HOW INSTITUTIONAL CONDITIONS SHAPE THE QUALITY OF WORK PRACTICES: EVIDENCE FROM THREE CARE COORDINATION PROGRAMS IN NEW YORK STATE

A Thesis

Presented to the Faculty of the Graduate School

of Cornell University

In Partial Fulfillment of the Requirements for the Degree of

Master of Science

by

Nikolaus Johannes Krachler

August 2017

ABSTRACT

Commentators have often celebrated care coordination as an encompassing solution capable of reducing costs and increasing quality in US healthcare. It is unclear, however, under which conditions organizations implement high-quality work practices that are essential for achieving improved outcomes in the context of care coordination programs.

My paper examines two institutional factors that improve the quality of work practices: occupational community, and regulatory intensity. I argue that the interaction of both factors produces higher quality than either would in isolation. I also demonstrate how in the absence of both factors, a prioritization of cost-effectiveness reduces the quality of work practices. To make my argument I draw on 80 semi-structured interviews, 80 documents, and 15 hours of observation in my study of three care management agencies that focus on serving low-income chronic disease patients in one of the most resource-poor communities in New York State.

BIOGRAPHICAL SKETCH

Nikolaus completed his BA in Political Science at the Otto-Suhr-Institute of the Freie Universität Berlin. In parallel, he completed a one-year course in Human Resource Management at the Department of Education and Psychology of the Freie Universität Berlin. He then completed his MSc in Political Sociology at the London School of Economics for which he received the Hobhouse Memorial Prize for the best performance in his cohort. Before starting his MS/PhD at the ILR School, Nikolaus worked as a paramedic, a management consultant, and a researcher on the project 'The Effects of Marketization on Societies' led by Ian Greer.

ACKNOWLEDGMENTS

I would like to express my immense gratitude to the workers, workers' representatives and policymakers who shared their experience and knowledge with me for this thesis. They did so at a turbulent time in the US health system's history and under strong time and resource constraints. I hope to have done justice to their extremely needed and admirable effort to help stabilize the health of people with chronic conditions and severe social issues.

I also wish to thank Rosemary Batt, Virginia Doellgast, Adam Seth Litwin, Ian Greer, and Pam Tolbert for their essential help in developing and reworking earlier drafts and presentations of this thesis. My thanks also go to the participants of the weekly ICL/LR workshop who gave me excellent feedback on aspects of the thesis. Moreover, I wish to thank Peter Lazes, Lowell Turner, and Lance Compa for their important assistance in developing some of the research contacts that formed the basis for the thesis.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

1. Introduction

Care coordination refers to the integration of care practices between two or more care providers (Bodenheimer 2008). Improving care coordination has been a long-standing policy aim in the US and other countries (Torjesen et al. 2016). For example, the Model Cities Program in 1966 tried to integrate health and social services across cities and States in the US (Hassett and Austin 1997). In the 1990s, supply-side economists pointed to more integrated delivery systems such as Kaiser Permanente as cost-reducing and quality-enhancing exemplars (Enthoven 2010: 65). The advent of accountable care organizations and similar programs in the 2010 Affordable Care Act demonstrated that improving care coordination continues to be the dominant way policymakers attempt to improve US healthcare (Marmor and Oberlander 2012).

However, care coordination programs, i.e. programs aimed at improving care coordination, have shown mixed results. Despite evidence demonstrating that care coordination programs can be successful, it remains unclear under which conditions these programs in fact realize their potential (Jackson et al. 2013). For example, programs in the 1960s and 1970s failed to generate savings, most likely due to their grand scope and resistance at the service delivery level (Hassett and Austin 1997). A recent meta-analysis of care coordination programs found only small significant increases in patient satisfaction but no other positive outcomes (Stokes et al. 2015).

Accordingly, the research question of this thesis is: under which conditions do organizations successfully implement care coordination programs, where success means increasing the quality of work practices? I understand the quality of work practices as a combination of the level of skill that workers apply in their work with how intensive their work

is, where ‘intensity’ refers to the frequency and quality of workers’ interactions with program members, physicians and co-workers, and to the quality of information workers generate. I examine the impact of two institutional conditions on the quality of work practices: social conditions as exemplified by occupational community and political conditions as exemplified by regulatory intensity. By bringing together a sociological institutionalist approach that focuses on social conditions and a historical institutionalist approach that focuses on political conditions (Hall and Taylor 1996) I demonstrate how it is their interaction that generates high-quality work practices.

Previous studies of care coordination have focused on establishing that care coordination and similar practices improve health outcomes. Based on these studies we know that care coordination practices can have desirable effects. These studies, however, connect these desirable work practices neither with their underlying social dynamics nor with broader political factors. They thus do not answer the question of the conditions under which organizational or public policymakers successfully increase care coordination. By contrast, this thesis focuses on the implementation of care coordination programs and provides an answer to the question of which factors shape variation in the quality of work practices in the context of such programs.

Previous studies of care coordination exist in the fields of health policy and employment relations. The health policy literature focuses on evaluating public policy programs on a large scale (usually across an entire State) by associating these programs with health and cost outcomes. This approach demonstrates that State-wide, public policy programs can be an important factor in shaping work practices by showing that such programs can reduce costs or improve health outcomes on a large scale. However, health policy studies do not focus on variation in work organization in terms of skills or work design because the policy programs they

have evaluated have usually had set of guidelines for all organizations that participate in the program. Moreover, the health policy studies that have associated particular practices with positive outcomes have shown that frequent, face-to-face contacts between care coordinators and members are desirable but they have also not examined under which conditions such desirable practices emerge.

While the health policy literature has identified policy programs as a potentially important conditioning factor, the employment relations literature has outlined a set of desirable work practices but without systematically investigating their underlying social and regulatory dynamics. Employment relations studies have shown that high-performance work practices that function as a system of practices also improve organizational performance in the healthcare sector. At the same time, they have not examined the factors that condition the success of such practices because their approach has not extended beyond formal management practices, neither in terms of social dynamics that underlie the workplace nor in terms of factors that extend beyond the workplace such as different public policy designs. Employment relations scholars who have researched care coordination and similar practices have understood the broader context as a set of empirical trends (for example escalating costs in the healthcare sector) that motivate the search for cost-saving or quality-enhancing practices but not as factors that condition the practices they recommend.

To build on these literatures and answer the question of when the practices they have identified as desirable become effective, I focus on the institutional conditions that lead to higher quality work practices in the implementation of care coordination programs. I argue that, depending on different institutional conditions, organizations implement care coordination programs with different levels of quality. Moreover, I identify the interaction between two

institutional conditions as a combination that leads to a higher quality of work practices than just one of them alone. My thesis thus makes three contributions: it examines the implementation of programs designed to increase the quality of work practices, identifies two institutional conditions that lead to variation in the quality of work practices, and conceptualizes the relationship between the two conditions. My approach contributes a richer understanding of variation in care coordination practices because the conditions I identify underlie and constitute the effectiveness of practices that employment relations scholars have identified as desirable. Furthermore, I connect workplace dynamics to broader regulatory conditions and advance recent literature on public contracting by demonstrating how and why public policymakers' occupationally-based (as opposed to cost-based) priorities in designing a program lead to a higher quality of work practices.

I make these contributions based on my matched case comparisons of how three care management agencies implemented outpatient care coordination programs at the same health system in New York State. By drawing on literature that investigates the importance of occupational and regulatory dynamics, I show how the interaction between occupational community and a high level of regulatory intensity leads to high-quality work practices.

I found that under the conditions of a lacking community that supports occupational norms, and low regulatory standards, enforcement and incentives, cost-effectiveness was the primary concern in one care coordination program. I dub this program 'LowQual' because its focus on cost-effectiveness led to the lowest quality of work practices among all care coordination programs. By contrast, I found a higher quality of work practices in a care coordination program that operated under the same low regulatory intensity as LowQual but exhibited a community that supported occupational standards, norms and identifications derived

from behavioral health. I dub this agency 'MedQual' because in following these occupational standards, norms and identifications, practitioners at MedQual generated high skill levels but only an intermediate level of intensity. The highest quality of work practices I found at 'HighQual' which did not only have a community that was supportive of occupational standards, norms and identifications like MedQual but also operated under a policy program that mandated, effectively enforced, and provided incentives for a higher intensity of work design. Furthermore, I found that the public policymakers who designed the program that generated higher quality at HighQual followed standards that a broader HIV/AIDS community spanning three decades had developed. By contrast, the main concern of public policymakers who designed the low regulatory intensity at both LowQual and MedQual was on cost-effectiveness.

Based on these findings I conclude that a community that supports occupational standards, norms and identifications at the workplace level generates a higher quality of work practices. Moreover, I conclude that under the condition of a public policy program with higher standards, higher levels of enforcement, and incentives for following these high standards a workplace-level occupational community generates the highest quality of work practices. In the absence of a workplace-level occupational community or where regulators do not amplify the standards of an occupational community at a broader level through high regulatory intensity, cost-effectiveness concerns lower the quality of work practices as far as regulations permit.

My finding of the impact of occupational community is relevant to organizational policymakers who want to know how to design jobs, recruit for, and implement a higher quality of work practices. Moreover, my finding of the impact of regulatory intensity is relevant for public policymakers who want to know how to design standards, enforcement mechanisms and reimbursement systems that generate a higher quality of work practices.

In the following sections, I review health policy and employment relations studies of care coordination to show why the question of broader structuring conditions is important and generally unanswered. I then review the concepts that guided my fieldwork and that I subsequently extended by showing how they relate to the quality of work practices and to each other. After describing my methodology, I then discuss my findings in light of these concepts. I conclude by reflecting on my research's internal and external validity, and on how I conceptualize the relationship between occupational community and regulatory intensity.

2. Perspectives on Care Coordination and the Quality of Work Practices

This section discusses previous approaches to understanding care coordination and introduces the concepts that form the basis for the richer understanding I wish to generate. The approaches that health policy and employment relations scholars have taken in studying care coordination have focused on identifying practices and policies that they associate with health and/or cost outcomes. These perspectives have established certain work practices as desirable and provided useful dimensions for understanding variation in work practices. They, however, have not examined the institutional conditions that enable the effective implementation of these practices, and the outcomes they studied only partially captured how work practices varied in my fieldwork. By contrast, I draw on the concepts of 'occupational community' and 'regulatory intensity' from sociological and other literatures, through which I develop a perspective that captures the broader conditions that structure variation in work practices, thus connecting particular workplace dynamics to broader, contextual dynamics.

The concepts of occupational community and regulatory intensity connect workplaces to broader contextual factors by identifying the sources of workplace dynamics not only in formal management practices but in social processes that lie outside of the immediate workplace and underlie its formal management practices. An occupational community at the workplace level means that workers practice and share norms that derive from the accumulated experience of workers in an occupation, either through previous positions at the same workplace or at other workplaces, or through skills transfers via on-the-job training. Occupationally-based practices thus transcend any particular workplace. Regulations entail public policymakers setting, enforcing, and providing incentives for workplace standards independently of any particular workplace. In the case of high regulatory intensity, policymakers design regulations in such a way that work practices are likely to conform to the standards set through regulations.

2.1 Establishing the Importance of High-Quality Care Coordination

The first set of relevant studies of care coordination come from the field of health policy. These studies show that public, often State-wide care coordination programs can lead to improved health or cost outcomes, indicating that the design of public programs is an important factor in shaping successful care coordination. Because they have, however, paid little attention to the underlying institutional and organizational conditions that shape the effectiveness of coordination programs they do not explain variation in care coordination practices within a given region or at a workplace level. For example, Brennan-Ing and colleagues provided evidence that the New York State (NYS) COBRA program, a care coordination program established in the mid-1980s to support families living with HIV/AIDS, helped program members receive medication for non-HIV/AIDS, chronic conditions and increase immunity compared to a control

group that did not receive care coordination services (Brennan-Ing et al. 2016: 7f.). Brennan-Ing and colleagues mentioned the program's goals and its use of multi-disciplinary teams but did not further investigate the program's work organization.

Other studies have also demonstrated the possibility of improving health or cost outcomes through public care coordination programs. A Medicaid transitional care program in North Carolina reduced the admission rates of high-risk Medicaid patients by 20 percent (Jackson et al. 2013). Furthermore, a care coordination program for Medicaid patients in Washington State significantly reduced costs for inpatient admissions by $318 per member per month (Xing et al. 2015). And four of eleven Medicare care coordination pilot programs reduced hospitalizations by 10.7 percent per 100 beneficiaries on average (Brown et al. 2012).

These health policy studies indicate some common practices among successful programs but they do not systematically investigate variation in work organization, for example variation in care coordinators' skill levels or in work design. This is because the programs health policy scholars have studied usually set State-wide guidelines for work organization; and health policy scholars' focus has been on evaluating programs at a large-scale, regional level. Successful programs have typically consisted of highly-skilled care coordinators (usually registered nurses) who coordinate health and social services for program members as needed, provide members with health education (including managing their medications), coordinate relevant information to all care providers, and interact with program members face-to-face at least once per month in addition to regular phone calls (Brown et al. 2012; DuBard et al. 2012; Jackson et al. 2013; Xing et al. 2015).

Despite these commonly identified successful practices, health policy scholars have not investigated why organizations have or have not adopted these practices, instead calling for more

research on the conditions that lead to effective changes in work practices (Jackson et al. 2013). Moreover, other than demonstrating that particular practices can be successful they have not systematically categorized the differences between successful and unsuccessful practices. DuBard and colleagues attributed different 'resource intensities' to how care coordinators can interact with program members (DuBard et al. 2012). Specifying this categorization further, Jackson and colleagues categorized telephonic or written communication as 'low intensity' interactions, face-to-face interactions during visits to the provider, patient education, and coordination of appointments as 'moderate intensity' interactions, and home visits by a care coordinator or a face-to-face appointment with a clinical pharmacist as 'high intensity' interactions (Jackson et al. 2013). While higher intensity practices occur in programs that improve health or cost outcomes, health policy scholars have not conceptualized why these differences in interactions are of importance.

Like health policy studies, the employment relations literature on care coordination has also found that care coordination and similar practices can lead to better care and reduced costs, however, without examining the institutional conditions that structure the success of these practices. These studies built on previous work that established the concept of 'high-performance work practices' and how they lead to better organizational performance in manufacturing, retail and telecommunications. Moreover, these studies only rarely examined broader contextual factors such as industry trends as conditions that shape workplace dynamics, instead conceptualizing them as motivators for the search for practices that improve performance. The main focus has been on how different levels of skills, worker discretion, and compensation fit together to constitute a given production model as a consistent 'bundle' or 'system' of practices (MacDuffie 1995; Appelbaum et al. 2000).

While the health policy literature has identified desirable care coordination practices the employment relations literature has provided rationales for how and why different dimensions of these practices fit together. For example, while a mass production model combines low skill levels with minimum discretion to minimize labor and other costs, a professional service model combines high skill levels with a high level of discretion to maximize quality (Batt and Moynihan 2002). More frequent communication with team members and technical experts in an organization also constituted a higher quality of work practices in this literature (Appelbaum et al. 2000: 119). In the context of inpatient, acute care nursing, Gil Preuss argued that not only the frequency of interactions but also the quality of information that interactions with patients produce is important for the outcomes of work practices (Preuss 2003). This is because higher skilled workers can apply their skills to incorporate not only the goals of the immediate task but also to gather contextual information that may reflect a more accurate version of a patient's health status (Preuss 2003: 593). Therefore, higher quality information not only derives from more frequent interactions but also from higher skilled workers' more accurate interpretations.

Jody Hoffer Gittell has identified similar relationships between high-performance work practices and increased levels of 'relational coordination' – a composite of frequent, accurate and timely information with mutual respect, and shared goals and knowledge – that she associated with shorter hospital stays and higher patient satisfaction in inpatient settings (Hoffer Gittell 2009). She identified 12 particular practices, for example recruiting workers with good teamwork skills or designing jobs around patient needs, that she categorized as high-performance work practices. In later work, Hoffer Gittell developed the concepts of 'relational leadership' (i.e. the situation in which supervisors who foster relational coordination) and 'relational co-production' (i.e. the situation in which workers extend relational coordination to include customers) (Hoffer

Gittell 2016). While Hoffer Gittell's studies demonstrated desirable work practices, including formal human resource management practices that promoted them, she did not investigate the institutional factors that underlie and enable the adoption and variation of these practices. For example, Hoffer Gittell does not investigate which knowledge or skills supervisors draw on to successfully foster shared goals and mutual respect and how these dynamics vary according to workers' different skill levels.

Other studies that emphasize concepts similar to care coordination practices such as collaboration, reliability-enhancing work practices and patient-centered care have also associated these practices with positive health outcomes. In their study of collaborative teamworking in neonatal intensive care, Nembhard and Tucker showed an association between the more frequent interactions of workers with different disciplinary backgrounds and lower patient mortality in 23 neonatal intensive care units (Nembhard and Tucker 2011). They identified deliberate learning activities and continuous improvement practices as factors that improved collaboration (Nembhard and Tucker 2011: 911) but they did not elaborate on the conditions for successfully implementing these factors nor on why there were no conflicts between workers from disciplinary backgrounds that may inhibit collaboration.

Vogus and Iacobucci use a related, but different conceptual framework, which they call 'reliability-enhancing work practices' (Vogus and Iacobucci 2016). They used a social-psychological scale that included hiring criteria that emphasized interpersonal skills and a culture of 'respectful interaction'. These were associated with fewer medical errors and patient falls (Vogus and Iacobucci 2016: 928). Building trust and permitting employee discretion are important reliability-enhancing practices but the determinants of trust and discretion in healthcare remained unclear in this study.

Patient-centered care is yet another concept that researchers and practitioners have used to define a set of work practices that promote interactions between care workers and their patients by incorporating patient preferences into their work practices and focusing more on patient education (Avgar et al. 2011). Avgar and colleagues associated patient-center care practices with reduced medical errors and increased patient satisfaction (Avgar et al. 2011: 432). Moreover, Burns and colleagues demonstrated that nursing homes with a focus on patient-centered care sustained the quality of care as measured by public regulators' evaluations because managers' and workers' prioritization of patient interests led them to seek out workarounds, for example foregoing breaks or extending job responsibilities, that shielded residents from the negative effects of deteriorating working conditions (Burns et al. 2016). However, both studies did not investigate the underlying dynamics that prompted managers and workers to choose patient-centered care.

Building on these approaches, I examine the institutional conditions that enable the successful implementation of high-quality, care coordination practices. I attempt to go beyond these approaches by demonstrating that the interaction of social and political conditions produces the highest quality of work practices. While the social condition of an occupational community centered around behavioral health increases the quality of work practices, it is only under the political condition of high regulatory intensity, i.e. regulations that promote and financially sustain high, occupationally-based standards, that an occupational community produces the highest quality of work practices. Without an occupational community and with low regulatory intensity, the prioritization of cost-effectiveness means that the quality of work practices is lowered as far as regulations permit. Moreover, my concept of the quality of work practices extends the health policy concept of 'intensity' by incorporating its relationship to skill levels but

it is also more focused than the high-performance work literature because it examines a smaller amount of work practice dimensions that exclude variation on worker discretion and compensation. While central elements of the health policy and employment relations literatures informed my research I develop a new understanding of the quality of work practices that is more precise.

2.2 Occupational Community as a Factor that Structures the Quality of Work Practices

While the health policy and employment relations literatures have established that better care coordination is associated with better patient care, they do not provide a deeper institutional explanation of creating the social dynamics necessary for better care coordination. The sociological literature on occupations and occupational community, by contrast, provides a framework for understanding how the knowledge, skills, values, and routines shared by members of the same occupation create the conditions for better work practices and care coordination. This literature has also often conceptualized this way of structuring work as an alternative to structuring work according to cost concerns derived from transactional exchanges in markets or abstract rules in bureaucracies (Adler et al. 2008). This perspective demonstrates that social processes beyond the immediate workplace can structure systems of work practices.

Like occupations in general, occupational community consists of individuals engaging in a similar set of tasks with similar skill requirements (Damarin 2006), where skill refers to a composite of knowledge and the "capacity to use knowledge in accomplishing a task" (Freidson 2001: 33). In addition to having similar tasks and skill requirements, an occupational community only exists if individuals identify strongly and positively with the work they do rather than viewing their work instrumentally as a means to gain income (Van Maanen and Barley 1984:

299). Moreover, an occupational community exists when these occupational members share and implement common standards and values relating to their work that do not derive from non-occupational sources (such as the work rules of a manager who does not have occupational education or experience). Individuals acquire these common work standards and values through informal on-the-job training by members of the occupation or through their own learning on the job over many years (Van Maanen and Barley 1984: 294). Having received membership through on-the-job training or work experience, occupational members can trust each other to act based on their common work standards, values, and commitment to the occupation (Lee et al. 2000), which means they are more likely to cooperate with each other to achieve their goals.

While occupational community constitutes a form of worker control it can also extend to hierarchically higher levels, for example as front-line supervisors or work unit directors, if occupational members take on such supervisory positions (Van Maanen and Barley 1984: 332). In supervisory positions, occupational members can choose to draw on the occupational training and experience they have acquired when they design and execute supervisory functions, and thereby support the reproduction of the occupational identifications, knowledge and norms that constitute an occupational community. For example, they can design job requirements according to occupational standards and thus, only select occupational members into their organizations. In this case, the character of common managerial functions such as job design, recruitment, work design, and the management of potential workplace conflicts take on an occupational character because the occupational member in this supervisory position decided to draw on her/his occupational knowledge and identifications to fulfil these functions. The underlying driver of these functions thus does not lie in administrative rules or market specifications but in a social process that undergirds and transcends the immediate workplace, namely in the occupational

knowledge and experience accumulated in other workplaces or other time periods in the same workplace (often mediated by on-the-job training).

Besides supervisory structures, another important workplace process that can sustain an occupational community is 'workplace assimilation'. Workplace assimilation refers to the situation in which non-professionals or other professions can "learn on the job a craft version of given professions' knowledge systems" (Abbott 1988: 65) and thus approximate or mimic some of the transferring profession's values and work practices.

This phenomenon is particularly relevant for the profession of social work in the US because social work has had a long history of workplace assimilation by non-professionals that started after non-professional social workers met a surge in demand after the Second World War (Austin 1978). Because social workers and other behavioral specialists like psychotherapists and psychiatrists constitute the most proximate sources of occupational standards for care coordination, non-professional care coordinators may assimilate their work practices if these behavioral health specialists view themselves as part of or are willing to be supportive of an occupational community with non-professional care coordinators. In this case, social workers may promote the importance of understanding individuals in relation to their social environment, individuals' empowerment to attain a better life (Austin 1978: 31) and a commitment to advocate for broader economic and social change (Schneider and Netting 1999), which are typically values that social work professionals have held since the profession's inception (Franklin 1986).

By contrast, professionals may inhibit workplace assimilation if they refuse to recognize themselves as part of the same occupational community with non-professional care coordinators. While professionalism shares the same criteria as occupational community it has additional criteria that increase its level of occupational control and enhance its status. Professions

generally draw on a codified body of knowledge, which means they must complete university education to certify their membership. Moreover, the state or professional associations sanction professionals' claims to perform tasks to the exclusion of other occupations through licensing or scope of practice laws (Krause 1971; Abbott 1988). If professionals refuse to cooperate with non-professionals this may constitute a defense of their exclusive rights and privileges that the profession as a whole has claimed on a society-wide basis rather than simple 'unwillingness' to cooperate.

Because physicians have successfully claimed the highest entry barriers, compensation, and status in the health field since the early 20th century (Freidson 2001) they can most easily refuse cooperation with non-professionals. In a study of the relations between radiologists and technologists, for example, Stephen Barley showed how radiologists in one hospital used their experience and professional authority to deride technologists' competence (Barley 1986). By contrast, the radiologists' lack of experience in working with a CT scanner in another hospital meant they were receptive to the technologists' competence and engaged in collaborative teamwork with them. Katherine Kellogg provided another example in which physicians in one health center were receptive to community health workers who brokered between physicians and lawyers to comply with new regulations for legal screening, given that physicians regarded these tasks as low-status while community health workers regarded them as status-increasing (Kellogg 2014: 925, 935).

An example of an occupational community that will be important for understanding care coordination in New York State is the HIV/AIDS community. Particularly in HIV/AIDS prevention, volunteers and untrained social workers proliferated to coordinate the needs of people living with HIV/AIDS. Gay Men's Health Crisis, one of the first community-based

organizations set up in 1982 in New York City, developed the buddy system, in which volunteers helped HIV positive people by navigating medical and social services appointments, and by acting as lay counsellors and advocates (Altman 1994: 38). Moreover, behavioral interventions such as peer education and care coordination expanded because of the lack of a medical solution to dealing with HIV/AIDS (Altman 1994: 125) until 1996. In this way, a community of practitioners that included volunteers and non-professional workers in addition to professionals developed and proliferated care coordination methods that can constitute a basis for current care coordinators' occupational communities.

Overall, an occupational community structures work practices according to occupational knowledge and experience. It refers to the operation of a community of practitioners in which supervisory structures, relations between different occupational groups, and worker identifications promote occupational standards to cooperate through and engage in higher quality work practices.

2.3 Regulatory Intensity as a Factor that Structures the Quality of Work Practices

The aim of this section is to develop a concept that captures how variation in the design of regulations as a political factor can structure work practices in addition to the social factor of occupational community. I build on research on the impact of regulations on organizations, on the impact of public procurement on working conditions, on the efficacy of private regulation, and on my fieldwork to develop the concept of 'regulatory intensity'. In contrast to the health policy literature on care coordination, this concept does not only take stock of the fact that there are policy programs that attempt to structure work practices but it also attempts to estimate when organizational policymakers are likely to translate these policy programs into effective work

practices. It thus highlights the importance of program design and tries to capture the variation in care coordination practices that different public care coordination programs produce.

I define regulatory intensity as the level of constraint that rules by actors external to an organization put on that organization with regard to the organization's ability to determine work practices. High regulatory intensity means that organizations have little ability not to follow regulatory standards because regulatory standards, enforcement, and incentives effectively promote compliance. Conversely, low regulatory intensity means organizations can set their own standards of work practices with little or no outside constraint because rule-setting explicitly permits this, the actor setting the rules is not able to enforce them effectively, or financial incentives undermine compliance. To add more specificity to this definition of regulatory intensity, I will now review previous studies that demonstrate the importance of regulations for the nature of work organization.

Organizational research has shown a general relationship between different aspects of regulations and work practices. These factors include public regulation, the unambiguity of standards, federal contracting, and professional influence. However, this research has not pinpointed the mechanisms and causal linkages underlying these relationships. Inspired particularly by the concepts of coercive and normative isomorphism (DiMaggio and Powell 1983), this research shows that the state is an important, rule-setting actor in an organization's environment (Oliver 1990). For example, Tolbert and Zucker (1983) showed that State-level mandates for civil service reform led to quick and sudden rates of adoption in comparison to States that did not mandate such reform. If, however, rules are ambiguous, professionals working in organizations interpret these rules differently which creates variation in how organizations adapt their practices to public regulations. Lauren Edelman found that equal employment

opportunity and affirmative action regulations were ambiguous (for example regarding what constitutes discrimination) and had weak enforcement mechanisms (of only requiring workforce reporting and a focus on procedures, not outcomes) (Edelman 1992: 1536). In response, organizations with personnel departments and with federal contracts were more likely to establish more extensive mechanisms (Edelman 1992: 1565). John Sutton and Frank Dobbin also looked at the effects of legal uncertainty (Sutton and Dobbin 1996). They found that increasing the state's ability to enforce regulations through stronger enforcement mechanisms such as higher monitoring requirements in the 1970s, more attention by Californian courts in the 1980s, and being a federal contractor made organizations more likely to institute grievance procedures (Sutton and Dobbin 1996: 805f.).

Another strand of recent research has focused on the relationship between public procurement of services, and employment relations. Because this research area is relatively new the findings have so far been confined to establishing the importance of public procurement for employment relations and less in identifying stable patterns leading to effective increases in labor standards. However, this research illuminates insights from organizational research relating to the importance of public contracts which is important in US healthcare because the government accounted for 48.3 percent of total health spending in 2014 (WHO 2014).

Karen Jaehrling discussed how public authorities can make contract awards conditional upon meeting labor and other standards such as mandated pay scales or quality criteria in addition to price criteria (Jaehrling 2015). Moreover, her empirical examples highlighted how a focus purely on lowering prices through public procurement led to employers understaffing or using non-standard employment contracts while meeting pay scale requirements (Jaehrling 2015: 159). Katherine Ravenswood and Sarah Kaine (2015) also have demonstrated the importance of

public procurement in long-term care in Australia and New Zealand. They showed how political contingencies such as a change of government prevented these states from promoting higher standards through contract awards (Ravenswood and Kaine 2015: 553). Similarly, Jantz and colleagues discussed how different political priorities such as diverting accountability for failed procurement attempts from national to local government in Denmark shaped the use of multiple, co-existing sources of accountability, including accountability through market incentives (Jantz et al. 2015: 8).

Research on private regulation in the context of global value chains has also demonstrated the importance of different types of enforcement mechanisms and financial incentives for structuring work practices, though in very different industry and country contexts compared to care coordination in the US. In a case study of one apparel value chain, Locke and colleagues described different types of mechanisms for enforcing private labor standards. While they found that the buyer firm was generally ineffective at raising standards because it did not sanction poor standards by withdrawing its business from non-compliant supplier, Locke and colleagues discussed examples of auditors building up long-term relationships with supplier firm managers and thereby using their workplace visits to help these managers implement better work practices (Locke at al. 2009). An earlier study (Locke et al. 2007: 16) also confirmed the importance of auditing through more frequent workplace visits by personnel capable of promoting effective work practices.

In contrast to this focus on audits, Maja Tampe emphasized the importance of a pricing mechanism that permitted higher quality labor standards in addition to standard-setting in the context of cocoa production (Tampe 2016). She found that a successful cocoa producing organization could use ties to various buyer firms to improve production processes, and thus

justify higher price premiums on their products than an unsuccessful producer. This enabled the successful organization to transfer the price differential on to farmers (Tampe 2016: 24). Tampe's study demonstrated how payment mechanisms can provide the financial viability required for higher quality work practices.

Building on these three research streams, I will now conceptualize a high level of regulatory intensity more concretely. Drawing on the organizational and public contracting literatures, setting unambiguous, specific standards related to work organization highly constrains organizations. Moreover, drawing on the literature on private regulation in value chains, enforcement through high monitoring requirements and more frequent, workplace-based visits also constitutes more constraints. Last, also discussed in the global value chains literature, a payment mechanism that either strongly sanctions non-compliance or actively rewards compliance with higher standards increases the risk of losing financial rewards, and thus, promotes the implementation of higher standards. The converse of lacking or ambiguous labor-related standards, low monitoring and infrequent, remote audits within a decentralized regulatory structure, and payment that does not provide incentives for complying with higher standards constitutes low regulatory intensity.

Through my case comparisons, I will demonstrate how both occupational community and high regulatory intensity improve the quality of work practices. Before discussing these findings, however, I will discuss my methodology.

3. Methodology

3.1 Research Design

I chose qualitative methods because my goal was to generate an empirically grounded, theoretical understanding of the institutional conditions that contribute to variation in the implementation of care coordination programs. Case study research is suitable for these kinds of questions (Yin 2003).

My research design consisted of comparing three care coordination programs – my units of analysis – that were located at three care management agencies. These agencies, in turn, were part of the same health system located in a large, urban area in NYS. Choosing care management agencies from the same health system excluded important potential causes of variation. The agencies experienced the same industry pressures (and the same industry sub-segment of clinic-based outpatient care), the same top and senior-level management strategy, the same financial pressures, the same electronic medical record, and the generally above average acuity of the health system's catchment area. The same trade union also organized all health workers (throughout the history of the care coordination programs under study). This meant that the same collective bargaining agreement applied to all CCs (without any differences in access to union resources such as training funds or workplace representation; see Section 4.4).

The area of my study sites had above average rates of Medicaid utilization, unemployment, mortality, suicide and homicide rates compared to the rest of NYS. Additionally, the health system had been in a resource-poor financial status since at least four years before the inception of all care coordination programs in the care management agencies. I chose this resource-poor research setting because it is appropriate to the populations that care coordination programs usually target, namely low-income, chronic disease patients (Jackson et al. 2013).

Moreover, this research setting was also apt because we would expect resource constraints to make it more difficult to achieve higher quality work practices. However, because the factors I identified occurred in a resource-poor setting, we would expect these factors to translate more easily into a resource-rich setting. Therefore, these factors are likely to be of interest also for resource-rich settings.

3.2 Data Collection and Analysis

I base my case comparisons on fieldwork I conducted between October 2015 and December 2016 which included 16 site visits. I conducted 80 semi-structured interviews and did 15 hours of non-participant observation (of team meetings, training sessions, and committee meetings of a public policy program situated at the health system). I collected 80 documents that among others included collective bargaining agreements, training materials, reports of State-level policy programs, and relevant organizations' annual reports.

Because I chose a grounded theory approach (Glaser and Strauss 1967) my data generation and analysis proceeded iteratively. During my first few site visits I tried to ascertain all areas at the health system that had some form of care coordination (including outpatient clinics dealing with substance abuse). I then chose the three care management agencies because they had the largest care coordination teams and were comparable in terms of the tasks they fulfilled as well as their general structure (being embedded in outpatient clinics). Moreover, the public policy programs that regulated each agency's care coordination program consisted of voluntary participation and had similar eligibility criteria and thus, admitted patient populations with similar acuity: the New York State Department of Health Health Home Program (NYS-DoH HHP) admitted Medicaid eligible individuals who were HIV positive, or had a severe

mental illness, or two common chronic conditions (for example diabetes and asthma). The New York City Department of Health and Mental Hygiene Care Coordination Program (NYC-DoHMH CCP) admitted HIV positive individuals but the provider manual also articulated a strong overlap with the NYS-DoH HHP, mentioning it 19 times, particularly in sections that concerned intake procedures that prohibited member enrollment in both Programs.

After choosing the three care management agencies, I tried to ascertain how the quality of work practices varied in the care coordination programs and then, what the potential factors shaping these differences were (based on reviews of some of the relevant literature discussed above; see also Section 4.4).

I defined the quality of work practices as including two dimensions: the level of skill required for the job and the intensity of the work design. Similar to Preuss's (2003) study, I defined higher levels of education and experience as constitutive of higher quality because it generated higher-quality information in combination with higher-intensity work design. Because my interest was in understanding occupational dynamics, I measured experience as experience in occupations that entailed the same or similar tasks as a worker's current care coordination position, rather than as seniority at a particular workplace.

The second characteristic of 'intensity' refers to the number and quality of interactions CCs had with other providers and with program members, and the number of staff members with whom members regularly interacted. Accordingly, I interpret a higher number of interactions among service providers, and between service providers and members as more time dedicated to a member's care (as indicated by caseloads, case conferences and the division of labor among workers and supervisors). Moreover, similar to the health policy literature's emphasis on face-to-face interactions and to Preuss's emphasis on the quality of information, I measured the quality

of interactions between CCs and other service providers, and CCs and members. I categorized acting as a translator in visits with medical providers as lower quality than engaging with medical providers through advocacy or in a case conference on behalf of members. Moreover, I categorized a reliance only on self-reported information through telephonic and written interactions as lower quality than additionally cross-checking this information with contextual information from agency or home visits.

Overall, higher levels of skill and intensity constituted higher quality work practices. This operationalization is also consistent with care coordination understood as the deliberate integration of the care practices of all providers involved in a patient's care (Bodenheimer 2008). This is because effectively integrating care practices does not simply mean more coordination of information but more coordination of more useful information, which in turn depends on workers' skill levels.

To ascertain how and why the quality of work practices varied across care coordination programs, I asked the Directors, Supervisors, CCs, and the doctors working with them about the background of the clinics, their care coordination programs, and the public care coordination policy programs; training and recruiting practices; their own educational and career backgrounds, what they value, and what motivates them about their work. I also asked them to describe a typical working day, including characterizations of the people with whom they interact; and how they viewed their working conditions and whether the trade union had a role in their daily work. In addition, I interviewed upper middle managers and senior managers at the health system to learn about its financial status, labor relations, general management strategy, and relationships with other organizations in the region. I also interviewed representatives from various trade unions responsible for the health system under study, other health systems close by or for the

entire State, and representatives at the NYS-DoH and NYC-DoHMH to learn about the priorities behind the two Programs. After fleshing out the major categories of differences in the quality of work practices, occupational community, and regulatory intensity, I interviewed representatives from other care coordination programs in the region to gain their perspective on these issues.

In following a grounded theory approach, I developed initial insights about my research question by comparing first interview transcripts, field notes, memos, and available documents. I then iteratively developed these initial insights into saturated categories through subsequent interviews and by triangulating different perspectives throughout the data generation and analysis process. Out of these iterative analyses, I generated two matched case comparisons: one between LowQual and MedQual, in which the regulatory intensity of the State-level policy program was the same (because both agencies' programs operated under the NYS-DoH HHP); and another one between MedQual and HighQual, where the level of occupational community was the same but the regulatory intensity of the policy programs varied (because HighQual operated under the NYC-DoHMH CCP while MedQual operated under the NYS-DoH HHP).

4. Findings

4.1 Differences in Implementing Care Coordination Programs

The three care management agencies all implemented care coordination programs with the same basic spectrum of tasks. These tasks included contacting and enrolling potential members in a care coordination program ('outreach'); then assessing the member's medical and psychosocial history and needs ('intake'); based on this assessment, drawing up a plan that included determining member goals, and how and by when to achieve them (known as a 'plan of care'); providing an extensive range of ongoing care services such as scheduling appointments,

arranging documentation and applications for welfare benefits, education about medical and behavioral conditions, and arranging other necessary services like transportation, to keep members engaged in care and compliant with medical treatments ('ongoing care'); finally, after regularly evaluating a member's progress towards stated goals, deciding to let the member leave the program because he/she is adequately capable of maintaining his/her health ('graduation').

Despite these similar tasks, the way each agency organized the quality of work practices differed considerably (see Table 1), though all agencies employed unlicensed workers as CCs. Two factors accounted for the differences between the agencies: whether the agency had an occupational community that was effective at promoting higher quality work practices or not, and whether the care coordination programs operated under a public policy program that exerted a low or high degree of regulatory intensity (see Figure 1).

LowQual and MedQual both operated under the same NYS-level policy program. However, LowQual had a low-skill, low-intensity care model whereas MedQual had a high-skill, intermediate intensity model. Because both agencies operated under the same NYS-level policy program and thus experienced the same level of regulatory intensity, the reason for these differences lay elsewhere: facilitated by the agency's historical development, the supervisory structures, relations with service providers other than CCs, and CCs' identifications formed an occupational community at MedQual that supported higher skill, higher intensity work practices than the State-level policy program required. Such an occupational community was absent at LowQual, leading to a model that focused more on cost-effectiveness and did not exceed the State-level policy program's minimum requirements.

Table 1: Differences in the Quality of Work Practices

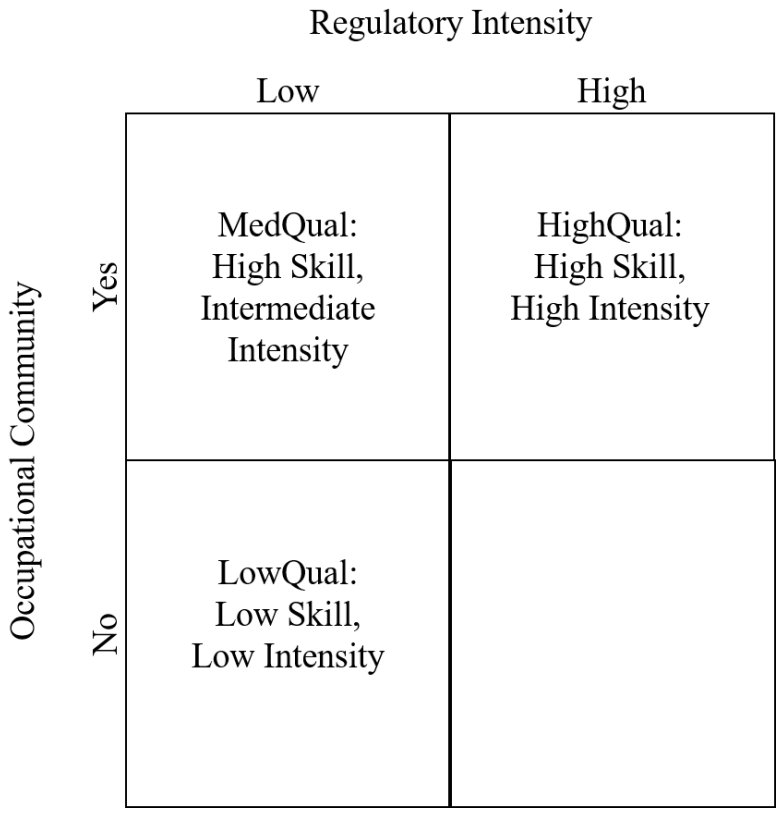
	Specific Dimensions	***LowQual***	***MedQual***	***HighQual***
Skill Level	*Education Levels*	Medical Assistant or Unrelated Background	Bachelors or Masters Degrees	Bachelors Degrees
	Years of CC Experience	<4 Years	>10 Years in Behavioral Health Care Coordination	>10 Years in HIV/AIDS Care Coordination
Work Intensity	*CCs' Caseloads*	50 Cases Plus 10 Outreach	45 Cases	15 to 25 Cases
	CCs' Rate of Case Conferencing	Extremely Rare	2 to 3 Per Week	5 to 10 Per Week
	Quality of Interactions	Telephonic, Provider Visits for Translation	Telephonic, Provider Visits for Translation and Advocacy, Agency Visits	Telephonic, Provider Visits for Translation, Agency Visits, Home Visits
	Division of Labor	Centralized: CCs Responsible for Full Spectrum of Tasks	Centralized: CCs Responsible for Full Spectrum of Tasks	Differentiated: Program Director and Supervisor also Involved in Some Tasks

In the case of HighQual, however, I found a care model that had high skill levels like MedQual but higher intensity work design than MedQual. HighQual also had an occupational community at the workplace level. The difference to MedQual was that HighQual operated under a different public policy program. The policy program's standards mandated and enforced higher intensity work practices but it also provided the necessary financial incentives to sustain the low caseloads needed for higher intensity work practices. Additionally, HighQual's occupational community enabled case conferencing and promoted normative justifications for higher intensity

interactions. The combination of high regulatory intensity and occupational community produced the highest quality work practices at HighQual.

In probing the reasons for these differences in regulatory intensity, I found that the public policymakers who designed the higher intensity program did so by drawing on the standards of a broader HIV/AIDS community going back to the early 1980s. Their priorities thus included realizing the standards and practices of an occupational community focused on HIV/AIDS prevention. By contrast, the policymakers chose lower regulatory intensity in the program under which LowQual and MedQual operated because they consciously prioritized cost-concerns over occupationally-based standards.

Figure 1: Summary of Findings



4.2 The Impact of Occupational Community

The NYS-DoH HHP, the policy program LowQual and MedQual both operated under, provided no mandates or guidelines regarding working conditions, educational qualifications or years of experience, except that a person with clinical qualifications (for example a registered nurse, licensed clinical social worker or PhD level therapist) (Lead HH Administrator) had to oversee the first rendering and subsequent annual reviews of plans of care. While the Program provided the documents for the assessment of member needs it did not specify how these should translate into a plan of care. Moreover, Program standards prescribed caseloads only for special, rare patient populations (Lead HH Quality Analyst), and did not discuss case conferencing. The Program standards clearly specified the full spectrum of care coordination tasks but no division of labor nor whether these tasks should be performed face-to-face, via letters or telephonically. Only for outreach was a home visit required in the third month of trying to enroll a potential member but agencies could outsource this home visit to other service providers. At both LowQual and MedQual, home visits were rarely needed (HH Director) and if they were, someone from outside the agencies (for example a visiting nurse service) did the home visit (CC3).

The Program's enforcement was also weak and both agencies had never been audited at the workplace. The Program's reimbursement structure also did not provide any incentives for higher intensity activities: as long as documentation was sound, agencies showed clinical supervision for a member's first rendering and annual reviews of all plans of care, and CCs contacted a member once per month at the very least telephonically, agencies received a flat-rate per member per month fee that was not acuity-adjusted during the study period (see section 4.3). More than anything else, this reimbursement mechanism provided an incentive to grow the

volume of billable contacts and to lower ongoing costs such as labor costs, particularly regarding educational qualifications and job classifications (Lead HH Director). Overall, this program design meant that the quality of work practices depended on already existing practices and/or on how managers decided to define the care model (Lead HH Director).

Despite this low regulatory intensity applied to both agencies, I found large differences between LowQual and MedQual regarding their care coordination program's work practices. This occurred in spite of both agencies formally sharing the same Director and RN clinical supervisor. The reason for this was that LowQual conformed with the minimum requirements and its supervisory structures and relations with medical providers suppressed the emergence of an occupational community in favor of cost concerns and medical compliance. By contrast, MedQual's supervisory structures, relations with other service providers and worker identifications established an occupational community that provided a basis for higher investment and a higher intensity of services, thus exceeding the NYS-DoH HHP's minimum requirements.

LowQual

Defining Low Skill and Low Intensity at LowQual

When the management team at the health system under study decided to participate in the NYS-DoH HHP at the beginning of 2012 it decided to house its HH services under existing care management agencies rather than to establish a separate structure (HighQual Director). While the senior manager responsible for all agencies at the health system I studied consulted the HighQual Director regarding how to structure HH services the responsibility for these services fell to

another person who decided LowQual's low-skill, low-intensity model, against the HighQual Director's push for a higher quality model.

The first Director who established LowQual housed it under a clinic that had little experience with care coordination (having only recently implemented light-touch care coordination). She established LowQual in March 2012 with a registered nurse who had been at the clinic for 15+ years and hired one CC with experience in substance abuse counselling. After receiving many members early in 2013 the first Director proceeded to grow the CC team gradually until she left in 2014 and LowQual's second Director continued the initial low-quality care model.

The LowQual Directors chose a low-investment model with a focus on containing labor costs. Both Directors chose to define job requirements such that they could hire workers without university education, and with no or little previous experience in care coordination. These skill requirements meant LowQual could pay their CCs the least of all agencies without any pay differentials (see Table 2). LowQual CCs' care coordination experience ranged between 6 months and 4 years. Ten of LowQual's fourteen CCs had either no related backgrounds or were medical assistants. Even though medical assistants' tasks provide relevant knowledge around how to interact with physicians and nurses, and how health systems work in general, their work has little else to do with care coordination. Among the remaining four CCs, one had a Bachelors degree in Health Administration, one was finishing a Bachelors degree in a related field, one was a licensed substance abuse counselor and another one was training to become one. Despite these higher education levels, these CCs did not receive a higher pay.

To maximize the highest number of billable contacts a CC could perform in a given month while complying with the NYS-DoH HHP's requirements, the LowQual Directors chose

low intensity to complement the low investment. LowQual CCs had the highest caseload among all agencies (Table 1). Moreover, after the Director and nurse care manager assigned a member to a CC this CC was responsible for all care coordination tasks. Instead of dividing labor across different positions in a care coordination team and thus instituting a differentiated division of labor, LowQual's division of labor was centralized. This meant that only one employee had to provide an extensive array of services to many members.

Because of this high workload, the quality of CCs' interactions with members was often low, focusing mostly on telephone calls and assisting high-need members in their visits to medical providers on the main hospital campus. These members were high-need because they did not speak or write English (they spoke Spanish or were illiterate) or their health had deteriorated severely, ending up in the Emergency Room or being admitted. Servicing these high-need members around the main campus meant that CCs had to be mobile across the whole campus, including the Emergency Room, the Intensive Care Unit, various wards and ambulatory clinics. However, their face-to-face interactions ended at the borders of the main hospital campus in the sense that they did not accompany members to outside agencies or visit members at home.

Another consequence of CCs' low quality interactions was that they engaged medical providers the least among all agencies (Table 1). When CCs visited a provider with a member, their role was limited to translation or to reinforcing what the provider had said. Case conferencing, in which two or more service providers allocate time to discuss the progress of a patient's case, rarely occurred at LowQual. The combination of centralizing all care coordination tasks in one position, assigning high caseloads meant that meant that low intensity prevailed at LowQual in the form of mostly telephonic interactions, limited provider visits, and a lack of case conferencing, agency or home visits.

Non-Occupational Supervisory Structures at LowQual

One reason for the reproduction of this low-skill, low-intensity model at LowQual was that its supervisory structures actively inhibited the emergence of occupationally-based practices. LowQual's Director prioritized cost-effectiveness as her main strategy but also suppressed any workplace assimilation that may have occurred within LowQual.

The Director had no previous background in care coordination but instead experience as a mid-level Finance Administrator (HH Director). Both LowQual's licensed social worker and HighQual's Director attributed the low-quality care model to this non-occupational background that prioritized cost-effectiveness. The CCs also thought that a reduction of labor costs was the reason for LowQual's model: "we're doing what a lot of case managers and even social workers do. And of course they're getting a way bigger salary than we are" (CC3).

The Director's stated strategy for LowQual aligned with the NYS-DoH HHP's minimum requirements. It consisted of growing her team to increase the number of LowQual's members, and in turn, the number of LowQual's billable contacts. LowQual's Director interpreted the regulatory requirements to mean that a telephone call once per month sufficed for payment. Additionally, she was planning to increase not just the number of CCs but also each CC's caseload from 50 to 60. Though she was not present at the time of establishing the low-quality model she though cost-effectiveness was the reason for designing jobs with low skill and high workloads:

"I'm sure the strategic thinking was money-driven. We get paid for every patient per month every time we meet the rules. We're bringing a lot of money into the hospital now…that's

because we keep increasing our population. I never say no to patients… some of the rules are just calling them once a month and I'll still get paid" (HH Director).

Apart from this low-quality job definition, LowQual's Director was also strongly involved in operations by exerting hierarchical control during team meetings held twice per week. Because of her lacking care coordination or clinical background, her control limited the adoption of occupational values and practices that clinicians at LowQual promoted. These clinicians included the registered nurse and a licensed clinical social worker.

For LowQual's Director, the nurse and the Operations Supervisor should complement the focus on cost-effectiveness by being unconcerned with care standards and instead concerned with making sure that process requirements were met. The nurse's description of her main responsibilities aligned with this, consisting mostly of administrative tasks and of little interaction with members.

At times, the Director's cost-driven strategy clashed with occupational standards that the nurse and the licensed social worker advocated. Together with the Operations Supervisor, the Director tried to suppress these occupational standards. One clash occurred because the Director had decided in early 2016 to start dis-enrolling members who were non-compliant with their medication to focus on members that would be easier to manage:

"it's important that we start graduating the old patients. [The nurse] is from the old school: 'well, they still have an A1C, they haven't really met their goals' but they're not coming to appointments, they're not taking their medication, they're non-compliant, we're wasting our time" (HH Director).

In this matter, the Operations Supervisor sided with the Director against the nurse: "it's not about not taking care of them, it's about getting more patients, making space for new patients". The nurse agreed that the practice until early 2016 of keeping members irrespective of

their behavior (often for up to 3 years) should be changed. For her, however, the goal was not to lower the time spent on members but to graduate them only when they were capable of managing their health independently: “we want them to be independent. They can call for their appointment. They can manage their medicine…[Graduation] should be after a year, if they are good" (HH Nurse).

I observed the conflict around dis-enrollment in one team meeting. A CC described how a new member was “one of those I’m gonna chase around” (CC4) and how she therefore wanted to dis-enroll this member when the nurse interrupted her and said she wanted to talk to the member. The Director asked her to justify this and the nurse replied: “we need to also take care of her”, especially because the member had severe behavioral issues. The Operations Supervisor and the Director then asked again what the point would be and the nurse insisted on speaking to the member, after which the Director stated the issue should be discussed later.

The licensed social worker reported several conflict areas and had also filed a grievance against the Director. She described their interactions as regular “headbutting”, particularly because the Director did not understand clinical issues. She expressed a strong professional identity stating that “social work has really always done care coordination” and that social workers should be “agents of change in someone’s life” rather than only checking in with members telephonically. She doubted whether CCs had the education and experience to be change agents. Moreover, she criticized the lack of home visits at LowQual because home visits allowed a CC to argue more persuasively for what a member needs. She cited the example of a member who might refuse a home attendant but might repeatedly fall due to an untidy home. A home visit would let the CC know that the root of the member’s poor health outcomes was

his/her poor living circumstances. This would provide a better basis for convincing members of necessary services.

The final conflict area was how the weekly team meetings proceeded. The licensed social worker felt they included little discussion about clinical issues. My observations of team meetings confirmed this assessment. The Director used meetings to exert her own hierarchical control rather than to develop better care practices. In one instance, the Director asked a CC why a member had missed two appointments. The CC explained some of the communication issues he was facing with the member. The Director then repeated the initial question to which the CC replied he was now arranging more convenient appointments. The Director repeated the question again after which a more experienced CC explained that scheduling the appointments more conveniently would run into procedural issues and was therefore not an adequate solution. The CC under question then admitted his ignorance of the procedures after which the Director let the issue go and moved on to questioning another CC. In this instance, it was not the Director who had offered the criticism based on effective work practices. Instead, the Director kept prodding the CC until he gave up defending his past work behavior and accepted her criticism.

The Operations Supervisor, who was the program's first CC and promoted three years into the program, tended to support the Director. His work consisted of ensuring compliance with the State's process outcomes and providing on-the-job training that he derived from his work experience at LowQual. While he also mentioned taking care of members as the HH's main aim, he connected this aim to efficiency and compliance with program requirements as opposed to viewing care as an end in itself, as the nurse did: "we understand the importance of getting that paperwork done…because the more we do that right, the more money we're going to get…we're getting money so that we can take care of the patient efficiently" (HH Supervisor). Moreover, the

Operations Supervisor emphasized that his training focused on what was needed to get the job done. Because LowQual's care model consisted of telephonic interactions with many members CCs needed to manage their time well but also try to build trust with members. The lack of alternative sources of information regarding the psychosocial roots of a member's medical issues made the issue of trust particularly salient for LowQual's Supervisor:

"The two most important things to being successful is to build the trust with the patient and to understand time management...because like I said, patients are hard to trust and in the environment we're in, we're in the ghetto, we're in humble surroundings. And trust is big…once you lost that trust, now you're gonna be spinning your wheels, because I'm not answering my phone, I don't trust you".

While the nurse and licensed social worker expressed care and advocacy principles as a basis for higher intensity practices like ongoing follow-ups or home visits, the Operations Supervisor's training focused on efficient procedural skills and the lack of face-to-face interaction with members. Moreover, in his attitudes and practices he supported the Director's strategy of growing member volumes.

Paternalist Relations with Medical Providers at LowQual

Another element that inhibited higher intensity work practices such as case conferencing and more engaging provider visits was that LowQual's CCs had mainly paternalist relations with physicians. CCs in all agencies clearly drew lines between their work and the clinical work of physicians, nurses or licensed social workers, and therefore subordinated themselves to these professionals' authority concerning clinical questions. However, at LowQual physicians were paternalist in the sense that only few physicians viewed CCs as helpful for communication purposes and for feeding information that patients would not tell physicians. CCs often stated

that most physicians did not know what they did, that care coordination roles existed, and some questioned CCs' value. Accordingly, physicians only rarely took time to case conference with CCs or engage with them in a more extended way in provider visits. Paternalist relations thus inhibited the physicians' support of an occupational community. Moreover, they also inhibited learning from physicians about anything more than medical compliance which justifies no other work practices but reminding members of medical appointments and medication regimes.

One factor for this lack of buy-in from physicians was the lack of mechanisms to create awareness (Physician 1) or educate physicians about care coordination services (CC5). Because LowQual started growing its team around 12 months after its inception there were few people in the beginning to associate with the program (HH Nurse). Moreover, though a clinic within the health system's hospital housed LowQual, CCs' offices were in an administrative building that was separate from the clinic and from hospital wards. This meant that rather than having a regular presence within a clinic or the main hospital campus, CCs turned up in clinics and wards irregularly and only in relation to specific hospital patients, thus putting a limit on their ability to build relationships with physicians. Another factor is that LowQual's Director had not actively promoted CCs throughout the health system to clarify their function. The Director was aware that this was problematic but she interpreted the problem to be that physicians did not refer potential members to LowQual as much as they would if they supported the program. In response, the Director had put up posters but this was ineffective (HH Director).

This lack of physician awareness meant that physicians did not want to allocate time to case conference with CCs. Moreover, it meant that only few physicians were receptive to engaging with CCs. Even in these instances, however, physicians saw CCs' value as limited: "it's not having a personal assistant [as physicians initially thought], it's to understand the

culture…and a second person to explain [physicians' treatments] (Physician Manager). One physician expected CCs to be more qualified and take on a clinical role but then adjusted his expectations. For this more receptive physician, CCs' work was mostly a function of his own medical work rather than a contribution in itself: "it's like an extended hand that you have for the care of the patient in the world outside" (Physician 2).

Moreover, most interactions between CCs and physicians concerned a member's medical compliance, i.e. how compliant the patient was with physicians' treatments (Physician 1). This reinforced CCs' work exclusively as a function of physician authority and inhibited learning about other principles relevant for care coordination such as a member's emotional stability. CCs interacting only with physicians, physicians' lack of awareness and physician paternalism inhibited case conferencing, more intensive physician engagement or the promotion of principles other than medical compliance.

Non-Occupational Worker Identifications at LowQual

CCs' values and goals also indicated LowQual's lack of occupational community. Because the Director hired CCs with little social work related education or experience they had neither been socialized into advocating social work principles nor had they experienced the utility of higher intensity practices before taking on their CC roles. They therefore lacked the occupational values that may have been the basis for higher intensity work practices. Instead, they drew on physicians' focus on medical compliance and the Director's and the Operations Supervisor's focus on cost-effectiveness to orient their work practices.

LowQual CCs' main goals were to enforce medical compliance and reduce ER visits and hospitalizations. To attain compliance, CCs needed to build trust with members. However,

because of their high caseloads CCs could only do this through telephonic interactions and sporadic face-to-face interactions. This was problematic because many members suffered from behavioral issues rooted in their living environments that undermined both their medical compliance and their relationships with CCs, and could lead to severe consequences such as an ER visit or being admitted. Uninformed and unknowing of the psychosocial causes of members' inability to be medically compliant, CCs engaged in recurrent attempts to build trust that the persistent psychosocial causes would undermine instead of trying to deal with the causes themselves. These ruptures explicated the limitations of CCs' work: "without members' willingness] we're at the same place as without [the CCs]" (Physician 1).

For the CCs, members' bouts of non-compliance also undermined their ability to view their work as part of a broader occupation, especially because they could not observe members' behaviors at home:

> "It's a battle. One month we're controlling this and then this month: 'I don't wanna do this anymore! I wanna eat what I wanna eat!' or they just start going to the ER instead of coming in…some patients are saying they are following what they have to do but sometimes they're not. Maybe they're not compliant with medications, I mean, we're not there to tell if you are" (CC6).

Accordingly, the CCs did not identify as social workers and referred to members as 'patients'. One CC even identified using the term 'patients' as opposed to the social work occupation: "it's because we at a hospital…I guess it's out of habit. I mean, mainly I see social workers who will call them a client" (CC6). These identifications created an opposition to the licensed clinical social worker rather than a community aimed at the same goals and sharing common practices.

Because CCs could not draw on their own previous experience, education, or interactions with clinical providers other than paternalist physicians, inhibited to a great deal by non-

occupational supervisory structures, no occupational community that could promote higher quality work practices ever emerged at LowQual.

MedQual

The Development and Reproduction of High Skill, Intermediate Intensity at MedQual

Around the same time as LowQual was being established in early 2012, the health system downsized its behavioral health services and laid off workers in behavioral health clinics. However, the management team that established LowQual also decided to assign six workers who had previously been case managers or intake workers at a behavioral health clinic to MedQual. The decision to establish MedQual at a behavioral health clinic and with workers who had been employed there accounts to a great degree for MedQual's high skill levels, and it also facilitated intermediate intensity work practices. The reason was that MedQual had been established among an existing occupational community based on behavioral health. Additionally, occupationally-based supervisory structures ensured the continuity of MedQual's high-skill, intermediate intensity model.

First, in terms of skill, a licensed clinical social worker who ran the behavioral health clinic recruited the workers with an emphasis on high educational qualifications, including field-related university degrees, 10+ years prior to their transfer into MedQual. At the behavioral health clinic, the workers had fulfilled roles that were similar to CC roles, providing them with a lot of useful experience. MedQual CCs had worked as intake workers who evaluated the needs of walk-in patients and referred them to the appropriate services (CC1).

Regarding intensity, like LowQual, MedQual also had a centralized division of labor but other than that, it achieved an intermediate level of intensity. Supportive supervisory structures

and CCs having established receptive relationships with clinical providers enabled an intermediate level of case conferencing and advocacy during provider visits (Table 1). Moreover, facilitated by lower caseloads, CCs drew on their identifications with social work principles to engage in more intensive interactions with members such as agency visits. Together, occupationally-based supervisory structures, receptive relations with clinical providers, and CCs' identifications formed an occupational community that facilitated more intensive work practices than the NYS-DoH HHP prescribed.

Occupationally-Based Supervisory Structures at MedQual

While MedQual's Operations Supervisor formally reported to the LowQual's Director, the Director had little day-to-day involvement in MedQual's operations. The Supervisor consulted the Director via email or telephone when she needed to but in the day-to-day operations, the Supervisor ran MedQual autonomously. The same nurse that sat with the LowQual staff was also formally responsible for MedQual's CCs but they interacted with her mostly via short telephone calls. This permitted MedQual to operate largely autonomously from LowQual's supervisory staff. Moreover, this autonomy permitted MedQual to be part of an occupational community based on behavioral health principles.

The main reason for MedQual being embedded in an occupational community was that the behavioral health clinic that housed MedQual was located separately from the main hospital campus where LowQual staff sat. Therefore, MedQual staff interacted with behavioral health clinic staff rather than with hospital staff, especially in monthly meetings with all behavioral health clinic staff, which gave them a visible presence in the clinic. The clinic had its own

inpatient beds, along with other psychiatric services across several floors, one of which contained MedQual's offices.

MedQual's Supervisor actively promoted links to the clinic and exerted occupationally-based management through her management style and support for social work principles. MedQual's Operations Supervisor interacted regularly with the clinic's Director (who was a licensed clinical social worker) based on whether the therapist or psychiatrist along with the clinic's Director deemed MedQual's services as beneficial for a patient. The clinic's Director had no formal supervisory responsibility over MedQual staff but the Operations Supervisor emphasized that the clinic's Director was particularly important in referring and handing over a potential member to the Operations Supervisor. This meant that most referrals to MedQual came from within the behavioral health clinic so that MedQual CCs did not have to outreach potential members, which lowered MedQual caseloads. Additionally, the Operations Supervisor insisted on lower caseloads because she wanted to maintain appropriate care standards rather than grow patient volume: "To me it's not necessarily caseloads per se, it's the quality of the work".

At the time of her arrival, the Operations Supervisor chose to reproduce the existing practices through delegated management, rather than to discourage CCs from engaging in more intensive work practices. Moreover, her background and values reinforced rather than inhibited social work principles.

The Supervisor had studied a sociological discipline, and worked 10+ years as a case manager where she coordinated the care of children, families and parolees. After that, she managed healthcare projects, including a multi-year project related to care coordination with a large team. Through these experiences, the Supervisor had developed a delegated management style in which her main function was to support her staff in autonomous working.

The Supervisor applied this management style at MedQual. She described her role as having to ensure adequate documentation and sometimes supporting the CCs with difficult cases. But for her, the CCs' extensive years of experience meant they would often have a better understanding of how to proceed with a case such that the Supervisor often deferred to CCs' judgement. Instead of coercive team meetings, she practiced an open-door policy that meant continuous interaction with CCs in addition to individual meetings every two weeks. This management style meant effective standards were often at CCs' discretion, so while the minimum standard was one contact per month the standard CC practiced was to contact members twice or three times per month, not only once. Moreover, CCs also engaged in agency visits and advocated for patients at provider visits (Table 1), which the Supervisor supported.

The occupational basis of supervisory structures also manifested itself in the Supervisor's values. She embedded care coordination's value in a psychosocial model in environmental factors determined health. Moreover, she emphasized the importance of advocating for members and of helping them empower themselves to demand transparency from physicians:

"A lot of times clients are afraid to demand services…just because you're poor …I tell 'clients' you have the right, the patients' bill of rights is very important. The exchange is: 'I am the client and you're my provider, you're providing!' [laughs], 'Provide!'".

Her priority of providing care manifested in her lacking awareness of reimbursement. She knew one contact per month was a requirement but thought it more of a minimum standard than a requirement for reimbursement:

"These are the minimum standards in terms of what's required in health homes. How that translates into funds I have no idea. I really don't, I don't know how much we get paid or how many people we bill for. So I guess that overall I wanna make sure that the clients are doing well. For me, it's not, I shouldn't say this, but the monetary is secondary to their wellbeing".

Instead of focusing on cost-effectiveness, her focus on care thus reinforced, rather than inhibited, more intensive face-to-face interactions with members. It also contributed to receptive relations with clinical providers in the behavioral health clinic.

Receptive Relations with Medical and other Providers at MedQual

While LowQual CCs interacted mostly with physicians, MedQual CCs interacted regularly with psychiatrists and therapists – in addition to primary care physicians. The CCs described their interactions with other service providers as receptive. In addition to the clinic's Director and MedQual's Supervisor, clinical providers thus also formed part of the occupational community that supported MedQual's more intensive work practices.

CCs attributed this receptive relationship to their backgrounds of having worked at the clinic in similar roles for many years. The responsibilities of these previous roles were more limited, meaning they had to work more closely with other providers to accomplish them. This background meant that all physicians, and therapists had more familiar and reiterative relations with the CCs which permitted the second highest rate of case conferencing amongst all programs (Table 1). When CCs needed to case conference with a provider, mostly to draw up the first plan of care but also when a difficult situation arose with a member or when members were discharged and a follow-up appointment needed to be scheduled (CC7), these providers were receptive to the CCs:

"when a case is assigned to me…the first thing I do is actually call the therapist...I've been working here for [10+] years, so a lot of people know me, so I'll say: 'Hi how are you doing? It's me, [CC1's name], I was assigned one of your clients so and so, can you give me a little bit of history or tell me where do you feel that I can assist this client?'" (CC1).

Even though there were preceding relations between CCs and providers, there was still some confusion about what the CCs would do in the behavioral health clinic. In particular, boundaries between therapists and CCs were unclear. Drawing on her previous experience of managing care coordination projects, MedQual's Supervisor responded to this uncertainty by explaining the services' aim and scope to providers in the behavioral health clinic. She had also had interactions with providers at the behavioral health clinic in her previous capacity as project manager which facilitated buy-in from physicians (MedQual Supervisor). This work to define boundaries and educate providers helped reduce resistance from providers and clarify misunderstandings:

"now the majority of the psychiatrists, and I mean with exception if they're new, right? They have a better understanding. And [MedQual Supervisor] has made it her business to introduce health homes, speak with the Units, speak with the therapists…explaining what role we play. What is it that we can do, what we're not able to do. What role continues to be theirs…sometimes that's a misconception, not only of the therapist but also of the client. So she's made it possible for that, to have an understanding in what role we play" (CC1).

Accordingly, the MedQual CCs did two to three case conferences on average per week with psychiatrists and therapists. This occurred when drawing up or adjusting a plan of care. If the CC had not been able to contact a member for extended periods of time a case conference also took place with the Supervisor and the member's therapist to ascertain whether a member was at risk of endangering him/herself or others. These receptive relations allowed not only for easier case conferencing but it also meant some physicians started asking for CCs in their medical record notes (MedQual Supervisor). Through case conferences, clinical providers also reinforced a focus on behavioral health instead of just on medical compliance. This provided clinical justifications for higher intensity practices like agency visits.

Furthermore, these receptive relations also meant provider visits had a different character. While CCs helped with communication they could also advocate for physicians to explain results more clearly: “He has to explain it to you in laymen's terms, not in a medical term…if I go with [members] I say: 'Doctor, can you please explain it to her like you're talking to a five-year old?' and I've been pretty successful with some, not all” (CC7).

Instead of functioning solely as an extension of physicians’ authority, CCs were thus often able to defend their members’ interests and actively engage physicians.

Occupational Worker Identifications at MedQual

In addition to supervisory structures and clinical providers, CCs’ own identifications with social work principles such as advocacy meant they were also committed to this occupational community. This motivated them to engage in more intensive interactions with members. CCs referred to members as ‘clients’ rather than ‘patients’ citing their location in a behavioral health clinic as the reason. Moreover, additional to improving compliance, they aimed at improving a member’s position related to their social environment. Their main goal was to help members become independent, not just from the HH, but in general. Accordingly, they knew of and offered a broader range of resources such as literacy classes, interpreting these as contributing to better health.

MedQual CCs also viewed their knowledge of resources as a factor setting them apart from other providers. It made them view themselves as part of a broader social group and helped them find pride in their occupation:

“It's not the same thing you going to therapy and telling your therapist: 'Oh, you know, Section 8 is this'…it's not that the therapist doesn't wanna help but the therapist doesn't have the knowledge that we have about the different resources that are available. How to communicate with these

different agencies, so you see we have that power. And we already have that experience, and we know where and with who to speak with. That's one of the things that I think that's not being acknowledged…but that has to be acknowledged. That we in reality are a powerful group" (CC1).

Based on their previous experiences and their identifications, MedQual CCs engaged in more intensive face-to-face interaction with members. For example, at their offices, they made phone calls in front of members to help them feel less isolated and to reduce their emotional stress. CCs also accompanied members to outside agencies, for example to the Human Resources Administration or to the housing court if these institutions reviewed members' benefits. These visits often consumed up to a whole work day. Moreover, they extended CCs' mobility beyond their clinic. CCs engaged in such intensive practices to manage their members' emotional states:

"they need someone there because they get very nervous or the anxiety of being in a crowded place with too many people, too much noise that sets in. So you have to be able to like: 'It's ok, you know we're going to this big place but you're there for one reason, so don't get upset…I've found guys that's like: 'Oh we've been here for an hour!', 'No we've only been here 10 minutes', 'Oh it feels like an hour!', 'I understand', so I have to like tone it down" (CC7).

MedQual's supervisory structures, receptive relations with other providers, and CCs' identifications constituted an occupational community that enabled MedQual CCs to provide higher intensity services compared to LowQual's lacking occupational community (Table 2).

Table 2: The Structure of Occupational Community

Community Dimensions	*LowQual*	*MedQual*
Supervisory Structures	• inhibiting social work or other care principles • promoting cost-effectiveness • unable to support buy-in from clinical providers	• promoting social work or other care principles • deprioritizing cost-effectiveness • able to support buy-in from clinical providers
CCs' Relations with Providers	• resistance from clinical providers • paternalism • focus on medical compliance	• little resistance from clinical providers • willingness to engage • skills transfers focused on emotional awareness
Worker Identifications	• derived from low-intensity work process • function of physician authority • opposed to social work principles	• derived from experience and interactions with providers • identification as a powerful group with unique skills base • identification with social work principles

4.3 The Impact of Regulatory Intensity

While MedQual's occupational community improved the quality of work practices compared to LowQual, MedQual still had lower intensity services than HighQual. MedQual had similar skill levels but many work practices were lacking or at a lower level of intensity compared to HighQual. HighQual had frequent home visits that could include crisis intervention, higher rates of case conferencing, a differentiated division of labor, a set health promotion curriculum, and low caseloads (Table 1).

These differences were far from trivial but created high work effort throughout the care team through intensive interactions between care providers and members, and among care providers. Home visits were particularly time-consuming, potentially dangerous, and stressful because CCs had to enter neighborhoods and buildings in which illicit activity such as drug deals

might be occurring. Home visits also enabled CCs to intervene in crisis situations at a member's home to prevent a member's health from deteriorating severely, at the cost of having to make stressful judgement calls. At a recent visit, a HighQual CC had to intervene because a member was intoxicated and close to being unresponsive: "She was on the floor…The patient tell me: 'You don't have to, I'm all right'. I said: 'You're not all right because if I leave you and something happens to you, I'm sorry'…I had to call the ambulance" (CC2).

The differences in intensity lay in different public policy program designs (see Table 3). The NYC-DoHMH CCP clearly specified and mandated the higher intensity work practices. However, it also underpinned these high standards with strong enforcement and a supportive reimbursement mechanism. By contrast, such high regulatory intensity was missing in the design of the program under which LowQual and MedQual operated. Additionally, a workplace-level occupational community at HighQual accounted for high skill levels and provided normative justifications to rigorously follow the CCP standards.

As mentioned above, the NYS-DoH HHP, the policy program under which LowQual and MedQual operated, had low regulatory intensity. In its standard-setting, it did not specify many important aspects of work organization such as minimum qualifications for CCs, caseloads, or clinical oversight of CCs other than to sign off on assessments and plans of care. While the 59-page provider manual emphasized a care team approach the closest it came to specifying work organization was the following sentence, generally describing a care manager's role: "The coordination of a member's care is done through a dedicated care manager who oversees and coordinates access to all of the services a member requires in order to facilitate optimum member health status" (NYS-DoH 2014: 9). The HHP paid participating organizations a per member per month fee that was not adjusted for acuity and only required one contact per month with a

program member that fell under ongoing care tasks (including also the lowest intensity of a phone call).

The HHP's enforcement structure was also weak, consisting of few audits and decentralized monitoring. Audits consisted of certifying a health system to provide infrastructure services (for example IT reporting tools and billing) to care management agencies before the program's inception and then again every three years after that. The infrastructure provider was a 'Lead Health Home' while the care management agencies that received infrastructure services from the Lead Health Home were called 'Downstream Providers'. As part of this recertification process, the State audited few patient charts and only from a small proportion of a Lead Health Home's Downstream Providers. It was also only these few Downstream Providers that the State auditors visited. In terms of monitoring, the Lead Health Home liaised with the NYS-DoH and monitored Downstream Providers. The required monitoring data did not include quality measures, only simple process measures such as the length of time taken to enroll a potential member: "The State monitors a lot of busy work and not results, like any cost reductions" (Lead HH Finance Manager). Data on health outcomes were unavailable because managed care organizations owned these and the NYS-DoH had not developed quality reporting for the HHP (Lead HH Director; Lead HH Quality Analyst).

The result of this low regulatory intensity was that Lead Health Home administrators had to design their own standards to a large degree, in turn resulting in a large diversity of forms of work organization at the workplace level. The Lead Health Home that housed LowQual and MedQual tended to exceed the HHP's standards for process monitoring but did not go so far as to monitor quality. For example, at their own initiative, Lead Health Home Administrators

decided to provide Downstream Providers with benchmarking reports to inform them of their performance on these process measures (Senior Lead HH Administrator).

Another result of low regulatory intensity was that there were no explicit standards for health homes to graduate patients (Lead HH Administrative Assistant; Lead HH Quality Analyst), leading to "indefinite care coordination" (Policy Program Chief Medical Officer). Furthermore, audits had little workplace effects and did not engender buy-in from participating organizations. When the State recertified the Lead Health Home that housed LowQual and MedQual the State audited 70 charts (from multiple thousands of members that the Lead Health Home structure managed) from only a third of the Lead Health Home's Downstream Providers. One of the Directors whose agency had been audited recalled successfully contesting the State's changes and furthermore felt the State criticized his team without proper grounds: "We were being held to standards we didn't know existed".

By contrast to the HHP's low regulatory intensity, the NYC-DoHMH Care Coordination Program, the policy program under which HighQual operated, exerted high regulatory intensity. It clearly specified high standards of work organization, enforced them intensively, and paid more for higher intensity services.

Regarding work organization, the CCP's provider manual included a section entitled 'Roles and Responsibilities' that clearly defined the Program Director's, Operations Supervisor's, CC's and Medical Provider's roles, as well as the specialized division of care coordination tasks among all team members of the care coordination program (NYC-DoHMH 2015: 22–26). As a justification, the section discussed taking over other team members' responsibilities to more effectively engage members, which was similar to the Operations Supervisor's interpretation of why it was beneficial for her to be involved in the initial

assessments and plans of care for program members. HighQual implemented this specialized division of labor as follows: after HighQual's Director and a physician assigned a patient to the CCP, the CCP Program Director collected all patient information and passed the case to the Operations Supervisor who then met with the patient to introduce the program, enroll the patient, do the initial assessments and start drawing up a care plan. In parallel, the Program Director assigned the member to a CC who reviewed the care plan and took over ongoing care tasks for the member. In this way, multiple team members knew and interacted with the member, which allowed the Program Director or Operations Supervisor to take over ongoing care tasks if CCs were not present at the clinic to attend to their members.

While the Program did not mandate qualifications or caseloads a separate appendix with a staffing plan recommended degrees and experience levels for supervisory staff, college education, "strong socio-cultural identification with the target population" (NYC-DoHMH 2015: 82) for CCs, and caseloads of 14 to 20 cases. Again, HighQual's care model aligned well with these recommendations, though caseloads sometimes went up to 25.

Regarding HighQual's frequent case conferences (Table 1), the CCP standards required a case conference with the member's primary care physician at least once per quarter but also when a medical appointment generated information relevant to a member's plan of care and when significant events occurred "e.g. loss of housing, pregnancy, etc." (NYC-DoHMH 2015: 39). Moreover, they should occur if providers outside of the CCP clinic needed information. The NYC-DoHMH provided a form to document these case conferences but informal case conferences should occur "as frequently as needed" (NYC-DoHMH 2015: 40) without documentation. Accordingly, HighQual CCs case conferenced not only when drawing up or revising a plan of care but also after a member's visit to the clinic. Moreover, these frequent case

conferences allowed CCs not only to help with communication issues but also to give non-clinical input into a member's care, giving their input a value separate from medical authority.

Other standards that were higher than the HHP included an outline of both social as well as medical criteria for graduation, and mandating members conclude an 18-topic health promotion curriculum the NYC-DoHMH supplied (NYC-DoHMH 2015: 58f.).

With regard to interactions between CCs and members, the NYC-DoHMH CCP specified that CCs should accompany members to all health and social services appointments as needed (accounting for provider and agency visits) but it also mandated home visits for the highest needs members that included the CCs observing members take their medication once per day (known as 'directly observed therapy' or DOT). Most importantly, the CCP tied the frequency and intensity of interactions with members to a member's acuity level and to the height of reimbursements. The higher a member's acuity was (defined by HIV viral loads but also by psychosocial barriers like substance abuse or homelessness) the more frequent and intensive the services should be. Additionally, the more intensive the services were the higher the reimbursement was that agencies received for those services. The CCP conceptualized this combination of acuity, intensity and payment levels as different tracks. The most intensive of these tracks included DOT and generated a separate payment for each documented, direct observation in addition to a per member per month fee. The second most intensive included a face-to-face meeting once per week with a review of medication charts members kept and generated a lower payment additional to the per member per month fee. The third track included one monthly face-to-face meeting and the least intensive track included quarterly face-to-face meetings.

At HighQual, this track structure clearly signaled a member's acuity to the CCs and meant that a CC's caseload included different frequencies for interacting with members face-to-face. CCs usually had between 1 to 3 members who fell into the highest acuity DOT track. Moreover, the requirement that all members go through the 18-topic health promotion curriculum before graduating meant that CCs engaged even the lowest acuity program members face-to-face over an extended period of time, keeping these members engaged in care.

In addition to providing incentives for more intensive services, the track structure had the workplace effect of encouraging members to cycle through the program relative to their acuity, rather than indefinitely staying with the program, as was the case in the low-intensity HHP. The HighQual Director interpreted the track structure as promoting a focus on seeking out and helping high-needs members: "In order to have a care coordination program that's going to be financially viable you really have to make sure that you have quite a lot of people in the higher paying tracks and that as you're moving people to the lower paying tracks you really try to make sure you get referrals in".

In terms of enforcement, the CCP also followed a high intensity approach. First, monitoring requirements were higher. While the NYS-DoH HHP had no paperwork requirements, the CCP separated reporting via electronic means from documentation, defined as paperwork. This paperwork was retained for each member for six years after contract reconciliation (NYC-DoHMH 2015: 59). Additionally, documentation was required more often, also for directly observed therapy, case conferencing and health promotion activities. While the HHP collected no quality outcomes the NYC-DoHMH established an electronic system called 'eSHARE' in 2012 which collected individual client-level health outcomes data and which

Federal administrators declared a best practice (HRSA 2014a: 13). These data were the basis for reports that benchmarked all CCP agencies.

Second, participation in the CCP depended on a contract, renewed yearly, between every service provider and the NYC-DoHMH. This contract-based arrangement put more pressure on service providers to meet standards than the recertification every three years of only the Lead Health Home in the NYS-DoH HHP.

Third, audits occurred not only electronically to check for appropriate documentation but every year at the beginning of the contract an NYC-DoHMH representative audited service providers through workplace visits. Two months later, a representative from Public Health Solutions (a consultancy with experience in HIV/AIDS contract management since 1991) also did a workplace audit, and towards the end of the contract, both representatives did a workplace audit together (CCP Program Director; HighQual Director). Moreover, four years into the Program, an independent agency also audited work practices (HighQual Director).

HighQual staff described this intensive audit structure as an opportunity to engage with auditors and improve their own performance, which generated their support for the CCP. Especially useful were the benchmarking reports that showed variation among all CCP agencies' performance (CCP Official) and HighQual as one of the top CCP performers. Moreover, HighQual staff described their interactions with auditors as a reiterative 'back-and-forth' in which proper justifications from both sides could be voiced. At a recent audit, these reiterative interactions allowed the Program Director to explain particular charts clearly and reach a common understanding with the auditors.

Table 3: The Structures of Low and High Regulatory Intensity

Regulatory Dimension	***Low: NYS-DoH HHP***	***High: NYC-DoHMH CCP***
Standard Setting	• No specifications of: education, experience, roles, case conferencing, division of labor • Low minimum standard for number and quality of interactions with members • Caseloads only for special populations	• Specifications of: roles, number and quality of interactions tied to member acuity, when to case conference, differentiated division of labor • Recommended: education, experience and caseloads
Enforcement of Standards	• No workplace audits at LowQual or MedQual • Only process outcomes monitored • Decentralized monitoring via Lead Health Homes	• Three workplace audits per year at HighQual • Individual patient-level health outcomes monitored in addition to processes • Centralized Monitoring by DoHMH and consulting firm
Financial Incentives	• Unadjusted per member per month fee: incentive to reduce labor costs and increase number of enrolled members	• Per member per month fee for lowest intensity services and additional payments staggered according to intensity: incentive to seek out higher-risk members

HighQual

Occupational Community at HighQual

While the CCP's high regulatory intensity accounted for HighQual's high-intensity practices, HighQual also had an occupational community that shaped its high skill levels and provided normative justifications for following the CCP standards. The latter was particularly important because the CCP regulations did not directly generate physician buy-in (for example

by tying reimbursement to their participation) nor did they mandate required work experience or qualifications (though it did recommend them). The fact that HighQual was among the CCP's highest performing agencies indicates further that occupational community is necessary to underpin the CCP's high regulatory intensity.

Similar to MedQual, HighQual's occupational community also consisted of occupationally-based supervisory structures, receptive provider relations, and workers' identifications with the social work occupation. The Center's Director had 15+ years' experience working in the HIV/AIDS field, including before the advent of highly active anti-retro viral therapies which turned HIV/AIDS from a likely fatal, acute to a potentially long-term, chronic disease. He spent several years as an administrator in HIV/AIDS care coordination before joining the health system under study. Moreover, he engaged in the broader HIV/AIDS community by chairing regional initiatives to promote HIV/AIDS prevention. The Director brought this strong occupational experience and commitment to bear in his role.

HighQual was located at an AIDS Center with many years of previous experience in care coordination. When the Center won the CCP contract in 2010 the Director created a new job classification that included university education and several years' experience in HIV/AIDS care coordination. The Director did this despite Human Resources suggesting he take the lower-paid, lower skill job classification that the LowQual CCs subsequently had. The Director emphasized multiple years of experience in care coordination when recruiting CCs because he thought it was necessary to know the population's health needs, the resources to deal with them, and how to draw up a plan of care that factored in the timelines within which those resources could be procured. Accordingly, he hired CCs with many years of experience in HIV/AIDS care

coordination (see Table 1). Additionally, both the Program Director and Operations Supervisor also had 10+ years' relevant experience.

The Director's strong involvement in the daily operations of the clinic also meant he promoted the HighQual care coordination program as a valuable part of the clinic's overall functioning, facilitating provider buy-in for case conferences. The Director did the visit planning for every work week which entailed looking at all patients coming in for appointments, evaluating them for different services based on the patient's medical and psychosocial progress, and suggesting physicians refer patients to these services at the weekly pre-visit planning meeting. Sometimes the Director would put patients into HighQual's CCP even without physician approval and receive physician approval afterwards. He was thus involved not only in such decisions but sometimes also overrode physicians' authority. At the same time, he was able to ensure that physicians understood a patient's need for care coordination, which made them willing to engage in case conferences with CCs.

One issue that sometimes occurred was when physicians referred patients to CCP but did not emphasize its voluntary nature and that a team of care coordination staff would provide services. This meant members sometimes did not understand care coordination's value. However, the CCP Supervisor found that referring to previous members' good experiences helped her convince potential members of care coordination's value.

In addition to facilitating receptive provider relations, the Director also articulated a psychosocial model of health, had extensive knowledge of community providers and resources, emphasized patient-centered care and the importance of cross-checking what patients reported with home visits as well as information from diagnostic tests. From his previous work in other sites he recounted multiple moments at which home visits revealed a crucial piece of information

that accounted for a patient's inability to engage in medical care, including illiteracy, domestic violence, dementia or schizophrenia. These stories served to justify the higher intensity work practices that the CCP prescribed: "That idea of going to a person's home will open your eyes sometimes to something that an experienced person might just catch... depending on the acuity of a person, health home, care coordination, it can't be one size fits all" (HighQual Director).

Similarly, the Program Director showed a strong awareness of high-risk, mental health members, and the Operations Supervisor emphasized advocacy and empowerment as care coordination aims. These supervisory structures reinforced social work principles that justified higher intensity practices.

CCP CCs also had the experience that made them understand the value of high-intensity practices. They articulated the importance of being aware of psychological issues such as suicidal ideation, intervening in crises and deriving important information from home visits. CCs identified as social workers and drew on each other's particular strengths that derived from their experiences, such as one CC's special knowledge on harm reduction. They could present various instances in which home visits were crucial in improving a member's care. For example, one CC recounted how she visited a member at home because he had not come to an appointment at HighQual. The reason was that he did not have enough money to afford transportation to the clinic. For the CC, this information allowed a more realistic understanding of a member's situation that could be easily remedied through the clinic's access to resources. Moreover, it reinforced more understanding among doctors as well of the socio-economic issues that members face:

"Because we do home visits we are able to see how this patient lives…if we don't do those type of outreach, we are never going to be able to bring that information back to the doctor

and this is where there's more caring. You know, the caring and the understanding that this patient didn't come, not because he didn't want to but because he couldn't…we deal with a lot of poverty, single Moms or males who live in shelters, who live in rented room or who depend from, I'm not gonna say depend from the system but cannot work for whatever reason. That's why we go out there" (CC2).

In these ways, HighQual's occupational community generated provider buy-in for case conferencing, and the promotion of social work principles as well as CCs' experience base that provided normative justifications for engaging in higher intensity work practices.

Regional Occupational Community as a Source for Higher Regulatory Standards

HighQual's occupational community derived from its staff's extensive prior occupational experience in care coordination and served to justify and enable the higher intensity practices that the CCP prescribed, enforced, and incentivized. However, the occupational community of which the HighQual staff formed a part also served as a basis for the CCP's high standards. By contrast, the officials who designed the low-intensity HHP consciously prioritized cost-effectiveness over following the region's previous experience in care coordination.

Both policy programs' origins were Federal in nature, with the HHP based on Section 2703 of the 2010 Affordable Care Act and the CCP based on congressional Ryan White Part A funds originally set up in 1990. Both Programs also served predominantly low-income individuals with the HHP being a Medicaid program and 67% of Ryan White clients living at or below the Federal Poverty line in 2014 (HRSA 2014: 4). Moreover, the Federal guidelines for both Programs limited eligibility only in a very general way and permitted States a lot of leeway in implementing the Programs.

The main difference between the Programs was that the officials in charge of implementing the Programs had different aims and priorities. Officials designed the low-intensity

HHP primarily to reduce costs while officials designed the high-intensity CCP to maximize improvements in health outcomes by drawing on practices that the HIV/AIDS community had developed.

Because NYS had the largest Medicaid bill in the US (NYS-DoH 2011) and Governor Cuomo's administration inherited a $10bn deficit (Senior Policy Researcher) in 2011, Cuomo established the 'Medicaid Redesign Team' to lower Medicaid costs and improve care quality. The Team recommended participating in a Federal waiver, capping the Medicaid budget, and participating in the HHP (NYS-DoH 2011).

Accordingly, the HHP's main aim was to consolidate previous care coordination programs for behavioral health and HIV/AIDS in NYS by grandfathering them into the HHP (Policy Consultant for NYS-DoH). Because individual agencies could bill the State directly under these programs the administration of these programs was highly fragmented and costly. From this perspective, the NYS-DoH HHP centralized billing through the decentralized billing and monitoring structure of Lead Health Homes managing multiple Downstream Providers (Lead HH Finance Manager). Furthermore, while service providers did not have to cooperate previously, the decentralized structure made Lead Health Homes and their Downstream Providers cooperate (Senior Policy Researcher) in the hope that existing resources would be used more efficiently. Despite this aim, the NYS-DoH's preliminary analyses showed improved outcomes but few cost savings because the cost of managing the HHP was still too high (DoH HHP Official).

In accordance with the aim of consolidating previous programs, the first program years' focus was to increase the maximum number of Medicaid beneficiaries enrolled in the HHP and reach 975,000 individuals. Only in later years and when the Centers for Medicare & Medicaid

Services had developed quality indicators would more refined reimbursement and monitoring occur (DoH HHP Official). The HHP was more successful in this regard. As of March 2016, the NYS HHP was the second largest HHP in the US with 231,543 enrollees (CMS 2016).

To achieve high participation, policymakers chose open, unspecific standards with a reimbursement system that provided incentives to increase the HHP's number of enrollees. The State chose flat-rate per member per month reimbursement because outcomes-based reimbursement might have kept service providers from participating, especially because the HHP's target population was the most complicated to serve (Management Consultant for NYS-DoH). Rather than specifying clear standards, the State issued guidance in response to provider questions. At the Lead Health Home under study, guidance usually enforced low, open standards. For example, the certification criteria for a Lead Health Home included "regular case review meetings" (NYS-DoH 2012) but it did not specify time frames for such reviews. Lead Health Home administrators decided to set the standard of reviewing initial assessments every three months (Lead HH Administrator). However, smaller Downstream Providers could not meet this standard, so the administrators changed it to every six months until the State decided that the initial assessment should be updated only "if something major happens" (Lead HH Administrator) like hospitalization.

In enforcing such open standards, State officials consciously decided not to draw on the higher standards from the previous care coordination programs it consolidated, for example the COBRA Program. Established in 1986, the COBRA Program included a maximum of 40 caseloads, a differentiated division of labor, and reimbursement set to units of services provided rather than per members (HIV/AIDS Community-Based Organization Director). In spite of staff with public health and social work backgrounds working on the NYS-DoH HHP's design, and

access to the people who designed the COBRA program (Policy Consultant to NYS-DoH), cost-effectiveness through consolidation remained the priority in the design of the NYS-DoH HHP.

By contrast, the CCP officials based their program design on 30 years of institutional knowledge and resources that an HIV/AIDS prevention community had developed and advocated for. This community is partly Federal in nature such as the AIDS Drug Assistance Program that was created in 1987 to help pay for necessary medical services and pharmaceuticals (AIDS Institute 2013). But with New York City being a large center for HIV/AIDS throughout the epidemic's history, NYS has had more resources for HIV/AIDS prevention and treatment in comparison to other States (Care Coordination Health Educator; HIV/AIDS Community-Based Organization Director; HighQual Director).

In the context of this strong institutional support on both Federal and State levels, a community of HIV/AIDS social and medical services providers developed that prepared much of the care coordination methodology in use today (HIV/AIDS Community-Based Organization CEO), including the above-mentioned buddy system, the COBRA program, and the NYC-DoHMH CCP's high standards. The AIDS Institute was a particularly important actor in this respect. The NYS-DoH established it in 1983 to provide (medical) research and educational services, and to develop standards for HIV/AIDS care, including to certify medical providers as Designated AIDS Centers from 1985 onwards (AIDS Institute 2013). In 2008, the AIDS Institute updated its standards to promote "a comprehensive, collaborative, integrated system of service provision" (AIDS Institute 2008) by requiring Designated AIDS Centers to work more closely with COBRA providers and to provide intensive care coordination to "patients with multiple and complex psychosocial/health related needs" (AIDS Institute 2006a: 4).

In 2006, the Institute also published a 52-page document outlining standards for HIV/AIDS care coordination (AIDS Institute 2006b), which was a pre-cursor for the NYC-DoHMH CCP, outlining much of the same procedures, tasks, values and specificity regarding work organization. For example, the standards mandated an assessment based on a long list of medical factors (including chronic conditions other than HIV/AIDS) and social factors (such as housing, financial resources or support systems) (AIDS Institute 2006b: 4-8). In terms of work organization, it also recommended caseloads of between 15 and 35 cases, detailed CC and supervisor qualifications, and required a home visit to initially assess high-needs cases.

Apart from these standards, the CCP officials also drew on numerous academic studies evaluating effective practices for HIV/AIDS prevention to design the high-intensity NYC-DoH CCP. They specifically drew on a model piloted first with low-income, HIV-positive individuals in Haiti and then applied in Boston. This model included directly observed therapy that community health workers conducted (Behforouz et al. 2004). Officials from the CCP Research and Evaluation Unit have since provided evidence from pre/post analyses that the model has significantly lowered viral loads and improved engagement in care (Irvine et al. 2015).

In these ways, CCP officials consciously built on 30 years of institutional knowledge, the application of which they evaluated in the CCP's context. Instead of cost-effectiveness, CCP officials thus prioritized evidence-based practices that the broader occupational community in HIV/AIDS prevention had devised. However, the decision to clearly specify work organization to such a high degree was novel: "we went a lot further than the minimum [Federal] guidelines…as guidance-heavy as we were, we had not done that previously" (CCP Official).

The impact of occupational community thus did not only precede workplace dynamics in terms of the previous occupational experience of clinic staff but the CCP officials' conscious

decision to draw on a broader occupational community enabled the combination of high regulatory intensity and workplace-level occupational community that led to HighQual's implementation of high quality work practices.

4.4 Alternative Explanations

Though my research design controlled for several alternative explanations, I examined others that I could not control for. One factor is demographic differences among the agencies' workforces, similar to DiBenigno and Kellogg's (2014) cases in which nurses and patient-care technicians were only able to collaborate effectively if they shared the same underlying demographics of age and race. In my case, the demographic composition of all care coordination programs was very similar: the CCs and Operations Supervisors were either African American or Hispanic while the Directors (except one), physicians, licensed social workers and psychotherapists were Caucasian. Moreover, the majority of all care coordination staff (including supervisory staff) was female, and all CCs either grew up or lived in the area of study, so they all knew the health system's catchment area well.

Another explanation may be that MedQual CCs were less motivated to do their job and thus engaged in lower intensity practices. However, though one physician mentioned that motivation had been an issue with a CC in MedQual's second year, the problem had been dealt with quickly. Moreover, MedQual's Operations Supervisor stated problems with motivation were rare and in these instances, a written warning made CCs perform their work adequately. A related explanation may be that MedQual CCs interpreted their compensation as particularly low and were less motivated to engage in high-intensity practices. However, despite higher pay at MedQual and HighQual, all CCs described their compensation as inadequate and felt underpaid.

Furthermore, CCs in all agencies described their motivations as helping others and finding meaning in members' gratitude.

Differences in the nature of tasks may also account for different skill levels. This understanding posits more difficult tasks required HighQual CCs to be more skilled compared to the LowQual and MedQual. However, if this were correct we would not see differences between LowQual and MedQual because they both had a centralized division of labor, the Director assigned them the same tasks, and the NYS-DoH HHP did not provide standards or incentives for higher intensity tasks in either HH. Moreover, we would then expect HighQual CCs to have the highest skill levels because they performed the highest intensity services. However, both MedQual and HighQual CCs had similar years of experience. Further, MedQual CCs had degrees in the related fields of Human Services or Social Work while HighQual CCs had non-related degrees.

Furthermore, neither HighQual nor MedQual CCs performed tasks that would inherently require higher skill levels. If home visits (the most intensive ongoing care task) were inherently more complex and required skilled personnel we would not see organizations other than highly professionalized ones such as hospitals performing home visits. However, community-based organizations with unlicensed social workers have traditionally performed home visits in the health system's region, often with minimal training and lacking or poor safety protocols (CBO CC1; CBO CC2; Training Field Note 12/01/2016). Furthermore, according to HighQual staff, home visits require entering potentially dangerous places in low-income neighborhoods, and accordingly, a safety protocol to deal with such situations. They further require a basic understanding of what social issues may inhibit members' medical compliance so that the CC doing the home visit can recognize such issues. If organizations develop adequate safety

protocols and provide on-the-job training, also unlicensed social workers without degrees may perform such home visits and add value to the health team treating members (CC2; HighQual Director), as they have historically in the social work occupation (Austin 1978).

Another explanation may be that the HighQual and MedQual had higher acuity members, in turn requiring higher intensity practices. However, as mentioned above, eligibility criteria for both policy programs included multiple or high acuity chronic disease patients. Moreover, when I asked Lead Health Home administrators whether the health system under study received particular patient types they replied it received substance abuse, mental health, HIV/AIDS and general medical patients. Furthermore, when I asked the CCs to describe their member population they said most their patients had mental health issues such as severe depression in addition to their chronic conditions. Moreover, HighQual staff also emphasized that patients commonly had behavioral health issues or severe social issues such as homelessness, and that severe mental illness such as schizophrenia had increased. Apart from a slight increase in West African individuals, physicians reported no changes in the health system's patient acuity over the past decade. A common justification for the high acuity, confirmed by community health needs assessments, was that the health system's catchment area had the highest acuity regarding several chronic and sexually transmitted diseases in its region. This was also the reason for a new care coordination program with the eligibility criterion of only one chronic disease to be struggling: it was common knowledge that chronic disease patients living in the health system's catchment area had more than one chronic disease.

Another possible explanation might consist of differences in management structures. Perhaps senior managers funded or prioritized some agencies over others. This, however, was also not the case. First, both Directors reported to the same senior manager with whom they

reported a good working relationship. Second, a focus on ambulatory care had been the health system's general strategy since 2006. Three upper middle managers confirmed this and counted the programs under study as exemplars of this strategy. Third, as described, the programs were revenue generating, meaning they required funds only for start-up expenses. For example, as mentioned above, the HH nurse had already been employed at the same clinic for several years and simply changed function. In addition to senior management support, the health system also had a "very thin layer of middle management" (Upper Middle Manager Population Management), endowing middle managers with considerable autonomy to allocate clinic funds.

Training or differences in worker autonomy may also account for difference. However, all staff reported the prevalence of on-the-job training with speakers from outside being brought in occasionally to discuss various clinical topics such as good nutrition. HighQual included a train-the-trainer model that the NYC-DoHMH CCP mandated. Once per month a CC designated as a trainer led a one-and-a-half-hour training session. However, the session's main benefit was to draw on other CCs' experience. LowQual's team meetings also fulfilled this function (albeit inefficiently due to the Director's hierarchical control) and MedQual CCs also reported drawing on each other's competencies informally. Moreover, the trade union offered training courses for ongoing education but only to nurses and technicians such as x-ray technicians, not to CCs. In terms of autonomy, all CCs described their working as autonomous most of the time. Except for the team meetings and the Operations Supervisor's periodic review of CCs' progress notes and tracking sheets, LowQual CCs decided autonomously how to deal with members, which they likened to a licensed practitioners' autonomy but without corresponding compensation.

The final alternative explanation may be that there were differences in how the trade union acted within the three agencies. The collective bargaining agreement defined the principle

that workers in the same job classification had to receive the same compensation, thus accounting for lacking variation in compensation within CC positions in each agency. Apart from this, however, the trade union did not impact work organization because the collective bargaining agreement did not empower the union to do so.

The trade union was powerful and its delegates effective at challenging management. The senior union official responsible for the health system described the union's power as deriving from the fact that it was "wall-to-wall", i.e. it was the only union covering all health workers there. Moreover, LowQual had a delegate in its care coordination team. This delegate had defended their interests in a separate matter relating to whether positions in a new care coordination program as part of a new policy program were to have the requirement of being degreed or not. Because this decision pertained to a policy program a public policymaker located at the health system, not a manager, decided not to include a requirement of being degreed (so that also LowQual CCs could apply for these positions). The policymaker was unconstrained by any collective bargaining agreement. LowQual CCs had informed the delegate they felt underpaid but the delegate had no recourse because the collective bargaining agreement did not permit the union to demand re-classifications of existing positions, only pay standardization for the same classification. Furthermore, HighQual's Director reported two incidents in the past three years in which a delegate grieved his decisions, including the need to do home visits. However, because the delegate had no backing in the collective bargaining agreement (and there was a safety protocol in place for home visits), the trade union organizer had to concede that the Director was correct, against the delegate.

The collective bargaining agreement stated that jobs had to be announced internally first and HR had to try to fill these positions with union members so that the union had influence over

how recruiting played out. However, managers still retained control over whom they hired as long as they showed that they considered the union candidates fairly for the job. The collective bargaining agreement gave managers full discretion over how to design job requirements, including tasks, the division of labor between jobs, and caseloads. Both Directors were aware of this and used it to their advantage by narrowing their job requirements:

"The union can't tell you how to build a job description…[or] how to build your protocol, they can't tell you what kind of staffing pattern you can have" (HighQual Director).

"When I have an opening, it has to be posted to the union, so I keep trying to narrow down my job requirements, so that I only get what I want" (HH Director).

Therefore, even though the health system was unionized and the union exerted power within the system and the agencies, managers had almost full discretion over the definition of the care model and once they had decided on a particular job design, union delegates, organizers and senior officials were unable to change the design because the collective bargaining agreement granted them no power to do this.

5. Discussion and Conclusions

The purpose of this paper was to understand the conditions that shape the quality of work practices in terms of their skill and intensity as part of the implementation of care coordination programs in three care management agencies. To study these conditions, I chose a research setting relevant to the type of services and population under study (care coordination services for low-income, high-acuity patients). My findings are thus generalizable to similarly resource-poor settings that are usually the focus of care coordination programs.

I identified the existence of an occupational community as a factor that improved the quality of work practices. Only, however, under the condition of a highly intensive regulatory environment did the highest quality of work practices emerge.

Relevant for organizational policymakers are the management decisions that enabled the occupational communities to emerge, even if these decisions were not always taken with the intent of promoting an occupational community. They located care coordination services within clinics with histories of similar types of services and a relevant occupational composition (such as behavioral health and HIV/AIDS prevention); they emphasized extensive, relevant experience in placing staff within such programs; and they raised awareness among other providers regarding the utility and scope of care coordination services through repeated meetings with other providers and through daily involvement in clinic operations. Except for the last point, the fact that the area had a previous history of community support facilitated these decisions because this history of community support resulted in a labor market that included many experienced, non-professional social workers. In areas without a history of community support, the labor market may be more limited in terms of non-professional social workers' experience. Rather than being a set of HR practices that are easily prescribed and implemented, the emergence of a broader social process of occupational community that included supervisors, clinical providers, and CCs working towards the same goal embeds these practices.

The second factor that was present in the clinic with the highest quality of work practices was a highly intensive regulatory environment consisting of clear, occupationally-based standards of work organization; high monitoring requirements and multiple workplace visits per year, managed not through a decentralized but through a centralized structure; and a reimbursement mechanism that provided incentives for higher intensity practices for higher

acuity patients. Relevant for public policymakers were not the priorities to reach broad enrollment and cost-containment but to draw on occupational standards from a community with three decades of experience in a related area and to provide incentives for higher intensity services. This type of design may be more difficult to achieve than an occupational community at the organizational level because it depended on extensive health activism (Altman 1994) that led to Federal and State level institutional support, including the development of care coordination methods and standards. However, where such methods and standards exist, public policymakers should draw on them to achieve more specific standards. For the literature on public procurement high regulatory intensity means that making contract awards conditional on standards is only one aspect of creating a successful policy apparatus: they also require appropriate enforcement mechanisms and incentives. Moreover, not only are regulations dependent on political contingencies (such as the broader institutional support in the HIV/AIDS area) but also on the availability of and public policymakers' ability and willingness to draw on occupational expertise. To the literature on high-performance work systems, I contribute a consideration of the regulatory intensity under which these practices operate and which conditions their success.

Moreover, my findings indicate potential interactions between occupational community (on the workplace level but also more broadly, on regional and political levels) and regulatory intensity. First, an occupational community at the workplace level may provide an additional level of commitment that reinforces a high level of intensity. Second, occupational community on a regional and political level may shape policymakers' choice of the level of regulatory intensity. In these ways, both interactions limit the prioritization of cost-effectiveness, which lowers the quality of work practices.

First, while MedQual's occupational community led to some higher quality practices, only the NYC-DoHMH CCP's higher level of regulatory intensity provided the basis for higher intensity practices such as regular home visits. Moreover, if high regulatory intensity were enough for the highest quality, all NYC-DoHMH CCP service providers would achieve HighQual's level of quality. However, HighQual was only one of few service providers who achieved close to full compliance in recent audits. At both MedQual and HighQual, occupational community provided normative justifications for following high-intensity work practices such as agency visits. However, only at HighQual did the CCP's high regulatory intensity provide the financial incentives necessary for keeping caseloads low enough to sustain the high work effort that high-intensity practices such as frequent case conferencing and home visits entail. By contrast, the HHP's low reimbursement did not permit the low caseloads that are necessary for such high work effort. This means that a workplace-level, occupational community by itself only produces intermediate intensity but high regulatory intensity is necessary to ensure the financial viability of implementing the higher level of intensity that HighQual exhibited.

Second, occupational community at HighQual and the NYC-DoHMH CCP built on a broader HIV/AIDS prevention and treatment community that consisted of State and Federal level institutions and medical and social services practitioners dating back to the beginning of the 1980s. By contrast, the NYS-DoH HHP's background resided more in cost-control by administrative consolidation and the extension of care coordination to the maximum of high-cost and high-needs Medicaid beneficiaries. Despite access to the experience and knowledge of higher standard care coordination programs, the overarching concern of the NYS-DoH HHP administrators was the implementation of cost-containment policies. In this way, the influence of

a broader occupational community may shape whether policymakers' design a program in favor of occupational (instead of non-occupational) aims and standards.

Overall, both social processes of occupational community at the workplace level and occupationally-based standards promoted through regulatory standards serve to limit the negative effect of cost concerns on the quality of work practices. In the absence of high regulatory intensity cost concerns reduced quality to an intermediate level. However, when a workplace level occupational community was also lacking, cost-effectiveness drove down quality to the level that low-standard regulations permitted. In these ways, prioritizing cost-effectiveness lowers the quality of work practices.

The propositions regarding the logical relationship between occupational community and regulatory intensity, their interaction between them, and their limiting effect on cost concerns could be subjects of further research in other resource settings and economic sectors that may yield a broader theory of the explanatory factors that shape the quality of work practices.

BIBLIOGRAPHY

Abbott, A. (1988). *The System of Professions. An Essay on the Division of Expert Labor*. Chicago/London: The University of Chicago Press.

Adler, P. S., Kwon, S.-W., & Heckscher, C. (2008). Perspective—Professional Work: The Emergence of Collaborative Community. *Organization Science*, *19*(2), 359–376.

AIDS Institute. (2013). *AIDS Institute Milestones. 1983-2013*. Retrieved from https://www.health.ny.gov/diseases/aids/general/about/30_years/docs/milestones.pdf

AIDS Institute. (2008). *Background to Revised Standards DOHM AI 08-01*. Retrieved from https://www.health.ny.gov/diseases/aids/providers/standards/designated_aids_centers/revised_standards.htm

AIDS Institute. (2006a). *Issuance of Revised AIDS Center Program Standard 17- Case Management*. Retrieved from https://www.health.ny.gov/diseases/aids/providers/standards/designated_aids_centers/docs/standards_17-case_management.pdf

AIDS Institute. (2006b). *Standards For HIV/AIDS Case Management*. Retrieved from https://www.health.ny.gov/diseases/aids/providers/standards/casemanagement/docs/casemanagementstandards.pdf

Altman, D. (1994). *Power and Community: Organizational and Cultural Responses to AIDS*. London: Taylor & Francis.

Appelbaum, E., Bailey, T., Berg, P., & Kalleberg, A. L. (2000). *Manufacturing Advantage. Why High-performance Work Systems Pay Off.* Ithaca/London: ILR Press.

Avgar, A. C., Givan, R. K., & Liu, M. (2011). Patient-Centered but Employee Delivered: Patient Care Innovation, Turnover Intentions, and Organizational Outcomes in Hospitals. *ILR Review*, *64*(3), 423–440.

Barley, S. R. (1986). Technology as an Occasion for Structuring: Evidence from Observations of CT Scanners and the Social Order of Radiology Departments. *Administrative Science Quarterly*, *31*(1), 78–108.

Batt, R., & Moynihan, L. (2002). The viability of alternative call centre production models. *Human Resource Management Journal*, *12*(4), 14–34.

Behforouz, H. L., Farmer, P. E., & Mukherjee, J. S. (2004). From Directly Observed Therapy to Accompagnateurs: Enhancing AIDS Treatment Outcomes in Haiti and in Boston. *Clinical Infectious Diseases*, *38*(Supplement_5), S429.

Bodenheimer, T. (2008). Coordinating Care - A Perilous Journey through the Health Care System. *The New England Journal of Medicine*, *358*(10), 1064–71.

Brennan-Ing, M., Seidel, L., Rodgers, L., Ernst, J., Wirth, D., Tietz, D., … Karpiak, S. E. (2016). The Impact of Comprehensive Case Management on HIV Client Outcomes. *PLOS ONE*, *11*(2).

Brown, R. S., Peikes, D., Peterson, G., Schore, J., & Razafindrakoto, C. M. (2012). Six Features Of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions Of High-Risk Patients. *Health Affairs*, *31*(6), 1156–1166.

Burns, D. J., Hyde, P. J., & Killett, A. M. (2016). How Financial Cutbacks Affect the Quality of Jobs and Care for the Elderly. *ILR Review*, *69*(4), 991–1016.

Centers for Medicare & Medicaid Services. (2016). Medicaid Health Homes: An Overview. Retrieved from https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/hh-overview-fact-sheet-sep-2016.pdf

Damarin, A. K. (2006). Rethinking Occupational Structure: The Case of Web Site Production Work. *Work and Occupations*, *33*(4), 429–463.

DiBenigno, J., & Kellogg, K. C. (2014). Beyond Occupational Differences: The Importance of Cross-cutting Demographics and Dyadic Toolkits for Collaboration in a U.S. Hospital. *Administrative Science Quarterly*, *59*(3), 375–408.

DiMaggio, P. J., & Powell, W. W. (1983). The Iron Cage Revisited: Institutional Isomorphism and Collective Rationality in Organizational Fields. *American Sociological Review*, *48*(2), 147–160.

Edelman, L. B. (1992). Legal Ambiguity and Symbolic Structures: Organizational Mediation of Civil Rights Law. *American Journal of Sociology*, *97*(6), 1531–1576.

Enthoven, A. (2010). Curing Fragmentation with Integrated Delivery Systems: What They Do, What Has Blocked Them, Why We Need Them, and How to Get There From Here. In E. R.

Elhauge (Ed.), *The Fragmentation of U.S. Health Care. Causes and Solutions* (pp. 61–86). Oxford/New York: Oxford University Press.

Franklin, D. L. (1986). Mary Richmond and Jane Addams: From Moral Certainty to Rational Inquiry in Social Work Practice. *Social Service Review*, *60*(4), 504–525.

Freidson, E. (2001). *Professionalism. The Third Logic.* Chicago: The University of Chicago Press.

Glaser, B. G., & Strauss, A. L. (2010). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New Brunswick/London: Aldine Transaction.

Hall, P. A., & Taylor, R. C. R. (1996). Political Science and the Three New Institutionalisms*. *Political Studies*, *44*(5), 936–957.

Hassett, S., & Austin, M. J. (1997). Service Integration: Something Old and Something New. *Administration in Social Work*, *21*(3–4), 9–29.

Hoffer Gittell, J. (2016). *Transforming Relationships for High Performance. The Power of Relational Coordination.* Stanford: Stanford University Press.

Hoffer Gittell, J. (2009). *High Performance Healthcare. Using the Power of Relationships to Achieve Quality, Efficiency and Resilience*. New York: McGraw-Hill.

Health Resources and Services Administration. (2014a). *Striving for an AIDS-Free Generation*. Retrieved from https://hab.hrsa.gov/sites/default/files/hab/data/biennialreports/2015report.pdf

Health Resources and Services Administration. (2014b). *Ryan White HIV/AIDS Program. Supplemental Client-Level Data Report.* Retrieved from https://hab.hrsa.gov/sites/default/files/hab/data/datareports/2014ema-tgasupplement.pdf

Irvine, M. K., Chamberlin, S. A., Robbins, R. S., Myers, J. E., Braunstein, S. L., Mitts, B. J., … Nash, D. (2015). Improvements in HIV Care Engagement and Viral Load Suppression Following Enrollment in a Comprehensive HIV Care Coordination Program. *Clinical Infectious Diseases*, *60*(2), 298–310.

Jackson, C. T., Trygstad, T. K., DeWalt, D. A., & DuBard, C. A. (2013). Transitional Care Cut Hospital Readmissions For North Carolina Medicaid Patients With Complex Chronic Conditions. *Health Affairs*, *32*(8), 1407–1415.

Kellogg, K. C. (2014). Brokerage Professions and Implementing Reform in an Age of Experts. *American Sociological Review*, *79*(5), 912–941.

Krause, E. A. (1971). *The Sociology of Occupations*. Boston: Little, Brown and Company.

Locke, R., Amengual, M., & Mangla, A. (2009). Virtue out of Necessity? Compliance, Commitment, and the Improvement of Labor Conditions in Global Supply Chains. *Politics & Society*, *37*(3), 319–351.

Locke, R. M., Qin, F., & Brause, A. (2007). Does Monitoring Improve Labor Standards? Lessons from Nike. *ILR Review*, *61*(1), 3–31.

MacDuffie, J. P. (1995). Human Resource Bundles and Manufacturing Performance: Organizational Logic and Flexible Production Systems in the World Auto Industry. *Industrial & Labor Relations Review*, *48*(2), 197.

Marmor, T., & Oberlander, J. (2012). From HMOs to ACOs: The Quest for the Holy Grail in U.S. Health Policy. *Journal of General Internal Medicine*, *27*(9), 1215–1218.

Mayer, F., & Gereffi, G. (2010). Regulation and Economic Globalization: Prospects and Limits of Private Governance. *Business and Politics*, *12*(3), 1–25.

Nembhard, I. M., & Tucker, A. L. (2011). Deliberate Learning to Improve Performance in Dynamic Service Settings: Evidence from Hospital Intensive Care Units. *Organization Science*, *22*(4), 907–922.

New York City Department of Health and Mental Hygiene. (2015). *Care Coordination for People with HIV. Program Manual*. Retrieved from https://www1.nyc.gov/assets/doh/downloads/pdf/ah/carecoordination-manual.pdf

New York State Department of Health. (2014*). Health Homes Provider Manual*. Retrieved from https://www.emedny.org/ProviderManuals/HealthHomes/PDFS/Health_Homes_Provider_Manual.pdf

New York State Department of Health. (2012). *NYS Health Home Provider Qualification Standards For Chronic Medical and Behavioral Health Patient Populations*. Retrieved from https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/provider_qualification_standards.htm

New York State Department of Health. (2011). *A Plan to Transform the Empire State's Medicaid Program*. Retrieved from https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf

Oliver, C. (1990). Determinants of Interorganizational Relationships: Integration and Future Directions. *Academy of Management Review*, *15*(2), 241–265.

Preuss, G. A. (2003). High Performance Work Systems and Organizational Outcomes: The Mediating Role of Information Quality. *Industrial and Labor Relations Review*, *56*(4), 590–605.

Schneider, R. L., & Netting, F. E. (1999). Influencing Social Policy in a Time of Devolution: Upholding Social Work's Great Tradition. *Social Work*, *44*(4), 349–357.

Stokes, J., Panagioti, M., Alam, R., Checkland, K., Cheraghi-Sohi, S., & Bower, P. (2015). Effectiveness of Case Management for "At Risk" Patients in Primary Care: A Systematic Review and Meta-Analysis. *PloS One*, *10*(7).

Sutton, J. R., & Dobbin, F. (1996). The Two Faces of Governance: Responses to Legal Uncertainty in U.S. Firms, 1955 to 1985. *American Sociological Review*, *61*(5), 794–811.

Tampe, M. (2016). Leveraging the Vertical: The Contested Dynamics of Sustainability Standards and Labour in Global Production Networks. *British Journal of Industrial Relations*.

Tolbert, P. S., & Zucker, L. G. (1983). Institutional Sources of Change in the Formal Structure of Organizations: The Diffusion of Civil Service Reform, 1880-1935. *Administrative Science Quarterly*, *28*(1), 22–39.

Dag Olaf Torjesen, Gro Kvåle, & Charlotte Kiland. (2016). The Quest for Promoting Integrated Care in the Scandinavian Countries - Recent Reforms, Possibilities and Problems. In *Towards A Comparative Institutionalism: Forms, Dynamics And Logics Across The Organizational Fields Of Health Care And Higher Education* (Research in the Sociology of Organizations Vol. 45, pp. 195–213). Emerald Group Publishing Limited.

Van Maanen, J., & Barley, S. R. (1984). Occupational Communities: Culture and Control in Organizations. *Research in Organizational Behavior*, *6*, 287–365.

Vogus, T. J., & Iacobucci, D. (2016). Creating Highly Reliable Health Care How Reliability-Enhancing Work Practices Affect Patient Safety in Hospitals. *ILR Review*, *69*(4), 911–938.

World Health Organization. (2014). *Country Statistics: USA*. Retrieved from http://apps.who.int/gho/data/view.main.HEALTHEXPRATIOUSA?lang=en

Xing, J., Goehring, C., & Mancuso, D. (2015). Care Coordination Program For Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs. *Health Affairs*, *34*(4), 653–661.
Yin, R. K. (2003). *Case Study Research. Design and Methods* (3rd ed.). London/New Delhi: Sage.