. Many of the Group 3 documents are proceedings from public municipal meetings, forums, or news releases containing CTH information relevant to this study. By regrouping the source documents, I was able to perform a systematic preliminary analysis that I could convert into a primary coding structure.

I began primary manual coding by identifying a representative group of 29 key words (e.g., *wellness*, *prevention*, *care*, *culture*, *patient*, *system*, *time*, *change*, *evaluation*, and *process*) in the primary source documents that reflected the focus of the study. These 29 keywords are shown in Table 1, grouped into their respective categories by color to facilitate my identification of categories and metathemes once the codes were uploaded into MaxQData11.

Table 1

Primary Codes and Categories

Primary codes (by color)			
Blue	Green	Orange	Purple
Care	Behavior	Administration	Period
Health	Change	Culture	Term
Prevention	Evaluation	Executive	Time

Primary codes (by color)			
Blue	Green	Orange	Purple
Wellness	Improve	Framework	Year
	Intent	Hospital	
	Outcome	Patient	
	Performance	Practitioner	
	Process	System	
	Reform	View	
	Stress		
	Transition		

Note. Blue codes = PPACA policy categories. Green codes = change catalyst. Orange codes = potential for change. Purple codes= interval measurements.

Using these preliminary codes and categories as a first-level manual coding strategy provided an organized approach for systematically disassembling source document data while allowing metatheme categories to emerge within a framework relevant to the study. Metathemes emerged from within as well as across source documents. The following quote is an example of keywords leading to metathemes within a single primary source document:

> Really, that's a part of *health policy* that was in play—but then we were back to the *family* again, aren't we? What's going on to that *medical home concept*? What is *impactful*? [*sic*] I think that would have been the fun part—to be able to *measure* and look at *outcomes* from a clinical trial. (Interviewee 1)

Interviewee 1's comment included keywords (e.g., *policy*, *impact*, and *outcomes*). It reveals relational category themes (e.g., family, measure, and medical home concept). *Family*, as used here, emerged in a metatheme as another name for *patient* (orange code) in the analysis. *Medical home concept* is associated with a metatheme related to delivery of care and hospital systems (Andrews, Darnell, McBride, & Gehlert, 2013; Gray, Weng, & Holmboe, 2012; Sanford, 2013), and so, in applying preliminary coding, I placed this phrase into the orange code group. *Health care* is associated with the blue code. *Measure* and *outcome*, as used here, reflect a driver of change in the hospital system. The notion that this process could be *fun* suggested a positive perception of the potential for change resulting from implementation of a PPACA-compliant initiative.

Interviewee 2 said, “The medical team needs to understand and appreciate the value of food in the treatment process,” a statement that incorporates the language of systems culture change, suggesting that the medical team needs to go beyond organizational changes in daily operating practices and procedures (i.e., process changes) and engage a change effort that includes shifts in how they view their actions during daily operational care delivery practices and protocols. This emphasis on developing an *appreciation* for food as a core component of patient treatment protocols is an example of emergent intercode: Intersource themes point toward a call for culture change, versus a call for daily operational process improvements. An example of this culture change is captured in Mason’s (2013c) reference to the patient services process protocol relative to the patient’s wellness journey: “the goal is to reinforce . . . and help the patient . . . by integrating tri-logic nutrition . . . for their wellness journey” (Mason, 2013d).

Interviewee 2 remarked on the prevailing cultural mindset in the healthcare industry. This statement is an example of a proactive stance toward industry culture change:

> The people who really push the food products are being looked upon as charlatans; they're not really the kind of guys with the scientific medical backgrounds. The medical world does not look at them very favorably. . . . Food as a medicine is a scientific concept, and it has a lot of science in it, and we haven’t yet adequately articulated this. . . . That is what we were starting to do. (Interviewee 2)

There are preliminary code and category matches in the three comments mentioned above. An emergent metatheme connecting stress and a change movement in the culture of a healthcare system is revealed. The stress and change movement are core tenets of the five stages of revitalization in RMT (Wallace, 2003). Interviewee 2 mentioned medical practitioners who are pushing for the change (food as medicine) in a healthcare delivery culture that looks negatively on this idea, and thus on them. Intersource metathemes introduce the RMT concept of stress, which is a primary catalyst that gives rise to calls for change focused on culture more than change predominantly focused on daily processes and procedures.

Interviewee 2's statement included a call for effective communication by leaders espousing food as a medical treatment protocol. Leaders' effective communication is another central principle of the RMT model (Wallace, 2003). According to RMT, communication is the second element and an important pillar in the process of initiating stakeholder buy-in for the desired culture change. As Interviewee 2 explained, culture change is an understanding of food as a scientifically viable alternative to medical treatment protocols and should be integrated into the protocols. During my data analysis, this quote emerged in the preliminary coding stage, as well as in the intersource metatheme analysis under *systems-culture change by practitioners*. This quote, coupled with similar references from other primary source documents, also emerged under the metatheme of *adaptation*, the fourth element in the initiation and anchoring of a RMT culture change. According to RMT, adaptation is important for determining whether a

revitalization movement has the potential to produce lasting change in a larger cultural context. Adaptation metathemes appear as "food as a medicine is a scientific concept" (Interviewee 2) coupled with the call to "adequately articulate" (Interviewee 2), implying this understanding of food as medicine is scientific.

Charismatic leadership is a core tenet of RMT; however it is nuanced in a particular type of charismatic leadership. This nuance incorporates vision and engagement of the supernatural (Wallace, 2003). The supernatural aspect of RMT charismatic leadership was coded as a spiritual metatheme, although the data do include potential proxy words (e.g. God, spiritual, calling). The supernatural dimension of program leadership emerged in the single source and intersource metatheme analysis. The following are examples of this particular type of charismatic leadership. Interviewee 1 explained, "The value of the Center for Total Health . . . was to re-infuse life-giving water." Interviewee 3 said, "Spiritually . . . I can believe in that. . . . It gives me something to believe . . . to strive for . . . something beyond myself." Interviewee 3 also said, "My calling is . . . to provide a source for the truth," and " "God puts us in a place . . . to do better . . . that divine guidance will help . . . find other folks that feel and think the same way."

At each stage of coding and analysis, the concept of time as a measureable variable was present in the data. According to RMT (Wallace, 2003), time is an accelerated concept. In RMT, this acceleration is attributed to an individual adopting a worldview he or she believes will bring a better physical and emotional quality of life.

Adopting this new worldview is key to the accelerated or rapid pace creation or adoption of a new culture. The analysis of time in this study revealed varying and sometimes opposing views on time as a measurement from an RMT perspective.

Interviewee 2 to time in the context of implementing CTH, saying, “This is a 25-, 30-, 40-year kind of investment . . . to see the changes.” Interviewee 1 said about time, “[We have to] make sure we have at least a 10- to 20-year commitment” to validate CTH population health outcomes. Here, time is nuanced as a performance evaluation measurement. This nuanced reference to time connects initial patient outcomes, an immediate program performance measurement, with an added evaluation time period focused on measuring the impact of the initial patient outcomes on measurements of the larger population’s health. Using time in this manner connects two levels of evaluation measurement. The first level is an implied shorter term, three- to five-year immediate patient outcome evaluation. The second level is a much lengthier period of tracking and data collection more typical of a longitudinal research or population health study. When grouped together, as was the case in Interviewee 1’s comment, this time reference does not meet the RMT definition of a rapid cycle culture change.

Regarding strategies and challenges for funding prevention and wellness initiatives like CTH, Interviewee 2 said, “Because these kinds are really long-term initiatives, they're not short-term initiatives, because short-term initiatives involve the sick care model.” Using the term *sick care* is a direct reference to the pre-PPACA dominant cultural mindset of the healthcare industry. This statement was the only

instance in the data where the RMT rapid-cycle culture change concept was referred to as being a problem. Interviewee 2 addressed time, culture, and a conceptualized perception of implied organizational change. This emerging logic could be stated as follows: If *sick care* is a short-term initiative (no longer effective) and *these kinds* (i.e., CTH-like prevention and wellness care programs) are *long-term* initiatives (much more effective and efficient), then we need to move away from sick care short-term initiatives to the wellness and prevention care long-term initiatives. Making this change requires more than a daily procedural modification. The RMT-oriented logic flow is best expressed as follows: helping patients and practitioners adopt and internalize a prevention and wellness care mindset would quicken the pace of change from a sick care culture to a wellness and prevention care culture, thus ensuring long-term sustainable results in a shorter period of time.

A shift from sick care to wellness and prevention care calls for a corresponding shift in mindset or worldview. One example of this call for a corresponding mindset shift, as Interviewee 2 expressed, is a need to better articulate the scientific efficacy of food as medicine. The current hospital system employs a sick care culture mindset; does not accept food as medicine. The current hospital system involves a culture focused on and adept at providing acute care for episodic health events. Supporters of this cultural mindset respond to these episodic health events by treating the immediate presenting symptoms with medication or surgery (or both); these approaches are important components in the short-term acute and episodic sick care patient treatment process. The

acute care episodic approach is inefficient in treating the growing number of cases of chronic lifestyle diseases such as diabetes, heart disease, and obesity (Hokanson Hawks, 2013; Moore et al., 2013; Reeve et al., 2013). The current sick care mindset does not consider food as a potential replacement for medication and surgery. The prevention and wellness care mindset does. RMT calls for a change from the sick care cultural worldview to the prevention and wellness care cultural worldview for there to be an appreciable change in patient treatment protocols incorporating the use of food as a substantive component in the patient treatment process (Hideki et al., 2014; Momenizadeh et al., 2014; Wahlqvist, 2014).

Attempts to change patient or population health outcomes without substantive changes to the sick care mindset are more representative of process improvement and slow multigenerational culture change. RMT calls for rapid cycles, shorter time periods, and culture change outcomes through a change in the mindset of individuals involved in the culture change. PPACA patient outcomes will be achieved much faster when healthcare practitioners and patients adopt and internalize a prevention and wellness care identity as their own. This change in patients' and practitioners' identity drives the rapid-cycle change to the hospital system culture.

The RMT framework highlights the connection between time as a measurement of culture change and the mindset/identity of the individuals involved in the culture change. The data reflect respondents' perspectives of time as secondarily important to the culture change process. Interviewee 2 expressed sentiments relative to time in the sick

care to wellness care culture change process as follows: "These are long-term strategies, the benefit of which won't be appreciable for a couple of years." Use of the term *long-term* is unexpected because it is grouped with a direct reference to having measureable patient care outcomes metrics in "a couple of years." Although the reference to *a couple of years* complements the RMT principle of rapid cycle culture change attributable to change in mindset and identity, the reference to the process being a *long-term* one, from a metatheme perspective, speaks to decades. The mention of *a couple of years* is the most direct reference to the RMT principle of rapid cycle time in the data. The overall analysis led me to place more weight on the notion of a *long-term strategy* versus the reference to *a couple of years*, although a couple of years would still align with an RMT rapid cycle culture change.

Using word frequency and metatheme analysis to understand this single and specific reference to a shorter change cycle was more than mitigated by calls for longer periods of time within which a change in the hospital system culture could be realized, along with prolonged periods of gradual changes to the mindset and patients or healthcare practitioners. *Time*, as a word concept, emerged 61 times in the data and more than 100 times as a theme related to change and transition. While *time* is well represented in the data, its usage was not in clear alignment with the RMT concept of a rapid cycle culture change. The data suggest CCHHS leaders are united in the call for a culture change, but how this change will occur as a measurement of time is much less clear. On occasion, this so-called united front for a culture change contradicts the much more direct call for a

shift from the current culture of sick care to a care delivery system and culture focused on prevention and wellness, as mandated by the PPACA. Identifying this mismatch to the use of time in the design of PPACA prevention and wellness-compliant programs provides a glimpse into the effectiveness of RMT as an evaluation tool for such programs. There is a need to clarify leaders' understanding of time as part of the culture change process. Such a clarification will help ensure a positive correlation between culture change processes, performance measurement metrics, and time as one of those performance metrics. This additional clarification was beyond the scope of the current data set and case study.

Evidence of Trustworthiness

Credibility, Dependability, and Confirmability

Using a triangulation process to enhance the credibility of the current study, I cross-referenced data codes and linked them, connecting data in individual documents to themes and metathemes identified across source documents, as shown in Table 2.

Table 2

CTH and CCHHS Source Documents

CCHHS		CTH project	
Leadership interviews	Organizational documents	Progress reports	Presentations
Interviewee 1, 30 minutes	Letter from CEO	Preliminary findings report	Farm-Med executive summary
Interviewee 2, 30 minutes	Dr. Raju's vision	Strategy recommendations report	CCHHS board presentation
Interviewee 3, 96 minutes	Board of directors strategic planning session report	CTH logic	CTH creative strategy brief
	Cook County budget hearing: Dr. Raju's CCHHS testimony	CTH status report	CTH overview: research
	Board of directors minutes: leadership/ system changes	Patient service process	CTH overview: programs
	Farm-Med scope of work: CTH design project parameters	CTH strategy recommendations report task list	Food as medicine brief sheet overview
	CTH scope of work: proposed extended scope of work		

I transcribed all of the audio-recorded interviews and returned the transcripts to the respective interviewee for validation(Yin, 2011), and made any modifications or additions to the transcript requested by the interviewees. The interview transcripts were validated as primary source documents only after each interviewee returned his transcript and indicated the transcript was complete and accurate. This process of member checking helped ensure each transcript accurately reflected the study participants' responses to the interview questions. The approved interview transcripts then served as additional primary source data for the multitiered triangulation process discussed in Chapter 3. Tier 1 represented links between source documents and the CTH design process. Tier 2 represented explored links between the research question, primary source data, and the RMT framework. Tier 3 was an expansion of the previous analysis to incorporate data describing the broader setting (culture) in which the CTH design process took place.

Transferability

The focus of the study was on evaluating the CTH design process, which limits the scope of the study to the CTH model, as defined by Mason (2012a), within the CCHHS culture in Cook County, Illinois, over a 12-month period from fall 2012 to fall 2013. According to Yin (2011), the findings of this single case study have the potential to be applied to other cases defined by the following characteristics:

- a healthcare reform culture change;
- a leadership-driven initiative based on PPACA compliance;

- hospital system initiatives focused on culture shifts from sick care to prevention and wellness care;
- hospital system initiatives using a food-as-medicine care delivery approach; or
- a municipal public healthcare systems seeking to improve compliance with PPACA wellness and prevention care outcome requirements.

This narrowly defined justification for transferability aligns with Yin's (2011) explanation of the two steps in analytic generalization. Step 1 was met in the direct application of RMT (Wallace, 2003) and Kingdon's (2011) three streams policy development theory. Step 2 of this process was to apply RMT and the three streams policy development to case studies identified has having similar defining characteristics as CTH. While Yin's (2011) two-step approach provides guidance for the application of these research findings to other similar case studies, I do not expect there to be a large number of cases similar to the defining characteristics of CTH, as presented in this research.

Results

The research question that drove this study was, "How could revitalization movement theory serve as an evaluation framework for prevention and wellness care programs under the PPACA?" Using RMT as an evaluation framework for PPACA-compliant prevention and wellness care programs, as was proposed in this study, called for the CTH program documentation and source documents to provide

- a clear identification of an intractable issue, the stress catalyst that erodes the quality of life for a defined group of people;
- a clearly delineated charismatic leadership role that anchors and drives the identity transformation process in CCHHS;
- presence of personal identity and transformation themes (i.e., wellness) for patient and practitioner, intentionally embedded in the program design; and
- a clear understanding of the program as a subculture representing prevention and wellness care as an adaptation or change to the larger CCHHS sick care culture.

Stress Catalyst

The intractable stress issue addressed in the CTH prevention and wellness care delivery model design is the struggle to provide access and adherence to healthcare with a focus on promoting prevention and wellness as a lifestyle in the patient's home and community. Elements are represented throughout the source data. Chronic diseases (e.g., diabetes, chronic obstructive pulmonary disease, hypertension, and obesity) are intractable stressors, as demonstrated by population health trends in the United States since the early 2000s (Li & O'Connell, 2012; Ward-Smith, 2010). The challenge for the present study was to identify wellness and prevention care rhetoric that referenced culture change in the healthcare industry versus references that promoted process improvements while leaving the sick care culture unchanged. PPACA identifies one aspect of this distinction through measures of improved health in the larger community. The following

quotes exemplify the rhetoric related to issues of prevention and wellness in the larger population:

> 100 million people in the United States have at least one chronic condition. Lower income and minority populations . . . have the greatest chronic disease burden. Yet . . . health systems have the fewest resources to provide high-quality chronic care. (Mason & Campbell, 2011)

> Men and women are then unable to provide for themselves and their children. It's a stressful situation . . . at the same time when you're adapting to the food that's available in your community and you do not have that source that teaches you how to still cook or even know that you should cook. (Interviewee 3)

> We have to look at the destructive nature of the food that we've been fed that has actually created the diseases that we see as manifest in the communities that many of us live in. (Interviewee 3)

Wellness is mentioned in the data as a personal experience. For patients and practitioners, the loss or limitation of experience with personal wellness is attributable to lifestyle habits and environmental conditions. These conditions can be negatively affected by public policies. Chronic disease, a growing trend among the U.S. population (Carreras et al., 2013; Moore et al., 2013; Smidth, Christensen, Olesen, & Vedsted, 2013), is evidence of the need to do something different to address rapidly decreasing wellness indicators. In addition to decreasing illness as an intractable issue, inadequacy of a national healthcare system represents a systemic stress in terms of addressing this

challenge to the health of U.S. residents (Ford et al., 2013; Johnson, 2013; Kindig & Isham, 2014). Data from the interviewees reflect CTH was designed to address the stress catalysts that challenge patients' and practitioners' ability to experience wellness as a lifestyle, at home and in their communities (Mason, 2012a, 2012b, 2013a, 2013d; Raju, 2012; Raju, , 2013).

Charismatic Leader

In RMT (Wallace, 2003), the charismatic leader is the person who has a vision and calling characterized as almost supernatural. Data from the interviewees revealed that among CCHHS leadership, the CTH wellness and prevention work was perceived as originating in and having a purpose that extended beyond professional ethics; it was characterized as coming from a *God*-ordained vision of healthy people in healthy communities practicing wellness daily:

> I think God puts us in a place where we know you're supposed to do better and He will or that divine guidance will help you find other folks that [*sic*] feel and think the same way you do. (Interviewee 3)
>
> For example, the reason why we really embarked on this whole thing about the Center for Total Health is . . . in my mind, 99.9% of all the problems are food-related—physical, spiritual, or mental food. All three, or combinations thereof. It's all related. (Interviewee 3)
>
> That's why I understand a little more what Jesus said: "Father, forgive them, because they know not what they do." I'm not saying I'm Jesus, but I

> understand what that meant because that's when you've given your life and your life's work to try to make something better for people. (Interviewee 3)

The CTH data reveal this sense of the supernatural is a shared understanding. Interviewee 3 was the most vocal about personally embodying the mantle of charismatic leader. Emerging metathemes support an interpretation of the wellness and prevention agenda containing references to transcendence as core tenets in CTH programming and definitions of patients' outcome measures. The CTH design documentation refers to nourishment as a prerequisite to wellness. This reference to nourishment extends physical food to incorporate mental and spiritual nutrition (e.g., "all the problems are food-related—physical, spiritual, or mental food"; Interviewee 3). Interviewee 3's comment about food as being physical, mental, and spiritual reinforces a leadership mindset of the program being designed to deliver care that reaches beyond traditional sick care, predominately body-centric traditional care practices. Defining food as having three primary representations—physical, mental, and spiritual—highlighted a thematic discourse in the data leading to wellness being more than a short-term treatment protocol. Wellness emerged as an identity needing to be embraced and even co-defined by both patients and practitioners (Mason, 2013d).

CTH was designed to include seven supporting research institutes, of which one is "Mind-Body-Spirit Studies"(Mason, 2013b). The CTH credo (see Appendix A) includes the following statement: "I believe total health is my right and responsibility… I commit my mind, body, and spirit toward experiencing and sharing total health, every day." The

credo includes nine personal pledges a program participant is invited to adopt. Two of the nine credo pledges involve the notion of one spirit. The first example is, “Exercise my body, mind, and spirit regularly,” and the second example is, “Seek spiritual harmony.” A third credo statement is, “Honor my ‘true’ self,” which suggests an expanded or expanding understanding of self, which reflects the RMT mazeway reformulation change individuals experience as they allow their worldview and thus their personal identity to be transformed by the vision of a new way of life.

This third statement supports the reference to reformulation, but it is not as explicit as the first two examples, which focused on spirituality. Analysis of this third statement points to RMT as an evaluation framework. Therefore, the explicit references to spiritual or spirituality in the context of wellness and prevention distinguish between wellness and prevention as mind or as body. As such, the third statement regarding one’s true self is evidence of wellness and prevention identity expansion, but lacking a clear indication of how this idea of true self provides a distinct function in the CTH wellness and prevention model. The RMT framework calls for a distinct transformation of a participating individual’s worldview and personal identity(Wallace, 2003).

Wellness Identity Transformation

The care delivery team is a priority for CTH; as such, one of the metrics of success for the CTH is development of a community health and wellness delivery team (see Appendix A). As Mason (2013b) explained,

> Delivery of this type of wellness care must come through a wellness-workforce that is technically proficient, culturally effective, and patient-customer oriented. This wellness-workforce [*sic*] will need to be trained and equipped to deliver these wellness protocols and training to the patient-customer at their home and in their communities on a daily basis. (Mason, 2013b)

Another success metric is to identify and quantify *measureable lifestyle changes and positive health outcomes* by patients, practitioners, and other program stakeholders. A documented challenge to the success of the CTH model is its focus on making the home and local environment a primary site for treatment and wellness promotion, as included in the CTH explanation for the proposed development of a wellness workforce (Mason, 2013b). This shift in the point of delivery for wellness and prevention care services from retail model of hospital systems to a patient's home and community reinforces a call for patients and practitioners to identify with and adhere to a healthcare services delivery model that emphasizes prevention and wellness. Prevention and wellness in the new model are the primary goal versus the more traditional dominant focus on sick care, treatment of acute episodic illnesses, and trauma-related services.

The CTH design document (see Appendix A) includes the definition of success as influencing "behavior change in care providers, patients alike." Another definition in the CTH design document addresses success as "sustainable health and wellness outcomes at the individual and community levels within Cook County, Illinois." This definition of success includes five ways to measure success in the CTH model. The definition of

success also identifies how this shift in mindset from sick care to wellness connects with a change in the hospital system care delivery culture:

> Healthcare providers have to work more collaboratively with patients, taking into account their lifestyle, and capacity to participate in the health and wellness care process. The patient has to learn and participate in ways to continually enhance their experience of health and wellness. This active collaboration between care provider and recipient is central to the Center for Total Health model and its compliance with preventative medicine services components of the Patient Protection and Affordable Care Act. (Mason, 2013a)

The specific link between calls for change in both the individuals' (e.g., patient and healthcare practitioner) worldview and the care delivery culture of the hospital exemplifies those reference points and the presence of the three theoretical themes. First, there is an active RMT mazeway reformulation. Second, this mazeway reformulation or transitioning worldview correlates directly to a larger cultural change: the transition of the hospital system from a culture of sick care to one focused on prevention and wellness. Third is the connection of the previous two theoretical markers to a public policy—PPACA—serving as the catalyst for culture change.

As expressed in the literature, promulgation of the PPACA has been the primary driver behind U.S. healthcare leaders seeking novel ways to meet prevention and wellness care patient outcomes in the first place (Koh & Sebelius, 2010). For hospital systems that have focused on sick care, meeting the PPACA patient outcome goals will

require a change in the culture of care delivery rather than incremental process improvements (Guo & Hariharan, 2012) to their current care process. These three theoretical anchors were built into the CTH program design documents and process to craft a healthcare delivery model that simultaneously facilitates the change in individual worldview, organizational culture, and compliance with the PPACA.

RMT proposes that an individual who can no longer find suitable ways to manage his or her growing stress and dissatisfaction with current cultural conditions is a candidate for rapid cycle culture changes(Wallace, 2003). This individual, in the search for relief from growing and unmanageable stressors, embraces a vision of an alternate cultural worldview where these stressors are not present; this behavior is an adaptation to a reformulated cultural pattern (Wallace, 2003). Adaptation to the preferred, reformulated cultural pattern is that point in a revitalization movement at which individuals outwardly demonstrate their new cultural identify through adaptive behaviors and rituals(Wallace, 2003).

I questioned during the data analysis whether there would be clear indications in the CTH design documentation of a process facilitating the reformulated cultural pattern adaptation. The patient service process (Mason, 2013d) is a three-stage patient-practitioner collaborative process; Stage 3 is integration. Integration is defined as "the transition from intake through orientation into the patient actively participating in their own wellness journey within the CTH process"(Mason, 2013d). During the integration stage of the patient service process, a patient-practitioner team interaction seeks to

"ensure comprehension of the various options . . . in the treatment plan"(Mason, 2013d). This patient service process was developed as a supportive educational and empowering experience for the patient (Jonas & Chez, 2004; Jonas & Rakel, 2009). According to critics of the current healthcare industry practice of sick care delivery, this experience is not a common one for patients or managed care supervised healthcare practitioners (Kovner & Knickman, 2008; Spetz & Kovner, 2013). Stage 3 in the CTH patient service process reflects the RMT reformulated cultural adaptation or identify transformation requirement by incorporating the following steps in the process:

1. Ensure comprehension of medical assessment results and treatment plan options.
2. Validate satisfactory initial patient orientation by asking the patient to sign off on this patient service process, "saying they are satisfied with the presentation, explanations, and understand the options presented through CTH"(Mason, 2013d).
3. Have "[t]he CTH Team . . . help the patient turn the treatment plan recommendations into a personalized Wellness Journey plan that, when completed, will be digitized and kept on file for Wellness Journey check-ins and progress reviews"(Mason, 2013d).
4. Will work with patients "until they complete their Wellness Journey plan . . . or "'opt out' of the program"(Mason, 2013d).

Stage 3, the integration phase of the patient service process of CTH, involves the CTH practitioner team and patient converting medical assessment data into a patient-defined plan for wellness. As part of this step, the CTH team "helps" the patient convert the treatment options and assessment data into the wellness plan. This CTH approach is an adoption of the medical home model. The medical home model is often used to help reform ineffective healthcare delivery practices (Hoff, 2013; Katz & Frank, 2010) and consumer-driven healthcare approaches. Consumer-driven healthcare approaches position healthcare practitioners to proactively manage the cost of patients' healthcare (Kovner & Knickman, 2008) into a process that moves beyond these process improvement approaches and establishes compliance with PPACA prevention and wellness reform (Spetz & Kovner, 2013). At the same time, this transition to a prevention and wellness process opens the door to wellness as an active, co-defined, and daily practiced reality.

During the data analysis process, I realized Stage 3 of the patient service process represented an RMT-defined reformulated cultural adaptation centered on wellness as the identity being transformed. The CCHHS was the culture being transformed, and the PPACA was the public policy foundation serving as the catalyst for an overall systemic culture change. This wellness and identity plan collaboration leads to patients becoming "heroes"(Mason, 2013d) in their wellness journey and CTH practitioners being "champions"(Mason, 2013d) of patients' hero journeys (Fowler III & Droms, 2010; Kelly & McFarlane, 2007). Interviewee 3's comment reflects a leadership perspective of purpose and power ascribed to this identity transformation process:

> [We must] help empower people so that we don't continue to see the sort of self-destructive activities that we see, because we're at war with our own self and we can't be silent about that. We can't tiptoe around that. (Interviewee 3)

The wellness care delivery team is characterized as having to "fundamentally believe" (Interviewee 2) the CTH wellness and prevention care approach is a viable medical care treatment strategy. To believe in this treatment strategy, the CTH healthcare practitioner must "understand and appreciate the value of food in the treatment process" (Interviewee 2). Requiring practitioners to develop an appreciation for the CTH food-as-medicine treatment protocols is an additional example of an RMT mazeway reformulation (Wallace, 2003). Healthcare practitioners working in CTH after having been trained in standard sick care with pharmacologically oriented industry practices may find the CTH food-as-medicine treatment priority (Afaghi, Ziaee, Kiaee, & Hosseini, 2009; Anand & Kapoor, 2012; Andersen & Fernandez, 2013; Barclay, 2010) to be a catalyst for revising their personal definition of wellness as an identity.

As revealed in the analysis of data collected via interviews with CCHHS leaders, there was an expectation that CTH staff would understand and appreciate food as another form of medical treatment. In the data analysis phase of the study, I grouped the difference between traditionally trained sick care medical practitioners working in CTH and leadership expectations of CTH practitioners to embrace the notion of food as medicine in a prevention and wellness care delivery approach. This grouping highlights an expectation of the practitioner to replace the traditional sick care cultural mindset with

a CTH prevention and wellness care cultural mindset. With this interpretive approach, based on leadership interviews and CTH design documentation, CTH practitioners are on a parallel track with CTH patients in learning how to adopt and adapt to a wellness identity worldview in which food as medicine is a viable and valid approach to healthcare (Andersen & Fernandez, 2013).

Adaptable Subculture

CTH was designed to operate as a specialty clinic within CCHHS. From an organizational operating structure perspective, being a specialty clinic further sets the stage for CTH to maintain a prevention and wellness care subculture within the CCHHS hospital sick care culture. CCHHS leaders publicly declared a key step in being PPACA-compliant was to move from a sick care culture to one that promotes wellness and prevention. The challenge of this move toward a successful CTH implementation, when evaluated from a RMT lens, is the need for CTH leadership to reasonably predict and prepare for resistance or retaliation from traditional culture advocates in CCHHS who do not agree with the CTH wellness and prevention care approach. In RMT language, this preparation is called adaptation. RMT considers adaptability to be the deciding factor in determining whether a revitalization movement survives to become a routine part of the larger culture. Applying adaptability of RMT to the CTH model meant CCHHS leadership needed to indicate their willingness to incorporate adaptation strategies into the CTH design.

I found evidence of adaptation strategies in Mason's CCHHS Board of Directors presentation (see Appendix A). In this presentation, Mason positioned CTH as a "specialty care" asset capable of fulfilling "unmet needs" within CCHHS. From an RMT framework, positioning CTH as a specialty care asset within CCHHS and being capable of meeting unmet care delivery needs is analogous to calling CTH a new subculture in the larger CCHHS healthcare delivery dominant culture. As a subculture, CTH was designed to meet healthcare service delivery needs currently not being met in the larger CCHHS healthcare delivery culture. The presence of unmet health care needs was revealed in a previous CCHHS (2010b) strategic planning report. Concern for brand image was revealed in a vision statement presented in the CCHHS (2010b) strategic planning report:

> In support of its public health mission, CCHHS will be recognized locally, regionally, and nationally—and by patients and employees—as a progressively evolving model for an accessible, integrated, patient centered, and fiscally responsible healthcare system focused on assuring high-quality care and improving the health of the residents of Cook County. (CCHHS, 2010)

Mason, in his CTH presentation to the CCHHS Board of Directors, portrayed CTH as an integral component of the solution to address concerns identified in the CCHHS (2010b) strategic planning report and the prevention and wellness approach required by PPACA that CCHHS had to satisfy. Examples of how Mason connected CTH to these planning and compliance concerns are provided in Table 3.

Table 3

CTH Positioned as Adaptive Subculture in CCHHS Care Delivery Culture

CCHHS strategic planning report	CCHHS area of concern/ opportunity for growth	CTH presentation highlights
CCHHS wants to develop a long term development plan for Oak Forest	Concentration of health disparities in Cook County southern suburbs	CTH would be developed and piloted at Oak Forest, located in Cook County's south suburban area
		(*Table continues*)
CCHHS wants to assure provisions for Public Health Services	Integrate population health strategies into an overall goal of increasing patient access to healthcare services	CTH was designed to provide care delivery services in the CCHHS patient's homes and communities – a Public/Population Health strategy
Locate healthcare delivery assets where healthcare services are needed most	Build additional capacity to delivery comprehensive outpatient services	CTH, as a Cook County south suburban asset, was positioned to address the concentrated health disparities located in the area
Optimize current CCHHS operations to reduce expenses	Mitigating the rising cost of healthcare delivery	CTH was designed to increase patient care and contact while reducing or eliminating dependency on expense pharmacology for patients with chronic diseases such as diabetes

According to RMT (Wallace, 2003), this type of movement adaptability reflects leadership taking steps to protect the subculture movement from opposition by members of the larger culture. Mason positioned data from the CCHHS (2010b) strategic planning report in his board presentation to connect CTH goals and development with the long-term strategic vision of CCHHS. Interviewee 1's comment supports this interpretive lens:

> I think the plan was that this program would help the health system move away from the acute care and the hospitalization focus and more towards prevention, wellness, the medical home, and the accountability of the consumer. (Interviewee 1)

Interviewee 1's quote provides a clue to the outcome of Mason's adaptation efforts. CTH was not funded for implementation beyond the design development phase (Mason, personal communication, May 15, 2015).

References to time did not conform to emerging thematic patterns during data analysis. I set a requirement that each data point had to present a clear and repeated connection to subsequent levels of data coding and analysis as a prerequisite for continued representation in emergent themes and ongoing analysis. Time, as a data point, had significant representation and inconsistent applications in the data.

Summary

How could RMT serve as an evaluation framework for prevention and wellness care programs under the PPACA? The data collected for this CTH case study revealed strengths and weaknesses to RMT being used as a prevention and wellness care

evaluation tool. There was alignment among data in the source documents, interviews, and the principles of RMT. This alignment suggests that RMT could help healthcare leaders position their prevention and wellness care programs to produce enhanced performance outcomes through clearly articulating and comprehensively integrating the cultural reformulation and adaptation of RMT to create a wellness identity transformation component in their programs. By creating this RMT informed wellness identity transformation in each phase of the prevention and wellness care operation, a wellness culture is likely to emerge.

Shifts in stakeholders' mindsets and worldview regarding prevention and wellness care will serve as a measurement of efficacy measurement. Shifts in patients' and practitioners' (i.e., the stakeholders') mindsets and worldviews will support an expansion of the wellness identity culture to the larger health system culture. Such an expansion will support a system-wide change from the current dominant sick care mindset to the emerging prevention and wellness care mindset. This CTH case study highlighted the importance of leadership predicting and managing potential conflicts between a dominant culture (i.e., CCHHS) and the emerging subculture (i.e., CTH). In the CCHHS dominant culture, withholding funding support for CTH implementation seemed to have been a dominant culture oppositional reaction. CTH, because it will be a subculture of CCHHS, must negotiate funding through the CCHHS Board of Directors (Mason, personal communication, May 15, 2015).

From a public policy perspective, the data suggest PPACA serves as both a catalyst and sustainer of culture change. PPACA is a catalyst for culture change because its formulation and passage represent a national coalition of multiple stakeholders and reflects worldview/mindset shifts in the national healthcare system culture. PPACA, and therefore public policy, sustains culture change because implementation of PPACA prevention and wellness care guidelines provide federally legislated and funded alternatives to sick care practices. Local municipal healthcare leaders can use these funds to implement and promote alternative cultures to improve the capacity of their hospital systems to address current and future population health challenges, such as chronic diseases. The RMT evaluation framework challenges prevention and wellness care program design teams to validate links between identified stress catalysts for the program and program design elements created to adequately address or eliminate the underlying problems driving the emergence of those stress catalysts.

Finally, the data suggest that RMT, as a PPACA-compliant prevention and wellness care evaluation framework, can be used to help healthcare leaders focus on opposition from internal programs, intrasystem discord, or larger cultural components of their wellness initiatives. These wellness initiatives might be perceived as an undesirable subculture movement, challenging the more traditional hospital system sick care culture. The data suggest RMT will help healthcare leaders to distinguish between policy implementation as daily operations process improvement and organizational systems culture change.

Both policy implementation as daily operations process improvement and organizational systems culture change involve changes to stakeholders' daily habits. The difference between them is culture change, as explained in the RMT model, requires a change in how stakeholders see the world around them, a mazeway reformulation. This mazeway reformulation incorporates daily habits that extend beyond task-centric processes to promote awareness of mindsets regarding wellness. As this awareness evolves, individual stakeholders are encouraged to adopt a wellness identity as the thrust of their mazeway reformulation.

A weakness of RMT as a prevention and wellness care program evaluation approach is evident in the data: the definition of charismatic leadership. In the CTH data, the supernatural was represented in the leadership. For example, there was mention of being divinely called, fulfilling prophecy, and having a larger purpose to fulfill. As in the case of the original applications of RMT, there were references to being guided by a vision that needed to be shared with other like-minded people. In interviews and source documents relative to CTH, this supernatural component was perceived as a weakness when the definition of RMT charismatic leadership was interpreted as a manufactured requirement as opposed to being an organic emergent leadership quality.

RMT focuses on the organic emergent quality of this charismatic leadership trait. In the highly regulated and professionalized world of medical care delivery and population health, there may need to be a broader definition for the RMT charismatic leadership trait requirement. In reviewing the data, I pondered a question about a key

tenet of the RMT framework: rapid pace culture change. The data were clear: at each stage of analysis, PPACA prevention and wellness care programs must achieve initial performance outcome patient results within three- to five-year federal funding cycles. These funding cycles match the rapid pace culture change characteristics of RMT. The data consistently indicated a prevailing leadership belief that a prevention and wellness care delivery process would require up to 50 years (Interviewee 2) to produce measurable outcomes.

Data analyses regarding time seemed to conflict with one another. A closer examination of the data suggested many of the time references addressed different time-sensitive variables. References to short cycle times indicated mazeway reformulations taking place at the level of an individual stakeholder. The longer cycle, multiple decade time references connected measureable change with large-scale shifts, such as those involving population health, public policy, and national healthcare systems. RMT seems to suggest that a successful revitalization movement in healthcare would integrate individual mazeway reformulations into the larger population health and dominant culture changes. By people changing their mazeway to a wellness culture from a sick care culture, changes in larger population and cultural context occur in shorter time periods. Limitations of this case study did not permit further exploration of the data for discrepancies regarding time.

This study proved the effectiveness of RMT as a viable tool for evaluating PPACA-compliant prevention and wellness care programs during the design stage. There

are at least two areas—leadership definitions and time measurement considerations—that need further development. These areas needing further development do not detract from the contributions RMT can make as a prevention and wellness care program evaluation tool. RMT can be used to support healthcare system leaders as they design and implement PPACA-compliant prevention and wellness care delivery programs. Chapter 5 builds on this analysis by offering interpretations of how these findings can be used to drive healthcare reform and effect positive social change. These findings expand on the tools available to healthcare leaders seeking to promote prevention and wellness care solutions in communities across the United States.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

I undertook this case study with two purposes. The primary purpose was to explore the effectiveness of revitalization movement theory (RMT; Wallace, 2003) as a framework for evaluating Patient Protection and Affordable Care Act (PPACA)-compliant prevention and wellness care initiatives early in their design and development process. The secondary purpose was to consider public policy as a catalyst of culture change, exploring the connection between personal identity and public policy development relative to driving positive social change at every level of public policy implementation.

Under PPACA (2010), the performance of hospital systems in the United States receiving federal funding is linked to patient outcomes, particularly readmission data (Cykert, 2012). A direct connection between federal payments for services rendered and patient treatment outcome data became a catalyst for many hospital systems to shift their culture from one focused on sick care to one that promotes prevention and wellness (Garrett, 2011; Johnson, 2011; Koh & Sebelius, 2010). Therefore, PPACA has prompted healthcare reform in terms of an adaptive culture change rather than healthcare reform as the next industry innovation in process improvements (Anson, 2000; Arar et al., 2011; Beil-Hildebrand, 2002; Best et al., 2012; Clayton et al., 2008; Davis et al., 2014; Edwards, Penlington, Kalidasan, & Kelly, 2014).

Part of the PPACA-driven change in healthcare industry culture is the prioritization of prevention and wellness (Koh & Sebelius, 2010; Majette, 2011) as key patient outcome performance metrics (Fielding et al., 2012; Jacobson & Jazowski, 2011; Johnson, 2011; Senzon, 2011). Prioritizing prevention and wellness in patient treatment and outcome measurement standards has had the additional effect of generating industry calls to integrate public health and public medicine into the emerging patient treatment standards (Andrews et al., 2013; Berman, 2011a; Costich, 2014; Monheit, 2010).

This case study explored the design of the CTH, a PPACA-compliant prevention and wellness care program, using RMT as an evaluation framework. Prevailing healthcare program evaluation approaches focus on improvements in daily operating procedures and protocols, termed *process improvements* in this study(Barbara, Almaawiy, Moore, Wai-Hin, & Straus, 2013; Colquhoun et al., 2014; Davis et al., 2014; Johnston, Matteson, & Finegood, 2014). PPACA (i.e., healthcare reform as culture change) calls for hospital systems to shift from a dominant culture-of-care mindset focused on treating sickness and trauma to a culture-of-care mindset focused on prevention of sickness and promotion of wellness (Bloomberg, 2012; Garrett, 2011; Marvasti & Stafford, 2012). This change in mindset, now legally required by the passage of PPACA, challenges hospital system leaders to incorporate patient treatment process improvements into culture change initiatives that are now required as part of federal healthcare reform compliance standards. In this case study, I assumed hospital system leaders were better served by using culture change tools that could help them improve

their capacity to facilitate this necessary culture change as opposed to implementing process improvements that do not effectively shift the cultural mindset. In this study, I used RMT, a culture change framework, to explore the efficacy of applying a culture change model to PPACA-oriented health care reform programming.

This study highlighted the overall effectiveness of RMT as an evaluation tool for CTH, a Cook County-based prevention and wellness care program. RMT has the potential to provide healthcare leaders with a clearly defined and structured culture change process that can be applied during the design phase of a prevention and wellness care program. Effective application of RMT during the design phase has the potential to provide critical program development feedback regarding program efficacy to promote culture change in the healthcare establishment. An advantage of applying RMT in this study was its ability to help identify the presence or absence of culture change elements early in the design development process. Serving as a type of early warning system, applying RMT creates opportunities for healthcare leaders to validate program design activities remain in alignment with program culture change goals. This alignment provides an additional benefit of distinguishing healthcare reform as culture change from healthcare reform as process improvement.

Interpretation of Findings

RMT as an Evaluation Guide

Research findings indicate that the structured approach to defining culture change using the five-stage process of RMT, with distinct actions representing each stage (see

Appendix B), is useful as a type of checklist from which the elements of culture change can be identified in a prevention and wellness care program design. The RMT culture change process is not a linear process; however, it does provide activity groupings within which culture change actions, identified in a prevention and wellness care initiative, can be matched to culture change identifiers listed as part of the five-stage RMT process. For example, the analysis of data from the CTH program revealed that elements of Stage 4 of RMT (e.g., communication and adaptation) were repeated functions executed simultaneously with the process of promoting an understanding of a wellness mindset (i.e., the emerging new prevention and wellness care hospital systems culture).

This emerging wellness mindset represented by CTH is occurring in the larger sick care culture of the CCHHS. The definition of a Stage 4 culture pattern reformulation in RMT is reflected in an emerging new culture of a wellness mindset among stakeholders who are also part of the larger, extant sick-care culture of CCHHS. This CCHHS sick-care culture failed to meet the healthcare needs of patients and practitioners in the era preceding PPACA (Integrated Clinical Solutions, 2010), a problem the analysis identified as a source of stress (see Appendix B, RMT Stage 2). I defined this situation as representing the characteristics of RMT Stage 2 (e.g., period of increased stress) because of the multiyear history of problems, which included budget shortfalls and marginal patient satisfaction (Mason, personal communication, May 15, 2015).

With the passage of PPACA ("Patient Protection and Affordable Care Act," 2009), CCHHS became a national pilot site for testing PPACA newly insured patient

enrollment procedures and outcomes ("CCHHS Announces 115,000 Apply for CountyCare," 2013; Illinois Department of Healthcare and Family Services & CCHHS, 2012). This national pilot site status, combined with the CCHHS CEO's organizational change vision (Raju, 2012) had the cumulative effect of moving CCHHS from a Stage 2 RMT level of stress to a Stage 3 level (see Appendix B). In Stage 3 of the RMT (Wallace, 2003), the stress becomes unmanageable, pushing individuals to seek or develop a mental and cultural framework that

- resolves the stress,
- mitigates the effects of the stress,
- exemplifies resignation to the stress, or
- expresses deviant behavior in reaction to the stress.

RMT (Wallace, 2003), in Stage 4, identifies personal worldview and self-identity as the key factor distinguishing between a culture change movement and a movement represented by innovative process improvements. There were several representations in the literature regarding innovative U.S. healthcare industry process improvements that were labeled as changes to the culture of healthcare (Lewin, 2012; McHugh et al., 2012; van Dongen et al., 2013). Many of these changes qualify more as process improvements than as culture changes, mainly because the stakeholders experienced no substantive change of worldview or self-identity. Based on calls for a shift from a sick-care culture to a prevention-and-wellness-care culture, correcting this process and program labeling is

important to the success of PPACA implementation (Barbara & Las Casas, 2013; Koh & Sebelius, 2010).

Stage 4 of RMT represents a required reformulation of cultural patterns (Wallace, 2003). This reformulation is characterized as a process through which individuals in a group adopt a vision of a new cultural worldview to find relief from escalating, unmanageable stresses they experience in their current culture mindset and context. Wallace (2003) called this transition a mazeway reformulation; the mazeway represents how the individual or group of individuals identifies with the culture (i.e., the individual's or group's worldview). At CCHHS, the dominant mazeway/worldview prior to CTH was that of a sick-care culture (Interviewee 2). Escalating stress in Stage 2 moved patients and healthcare practitioners into a Stage 3 position, where the reaction to the sick-care culture stress was to seek an alternative care culture. PPACA helped to define prevention and wellness as the emerging new culture of choice and a response to the existing sick-care hospital systems culture (Koh & Sebelius, 2010).

Public Policy and the RMT Model

The role of public policy in helping to create a new culture identity is not directly reflected in the RMT model (Wallace, 2003). Instead, the RMT model mentions leadership having a vision for a new culture solution to the current stress-filled culture. This leader role is characterized as charismatic, visionary, and taking one of three general approaches to launch the creation of a revitalizing cultural movement. Approach 1 is to revert to a previous time in the existing culture and readopt abandoned practices.

Approach 2 is to adopt practices from a culture foreign to the existing culture. Approach 3 is to create cultural practices that may be a hybrid of the previous two.

This study revealed the presence of the third approach, in which CCHHS leadership discussed working toward a culture of wellness and prevention at least 10 years prior to the passage of PPACA (Interviewee 3). Analysis of data from interviews and extensive document review confirmed a leadership opinion that the CCHHS culture needed to change at the patient and practitioner levels from sick-care culture to prevention-and-wellness-care culture. These combined leadership perspectives helped to identify the changes needed and proposed through CTH for CCHHS to be culture-change oriented rather than strictly process-improvement oriented. This distinction rests on the call for patients and practitioners to adopt a hospital systems culture worldview in which everyone in CTH identifies with wellness and prevention as the primary approach to patient medical treatment (Mason, personal communication, May 15, 2015).

At the core of this prevention and wellness identity for CTH patients and practitioners is what Mason (personal communication, May, 15 2015) called a *food-as-medicine* approach to patient treatment. In support of Mason's CTH wellness identity position, Interviewee 2 called for a move from sick care to wellness care. As discussed in Chapter 4, these data were revealed in my interviews with study participants and aligned with the CTH program design and the five-stage structure for culture change explained in the RMT model (Wallace, 2003).

PPACA: A policy window for culture change. The RMT (Wallace, 2003) structure and definitions helped me to identify the presence of culture change dynamics while providing a type of scaffolding for grouping these culture change dynamics into stages. This scaffolding also served to identify a policy window (Kingdon, 2011) in which PPACA inspired culture change in multiple streams of public development (Illinois Department of Healthcare and Family Services & CCHHS, 2012) and implementation at both a federal and local municipal level. Based on the findings of this research study, healthcare leaders using RMT as an evaluation framework have the potential to identify culture change elements in their program design documentation. They can also use the RMT model to distinguish culture change from process improvements that do not promote culture change. Finally, they can match culture change elements in their program designs with PPACA performance outcome requirements by mapping levels of stress escalation with culture change stress mitigation strategies. These correlations did not extend to the definition of time as a rapid cycle in which the culture change takes place according to RMT.

Policy entrepreneurship in the policy window. The data collected in this study strongly suggest the need for public health medicine and public health leaders to collaborate to address rising trends of chronic disease in municipalities across the United States (Costich, 2014; Hacker & Walker, 2013; Knoblauch, 2014; Sanford, 2013; Shim & Rust, 2013). CCHHS leaders' reaction was to launch policy entrepreneurship strategies (Kingdon, 2011) by actively lobbying Illinois state legislators and Cook County leaders

to implement a municipal model to create a "managed care community network" and obtain a "health maintenance organization" license (CCHHS Board of Directors, 2013b). These efforts to enhance the market position of CCHHS would also merge public medicine and public health under one healthcare delivery system: CCHHS.

Leaders of CCHHS actively engaged in state and municipal policy formation to demonstrate CCHHS leadership policy entrepreneurship efforts and how these efforts could be positioned to take advantage of state and local policy windows created by the passage of PPACA at the federal level. In these policy lobbying efforts, the CTH design was presented as the population health component of the overall care delivery strategy (Interviewee 2). From a sick-care culture perspective, this labeling positioned CTH to be perceived as subordinate to the larger CCHHS medical care delivery agenda (Mason, personal communication, May 15, 2015). Changes in senior leadership at CCHHS were concurrent with shifts in funding and program priorities, which left the subordinated program—CTH—unfunded beyond design implementation (Mason, personal communication, May 15, 2015). From an RMT perspective, this lack of funding represents a halted revitalization movement because of problems with adaptation with the larger CCHHS and the sick care worldview mindset and culture (Interviewee 2; Wallace, 2003).

CTH: An Integrated Healthcare Delivery Design

Though positioned as subordinate to and within the overall CCHHS patient and community services model, the CTH design integrated elements of direct medical care

and population health under a comprehensive prevention and wellness care delivery clinic model. The goal was to have a full-service prevention and wellness care delivery model with the capacity to serve CCHHS patients and Cook County community residents (Interviewee 3). The express purpose was to generate PPACA-compliant patient and community health outcomes while teaching evidence-based prevention and wellness care practices to other care delivery units in the CCHHS system (Interviewee 3).

This dichotomy between the intention behind the CTH design initiative and how CTH was positioned within the larger CCHHS sick-care culture emerged from the data as system stress, magnified by the pressures of rising chronic disease treatment needs and escalating costs of care related to current population health trends in Cook County (Interviewee 1). From the evaluative framework of RMT, CTH represented a vision of a new cultural worldview (prevention and wellness care) and entered into a RMT Stage 4 cultural reformulation process, but it was not able to navigate the adaptation requirements of Stage 4 for the revitalization movement to progress (Wallace, 2003). While adaptation was one of the challenges identified in the data, another was the use of time as a measurement of culture change. My analysis of the use of time as a measure for the culture change process in the CTH design documentation yielded inconclusive findings.

Time as a Variable in Culture Change

In RMT, time is used as a measure of culture change: culture change must take place rapidly (Wallace, 2003). Escalating exposure to unmanageable stress challenges and even destroys an individual's acceptance of current cultural conditions, thus

prompting action to replace cultural worldviews that are no longer useful with cultural worldviews that are useful and mitigate stress. This replacement is an expedited cultural reformulation to meet the needs of the individual to find immediate, suitable resolution to stressors that destroy the quality of life (Wallace, 2003). Data from this case study revealed opposing perceptions of this time measurement.

One perception of time correlated with the notion of escalating stress as a trigger of change in RMT (Wallace, 2003). In my analysis of the data, I grouped the intersection of rising healthcare demands, diminishing effectiveness of healthcare services, and PPACA prevention and wellness care compliance standards requiring an immediate shift from current sick care culture mindsets to prevention and wellness care culture mindsets. The policy window in which federal reimbursement for healthcare services rendered are linked to patient care outcomes ensured the prompt shift from a sick care culture to a prevention and wellness care culture. This component of the data aligns with the rapid cycle culture change of RMT as a distinguishing characteristic of a revitalization movement instead of the more common multigenerational culture change processes (Wallace, 2003).

A second perception of time revealed in the data was the more traditional notion of culture change as that which takes place over multiple decades or generations, in contrast to that which happens within a decade. This second view prompted me to question the possibility of time being defined in multiple ways. An example might be the participants' addressing nonculture change issues, such as research reporting

requirements using the language of time, which is separate from a RMT culture change discussion incorporating time as a rapid cycle measurement. Addressing this topic was beyond the scope of this case study. This tangential concept lends itself to follow-up research on the use of RMT as a PPACA prevention and wellness care program evaluation tool for healthcare leadership.

Limitations of the Study

The CTH program design project was a CCHHS pilot initiative with a narrow scope focused exclusively on developing a PPACA-compliant prevention and wellness care delivery unit within CCHHS for Cook County, Illinois (Interviewee 3). Mason defined the vision for CTH and crafted the initial scope of work used to create the CTH design project (Interviewee 2). The emphasis on using food as medicine in the patient medical treatment process was a core tenet of this scope of work (Mason, personal communication, May 15, 2015). As an experimental CCHHS pilot initiative, three senior executives approved and provided exclusive oversight for the CTH design project. All three executives were engaged in this study as interview participants, and their public testimonies were included in the data analysis as primary source documents. Within the confines of these limitations, this case incorporated triangulation, respondent validation, and discrepant evidence to ensure validity of the research findings (Yin, 2011). Triangulation incorporated data from participant interviews, publicly available project documentation, public municipal testimony, project design documentation, and a coding process that identified and analyzed themes across all primary source data.

The CTH model is a PPACA-compliant prevention and wellness care delivery program that was designed to operate within the Cook County municipal healthcare system. As a single case study and because of the uniqueness of each municipal government, the findings and conclusions based on those findings are transferable primarily where there is a case representing defining characteristics similar to those of CTH and CCHHS in a municipal government structure (Yin, 2011). Insights gained from this single case study may prove beneficial to healthcare leaders across the United States who are challenged to meet or exceed PPACA outcome goals. Additionally, the potential to provide an RMT evaluation tool for healthcare leaders tasked with facilitating a PPACA-oriented culture change project represents a significant contribution to those working in healthcare reform in the United States.

Recommendations

PPACA, a federal law, is driving changes throughout state and local healthcare systems across the United States. These changes translate into challenges for healthcare leaders across the United States to ensure their areas of responsibility meet the performance standards of PPACA. One of the compliance areas is centered on increasing the capacity of each hospital system to improve prevention and wellness care as a measure of patient health outcomes. This case study of CTH highlights the benefits of using RMT as an evaluation tool able to enhance the design process and outcome of prevention and wellness care programs (Knickman & Kovner, 2008; Spetz & Kovner, 2013). Findings from the use of this innovative application of RMT as an evaluation tool

will help healthcare leaders identify and facilitate culture change requirements from a programmatic perspective. For the healthcare leader, applications of RMT to the design programming initiative should help address the need for incorporating culture change principles into PPACA-compliant healthcare delivery programs as a practice of compliance that supports achieving required patient outcomes.

A caution to this application of the RMT model, and an area for additional research, involves investigating ways to refine the definition of leadership within the model in order to maintain the integrity of the RMT leadership mindset while positioning health systems leaders to optimize communication and management protocols within the highly regulated healthcare industry. In addition, I recommend an examination of the RMT conceptualization of time as being compressed and moving at a rapid pace. The data collected and analyzed in this study regarding the conceptualization of time were inconclusive and worthy of additional research. Addressing the leadership and time measurement implications of the RMT model and making appropriate adjustments may position RMT as a culture change management tool for healthcare leaders in applications beyond PPACA-compliant initiatives.

Implications for Positive Social Change

With the passage of the PPACA, prevention and wellness have become a national priority. This policy has not immediately translated into healthier individuals in the United States. The sick care-dominated healthcare culture of the United States is a primary component of this disparity between the declared national priority and the health

of the U.S. population. This study demonstrated the benefits of equipping healthcare leaders with tools such as RMT that can help change the culture of healthcare from the current sick care-dominated practices to compliance with PPACA prevention and wellness care standards and outcome measures.

The U.S healthcare industry is excellent at addressing trauma and acute care episodes. Pharmacology is a first line of defense and writing prescriptions is a first response to illness. The hospital industry is not trained or equipped to deal with lifestyle illnesses and chronic disease efficiently. Against this backdrop, PPACA opened the doors for large numbers of previously uninsured and untreated citizens to receive care. Many of these newly insured citizens are represented in public health trends, contributing to presentations of a rise in chronic disease. Hospital leaders are now under federal mandate to serve a much larger patient population exhibiting conditions they are often insufficiently equipped to treat.

These stressful, interconnecting dynamics are exactly the type of scenario that leads toward calls for change. This type of change extends beyond the development of new procedures and into the creation of a new healthcare system culture. The sick care culture has proven itself to be ineffective in addressing the growing health challenges of the general population. A successful application of RMT, as reflected in this study, can equip healthcare leaders to meet and exceed PPACA patient outcomes standards while also transforming the capacity of health systems to address lifestyle and chronic disease challenges. A healthcare culture that is focused on disease prevention and wellness as a

normative daily experience will position healthcare leaders to promote increases in wellness among children and adult populations in the United States.

This research calls for a focused look at public policy as a catalyst to culture change. It opens the discussion and exploration connecting personal identity transformation elements in policy formulation and policy implementation efforts. Becoming skillful at mapping these connections has the potential to empower policy entrepreneurs and drive positive social change at every level of legislative activity and policy implementation.

Conclusion

RMT (Wallace, 2003) identifies individuals' three primary reactions to intractable lifestyle stressors such as sickness in a society. First, individuals give up hope for any resolution and die under the impact of the stress. Second, individuals exhibit self-destructive and socially destructive behavior in response to a personal inability to experience relief from the effects of the stressors. Third, individuals choose to adopt an alternate worldview/culture that helps address or eliminate what they previously believed were intractable stressors. Population health trends in the United States reflect each of these responses.

Some citizens resign themselves to a poor quality of life and even premature death because of lifestyle-related diseases that can often be mitigated through consistent lifestyle changes. Simple examples are eliminating smoking; reducing salt and sugars in

the diet; or engaging in more physical activity, such as walking. Other citizens exhibit self-destructive behaviors such as alcohol and drug abuse or emotional overeating.

This research identified a third group: those who choose to adopt a new worldview that serves as a positive transformation in their lives. The transformation in this research was a shift from a sick care culture worldview to a prevention and wellness care culture worldview. Providing healthcare leaders with an evaluation and design tool such as RMT to design initiatives that facilitate culture change in the healthcare system is an important step toward realizing the quality of life improvements all stakeholders can experience, thus countering rising healthcare cost and sick care cultural thought patterns that imply declining health is a definite for anyone over a particular age. It is equally important to acknowledge the power of the individual, as reflected in these findings, to actively engage his or her own health identity and be empowered to choose how he or she will be a collaborating partner, creating expressions of prevention and wellness at every level of society.

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Appendix A: CTH Design and Development Documents

CTH Overview

The Center for Total Health: Healthcare Reform in Cook County, Illinois

Dr. Terry Mason

Chief, Systems Medical Officer

Cook County, Illinois, Health & Hospitals System

January 2013

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"Having good food in the community is good business and good health."

Dr. Terry Mason

The Center for Total Health

Definition of Total Health

Total health is a state of regeneration that enhances an individual's ability to enjoy life, family, and community. (Dr. Terry Mason)

Overview

Total health is a wellness focused state of existence that enhances an individual's ability to enjoy life, family, and community.

The Center for Total Health is an evidence-based health and wellness care delivery system driven by a seven-institute applied research organizational model: food science, healthcare delivery, physical movement, mind-body-spirit studies, addiction release, employee wellness, and social determinants of health.

The Center for Total Health promotes living a positive, active life, which includes growing, consuming, and experiencing the natural food sources, natural environments, and positive social experiences available within one's local or regional area as part of a daily regimen designed to support and optimize one's physical, mental, and spiritual wellness.

The Center for Total Health seeks to address the following challenges in its approach to healthcare reform:

- Challenge 1: How does a municipal healthcare system achieve the health outcomes and performance mandates specified in the Patient Protection and Affordable Care Act of 2010?
- Challenge 2: How will healthcare reform address healthcare delivery and health outcome disparities in minority and impoverished communities?
- Challenge 3: Can the use of fruits, vegetables, and other measureable lifestyle habits be prescriptively applied, at the community level to reduce the growing presence of chronic disease while also improving socio-economic conditions for the community being served?

Success

Success is to influence behavior change in care providers and patients alike, leading to sustainable health and wellness outcomes at the individual and community levels within the Cook County Health and Hospital Systems Service area. Success will be measured by the following:

- **Success Measurement 1:** Reduction in obesity rates among program participants.
- **Success Measurement 2:** Reduction in medication use by program participants.
- **Success Measurement 3:** Increase in awareness and consumption of plant-based nutrition and foods by program participants in their homes.
- **Success Measurement 4:** Increase in physical movement (strength, range of motion, & endurance).
- **Success Measurement 5:** The number of healthcare delivery personnel trained in CTH wellness delivery protocols.

Success requires the development of innovative approaches to coordinated care that start where the patient/recipient lives and works versus starting at a central facility housing medical professionals and diagnostic equipment. Healthcare providers have to work more collaboratively with patients, taking into account their lifestyle and capacity to participate in the health and wellness care process. The patient has to learn and participate in ways to continually enhance his or her experience of health and wellness. This active collaboration between care provider and recipient is central to the Center for Total Health model and its compliance with preventive medicine services components of the Patient Protection and Affordable Care Act.

CTH Patient & Program Participant Process

The CTH process starts with a comprehensive health and wellness assessment that teaches program participants to be the hero on their journey toward optimal health and wellness. As program participants progress from the initial wellness assessment, the CTH

process will apply structured education and support that enhances adherence to these prescriptive applications. An example of support in the food and nutrition category would range from extensive education in the proper foods to eat in support of a particular patient's treatment plan to CTH dispensing prescriptively designed meals and meal plans in accordance with a patient's treatment plan. Each of the seven institutes will provide thought leadership and applied research practices that support community and patient adherence to their CTH hero's journey prescriptive treatment plans.

The Center for Total Health Programs

Fit-for-Life. Target: those who are obese or struggling with some other occupational health/chronic disease connected challenge. Participants are guided in the development of a renewed personal worldview that says they are "Fit-for-Life, a life of health and a quality existence in their home and community. At the Center for Total Health, this is the 'hero's wellness journey,' and our program participants become their own heroes while encouraging other program partners in their own hero's wellness journey."

Youth Wellness Corps. Target: youth and young adults ages 9–20. This is a personal wellness and leadership development-centered activity. The focus is to create opportunities for youth and young adults to lead community resilience efforts that revitalize community, promote personal wellness, and model interdependent self-sufficiency.

My Health, Our Health. Target: ages 40+ and retirees. Baby boomers have considerable influence in family and community, as well as many personal pressures. This program offers a space, place, and developmental tools for older adults to create and sustain their wellness journey while also gaining valuable resources to help those around them do the same.

Eat Well, Learn Well. Target: school-age youth served through designed healthy-eating school lunch and (in some cases) after-school meal and snack programs. In addition to feeding the children, there will be nutrition, gardening ("where food comes from") training, and food preparation skills development training (raw and lightly cooked).

The Healthy Professional. Target: workplace health, employee wellness and workplace productivity . . . "from holes to wholeness" is a good way to view this program. The primary focus is to collaborate with employees and workplace leadership in the identification of gaps (holes) in their wellness behavior that cause personal health challenges, illness, or losses in productivity. Through this program, employees will identify the gaps and develop and execute a plan of action to close the gaps while moving toward their definition of personal wholeness as an individual and part of a collective, productive workplace team.

Resilient Communities Now. Target: geographically defined targeted communities. Goal is to raise awareness regarding health and wellness, promote capacity building, and facilitate the integration of sustainable wellness strategies at the level of a

geographically defined community. These concentrated pockets of wellness capacity building will serve as "leaven" from which the community residents will be encouraged and aided in developing plans for making their community healthy and whole for all. This is also the vehicle through which the Center for Total Health will implement its community health and wellness delivery model, making the residents' home their true medical home, supported by the larger medical healthcare establishment.

The Center for Total Health Background

In January 2012, the Cook County Health and Hospitals System (CCHHS), along with the Illinois Department of Healthcare and Family Services, submitted a Medicaid 1115 waiver (1115-waiver) proposal, which is a formal request submitted by a state and local government to the national Centers for Medicare and Medicaid Services (CMS), seeking permission and funding to begin providing medical services to uninsured and underinsured citizens within their jurisdiction. Cook County, with over 5 million residents, wanted to expand the reach of its healthcare services within the uninsured and underinsured population, prior to the 2014 full implementation date for the Patient Protection and Affordable Care Act (PPACA) of 2010. The 1115-waiver allows CCHHS to enroll approximately 100,000 adults with income at or below 133 % of the federal poverty level. The absence of an approval means this same segment of the population will continue to have limited access to healthcare services, thus receiving limited to no treatment for their healthcare needs. A lack of proper treatment means many among this underserved population, by 2014, will seek services for previously preventable health

conditions that have become worse and, according to current health statistics, will present as chronic conditions requiring expensive medications and treatment protocols. Approval of the CCHHS 1115-waiver provides an opportunity to deliver healthcare services to a larger segment of the population but does not address the limitations within current healthcare practices proven inadequate in addressing rising negative health trends, including cost of care, within Cook County and the nation as a whole.

The Farm-Med Pilot

While CCHHS was waiting for a response to their 1115-Waiver request, Dr. Terry Mason, the Cook County Health and Hospitals System chief medical officer, presented his model of a wellness center prototype, initially called Farm-Med. Farm-Med was designed to be a multidepartment consortium at the Oak Forest campus where program participants are introduced to planting and harvesting vegetables and herbs, movement and exercise for healthy living, cooking, and kitchen supplies management as the family's primary pharmacy for wellness and illness treatment. Farm-Med's training incorporates meal planning, food label reading, eating away from home, and how to create a healthy home-community environment. In addition to these patient-centered training and treatment services provided at a CCHHS facility called the Oak Forest Health Center (OFHC), a 300+ acre campus and former long term residential hospital, the Farm-Med plan includes community-based health and wellness programming that leverages existing healthcare and primary care community assets while developing

innovative protocols for delivering health and wellness care services to residents in their homes within targeted communities.

The Farm-Med wellness model promotes the use of food, particularly vegetables and fruits, as a cost-effective treatment for chronic disease. Dr. Mason and his team conducted a 6-month test of patient receptivity to the Farm-Med model by incorporating vegetable garden planting, harvesting, and produce cooking instructional content, into occupational therapy training for persons diagnosed with a chronic disease such as diabetes. The 6-month test was considered successful by Dr. Mason, the OFHC occupational therapy team, and master gardeners from the University of Illinois Extension program. Patients learned new gardening, cooking, and lifestyle management skills that promoted body health while reducing the negative effects of their individual chronic health condition diagnosis.

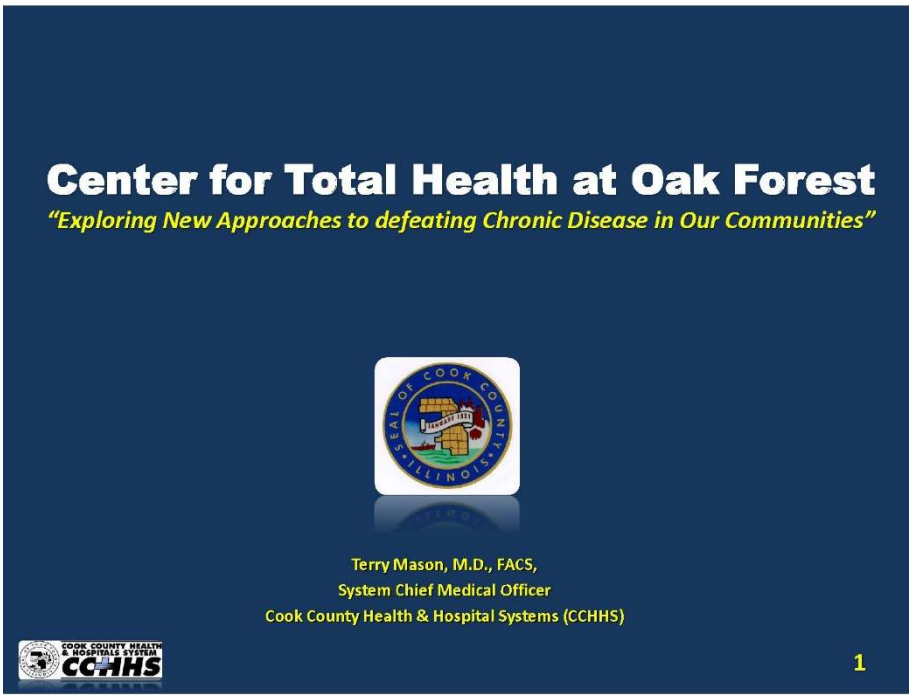
The Next Steps

Based on this positive feedback, Dr. Mason began the process of transforming the Farm-Med initiative into a full service health and wellness care delivery model. The proposed health and wellness model is designed to treat, from a patient-centered perspective, chronic health conditions related to food and lifestyle through protocols that prescriptively apply evidence-based food and lifestyle behavior change protocols. The early stages of this contract work led the health and wellness care delivery model called the Center for Total Health (CTH) described above. The CTH model is designed to help drive innovations in CCHHS healthcare delivery reform and revitalize definitions of

personal and collective health among CCHHS stakeholders while improving CCHHS with enhanced capacity to meet PPACA standards and mandates.

Dr. Terry Mason's CCHHS Board Presentation

CTH Powerpoint Presentation Slide Images



GUIDING PRINCIPLES

- Shift to **a population-centered** vs. hospital-centered health delivery model.
- Enhance **accessibility** to services.
- **Align service** delivery **with population demand** for services.
- Build **specialty care** capability to fulfill **unmet needs**.
- Extend primary care services through **partnerships.**
- Provide **quality-cost effective** healthcare.
- Focus on **service excellence**, employee satisfaction, and leadership development.
- Strengthen CCHHS **image** in the market.

2

CCHHS

Core Goals

I. Access to Health Services

II. Quality, Service Excellence, and Cultural Competence

III. Service Line Strength

IV. Staff Development

V. Leadership

CCHHS

Disparities in Access

CCHHS access points are not aligned with the poorer parts of the county, many of which have seen considerable population migration

CCHHS Locations and Median Household Income by ZIP Code

ACHN Locations

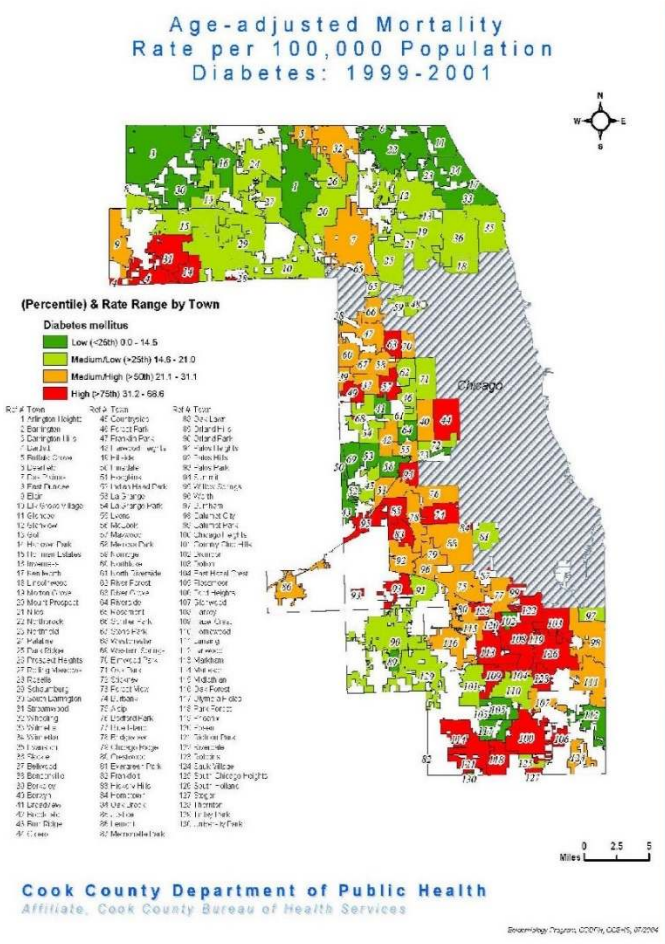
Hospitals

Median HH Income (2007)

- $100,000 to $500,000
- $75,000 to $99,999
- $50,000 to $74,999
- $25,000 to $49,999
- $0 to $24,999

Sources: CCHHS; Microsoft MapPoint data

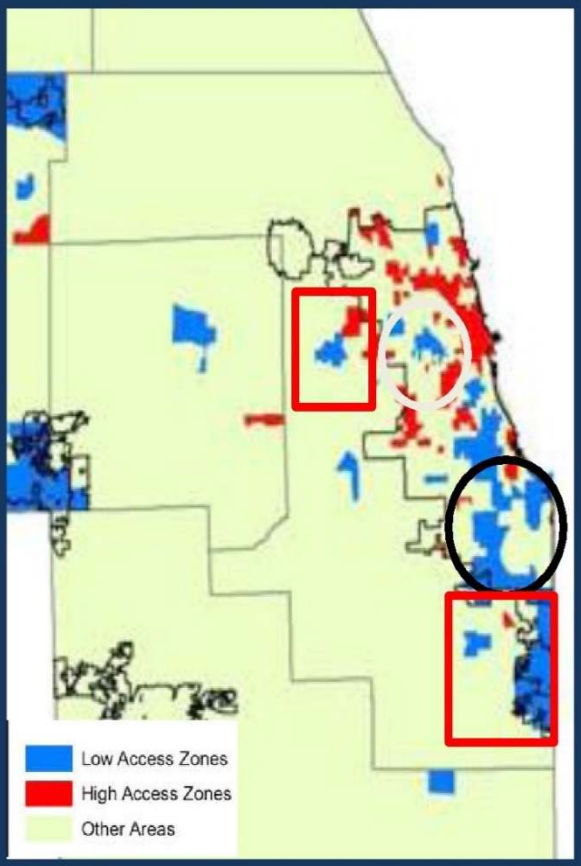
CCHHS



Deaths for Diabetes Mellitus (Percentile) and Rate Range by Town

Source: wePLAN, CCDPH, 2005

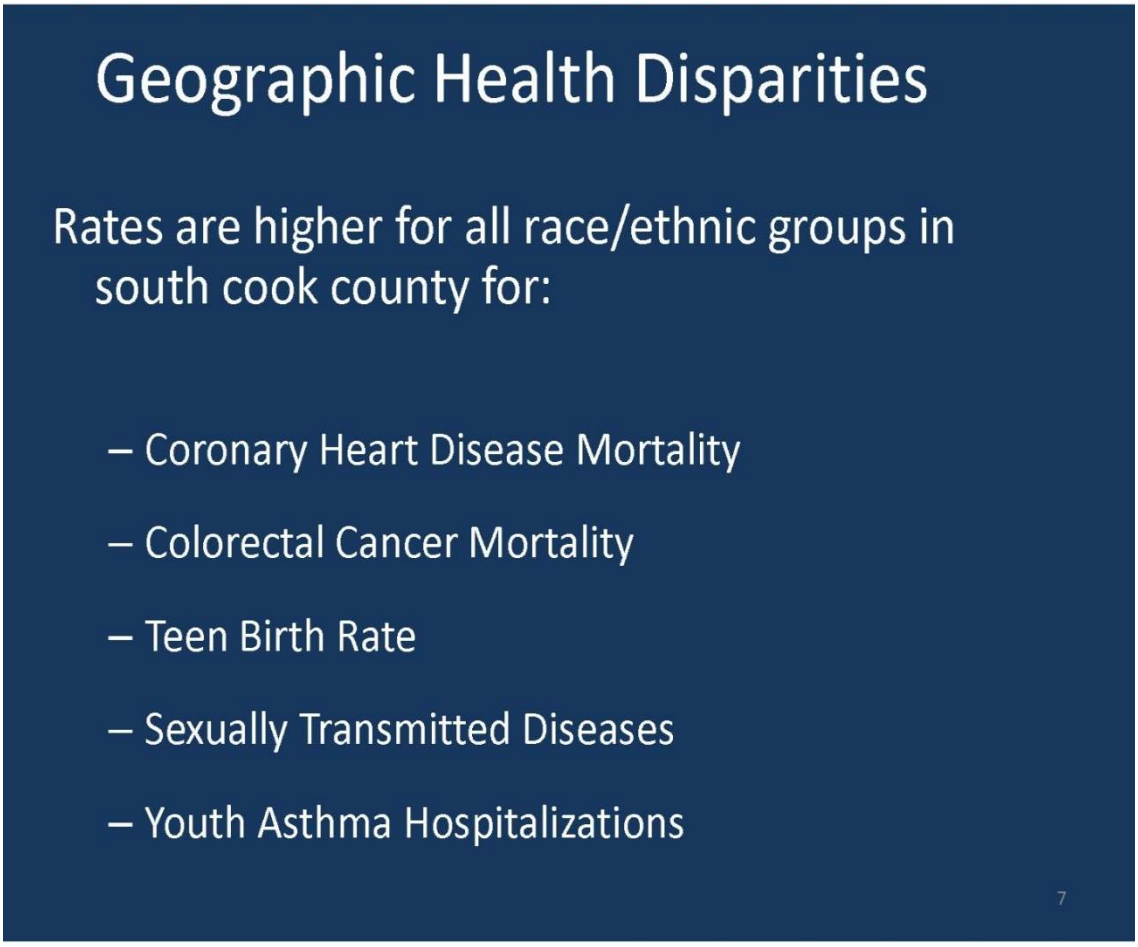
RED = High >75th 31.2 - 68.6



Access to Food

- "Food Deserts"
  (Lack of large supermarkets)
- Low income and minority communities most affected
  - Chicago:
    - Southside/Westside
  - Suburb:
    - South/West suburbs

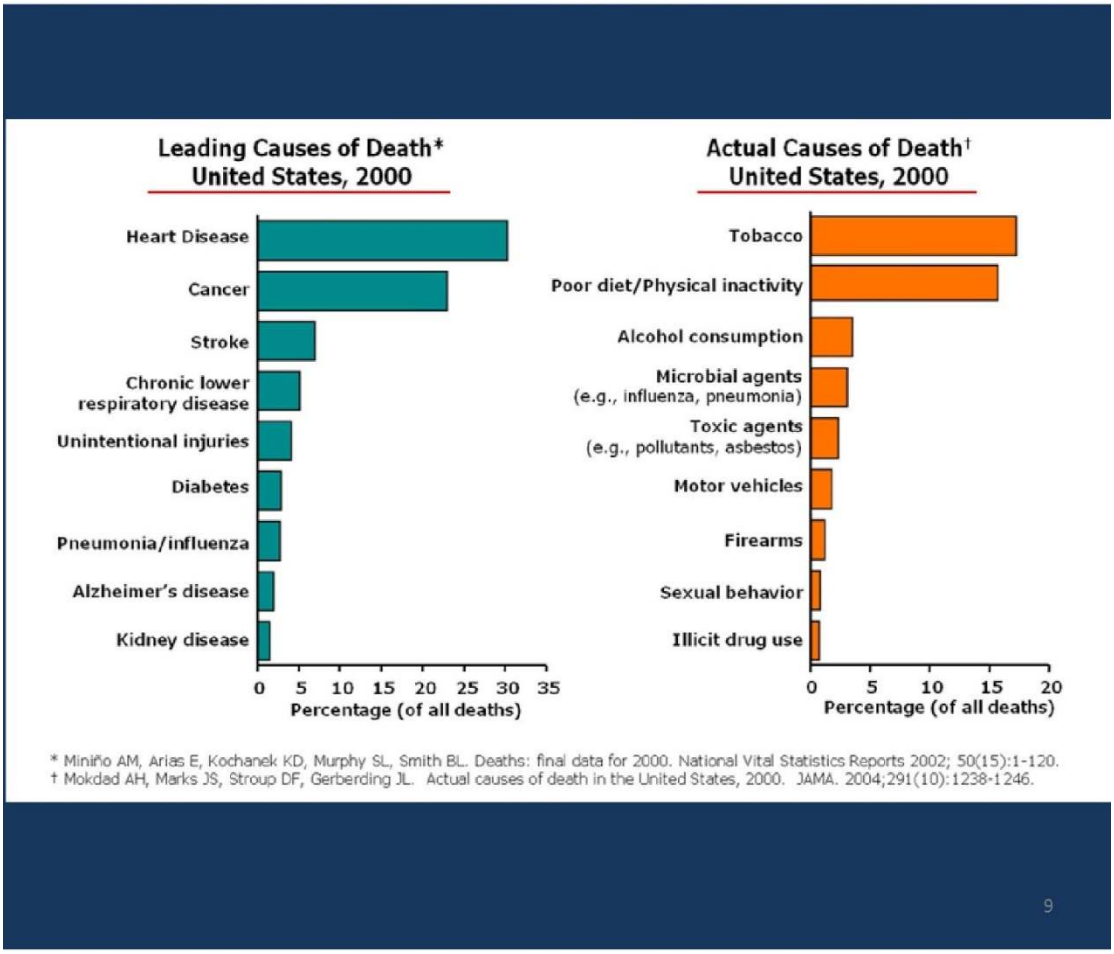
6



Slide notes: Given the poor economic and social conditions that influence the health of individuals and communities in the South district, it is not surprising that the result is poor health outcomes. Place does matter. ALL racial/ethnic groups living in the South district experience some of the poorest health outcomes in SCC.

Summary

- The southern area of SCC experiences some of the highest rates of poor health outcomes.
- High rates of unemployment, poverty, low high school graduation rates, and other poor socio-economic factors serve as major contributors.
- Health improvements can best be achieved by addressing the social determinants of health through policy, environment and systems change.


Leading Causes of Death*
United States, 2000
Heart Disease
Cancer
Stroke
Chronic lower respiratory disease
Unintentional injuries
Diabetes
Pneumonia/influenza
Alzheimer's disease
Kidney disease
0 5 10 15 20 25 30 35
Percentage (of all deaths)
Actual Causes of Death†
United States, 2000
Tobacco
Poor diet/Physical inactivity
Alcohol consumption
Microbial agents (e.g., influenza, pneumonia)
Toxic agents (e.g., pollutants, asbestos)
Motor vehicles
Firearms
Sexual behavior
Illicit drug use
0 5 10 15 20
Percentage (of all deaths)
* Miniño AM, Arias E, Kochanek KD, Murphy SL, Smith BL. Deaths: final data for 2000. National Vital Statistics Reports 2002; 50(15):1-120.
† Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual causes of death in the United States, 2000. JAMA. 2004;291(10):1238-1246.
9

Diet-Related Premature Deaths in the U.S.

Table 7—Number and value of diet-related premature deaths, 1994

Cause of diet-related death	Age at death 55-64	65-74
	Number of diet-related deaths[1]	
Coronary heart disease	9,113	20,836
Stroke	1,915	5,077
Diabetes	2,335	4,723
Cancer	26,775	49,138
All 4 causes	40,138	79,774
	$ billion (1995)	
Value[2]	16.6	11.4

[1] Defined as 20 percent of CHD or stroke deaths, and 30 percent of cancer or diabetes deaths, among those who died between ages 55 and 74.

[2] Deaths among those age 55-64 are valued at $412,751 in 1995 dollars, and deaths among those age 65-74 are valued at $143,760.

Source: USDA/ERS, adapted from Singh and others, 1996.

It's expensive to ignore prevention

Costs of Diseases Associated with Diet and Inactivity*

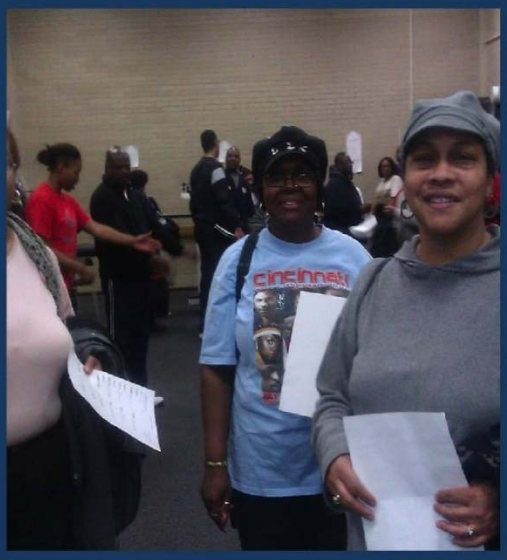
Cancer[11]	$180 Billion
Coronary heart disease[3]	$112 Billion
Obesity[3]	$117 Billion
Diabetes[12]	$98 Billion
Stroke[3]	$49 Billion
High Blood Pressure[3]	$47 Billion
Osteoporosis[7,**]	$14 Billion

* Estimates of annual direct + indirect costs for diseases overall (including portions caused by factors other than diet and physical inactivity.)
** Figure includes direct costs only.


Center for Total Health
"Exploring New Approaches to defeating Chronic Disease in Our Communities"
Using Food as Medicine
To Make the home the
"Medical Home"
11

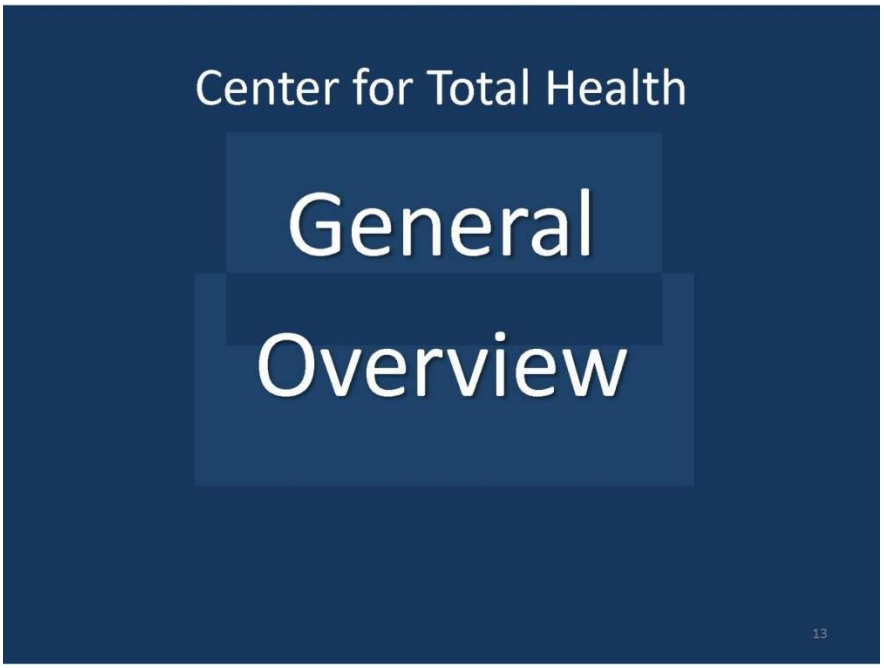
The People want to know!

Malcom X- Fitness

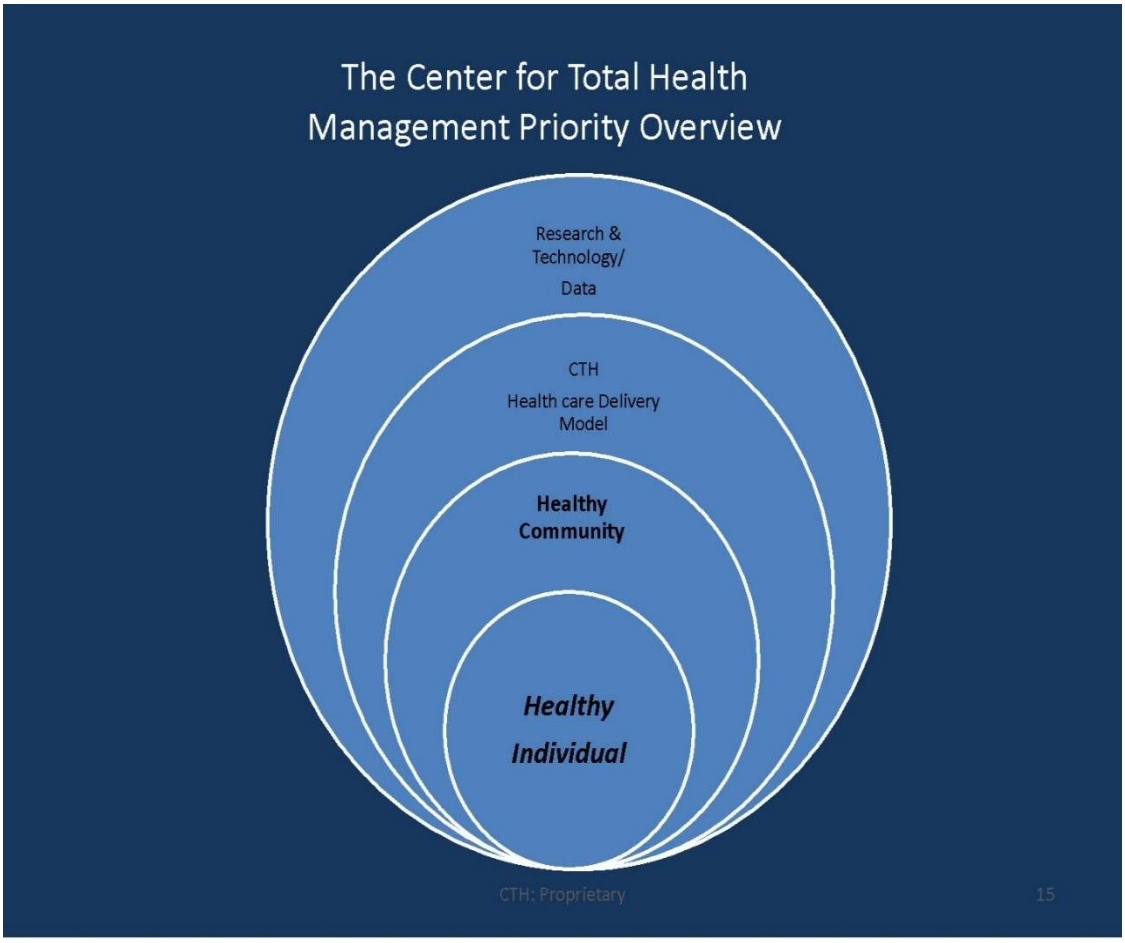


Trinity

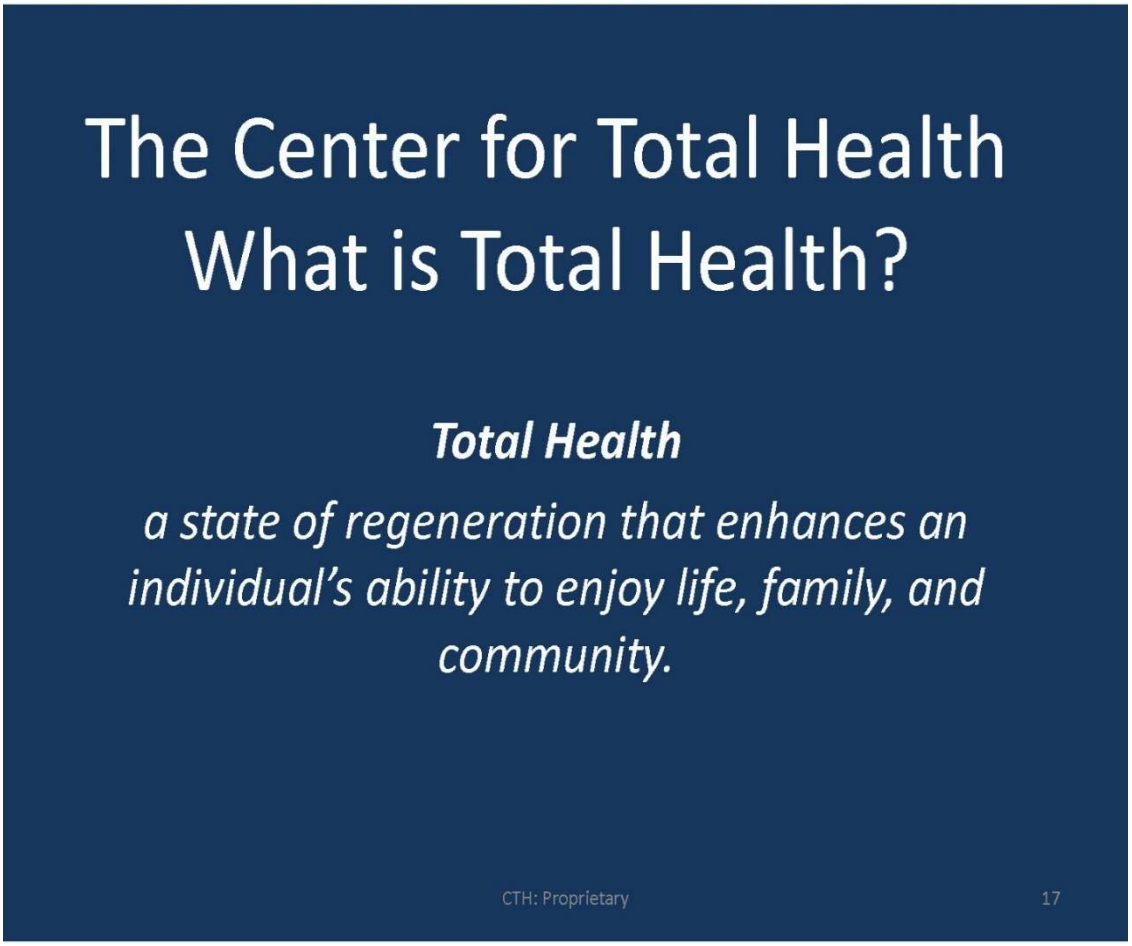
12


Center for Total Health
General
Overview
13


Positive Challenges
Patient Protection & Affordable Care Act mandates
Close medical care disparity gaps in Cook County
Prescriptively apply food, nutrition, and lifestyle protocols to health and wellness treatments
Help county residents turn their home into their primary source for treatment, health, and wellness care… their
True "Medical Home"!
14


The Center for Total Health Management Priority Overview
Research & Technology/ Data
CTH
Health care Delivery Model
Healthy Community
Healthy Individual
CTH: Proprietary
15


The Center for Total Health Model
• Evidence based Wellness-care delivery system
• Comprises Seven Institutes
• Promotes Individual & Collective Wholeness
• 21st century move from Disease/Sick-care to wellness-care & regenerative health
• Improves Community & Employee health outcomes
• Revitalizes Public Health practices & healthcare delivery
CTH: Proprietary
16

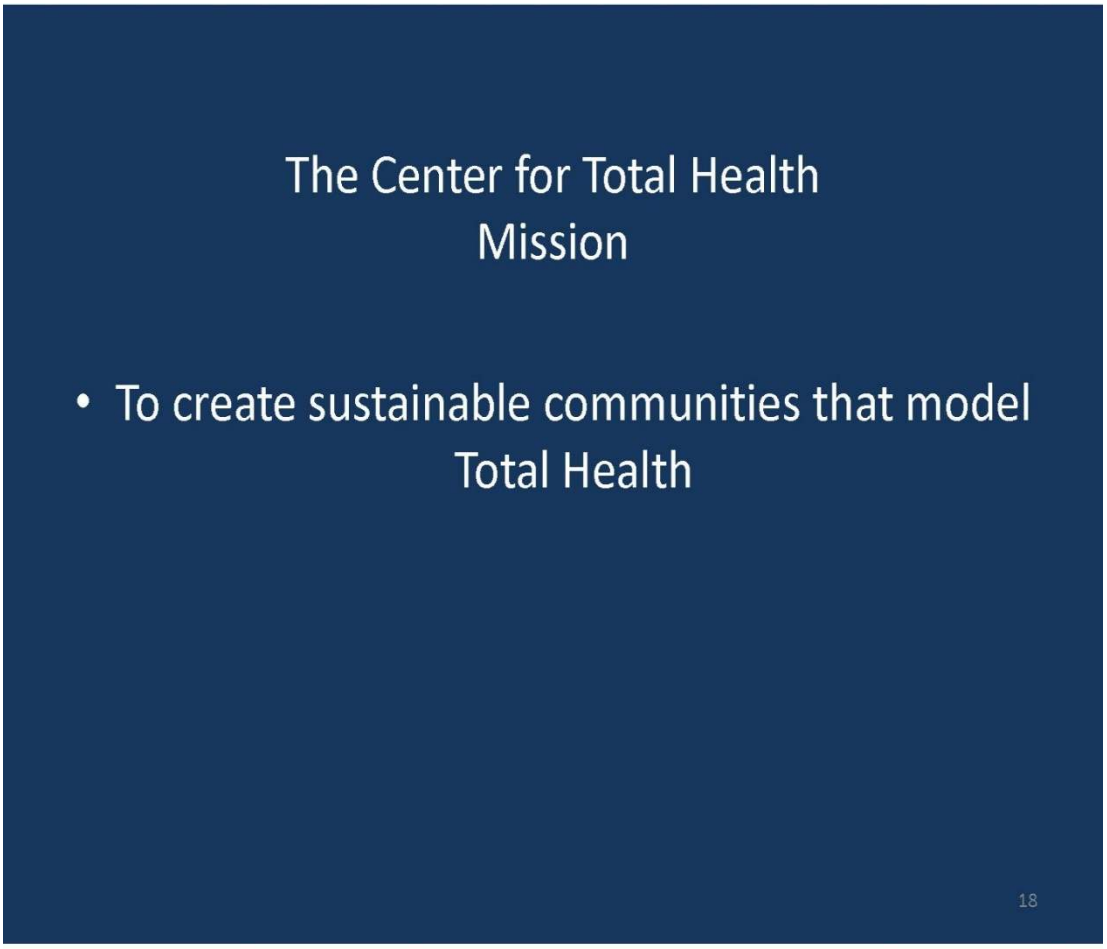


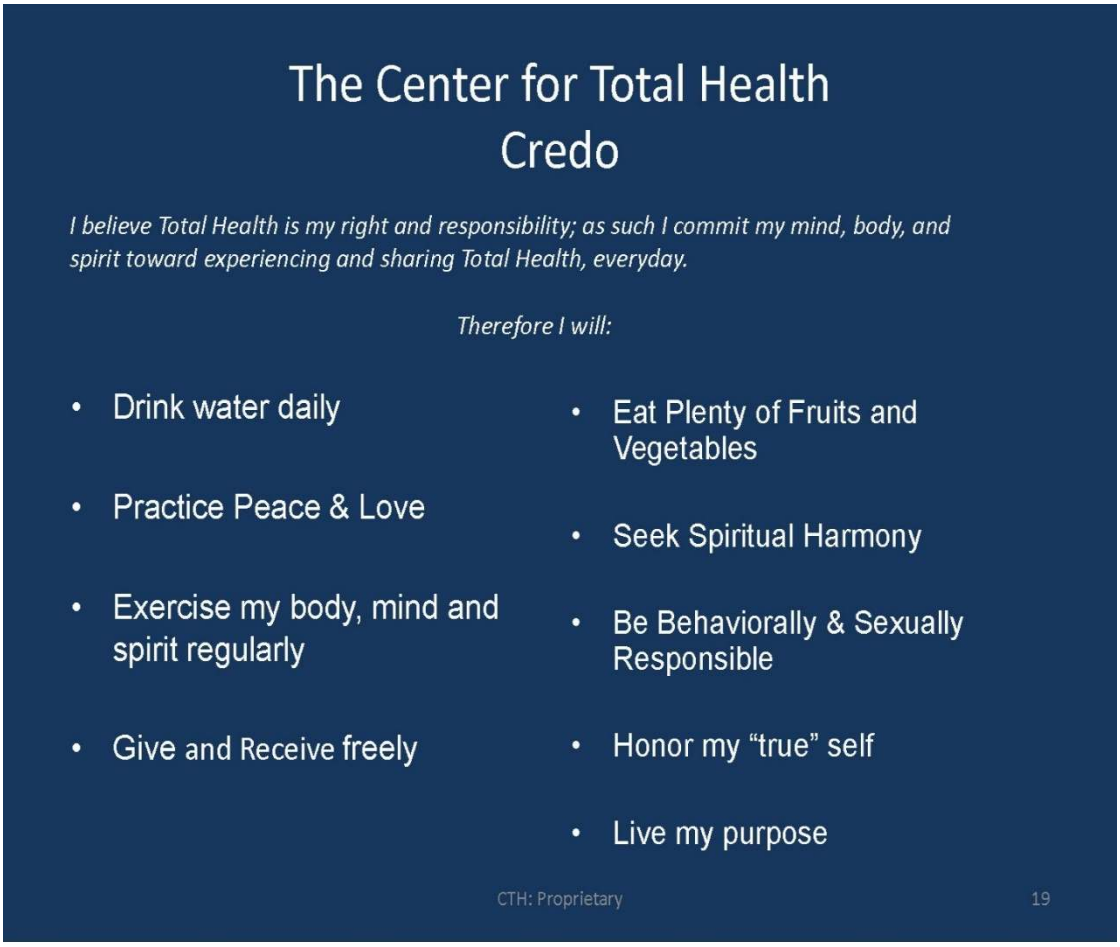
Slide notes: *re·gen·er·ate*: form again: to form again, or become formed again

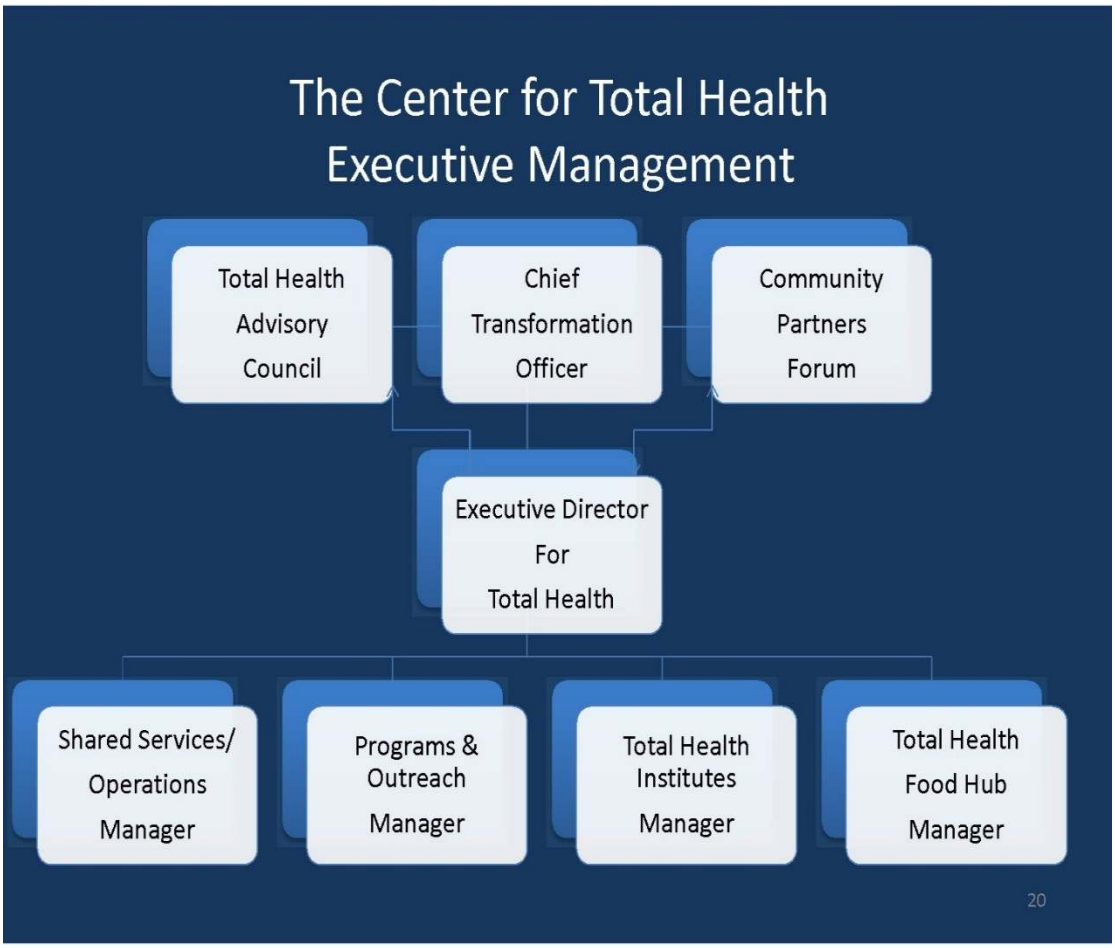
recover from decline: to return from a state of decline to a revitalized state, or cause something to do this

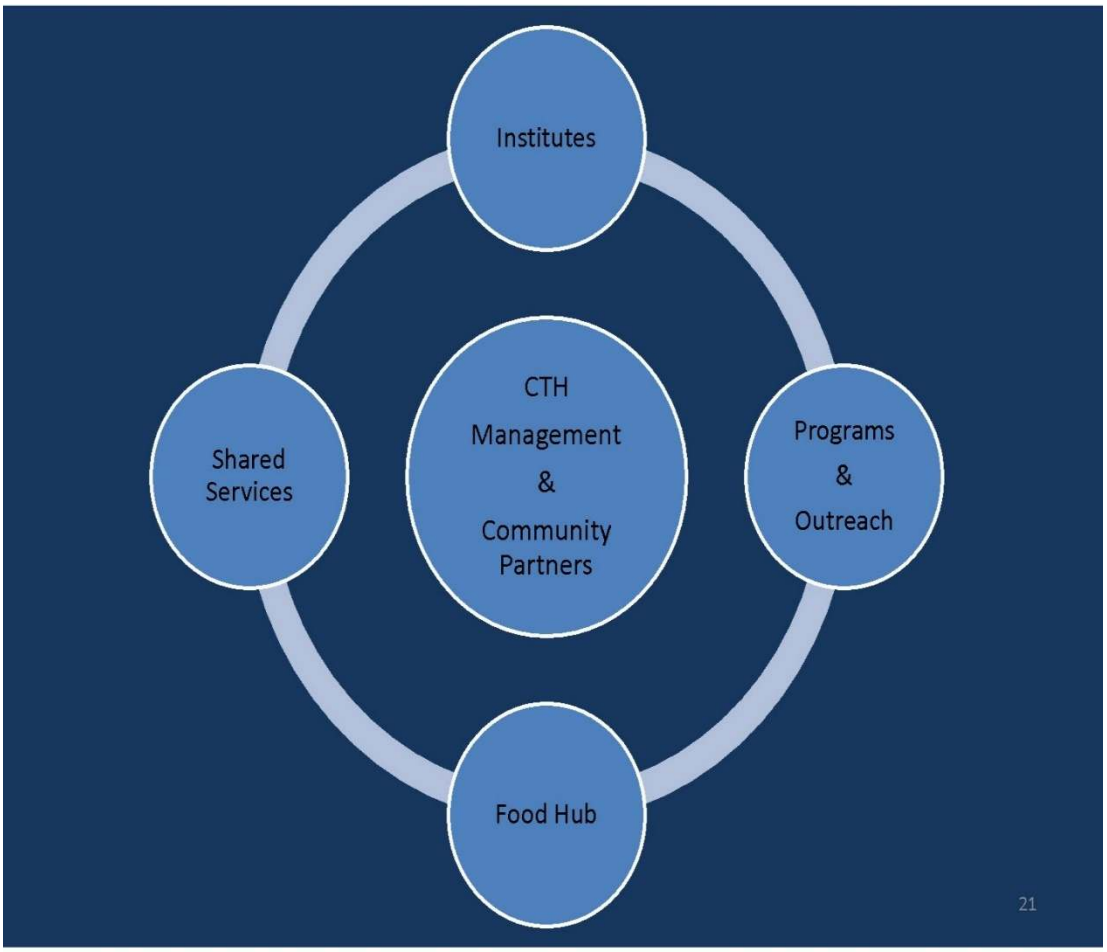
replace body part by new growth: to replace lost tissue or a lost limb or organ with a new growth, or grow again after loss

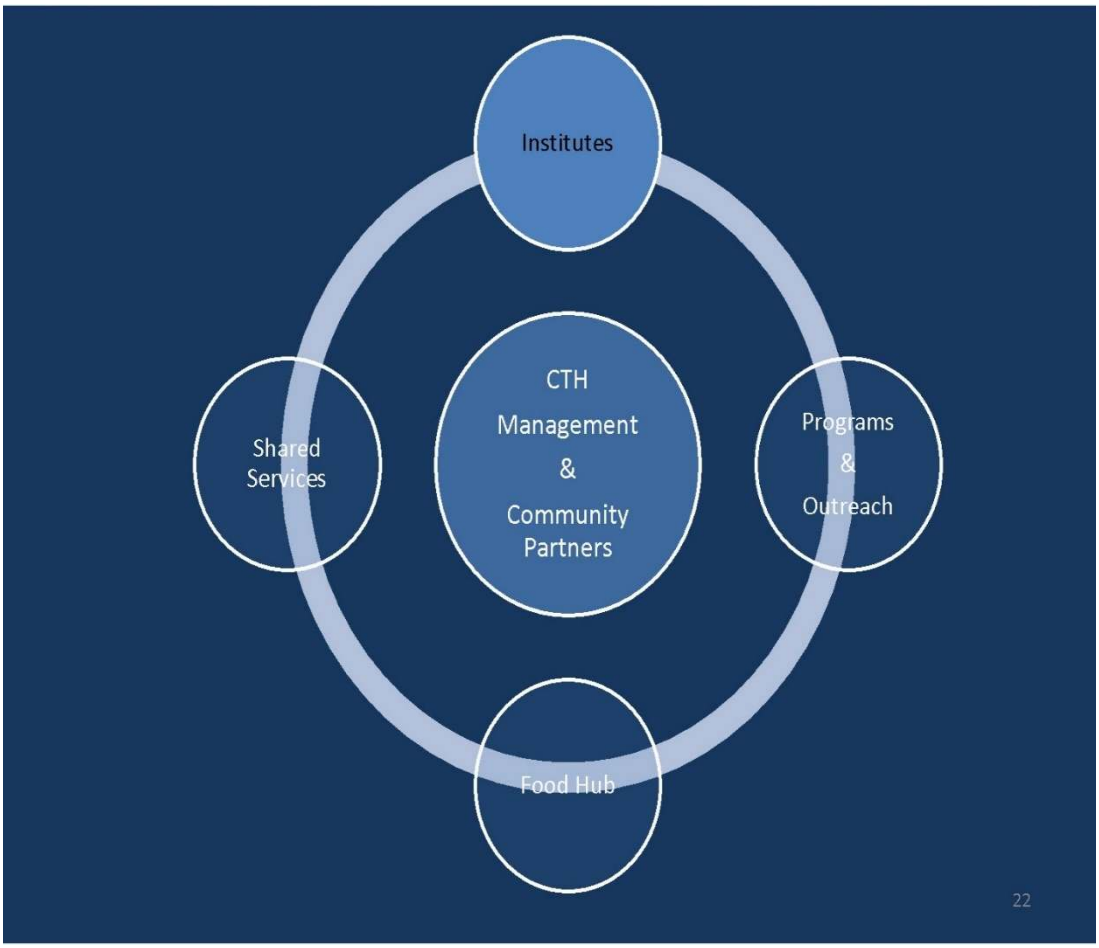
Synonyms: renew, restore, revive, redevelop, reinforce, stimulate, restart, rejuvenate, revitalize, rekindle


The Center for Total Health
Mission
• To create sustainable communities that model Total Health
18

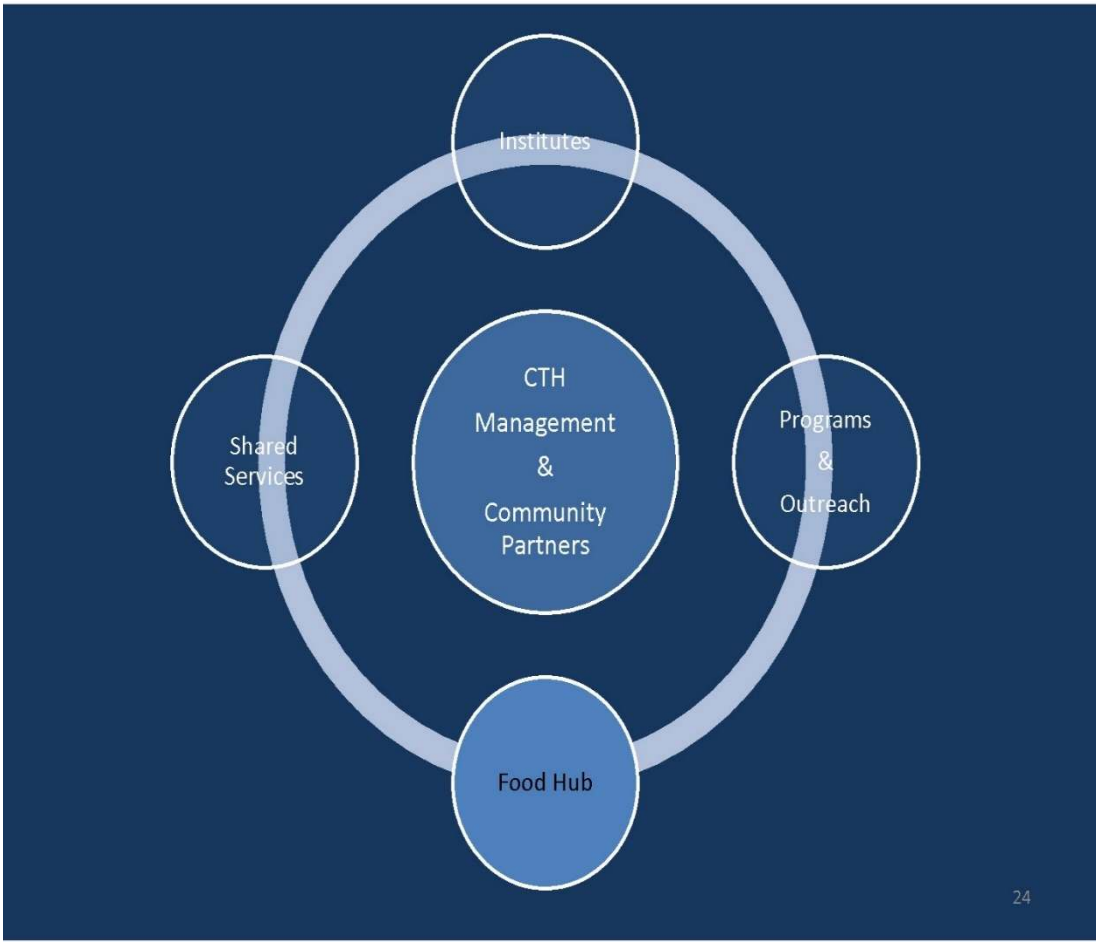

The Center for Total Health
Credo
I believe Total Health is my right and responsibility; as such I commit my mind, body, and spirit toward experiencing and sharing Total Health, everyday.
Therefore I will:
Drink water daily
Practice Peace & Love
Exercise my body, mind and spirit regularly
Give and Receive freely
Eat Plenty of Fruits and Vegetables
Seek Spiritual Harmony
Be Behaviorally & Sexually Responsible
Honor my "true" self
Live my purpose
CTH: Proprietary
19


The Center for Total Health
Executive Management
Total Health Advisory Council
Chief Transformation Officer
Community Partners Forum
Executive Director For Total Health
Shared Services/ Operations Manager
Programs & Outreach Manager
Total Health Institutes Manager
Total Health Food Hub Manager
20


Institutes
Shared Services
CTH Management & Community Partners
Programs & Outreach
Food Hub
21


Institutes
Shared Services
CTH Management & Community Partners
Programs & Outreach
Food Hub
22


The Institutes
of
The Center for Total Health
The Total Health Institutes is the Center's research and content creation services Division. There are seven institutes in the Center for Total Health:
• Food Science
• Movement
• Addiction-Release
• Social Determinants of Health
• Healthcare Delivery
• Mind/Body/Spirit Studies
• Employee Wellness
23


Institutes
Shared Services
CTH Management & Community Partners
Programs & Outreach
Food Hub
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The Center for Total Health: Food Hub

The Food Hub Division is our food sourcing, processing, and distribution unit. The Food Hub will provide the following services:

- Local Food Sourcing & Management
- Urban Farm & Gardening Services
- Food Processing & Packaging
- Total Health Cooking Academy & Kitchen Incubator

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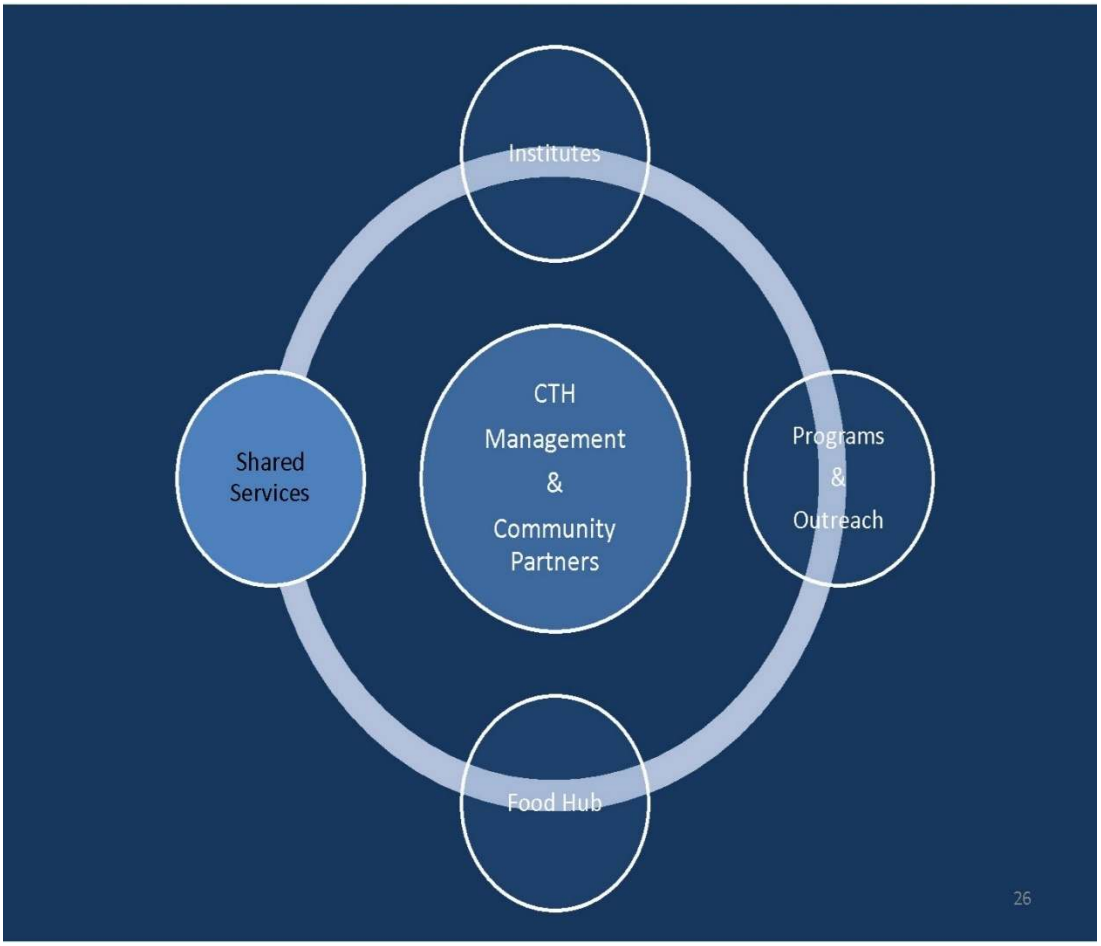
Institutes
Shared Services
CTH Management & Community Partners
Programs & Outreach
Food Hub
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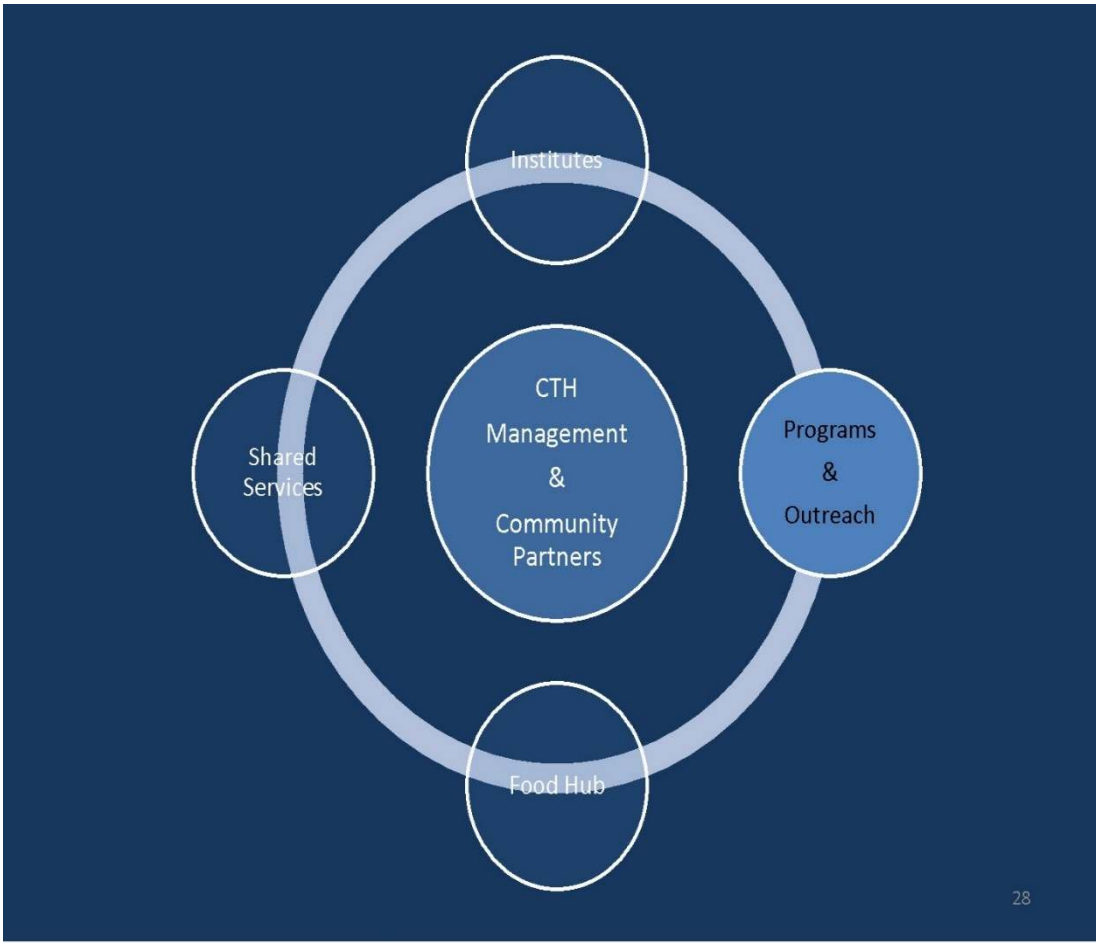
The Center for Total Health: Shared Services

Shared Services, our daily operations center, keeps all aspects of the Center for Total Health functioning as an integrated system. This division is comprised of three operating units:

- Business Development
- Internal Operations
- Corporate Affairs


Institutes
Shared Services
CTH Management & Community Partners
Programs & Outreach
Food Hub
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The Center for Total Health: Programs & Outreach

The Programs & Outreach Division will facilitate the design, development, delivery and management of the Center's outreach initiatives. Three operating units make up the Programs & Outreach division:

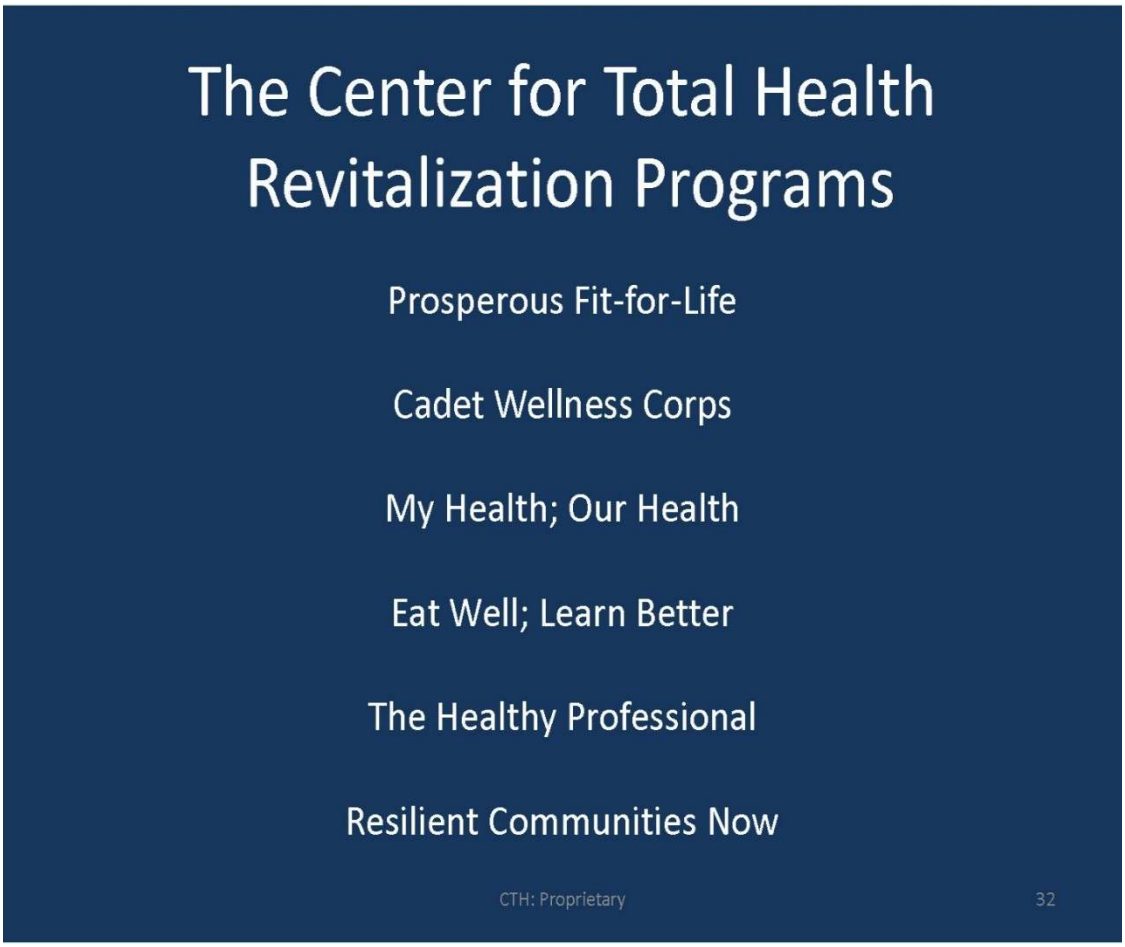
- Community Intervention & Training programs
- Corporate Training
- Conference & Webinar Services


Center for Total Health
Programs & Measurements Overview
CTH: Proprietary
30

Slide notes: **re·gen·er·ate:** form again: to form again, or become formed again recover from decline: to return from a state of decline to a revitalized state, or cause something to do this replace body part by new growth: to replace lost tissue or a lost limb or organ with a new growth, or grow again after loss. Synonyms: renew, restore, revive, redevelop, reinforce, stimulate, restart, rejuvenate, revitalize, rekindle

re·vi·tal·ize [ree v [illegible] somebody or something: to give new life or energy to somebody or something. Synonyms: refresh, invigorate, revive, rejuvenate, regenerate, renew, give a new lease on life

re·sil·ient [ri zíllyənt]: recovering quickly; able to recover quickly from setbacks elastic; able to spring back quickly into shape after being bent, stretched, or squashed



Slide notes: **Prosperous Fit-for-Life.** Target: those who are obese or struggling with some other occupational health/chronic disease connected challenge. We can even create an Olympics-/ Para-Olympics-like event to celebrate program participants breakthroughs (not all activities have to be intense athletics). The idea here is to help the participants see they are fit-for-life, a life of abundance ("I came that you might have life and have it more abundantly . . . I wish that you may prosper even as your soul prospers"). It is in

this program that we drive the teachings of the set-point wellness hero's journey, our 0–3 Total Health model. Helping people see we are all fearfully and wonderfully made with the tools to manage whatever life puts in our path and still come out victorious in mind-body-spirit.

Cadet Wellness Corps. Target = youth & young adults 9–20; purpose develop a cadre of youth and young adults able to lead community resilience efforts that revitalize community, promote wellness, and model interdependent- self sufficiency

My Health; Our Health. Target: 40+ & retirees; purpose promote and help facilitate community penetration of wellness programming while helping target group personally move along the wellness hero's journey (our set points).

Eat Well; Learn Well. Target: school-age youth served through designed healthy-eating school lunch and (in some cases) after-school meal and snack programs. In addition to feeding the children, there will be nutrition, gardening ("where food comes from") training, and food preparation skills development training (raw and lightly cooked).

The Healthy Professional. Target: workplace health and the workplace leader/professional . . . "from holes to wholeness" is the campaign goal using CTH's trilogic wellness model to teach and promote person/space wholeness in the workplace as a performance improvement-employee satisfaction enhancement tool and process

Resilient Communities Now. Target: geographically defined targeted communities. Goal is to teach/raise awareness, promote capacity building(infrastructure

& networks), and facility the integration of sustainable strategies. All for the purpose of creating whole communities and living wellness models of networked community medical homes and medical home support structures.


Center for Total Health
Implementation Plan
CTH: Proprietary
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Phases of Implementation
CTH will use a four stage implementation strategy timeline:
1) Pre- Launch; Jan. – Jun. 2013
2) Phase I; Jul. – Dec. 2013
3) Phase II; Jan. 2014 – Jun. 2014
4) Phase III; Jul. 2014 – Jul. 2015
CTH: Proprietary
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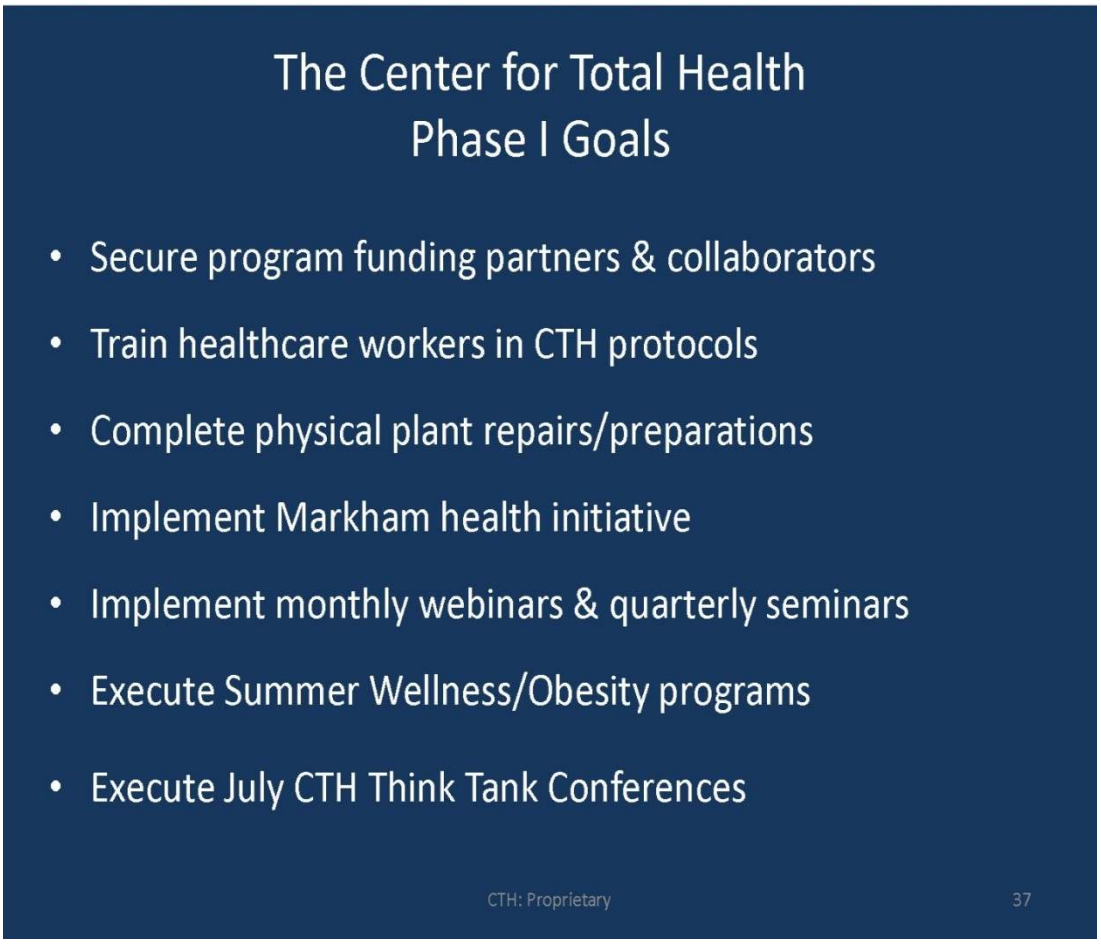
The Center for Total Health
Pre-Launch Goals
• Secure start-up funding
• Establish & Test Management Systems
• Prepare physical plant (Oak Forest) space for Pre-launch & Phase I
• Recruit & orient CTH start-up team
• Implement Food Science & Food Hub start-up plan
• Execute pilot programs
• Develop South Suburban stakeholder network
• Execute April CTH Think Tank Conferences
CTH: Proprietary
36


The Center for Total Health
Phase I Goals
• Secure program funding partners & collaborators
• Train healthcare workers in CTH protocols
• Complete physical plant repairs/preparations
• Implement Markham health initiative
• Implement monthly webinars & quarterly seminars
• Execute Summer Wellness/Obesity programs
• Execute July CTH Think Tank Conferences
CTH: Proprietary
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The Center for Total Health
Phase I Oak Forest Space Allocations
– H Bldg. – Trilogic (mind/body/spirit) treatment and training center
– J Bldg. – CTH Institutes Bldg. & program/resident space
– Laboratory Suite & equipment – F.I.M., Food Science program
– Greenhouse – Year round growing & Aquaponics
– Demonstration Gardens
– Country Store – F.I.M. Food Science Program
– Kitchen
– Administration Office Suite
– Protestant Chapel & inner courtyards – Mind-Body-Spirit
– 1 acres (Cicero side of campus)
– Auditorium & conference/video conference rooms
– Planning for Regenerative Medicine & Domicile – Bldg. B or C (Phase II)
CTH: Proprietary
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The Center for Total Health
Phase II Goals
• Secure Program / Community funding partners
• Build out Remote medical services control center
• Expand Food Hub into prepared & packaged food services
• Expands service beyond South Suburban Cook County
• Hold campus based community education & wellness programs
• Publish 1st annual Total Health 'Journal'
CTH: Proprietary
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CTH Start-up Funding

- Startup
  - $2,000,000.00 – Pilot Startup
    - $22,000,000.00 - Total Startup estimate
  - $11,800,000.00 - Annual Operating
  - $ 5,200,000.00 - Annual special programs/outreach

- Key Considerations
  - Business Intelligence Suite and social media portal
  - Healthcare worker & wellness internships training program
  - Food Science laboratory & food hub center setup
  - Patient assessment, monitoring and remote access service equipment
  - Oak Forest facilities preparations (to include greenhouse)
  - 17 person CTH Startup Team
  - Community awareness, communication, & volunteer campaign
  - Training and event Management suite of tools
  - Population based, applied wellness research initiatives

CTH - GUIDING PRINCIPLES

- Shift to **a population-centered** vs. hospital-centered health delivery model.
- Build **wellness care** capability to fulfill **unmet needs**.
- Extend wellness care services through **partnerships** into our communities**.**
- Provide **quality-cost effective** food, nutrition, and life management services.
- Focus on **service excellence**, workplace satisfaction, community resilience, and leadership development.
- Strengthen CCHHS's population wellness agenda in Cook County

CCHHS

CTH - Core Goals

I. Quality, Service Excellence, and Cultural Competence

II. Access to Health & Wellness Services

III. Enhanced Food & Nutrition Security

IV. Resilient Communities

V. Leadership

CCHHS


Thank You !
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Farm-Med Statement of Work

Farm-Med Statement of Work

Cook County Health and Hospitals System

May 2012

Exhibit A

Scope of Work

Overview

This scope of work is designed to facilitate the fulfillment of three primary objectives through the Center for Chronic Disease: (a) develop a program that uses food as medicine to decrease or eliminate a patient's use of medications; (b) help program participants make their personal home their "medical home"; and (c) the development of a regional food hub to provide fresh and prepared fruits and vegetables.

The Center for Chronic Disease incorporates four primary project activity centers: (a) Farm-Med; (b) Smart Kitchen; (c) Healthy Food market; and (d) Community Selection. This scope of work provides overall project development, facilitation, and progress tracking support for all four project activity centers.

Project Reporting

Regular standard reporting will include monthly project progress summaries and quarterly comprehensive project reviews. Subject or task specific reporting will take place as directed and in accordance with the project work plan during this 12-month

contract period. A schedule of deliverables is included in the project timeline section below.

Approach/Methodology

This scope of work will follow the three-staged strategy implementation process (SIP) developed by Dr. James L. Miles, Sr. Each stage is progressive and designed to provide an efficient, expeditious, customized process for turning a concept/vision into measureable, executable strategies in three highly manageable stages. Stage 1 identifies and clarifies the concept/vision within a definable context. Stage 2 identifies and validates strategies for accomplishing each component of the vision, to include general cost estimates. Stage 3 creates an interactive, highly manageable implementation plan customized to the project goals, context for implementation and organizational culture through which the project must be developed.

Project Timeline/Work Schedule

This scope of work covers a 12-month timeline commencing on the first actual workday after contract approval.

The SIP will define the task and schedule of deliverables for the first 135 days of the project. The remaining 9-month of the contract will be governed by the SIP Stage 3 implementation plan.

SIP Stage 1: clarify project goals, general resources available for the project, and overall implementation timelines/deliverables. Key performance measures and general cost estimates are incorporated, with stated assumptions, as appropriate.

- Stage 1 deliverable: a preliminary findings report
- Time to deliverable: 15 days from actual work start date
- Additional task/deliverables:
    - Identify first-year goals for setup and food production through the Farm-Med & Healthy Food Market components

SIP Stage 2: research and validate project performance, process assumptions, and outcomes. Develop and present strategic implementation recommendations based on the preliminary findings report. Facility strategy implementation selection process with key stakeholders and executive decision makers.

- Stage 2 deliverable:
    - Part I – Strategy recommendations brief (45 of the 60 days)
    - Part II – Strategy recommendations report
    - Time to deliverable: 60 days from approval of preliminary findings report
    - Additional task/deliverables.
- Start preliminary implementation, based on approved strategy, for the Healthy Food Market:
    - Create list of marketplace collaborators for food distribution
    - Create vendor list for procurement of fruits and vegetables
    - Create a vendor list for procurement of packaged food service support
    - Prepare store layout plan for review and implementation

- Generate funding support for the development of the Farm-Med & Healthy Food Market project component
- Identify and execute soft-launch strategy for the Farm-Med component
- Conduct and document market survey of existing urban gardens and their primary growing capacity within the targeted communities selected for the community selection component.
- Launch Phase 1 of the Farm-Med program
- Facilitate the development and delivery of an internal training module for doctors, care team members, and key project stakeholders
    - Develop draft project training guide for medical team and primary caregivers
    - Coordinate the selection and orientation of the first patient group
    - Secure Smart Kitchen design and development plan
- Develop and implement a project communication protocol for project collaborators of the Center for Chronic Disease
    - Conduct stakeholder meeting and project overview briefing for key project collaborators. Feedback from this meeting will be reviewed and incorporated into the project implementation plan.

SIP Stage 3: create a project implementation plan to guide day-to-day project management task, performance tracking, financial pro forma, and executive oversight.

The project implementation plan will have to be approved in order to officially start the full implementation process.

- Stage 3 tests and launches full systems reporting, systems compatibility/integration, and project communication protocols. Project communication protocols are enhanced to facilitate an expanded into the larger community and address brand/program awareness, community feedback opportunities, and social media strategies.
- Stage 3 deliverables:
    - Project organizational chart annotated with duty/oversight responsibilities
    - Project resource allocation list (available and projected)
    - Project financial pro forma (working budget & funding strategy)
    - A 24-month project implementation plan with reporting templates
    - A standard operating procedure manual as a working document
    - Coordinate first project review session with patients, doctors, and key stakeholders
    - An online presence and identity for the project
    - Time to deliverable: 60 days after completion and approval of SIP Stage 2
    - Additional task/deliverables

- Coordination of the Center for Chronic Disease grand opening celebration and open house
- Launch the food distribution network plan
- Set up Healthy Food Market store and support infrastructure

Program Launch I

Program Implementation Stage I: this primary focus in this first stage of full implementation is to secure the overall project management, communication and reporting systems. We will continue the development of all four key project components simultaneously

- Communicate official program start date with all stakeholders as appropriate
- Test all project management tools and equipment
- Confirm availability of project resources needed for the project launch
- Provide program training to stakeholders as needed
- Review program implementation plan with key executives and management team
- Provide feedback and revision opportunities for any last minute changes or adjustments using the program collaboration portal
- Launch Smart Kitchen startup/training plan
- Implement Farm-Med & Healthy Food Market development/distribution plan
- Program Implementation Stage 1 deliverables:

  - Sample program management, performance, communication protocol reports /tracking tools
  - Program operations manual
  - Access to online program collaboration portal
  - First patent group evaluation report
  - Time to deliverable: 30 days

Program Launch 2

- The primary focus in this second stage of full implementation is the development of the Farm-Med and Healthy Food Market
- Self-funding strategies and collaborative partner support are significant considerations to be addressed while developing the Farm-Med and Healthy Food Market components
- Program Implementation Stage 2 Deliverables
  - Community partner seminars and workshop development and coordination
  - Patient participation in Farm-Med and social media activities
  - Community participation in Farm-Med and the Healthy Food Market
  - Program participation/performance reports
- Secure distribution and vendor agreements for the following
  - Raw food acquisition and distribution
  - Cooked food preparation and distribution

  - Program participant cooking classes
  - Program collateral literature for broader community
- Time to deliverable: throughout a 90-day period

Program Evaluation I

- A full 7-day evaluation of the project launch will be conducted. The emphasis will be on stakeholder and caregiver experiences
- Deliverable
  - Project evaluation report/ briefing

Program Launch 3

- Community outreach and the development of community distribution centers is the primary focus on the implementation stage.
- Program Implementation Stage 3 Deliverables
  - The launch of the Farm-Med food distribution network (earned income strategy)
  - The expansion of the social media campaign
  - Facilitate program training internally & externally
  - Facilitate growing or acquisition of fruits and vegetables to meet market outreach interest
  - Program participation/ performance reports
  - Additional task/deliverables

- Project collaborators and key stakeholder briefing on the overall Center for Chronic Disease model launch.
- Time to deliverable: 90 days

Project Annual Performance Evaluation and report

- Time to deliverable: 7 days

Appendix B: The Five Stages of Revitalization Movement Theory

Five Stages of a Revitalization Movement

The five stages listed below, when present within the progression of a culture change, help distinguish the culture change as a revitalization movement (Wallace, 2003).

Stage 1: The Steady State

In this original steady state, individuals in a societal culture are able to use culturally acceptable means to manage stressful incidents and chronic stress. Individuals who respond to growing or chronic stress in culturally unacceptable ways are perceived as exhibiting deviant behavior within that society. The central focus is the availability and use of stress management or stress reduction techniques in culturally acceptable manners.

Stage 2: The Period of Increased Individual Stress

Stage 2 is characterized by a growing awareness that a major change is needed in the social culture. Culturally acceptable stress reduction techniques are no longer effective and the resulting increase in stress is approaching levels considered intolerable by individuals in the society. The idea of a change brings about an additional level of stress experienced by individuals in the society.

Stage 3: The Period of Cultural Distortion

Cultural distortion brought on by anxiety over the prospect of change and the inability to effectively reduce the experience of stress prompts individuals to respond in various ways. These response fall into three primary groups. Group 1 would prefer

tolerate progressive experiences of chronic stress rather than make systematic changes to their worldview and behaviors. Group 2 responds by making changes in their world view and behavior. Groups 2's changes provide opportunity for adopting culture practices believe to effect positive change and reduce the stress experience. Group 3 makes behavior changes Wallace (2003) called regressive, such as resorting to alcoholism, intragroup violence, self-reproach, negative behavior by public officials, and depression. Group 3's repressive behavior approach to change brings about added stress, although Wallace considered these stresses to be new culture patterns.

Stage 4: The Period of Revitalization

Mazeway reformulation. An emergent leader has a vision that provides guidance towards the pursuit of alternative ways to behave and see the world. This moment of insight becomes a turning point, a type of "funeral ritual" (Wallace, 2003, p. 17) for the leader, where the old ways are now considered dead and the vision of a new way to behave and see the world is abruptly embraced, communicated, and internalized. It is this process of embracing the new vision through thought and action that represents a mazeway reformulation.

Communication. The vision is communicated as a call to action for new converts. This communication to paint a picture of a new culture in which the convert will experience protection and a more beneficial life in comparison to the old culture, which was full of stress and death. It also provides a template for the development of

disciples who can assume the task of communicating the visionary message to a growing group of converts.

Organization. At this point, a "charismatic leader" (Wallace, 2003, pp. 20–22) must organize the disciples by distributing the charisma/ power to the disciples in a "stable institutional structure" (Wallace 2003, p. 21). This distribution of power acknowledges the "revitalizing personality transformations" (Wallace, 2003, p. 20) experienced by the converts who have become empowered disciples.

Adaptation. The leader and converts, in response to resistance from factions in the dominant society, adapt their doctrine, practices, or communication strategies to constructively address the resistance. When these constructive adaptations prove ineffective, the leader and disciples frequently engage in "combat against the unbeliever" (Wallace, 2003, p. 22).

Cultural transformation. As the number of converts in the larger societal population becomes large enough to exercise societal influence or control, some form of organized group action takes place. These group actions can be constructive, social, political, or economic programs of benefit. It is also possible for these group actions to take on decidedly destructive agendas that are "literally suicidal" (Wallace, 2003, p. 22). In some cases, these failures of a movement are inevitable as a result of circumstances beyond the control of the leader and people.

Routinization. If the group action is effective in "reducing stress-generating situations" (Wallace, 2003, p. 22), it becomes a new norm in society, politically, socially,

or economically. As the group action becomes the new norm, the leader and disciples of the movement frequently take over responsibility for the preservation of ritual and doctrine.

Stage 5: The New Steady State

A general satisfaction is experienced with the group's new social and/or natural environment.