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LA MAESTRA'S CIRCLE OF CARE: STUDYING THE IMPACT OF AN
INTEGRATED SERVICE MODEL ON THE HEALTH AND WELL-BEING OF
VULNERABLE POPULATIONS

by

Zara M. Marselian

A dissertation submitted in partial fulfillment
of the requirements for the degree of

Doctor of Philosophy

May 2020

Dissertation Committee

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TITLE OF DISSERTATION: La Maestra's Circle of Care: Studying the Impact of an
Integrated Service Model on the Health and Well-Being of
Vulnerable Populations

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DATE: April 7, 2020

ABSTRACT

There is an urgent need to reform the health care delivery system in the United States, as recognized through current bipartisan efforts. Society's vulnerable populations especially need health care reform as health care outcomes are the poorest among disadvantaged populations. Moreover, vulnerable populations are twice as likely to develop chronic diseases than the general population and they remain ill due to other contextual, societal factors affecting their ability to achieve health and well-being. This population is subjected to adverse life events that suggest a more comprehensive approach to health and well-being is called for.

The Circle of Care is a multisectoral health care model provided at La Maestra's health care facility, a federally qualified health center designed to attend to the multiple needs of vulnerable individuals. The medical services are integrated with other social determinants of health: economic development, housing, youth development, legal, immigration, food pantry, community garden, eligibility, and other social services.

The goal of this qualitative study was to identify, through the perspective of patients, the overlapping prior adverse life events that brought patients to the Center and their experiences accessing the Circle of Care services. Data was disaggregated by gender, ethnicity, and age to gain an understanding of how these factors influenced access, engagement with the integrated model and its influence on their health and well-being.

Results from 20 in-depth interviews with La Maestra patients over the course of one year indicate that participants found value in the instrumental resources of comprehensive, integrated social determinants services. The transactional exchange of

social capital facilitated by the Circle of Care professionals empowered patients, increased social connectivity and promoted access to additional social capital resources. La Maestra's network facilitated cultural alignment and trust and provided resources that proved intrinsically valuable to participants in advancing their health status.

The findings provide insights useful to the fields of health care and social work in the development of best practices. Layering services to address the adverse social determinants through an integrated community-based strategy creates opportunity, empowerment and well-being for our most vulnerable populations.

Keywords: vulnerable populations, social determinants of health, social capital

DEDICATION

To God who has inspired me.

To Zygmunt Krylat, Alexei Ochola, and my family who have encouraged me.

To the Boards, staff, and patients of La Maestra Community Health Centers, La Maestra Foundation, and the communities included in this dissertation for entrusting me with this research study.

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CHAPTER ONE

INTRODUCTION

Reforming the health care delivery system in the United States is urgent.

Society's vulnerable populations especially need health care reform, as health outcomes are the poorest among disadvantaged populations (Braveman, 2006). Health disparities persist despite an increased number of federal government initiatives to promote better health outcomes among the less affluent of our society, those who are primarily enrolled in Medicaid and represent 72.2 million individuals (Medicaid, 2019). The United States spent over \$3.5 trillion in health care costs in 2017, including \$600 billion for Medicaid recipients, which is 2.5 times higher than any other country; yet it has not yielded the desired health care outcomes (Brooks & Whitener, 2018).

According to the Organisation for Economic Cooperation and Development (OECD) indicators, life expectancy in the United States in 2017 dropped 2 years below the average life expectancy. Disadvantaged populations are twice as likely to develop chronic disease than the general population and remain ill due to other contextual societal factors affecting their ability to achieve health and well-being (Appleton, Holdsworth, & Kubzansky, 2016). The United States is believed to have one of the largest income-based health disparities in the world. Poor adults in the United States are five times as likely to report poor health than those individuals in other socioeconomic classes in other countries (Adler & Stewart, 2010). The National Research Council and Institute of Medicine (2013) offered potential explanations for the health disadvantage in the United States compared to 16 other comparable high-income countries.

The first difference between the United States and the 16 peer countries included in the study is the fragmented health system in the United States that has limited public health and primary care medical services for the large number of uninsured or underinsured Americans. There are higher poverty rates and income disparities in the United States compared to the other 16 countries. Lack of sufficient “safety net” programs is the third difference listed in the report, which, in other comparable countries, serve to buffer adverse social and economic conditions for vulnerable populations. Stressful environments due to adverse social determinants including unhealthy housing, unsafe neighborhoods, and violence, are among those contextual factors that are more prevalent in disadvantaged neighborhoods in the United States compared to peer countries (National Research Council & Institute of Medicine, 2013).

Bradley and Taylor (2013) found that the United States is spending substantially less (i.e., 10% of GDP) for social services than Italy, France, Sweden, Austria, Switzerland and Denmark, which each spent 20% GDP on social services. For every dollar spent on health care services in these European countries, the United States spent \$0.60 for social services. The aggregate spending on health care and social services in the United States is comparable to that of Korea and Mexico, with the majority of this line item spent on health care services. Health care expenditures and social services is a combined line item in the federal budget in the United States. In contrast, the other 33 industrialized countries listed in the 2007 OECD report spend twice as much funding for social services than health care service expenditures or 30 to 33% GDP on social services (Bradley & Taylor, 2013). In comparison, the United States spends less than half of what 12 other industrialized countries listed in the 2007 OECD report on the aggregate health

and social service expenditures than. Bradley and Taylor's (2013) study established that countries with lower social service spending experience poorer health outcomes than comparable countries that spend more on social services and achieve better health care outcomes. The findings from both the OECD study as well as Bradley and Taylor's study point to the lack of spending for social services—a major contributor to continued health disparities among vulnerable populations in the United States.

Federal initiatives in the United States currently focus on increasing access to medical services with limited consideration for the other social determinants of health. According to the National Institutes on Minority Health and Health Disparities, additional studies are necessary to gain insight into the pathways that help to explain causality between poor health outcomes, social determinants of health (e.g., housing, employment, and social services) and disparities between vulnerable populations and more affluent citizens (Palmer, Ismond, Rodriguez, & Kaufman, 2019).

La Maestra *Circle of Care* is an innovative social service model that integrates medical services and other social determinants of health through one overarching, community-based nonprofit organization (California Health Care Foundation [CHFC], 2020b; Gardner, 2012). The model has been recognized as unique among federally qualified health centers in the United States for its holistic, multidisciplinary approach. This dissertation examines the Circle of Care model through an interpretive lens to gain an in-depth understanding of the participants' ontological paradigms that emerged from their experiences as they accessed three or more services at La Maestra's integrated social determinants Circle of Care model.

Purpose of Study

This dissertation expands on two previous exploratory studies that revealed contextual factors that impact the health and well-being of vulnerable populations. Health care outcomes are potentially influenced when there is an ability to access social networks and increase social connectedness, self-esteem, trust, reciprocity, and hope. Preliminary findings from these two exploratory studies suggest that participants find value in the social connectedness aspect of relationships which is achieved through the social network characteristic of the Circle of Care model. Some of the initial findings also align with the tenets of social capital theory which state that vulnerable populations can access needed resources through the social capital forms of bonding, bridging, and linking. The forms of social capital will be discussed more in depth in Chapter 2. Specifically, the tenets of trust building, social connectedness, empowerment, accessing social networks, reciprocity, increased self-esteem, and hope. This dissertation is informed by these earlier findings and goes further to examine other factors that support and, also, inhibit the creation of improved health outcomes and well-being among a group of clients who sought help at La Maestra.

The purpose of this study is to explore clients' experiences of participating in a health care services initiative that intentionally does not focus on health care services alone but, rather, targets a variety of social factors that potentially contribute to the health of the client and the client's general sense of well-being. In this study, I included an additional fourteen participants in addition to the six of those interviewed in the two exploratory studies, to deepen our understanding of factors that support improved health outcomes and well-being. I focused on the participants' perspective of the comprehensive

care model of La Maestra because the participant lens is a perspective that is often missing from the literature. I collected qualitative data through in-depth, open-ended interviews, questionnaires, and patient or client files from a total of 14 participants. Aside from the convenience factor of accessing services through one overarching, emerging delivery model, I was interested in identifying from the participants' perspective, any value derived from the integration of services offered by La Maestra's Circle of Care model.

Research Questions

The following research questions were used to guide the study:

1. What do patients or clients perceive to be the value of La Maestra Circle of Care integrated model in improving their health and well-being?
2. How does the perceived value vary by participants' gender and ethnicity?
3. What strategies does La Maestra Circle of Care use to address the needs of vulnerable populations seeking health care?

Significance of Study

This research study is important because ill health continues to persist among disadvantaged populations. This dissertation adds important information to the current debate around responsibility for persistent ill health among disadvantaged populations, the extent to which it lies with the individual or is a result of contextual, and the role that societal factors play in the construction of this persistent problem. This study also has significant implications for the practice of medicine by analyzing the influence of a health model that gives participants' access to a variety of social services within the community health center setting, such as housing, employment, food sufficiency, youth

development programs. Finally, the participant lens, often missing from literature, is significant as it provides direct input from patients and clients as to their needs. In this study, participants identify which characteristics and mechanisms from La Maestra’s integrated model have contributed to their health status and well-being. The study provides insight into the intersectionality between population health, a service model integrating social determinants, and social capital.

La Maestra

La Maestra is comprised of two related main nonprofit organizations: La Maestra Family Clinic Inc. (LMFC) and La Maestra Foundation Inc. (LMF). Together they form La Maestra Circle of Care. All of the medical related services are provided through La Maestra Family Clinic’s subsidiary La Maestra Community Health Centers. Nonmedical services addressing social determinants are offered through La Maestra Foundation. The Circle of Care model is an integrated model.

La Maestra Family Clinic’s’ mission is:

to provide quality health care and education to improve the overall well-being of the family, bringing the underserved, ethnically diverse communities into the mainstream of our society, through a caring, effective, culturally and linguistically competent manner, respecting the dignity of all patients. (La Maestra Family Clinic, Inc. Mission Statement, see Appendix A)

La Maestra Foundation’s mission is to “provide and support advocacy and community services that improve the overall well-being of low-income, culturally diverse individuals and families in San Diego and guide them along the path to self-sufficiency” (La Maestra

Foundation, Mission Statement, see Appendix A). Both of these related nonprofit organizations comprise the La Maestra Circle of Care as depicted in Figure 1.



Figure 1. La Maestra Circle of Care model.

La Maestra Circle of Care is a grassroots model comprised of comprehensive primary care and care to address other social determinants of health. Cultural respect is at the core of this integrated, community-based model which provides services in over 30 languages through La Maestra Community Health Centers and its related nonprofit, La Maestra Foundation. For over 30 years La Maestra has evolved from offering English proficiency classes to 12,000 amnesty applicants to prepare for legal residency status

through the Immigration and Reform Act of 1986, to a Federally Qualified Community Health Center (FQHC) to providing 247,000 medical visits to over 50,000 low-income patients annually, with an additional 58,000 nonmedical, social determinants services.

The model was developed in response to contextual needs that were not available to the La Maestra's patient base – a population that faces barriers primarily related to language, transportation, eligibility, and the absence of services existing within the community. The Circle of Care holistic approach makes La Maestra unique among Federally Qualified Health Centers because it incorporates social determinants through an integrated model for its patient and client base. Most FQHC's only provide medical services. Over 600 employees and scores of volunteers operate 17 primary care accredited clinics offering comprehensive medical services including a designated homeless clinic, 10 dental suites, four school-based sites, a mobile medical and dental clinic, a mobile mammography clinic, and a behavioral health substance abuse disorder clinic. Specialty services include a medication-assisted treatment program for substance abuse, a liver clinic, diabetes clinic, pediatrics, obstetrics and gynecology, senior medicine, telemedicine, chiropractic, laboratory, pharmacy, and imaging (La Maestra, 2019). Multidisciplinary, patient-centered care teams collaborate in this primary health care setting through internal as well as external referrals to partnering organizations within the health care field to meet patient needs. Interventions to increase access to needed services include same-day appointments, walk-in services, after-hours care, telemedicine consults, school-based clinics, mobile clinic services, and outreach programs (La Maestra, 2020). Referrals are also made to nonmedical social determinants within La Maestra Circle of Care and to collaborating partner agencies and organizations

developed through 34 years of networking among numerous service sectors. Nonmedical social determinants programs include economic development through job training and placement, Microcredit, microenterprise, legal assistance, immigration, domestic violence and human trafficking assistance, social services, food pantries and community gardens, transitional housing and re-entry services, child and youth development, and various outreach and health education services (La Maestra, 2020).

Ninety-seven and one-half percent of La Maestra's patients and participants are low income and at or below 200% of the federal poverty level. Thirty percent are uninsured, and 70% are Medicaid eligible. Uninsured patients are charged according to a sliding fee discounted rate for services they receive from La Maestra Community Health Centers. The sliding fee discounted rate is established by the federal government and takes into account the family income and the number of members in the household. Please see La Maestra's Sliding Scale in Appendix B.

Populations that La Maestra serve are ethnically and culturally diverse, including immigrants, refugees, veterans, homeless individuals, migrants, victims of human trafficking, victims of domestic violence and violent crime, and the recently paroled. All of these vulnerable populations experience some degree of health, behavioral, or contextual challenges which interfere with achieving health equity, which is defined as "the opportunity for patients to achieve their full health potential" (Centers for Disease Control and Prevention [CDC], 2016, p. 1).

According to a study by Capital Link for 2018, La Maestra provided savings of \$96 million to the overall health system of the United States. The availability of the comprehensive services offered through the clinical programs alone resulted in \$78

million dollars to Medicaid by providing services at 22% lower costs for Medicaid patients. The study determined that La Maestra's economic impact of \$94 million in 2018 included providing 749 jobs, of which 470 were full-time positions through the health center programs and 279 were created in the community. In addition, La Maestra contributed \$10 million to federal tax revenues and \$5 million to state and local tax revenues (Capital Link, 2019; La Maestra, 2020).

As a comparison to La Maestra's sliding fee scale based on the federal poverty guidelines, the City of San Diego's income limit is hereby included which is set by the Department of Housing and Urban Development (HUD) in Appendix C. Patient income levels at La Maestra fall into even lower income brackets than the City of San Diego's extremely low income categories.

Who Are Vulnerable Populations Served Through La Maestra Circle of Care?

La Maestra served the community of City Heights which is located in San Diego County, California. It is a culturally diverse and urban community. According to data from the 2017 American Community Survey, 24.3% of the population of City Heights were living below 100% of the federal poverty level (FPL) and 46% were living below 200% of the FPL, which is much higher than the national average of 32% of the population living at or below 200% of the FPL. La Maestra's populations are at an even lower income level than the federal poverty level with 97% categorized as low income. La Maestra's service area boundaries include 35 zip codes and 283 census tracts in the central, south, and east regions of San Diego, California. The populations residing in the areas served by La Maestra are comprised of Latinos from Mexico and Central and South American countries; Asian refugees from Vietnam, Laos, and Burma; African refugees

from Somalia, Sudan, Congo, Kenya, and other African countries; the refugees from the Middle East including Iraqi, Chaldean, Syrian refugees; Afghani, Pakistani, Russian, Haitian, Cuban, and Puerto Rican immigrants. Additional low-income populations represent as Caucasian, African American, and Other, according to the latest U.S. Census (n.d.). Seventy-seven percent of La Maestra's populations identify as an ethnic or racial minority. Of the 48,545 unduplicated patients (patients counted once per year regardless of the number of visits made by each patient during the year) served by La Maestra in fiscal year 2017-2018, there were 38,768 eligible for public housing, 5,776 identified as homeless, and 15,805 patients were children and adolescents (Capital Link, 2019; La Maestra, 2020).

La Maestra's patients and clients served through the Circle of Care are all classified as low-income. In addition to socioeconomic challenges, they experience disparities due to adverse experiences. Most are ethnically diverse and are nonnatives of San Diego or the United States. Their life experiences are as refugees, immigrants, veterans and their families, migrants, victims of domestic violence, victims of rape, victims of human trafficking, homeless, incarcerated, parolees, and substance use disorder victims. These populations have numerous and complex needs, often experiencing co-existing adverse conditions and requiring high-level case management. La Maestra Circle of Care has expanded over 34 years, developing service areas to address social determinants of health needs. Insufficient resources, eligibility barriers, transportation challenges, and a lack of culturally competent services prompted La Maestra to grow its own service units to meet the needs of these disadvantaged populations (La Maestra Community Health Centers, 2018). The Circle of Care model

employs strategies to approach changes at the individual and structural levels of our society. The individual approach addresses immediate survival needs through comprehensive, integrated services for patients and clients. La Maestra also networks with other nonprofit and for-profit organizations at a local level to leverage needed resources for the populations served. Participation in associations at the local, state, and national levels is another strategy that brings heightened awareness through collective advocacy to the needs of vulnerable populations. Additionally, La Maestra has engaged in direct advocacy through regular visits with elected officials in Washington, D.C., with funding agencies to share emerging needs of the populations served. These efforts include promotion of innovative strategies developed by La Maestra, as well strategies created with community partners through strong collaborative networks with other community-based organizations. These efforts advocate for structural and systemic change through direct advocacy and through speaking engagements at nationwide conferences. The Circle of Care is an upstream, grassroots approach which directly serves vulnerable populations, and serves as a voice for disadvantaged populations among policy makers to influence change and reduce disparities. Through numerous collaborations with other nonprofit and for-profit organizations, La Maestra is a partner within the community to collectively effect positive change at the meso level of society. At the macro structural level of society, La Maestra advocates for vulnerable populations needs and programs through nationwide associations.

The following sections provide further insight into the subgroups of populations served by La Maestra, and some of the challenges that La Maestra's vulnerable populations strive to overcome within their contextual environment. Each problem

overview is followed by a description of services La Maestra has developed in response to these vulnerable populations' needs.

Refugees

The United Nations High Commissioner for Refugees (UNHCR) is the agency mandated to care for the well-being of refugees on a global basis. The agency offers the following statistics on the global trends of refugees worldwide (UNHCR, 2018).

According to the United Nations, there were 70.8 million refugees who were “forcibly displaced due to conflict, persecution or human rights violations”(UNHCR, p.3).

Children constituted half of this number of refugees. The number of refugees is historically the highest number ever reported. Unaccompanied children represented 138,600 of this number. Two-thirds of the world’s refugees came from five countries: Syrian Arab Republic, Afghanistan, South Sudan, Myanmar, and Somalia. Less than 3% of refugees worldwide returned to their native countries.

Most refugees (90%) flee to neighboring countries. The host countries who take in the most refugees are: Turkey, Pakistan, Uganda, Sudan, Germany, Islamic Republic of Iran, Lebanon, Bangladesh, Ethiopia, and Jordan. Protracted refugee situations are those with 25,000 or more refugees from the same country who have been exiled in the host country for more than 5 years. Seventy-five percent of all refugees are protracted refugees.

In 2018, 92,400 refugees were resettled in 25 countries. Canada accepted 28,100 refugees, the United States accepted 22,900, Australia admitted 12,700, the United Kingdom took in 5,800, and France accepted 5,600. The remaining number of refugees awaiting resettlement in host country camps is staggering. Naturalization efforts in 2018

resulted in 62,600 refugees being offered legal residency or citizenship. Turkey offered naturalization to 29,000 refugees from Syria. Canada granted 18,300 refugees naturalization from 162 countries. Naturalization numbers in the Netherlands, Guinea-Bissau, and France were 7,900, 3,500, and 3,300, respectively.

Since the enactment of the National Refugee Act of 1980, the United States has admitted an average of 95,000 refugees per year (United States Committee for Refugees and Immigrants [USCRI], 2019c). The number of refugees accepted for resettlement to the United States has been steadily declining over the last 4 years. In recent years, this number has reduced to 30,000 and the projection for incoming refugees was at 0 for 2020 (USCRI, 2019c). In the September 27 report to Congress, the State Department formally announced that 18,000 refugees will be admitted to the United States in 2020 (USCRI, 2019c). While the 18,000 refugees slated for resettlement in the United States is higher than the early projections of 0 for 2020 (USCRI, 2019c), refugee advocates are critical of the presidential determination. USCRI is among the most vocal critics, stating that these drastically reduced refugee admissions will alter the identity of the United States from a country recognized globally, as welcoming refugees since its founding, to a country that no longer values diversity or cares for displaced citizens of the world (USCRI, 2019c). Others fear that public sentiment in the United States will mirror the presidential determination on refugee admissions for fiscal year 2020 of decreased receptiveness towards incoming refugees, further complicating their acculturation and assimilation process in this country. Will refugees in the United States become stateless individuals? The Global Trends reports have reported that there are 3.9 million stateless individuals for 78 countries (UNHCR, 2018). Stateless people are residents of countries that do not

have equal rights under the law as citizens. They are not counted as legal residents and consequently do not have the ability to access basic services including health care, education, purchasing rights, and legal employment. The rationale provided by President Trump's administration for the decrease in refugee admissions to the United States in 2020 is to prevent terrorists from entering the country and relieve the burden on the U.S. immigration system. The administration is focusing on processing the backlog of asylum seekers at the southern border (U.S. Department of State, 2019a) in response to the humanitarian crisis.

The United States accepted the largest number of asylum seekers from 2017-2018 at 254,300 from 166 countries, with the majority from Central America, Venezuela, and Mexico. Other countries including Peru, Germany, France, Turkey, Brazil, Greece, Spain, Canada, and others also admitted asylum applicants. Of the 1,134,200 asylum applications, over 514,900 were denied or closed. As of 2018, there were 3.5 million asylum applicants worldwide still waiting for adjudication of their cases.

La Maestra's response to humanitarian crisis. On November 14, 2018, La Maestra responded to the humanitarian crisis in California, in collaboration with the Rapid Response Network, to provide medical, dental, and mental health services to asylum applicants entering the immigration custody port of entry at the San Ysidro and Calexico Border. La Maestra's sites are located within 16 miles from the U.S.-Mexico international border. To date, over 3,000 medical, dental, and mental health services have been provided to the families released from Immigration and Customs Enforcement (ICE) detention facilities to a shelter downtown San Diego. La Maestra's medical team

provides trauma informed care, in response to the adverse experiences of asylees over extended period during their long journey to reach the United States.

La Maestra's Efforts for Refugees

La Maestra's sites are located in San Diego, in communities with the largest number of refugees and immigrants in California and one of the largest refugee resettlement areas in the United States. The Circle of Care services have expanded over 34 years to meet their numerous medical and social determinants needs. Many refugees have experienced trauma, abuse, deprivation, and severe hardships in their countries of origin, and in the refugee camps, before arriving in the United States. Large numbers of refugees were first resettled in other states and then moved to San Diego to rejoin family or other ex-patriots where the climate most resembled that of their native countries. To facilitate access to the comprehensive health and social determinants services, La Maestra developed the cultural liaison model to enhance outreach into the culturally diverse communities in San Diego and to assist those newcomers to connect with needed services. Through La Maestra's medically trained cultural liaison (MTCL) model, La Maestra is able to cross-train respected members of the diverse cultures within the community, equipping them with basic medical knowledge so that they can provide translation and cultural interpretation services to patients within a clinical setting. Many of the cultural liaisons also serve as medical assistants, case managers, outreach workers, eligibility assistors, referral technicians, and health educators. To address the linguistic and cultural needs of the diverse populations served, La Maestra is constantly improving its MTCL program to incorporate additional languages and services. Currently, there are over 30 languages and dialects spoken through the cultural liaison program. Over 89,875

translation services were provided in 2018 by cultural liaisons for patients at La Maestra. Cultural liaisons serve as conduits between providers, leadership staff, and patients, to promote improvements in patient care delivery and impart feedback and education about the needs of their respective communities. Cultural liaisons are also employed from within the populations who have experienced: substance use disorder, homeless, veterans, victims of violence, victims of human trafficking, LGBTQ, correctional facilities. Liaisons from these vulnerable populations are represented among La Maestra's staff to facilitate cross cultural awareness and competency. The liaisons are sensitive to the needs of the populations with vulnerabilities as they previously experienced those challenges on a first-hand basis. The liaisons relate to the needs of the patients and clients around access barriers to needed services and advocate for their population's needs.

La Maestra has developed programs specifically to address health conditions commonly found among refugees and immigrants. An example is La Maestra's Liver Clinic, which addresses liver screenings for hepatitis B and other related co-infections (hepatitis C, HIV/AIDS). Through early diagnosis and treatment, undetected liver conditions common among foreign born can be addressed before fatalities occur. According to the Hepatitis B Foundation (2020), hepatitis B affects over 2 billion individuals worldwide and is the main cause of liver cancer. Approximately 1 million global deaths per year are attributed to hepatitis B. In the United States, 50% of the 2 million individuals infected with hepatitis B are of Asian and Pacific Islander descent. African refugees are also at high risk due to a lack of screening during prenatal visits for hepatitis B in many African countries (Hepatitis B Foundation, 2020). Hepatitis B is transmitted to newborns through blood exchange from the infected mother to the

newborn. Unsterile needles and unprotected sex are also ways for which the hepatitis B virus to be transmitted. As the disease is usually asymptomatic until age 40 and above, liver cancers are allowed to develop without detection until the condition becomes severe. La Maestra was alerted to this issue with the influx of refugees from African countries to the City Heights area beginning in the mid 1990s. It is projected that 80,000 Americans will become infected each year (Hepatitis B Foundation, 2020).

For the past several years, La Maestra has operated an onsite Liver Clinic and been an active member of the Hep B United coalition. The Hep B United coalition has been collaboratively addressing hepatitis B health disparities among Asian American, Native Hawaiian and Pacific Islander, and African communities by implementing outreach events, hepatitis B triple panel screening tests, and implementing Project ECHO, a program utilizing a new Fibroscan machine. Moreover, La Maestra has been working alongside the Asian Pacific Health Foundation to improve patient care management and referrals and maintains a collaborative effort to improve hepatitis B-related screening and treatment under the guidance of renowned hepatologist Dr. Robert Gish.

Additionally, La Maestra works with several other community partners to fight liver disease and overcome hepatitis B-related health disparities in the region. These organizations include, but are not limited to, the University of California, San Diego (UCSD), American Liver Foundation, and the County of San Diego. Working with the University of California, San Diego Owen Clinic has led to the development of outreach, screening, and referral protocols for hepatitis B and HIV. With a strong emphasis on improving the quality of life for those with chronic hepatitis B and preventing the spread of hepatitis B, La Maestra conducts community screening days and awareness events and

is in the process of implementing a home visiting program to provide better care for hard to reach populations in the convenience of their own home.

Human Trafficking and Domestic Violence

Human trafficking is defined as:

the recruitment, transportation, transfer, harboring or receipt of persons, by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving and receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs. (United Nations Convention Against Transnational Organized Crime, 2000)

Human trafficking is the third largest crime worldwide, and 30% of the victims are children. Refugees and immigrants are considered to be most vulnerable due to increasing migration patterns worldwide. According to the United Nations, only 10% of human trafficking is detected in Western European countries (United Nations Convention Against Transnational Organized Crime, 2000).

The United States Department of Health and Human Services issued 412 certification letters to adult victims of human trafficking in 2018. The process to qualify as “victims of severe forms of human trafficking” is onerous and sometimes takes years for approval. The Attorney General and the Secretary of Homeland Security are involved in this certification process, which requires the victims to demonstrate, through

documentation and numerous interviews, that they have undergone damaging psychological and physical trauma. Survivors of human trafficking must also agree to assist in the prosecution of or testifying against their trafficker.

Human trafficked victims are not eligible to receive assistance or public benefits of any kind, or be gainfully employed, until their petitions are reviewed, approved, and they are issued a certification letter. According to the United States Committee for Refugees and Immigrants (USCRI), there is no official number of human trafficking victims in the United States (Bena, 2019). Estimates are in the tens of thousands. In 2018, USCRI served over 1,000 survivors with only half of that number receiving certifications. USCRI contracts with many nonprofit community-based organizations across the nation to provide victim assistance including health care, housing, food, and immigration assistance. La Maestra is one of the largest contracted sites for USCRI nationwide and serves the most LGBTQ human trafficked victims in the United States (USCRI, 2019a). In 2017, IOM Counter Trafficking Data Collaborative (CTDC) was established to serve as a central repository site for NGOs dedicated to assist human trafficked victims worldwide. In 2019, CTDC reported 91,416 cases globally. One of the collaborative member organizations, Polaris, reported over 49,000 cases of human trafficking over the last 10 years in the United States (U.S. Department of State, 2019b). According to the U.S. Department of State (2019b), there is a rise in reported cases in the United States among foster children.

La Maestra's Human Trafficking Victim Assistance Program

La Maestra's main headquarters is located in City Heights, the second largest zip code with the largest number of human trafficking victims. La Maestra's human

trafficking assistance program serves survivors of labor and sex trafficking who are low income, at or below 200% of the federal poverty level. Many of these survivors are refugees, immigrants, migrants or unaccompanied minors. The program provides critical recovery services to survivors, including support groups, survivor rights education, legal representation, advocacy, and stipends.

La Maestra aids survivors in rebuilding their lives through access to the organization's comprehensive health care and social determinants programs. These resources help survivors to connect to critical services and resources and provide support to overcome challenges resulting from being trafficked. The program has served over 209 human trafficking clients from 24 countries who have qualified for certification. Seventy-two percent of the clients were sex trafficked and 28% labor trafficked. Thirty-one percent are male, 55% female, and 14% identified as transgender. The human trafficking assistance program has seen over 1,500 clients but only 209 have been able to qualify for certification through Health and Human Services, Homeland Security, and the Attorney General's Office. The program has a large network of collaborating governmental agencies and organizations within and outside of San Diego County that refer clients to the program. Many of the referrals to the program are from other service sectors within La Maestra's Circle of Care. The program relies heavily on the cultural liaisons who serve on La Maestra's staff. The program also provides assistance to victims of domestic violence through a similar service delivery model, with strong collaborations between La Maestra's medical, mental health, and behavioral health programs.

Substance Use Disorder

Substance use disorder is defined as an individual's substance use that has become habitual and leads to failure to fulfill duties in life (e.g., home, school, and work). Substance abuse becomes a pattern that interferes with normal routine responsibilities and is physically hazardous to the individual's health (CHFC, 2020b).

Drug and opioid involved deaths rose by 45.2% between 2016 and 2017 in the United States (CDC, 2019). In San Diego County, the opioid use among individuals 12 and older in 2016 was 171,037, of which 72% were identified as having an opioid addiction and did not have access to treatment. Access to medication assisted treatment (MAT) providers is believed to be a major contributor to the lack of treatment services. According to the 2018 *Adult Arrestee Drug Use in the San Diego Region* report, 74% of adult females had an illicit substance in their system at the time of arrest. This finding is comparable to the rate of males arrested with findings of illicit drugs in their system at 75% (San Diego Association of Governments, 2018). Fifty-five percent of arrestees reported that they were intoxicated with alcohol or drugs at the time of admission for care in mental health facilities. In California prisons, the overdose rate increased by 113% between 2017 and 2018, and, specifically in San Diego Donovan Correctional Facility, the overdose rate increased by 159% (San Diego Association of Governments, 2018).

According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2018), the substance use disorder rate for youth in California in 2017 -2018 was 13%, whereas the disorder rate for adults was 27% and the national rate was 11%. One third of all individuals with a substance abuse disorder also experience mental

illness. Individuals age 18 to 25 are more likely to have co-occurring conditions of mental health and substance use disorders than older adults (CHFC, 2020b).

The reported use of alcohol or drugs among school-age children from grades 7 through 11 has risen dramatically to get high. The majority of teenagers in their junior year of high school reported that they have used alcohol, and one-third reporting that they have used marijuana. Taking prescription pain medications to get high was reported by one out of five junior grade students. Data revealed that alcohol, cough and cold medicine, marijuana, and prescription pain medication were listed as drugs of preference among school children. Cocaine use was reported in ninth grade and rose to 6.4% in the 11th grade (CHFC, 2020a).

La Maestra's Behavioral Health Centers for Hope

La Maestra developed a comprehensive re-entry program in collaboration with all seven local correctional facilities to provide re-entry services for: referrals to onsite mental health and substance abuse disorder treatment, medication-assisted treatment (MAT) for opioid treatment, and comprehensive primary health care including medical, dental, behavioral health (SAMHSA, 2019). The program also addresses the social determinant needs for those released from correctional facilities in the areas of job training, Microcredit, microenterprise, housing application assistance, and eligibility assistance to apply for state-funded health coverage. Legal services are also available onsite. La Maestra operates clinic sites in three local schools and regularly visits other school campuses with the mobile medical clinic. Outreach programs include local schools for drug use prevention and referrals to screening and screening services at La Maestra clinic sites. La Maestra has an extensive network of collaborating partners around

substance use disorder programs, involving all school districts, mental health services, treatment facilities, Child Protective Services (CPS), law enforcement, correctional facilities, and transitional, sober-living housing.

Homelessness and Housing Disparities

According to the U.S. Interagency Council on Homelessness (USICH, 2019), California reported an estimated 129,972 residents who experienced homelessness, or 47% of the total number of homeless reported nationwide. Of the homeless in California, 68.9% were unsheltered. The number of homeless in California shelters is decreasing. Of that total 6,702 were family households, 10,836 were veterans, 12,396 were young adults (ages 18-24), and 34,332 experienced chronic homelessness.

California public schools reported that during the 2016-2017 school year, there were approximately 246,296 public school children who had experienced homelessness (U.S. Interagency Council on Homelessness [USICH], 2019). The children who were unsheltered, or on the streets, was 7,533, and 10,095 were in motels or hotels. The largest number of homeless children, 211,607, reported living in shared occupancies with other people, or “doubling up,” and 17,061 children were living in shelters

Mental illness and substance use disorder are co-occurring conditions among many homeless individuals. The lack of facilities to care for those with severe mental health disorders has increased the number of individuals living on the streets. Individuals suffering from mental health illnesses are often self-medicating through the use of street drugs to manage their conditions because they lack the resources to obtain prescription medication and counseling (USICH, 2019).

Research has linked the high cost of living in California to the increasing rates of homelessness (USICH, 2019). Income inequality in the United States continues to increase, with income for many Americans declining or stagnating despite increasing housing costs. Housing prices and rental rates continue to increase, yet the median household income has not increased to meet the housing costs. The median sales price for attached homes in 2019 for San Diego County was up by 4.8% at \$445,000. California renters pay 40% more than the national mean, yet the state's median household income is only 18% higher than the nation's average (Baldassare, Bonner, Kordus, & Lopes, 2017). Meanwhile, the waiting list for public housing vouchers (i.e., Section 8) in San Diego County is currently 10 to 12 years for new applicants. Each year the applicants must submit updated information to the Housing and Community Development Services to keep their place on the waiting list placements in San Diego (San Diego Housing Commission, 2019; Section 8, 2020).

La Maestra Housing and Housing Assistance Programs

La Maestra provides homeless services through its Centers of Hope program. This model includes medical services specifically tailored for the needs of homeless individuals through comprehensive medical, dental, behavioral, and mental health services and social services integrated with substance use disorder clinics and treatment. La Maestra's first homeless designated clinic, Hope Clinic, was established in 2012, complemented by a mobile medical and dental unit at various homeless camps throughout the city of San Diego. Outreach services to the homeless operate daily throughout the county in collaboration with partner agencies. Substance use disorder services include screening, counseling, and medication assisted treatment. Transitional

housing and sober living are available on-site at La Maestra’s City Heights location.

Housing is part of the recovery program, which also includes job training, legal services, behavioral health counseling, computer literacy, healing through arts, community garden activities, employment opportunities, and music classes. Referrals to transitional housing are made from mental health services, drug court, probation, and other partners in the recovery community and law enforcement sector.

Economic Disparities

According to the U.S. Bureau of Labor Statistics (2018), workers with less than a high school diploma made an average of \$504 per week. Approximately 55% of low-income populations in the catchment areas of La Maestra sites have high school diplomas. Lower wages are related to lower educational attainment (U.S. Bureau of Labor Statistics, 2018). The majority of low-income families are working but do not earn enough to pay for health care costs, rent, utilities, transportation, childcare, food, and other living expenses. In the Latino population, 66.4% of Latinos 16 years and older are working (U.S. Bureau of Labor Statistics, 2019).

La Maestra’s Economic Development Programs

Many of La Maestra’s patients and clients are employed in sectors requiring unskilled labor. These sectors include construction, domestic service, childcare, fast food workers, agricultural migrant work, taxi service, maintenance, and other forms of manual labor. Some jobs are full-time, with the majority working in temporary or part-time employment positions.

The low-income communities where La Maestra has clinic sites are comprised of newly arrived residents who might not have developed ties to strong social networks in

the community because they are new to the area. These populations include refugees, immigrants, victims of domestic violence and/or human trafficking under relocation efforts to escape from their perpetrators, veterans released from military duty, previously incarcerated felons, those in recovery from substance abuse, and low-income families moving to San Diego from other states.

The majority of these low-income populations require job training as they do not have marketable skills to attain steady, sustainable jobs in San Diego. The political climate adds challenges to entering into the job market for a number of these residents in San Diego due to the proximity to the international border with Mexico and the ensuing efforts to curb migration, immigration, and resettlement of refugees and immigrants into the United States. Previous opportunities for application to Homeland Security's Department of Immigration and Naturalization have been greatly reduced for individuals seeking lawful entry, through family petitions, asylum, and other adjudication pathways, to obtain work permits through application petitions for residency. Those with applications already filed in the system are experiencing years of wait time and delays. Actions taken by the federal government to curb immigration have contributed to the challenges for subsets of San Diego's low-income communities to find gainful employment. Many live in fear of deportation, resulting from daily raids by Homeland Security occurring in disadvantaged neighborhoods. Local supermarkets, apartment complexes, elementary schools, local buses, construction companies, local fast food and other restaurants, and local shops are all targets for raids, even sidewalks and main streets are subject to the presence of border patrol agents stopping and interrogating residents of the communities. Regardless of political agendas on the immigration issue, these

residents are living in San Diego's communities. If individuals cannot find employment their health is impacted. Many believe that their immigration status presents health challenges as they are living under constant stress, fear of being stopped by the border patrol, and the fear of being deported. If the main income earner of the family is deported, the economic challenge is overwhelming, leaving the other family members to struggle with attaining the basic necessities to survive.

La Maestra's Immigration Unit

The origins of this unit began in 1986 under the La Maestra Amnesty Assistance program. The services assisted eligible applicants to apply for permanent residency under the federal Immigration and Naturalization Act of 1986. As a Qualified Designated Entity (QDE), under the Immigration and Naturalization Department, La Maestra was also able to assist permanent residents and citizens to submit family reunification applications so that family members could obtain residency status as well. The unit grew to meet the needs for other forms of visas, including political asylum, human trafficking, domestic violence, work visas, deportation intervention applications, J Visas for foreign professionals to work at La Maestra, and other petitions. As the amnesty application opportunity drew to a close, La Maestra continued to assist the community with applications for the remaining pathways to residency and citizenship status. The unit has developed extensive collaborations with other nonprofit organizations and law enforcement agencies over 34 years. Currently, the unit provides the following services at reduced rates (see Figure 2).

| Service Type |
|---|
| Green Card Package (I-130, I-485, I-864, I-765) |
| Petition for Alien Relative (I-130) |
| Adjustment of Status with Sponsor (I-485, I-864) |
| Adjustment of Status (AOS) w/o Sponsor (I-485, I-864W) |
| Fiancé Petition (I-129F) |
| Green Card Renewal (I-90) |
| EAD (Employment Authorization Document) Renewal (I-765) |
| |
| Removal of Conditions on Green Card (I-751) |
| |
| Naturalization (N-400) |
| Certificate of Citizenship (N-600) |
| Replacement of Naturalization Certificate (N-565) |
| Passport Services |
| |
| U-Visa (Victims of Crime) |
| T-Visa (Victims of Trafficking) |
| VAWA-Petition (Violence Against Women Act) |
| Adjustment of Status (AOS; I-485, I-765) |
| DACA (Deferred Action for Childhood Arrivals) Renewal |
| |
| Consular Processing/NVC (National Visa Center) |
| |
| FOIA (Freedom of Information Act) |
| Inadmissibility Waiver (I-601/I-601A) |
| Permission to Reapply (I-212) |
| Application for Travel Document (I-131) |
| |
| Consultation |
| Interview (only if other service)/Infopass |
| |
| I-912 Fee Waiver Request |
| Request for Evidence (RFE) |

Figure 2. La Maestra immigration unit list of services 2020.

Threats to Improved Health Outcomes and Well-Being Efforts

Federal law, through the Immigration and Nationality Act (INA, 1954), has currently undergone a shift in the factors affecting public charge status, which could further impact individuals from accessing health services and other public benefits

(Zallman, Finnegan, & Himmelstein, 2019). The final rule on “public charge” will take effect as of October 15, 2019, superseding the 1999 Interim Field Guidance on Deportability and Inadmissibility on Public Charge Grounds (2019). *Public charge* is defined by the likelihood of foreign nationals to become dependent on public benefits. Several groups of immigrants are excluded from the public charge ruling (e.g., naturalized citizens, asylees, refugees, and survivors of human trafficking or domestic violence; Inadmissibility on Public Charge Grounds, 2019). Currently, if individuals are seeking permanent residency status or applying for family members to join them in the United States, they are prohibited from accessing public benefits in the United States. The INA, however, is proposing to change the definition of public charge and the criteria that immigration officials utilize when making determinations on immigration applications. The new ruling proposes adding to the list of factors for the immigration officers to consider assessing the likelihood of becoming a public charge. Age, health, family status, assets, resources, financial status, education, and skills are now all part of the cumulative assessment for the potential public charge utilization. If the applicants have accessed the public health benefits of cash assistance and institutionalization for long-term care, then they are considered a public charge.

In addition, the federal ruling now proposes expanding the existing two forms of public benefits, which determine public charge to include: supplemental nutrition assistance, Section 8 rental assistance, nonemergency Medicaid, Medicare Part D for medications, and cost sharing subsidies for insurance coverage. In essence, this proposed ruling would classify many as a public charge, making it impossible for them to apply for immigration status for themselves or their family members. More importantly, the new

ruling will severely impact access to health care services or social services for fear of being classified as a public charge.

Under the Accountable Care Communities Act (ACO, 2010), many uninsured individuals were able to qualify through Medicaid and Medicare to receive discounted insurance coverage made possible through subsidies paid for by federal and state mandates. Under the new public charge ruling, enrollment in school lunch programs, Medicaid for children, pregnant women, new mothers, and enrollment in Children's Health Insurance Program (CHIP) will not be considered as public charge. Although subsidized medical insurance will still be available, many predict individuals will not apply for fear of being classified as "public charge" under the new proposed INA definitions. This new ruling is expected to add to the 28 million uninsured rate in the United States and negatively affect 382,000 individuals seeking to adjust their immigration status, resulting in reducing legal immigration by 50% (USCRI, 2019c). Anticipated results include an increase of child deaths and future disabilities, a rise in deaths attributed to a lack of preventative care, a lack of screening and treatment for chronic illness, malnutrition, and other unmet basic assistance to survive (Zallman et al., 2019). Housing assistance programs are also under revision which could adversely impact the living conditions for those with unverified immigration status.

The Housing and Urban Development (HUD) agency of the federal government is proposing similar limitations on eligibility for public housing assistance (Mazzara, 2019). Currently, families with mixed immigration status can qualify. The term "mixed" means that housing assistance is available to families with legal residents, citizens, and family members who do not have legal immigration status, with an imposed prorated assistance

calculation. The head of household or the spouse is not required to have immigration status to obtain housing assistance. The new HUD ruling proposes to change the eligibility criteria to require that all members of the family have legal immigration status verified by the federal government, including families with children who are U.S. citizens. The revisions are expected to add to the adverse living conditions for children and their families who have unverified immigration status.

The State of California recently passed a law to provide medical insurance to all residents in California, regardless of immigration status (Hernandez, 2019). The paradox is that if California, as other states, receives 50-80% of federal funds for health care, then those federal dollars come with the aggressive federal mandates classifying recipients as “public charges” if undocumented individuals enroll in subsidized health insurance plans, regardless of state laws. The only way to avoid the federal immigration laws and public charge ruling would be for the states to fund health insurance subsidies through nonfederal dollars. This option is not viable as the percentage of funds from the federal government to the states is 50-80% of each state’s health care budget.

Overall, the future of health care services in the United States is predicted to negatively affect the health and well-being of vulnerable populations should the 2020 federal budget, as proposed by President Trump’s administration, pass into law. Cuts of \$777 billion to Medicaid over the next 10 years, changing the methodology for block grants to states for health care, and repealing many of the advancements brought about through the Affordable Care Act, will reverse the progress of expansion efforts to serve vulnerable populations. The budget includes severe reductions in housing assistance predicted to affect over 100,000 individuals of which 95% are people of color (Mazzara,

2019), curtailment of food stamps by 30%; and reductions in health care services to vulnerable populations. All of the proposed reductions are predicted to increase income inequality and widen health and racial disparities (Van De Water, Friedman, & Parrott, 2019). As federal assistance and support for social determinants of health continue to decline, the need for economic development programs geared for vulnerable populations becomes even more essential for low-income families to meet basic survival needs. In answer to this escalating need, La Maestra continues to expand economic development programs.

Economic Development

The service area of City Heights and surrounding communities is one of the most underserved, ethnically diverse communities in San Diego County. According to data from the 2014 California Health Interview Survey-Neighborhood Edition (CHIS-NE), 53.1% of adults age 18 and older in the City Heights zip code are foreign-born, whereas only 28.6% of adults in the county and 33.9% of adults in the state are foreign-born. Correspondingly, according to the 2016 CHIS, 36.9% of adult residents in central San Diego, where City Heights and surrounding communities are located, do not speak English at all or do not speak it well. Acculturation is often a long and difficult process, and many City Heights residents struggle to learn English as they search for sufficient income and navigate unfamiliar educational, health, legal, and other systems. Low English proficiency is one significant barrier to securing self-supporting employment, as is the lack of formal education and lack of transportation.

In addition, according to the most recent data in the California Healthy Places Index (HPI), the service area of City Heights, and surrounding communities, ranks

significantly lower than other California communities when it comes to economic conditions, educational attainment, transportation conditions, and health care access (Public Health Alliance of Southern California, 2018). In the region, 71.65% of people have an income at or below 200% FPL, and 36.72% of people age 25-64 are unemployed. Most residents also have low education attainment, as only 10.99% of people over the age of 25 have a bachelor's degree or higher. Additionally, 18.47% of households in the service area do not have access to an automobile and must find other means to commute. Finally, a significant number of residents aged 18-64 are uninsured, at a rate of 39.22%.

La Maestra's Economic Development Programs

La Maestra has developed numerous programs to provide employment training and placement. Assistance is also available to individuals who want to start or expand on their own business.

Job training and job creation. La Maestra has successfully created many new jobs for those in La Maestra's job training programs. Participants have found training and employment working for the clinic in health care positions as medical assistants, dental assistants, case managers, health educators, case managers, patient service representatives, outreach workers, referral clerks, and other supportive positions. Additional job opportunities within the organization, participating in job training include: patient van drivers, couriers, fleet management, facilities maintenance, reconstruction of La Maestra facilities, landscaping, community garden and farmers market coordination, laundry services for La Maestra sites, parking attendants, security, shipping and handling, office supply coordination for sites, coffee cart staff, food pantry staff, outreach, community liaison staff, florists at La Maestra's Blossoms Flower Shop, La Maestra

Printing, youth programs, housing units, and numerous administration positions. Aside from job development and placement activities within La Maestra, there are additional training and employment opportunities with La Maestra's community partner organizations. Examples are: medical certifications for support positions in health care; electrical, HVAC, and plumbing certifications; class C driver's licenses; childcare certifications; food handlers licensing; nutrition and health education certifications; translation training; and others. For those seeking advanced degrees, La Maestra supports tuition and education through federal and state loan repayment programs for those employees desiring to continue their education. Internships and residency programs from local and national medical, dental, mental health, naturopathic, pharmacy, and chiropractic programs through partnering universities and colleges all facilitate job training efforts.

In addition, La Maestra also provides service industry and entrepreneurial job opportunities including those available at the organization's onsite flower shop, linen and janitorial services, print shop, community garden, food pantry, coffee cart, and Microcredit programs. La Maestra selected these job training fields because they are all currently offered within the organization's Circle of Care model.

The organization uses the "Model for Success" as a basis for implementing a peer-to-peer, hands-on curriculum. Program participants undergo a work readiness training program and are provided referrals for additional behavioral health services and additional social services (e.g., transitional housing, food pantry, etc.). During this time, participants can also obtain clothing for job interviews from La Maestra's professional attire closet. La Maestra also offers job training workshops that focus on resume building,

cover letters, interview skills, thank you letters, LinkedIn strategies, and exploring job options.

Microcredit. The goal of the Microcredit Program for Women (MPW) at La Maestra is to empower low-income, immigrant, and refugee women by improving access to credit and banking and financial literacy. Microloans are offered to women who do not have collateral or credit history to help them establish and grow their own small business. The program facilitates weekly meetings and coordinates guest lectures to cover topics such as opening a bank account, establishing personal savings goals, and developing business plans to receive microloans. Many of the women in the program are heads of household, caregivers, survivors of domestic violence or human trafficking, active seniors in recovery for substance abuse or previously incarcerated. Most have low English language proficiency and minimal marketable skills. All of these factors, added to the challenge with immigration status, results in difficulties for these women to find employment. Therefore, the women in the program lack the resources and confidence in their ability to achieve upward mobility. The program provides participants with the skills needed to attain financial independence, build confidence, and achieve self-sufficiency. Access to transportation, additional education, certifications, business mentors, and marketing and product display informational sessions are just some of the many items that La Maestra provides through grant funding for the Microcredit women.

Participants in the program sell a variety of handmade goods such as food items, candies, jewelry, clothing, tablecloths, beauty products, and purses made from recycled materials. However, even with the microloans they receive, many women need to save money for some time before they are able to purchase the items they need to transport

and display their goods. Most participants in the program do not have their own means of transportation. Until their businesses can afford to purchase vehicles, La Maestra provides transportation to participants.

La Maestra leverages collaborating organizations to include La Maestra Microcredit vendors in their events, community fairs, art exhibits, and annual events. Utilizing La Maestra's vast network of partners creates pathways for Microcredit participants to sell their products in the macrosystem or wider society, outside of La Maestra's mesosystem. Additionally, participants gain access to the wide range of primary care and social services that La Maestra Circle of Care offers.

Job placement. In 1998, La Maestra was the recipient of a \$6 million Office of Refugee Resettlement (ORR) grant in which the organization conducted a workforce program that provided job placements for 274 African refugees. In 2002, La Maestra Works was funded in the amount of \$700,000 for a 2-year job readiness program. The program provided jobs for 120 low-income minority women in the health care field. Based on the success of the ORR funded programs, La Maestra received additional ORR funding in 2003 for the organization's Jobs-4-You program. Jobs-4-You helped refugees transition into permanent, full-time employment. The organization's successful, federally funded programs led La Maestra to open a Job and Training Center (JTC) in 1998. In the program's first year, La Maestra trained and placed 300 immigrants and refugees in service sectors in San Diego utilizing established links with collaborating organizations. Placement sites included local school cafeterias; Headstart programs; nursing homes; hospital laboratories; managed health care organizations; local banks; home health agencies; Women, Infants, and Children (WIC) supplemental nutrition programs; local

YMCAs; property management companies operating Section 8 low-income housing units; and local restaurants. La Maestra continued to grow this program, leading to additional employment partners, expanding economic development in San Diego for vulnerable populations who are considered to be “the hardest to place” by the Office of Refugee Resettlement.

La Maestra was one of ten organizations nationwide to receive this grant and deemed to be the only successful program of the ten. The grant was extended to 7 years. There were three main differences between La Maestra and the other nine grantees, which attributed to this success. La Maestra’s extensive multisectoral network allowed for the program to take advantage of existing ties through years of collaboration and trusted relationships. Convincing partners to employ refugees and immigrants was made easier for La Maestra due to the long-term existing relationships. The second difference, which was pivotal to La Maestra’s success, was the strong relationship with immigrant and refugee communities in San Diego. La Maestra already had years of demonstrated service to these populations, not only by providing medical and social determinants services but also by employing them. Refugees and immigrants have also served as members of the La Maestra Board of Directors since 1986. These established linkages with refugee and immigrant residents built trust and created willingness on their behalf to participate in the job training and placement program. The third factor which led to successful outcomes of the program was that La Maestra was the only grantee out of the 10 that was already involved in the target community providing immigration assistance for amnesty, offering English as a second language, vocational training, preschool programs, youth development, housing assistance, food pantry, and medical services. The

other nine grantees were not already established as providers of service to the community, so they lacked the ties to the target community and the collaborations with potential employment sites to leverage. Without an existing presence in the community, it was impossible to place refugees and immigrants into new job opportunities. The job placement program has continued at La Maestra despite limited funds to support the program. This example speaks to the established networks that La Maestra has formed across sectors.

Youth Development Programs

As La Maestra recognized the need for additional youth and family services, the organization expanded the La Maestra's Circle of Care by developing an intergenerational community center, Generations, through La Maestra Foundation. La Maestra's Generations program was established in 2005 to provide youth development and socialization services for at-risk youth and seniors: the two marginalized subsets of vulnerable populations in City Heights. Participants include at-risk youth, seniors, and survivors of domestic violence, human trafficking, substance abuse, and victims of assault. The youth services encourage students to graduate high school, apply to college, and offers opportunities for civic engagement. Generations has sustained its youth education programs through private foundation funding, including the Verizon Foundation and the California Endowment, and through La Maestra operating budget allocations. The senior participants assist with the youth programs and have dedicated classes for sewing, floral design, crafts, jewelry making, music, dance, yoga, and art. The Generations program offers healing through cultural arts and has subcontracts from the City of San Diego to design three community artworks in public areas showcasing the

cultural diversity in City Heights through the preservation of cultural art techniques and culturally diverse gardening and cooking. Youth empowerment and leadership skills are included in the curriculum to encourage civic engagement and environmental sustainability. The program collaborates with other youth development organizations throughout San Diego, including those that promote art, music, environmental justice, science, academics, and self-care.

La Maestra has also developed and successfully implemented “La Maestra Model for Success,” to prepare candidates for employment. The model uses mentorship as a basis from which to build communication and trust while improving overall attitude and workplace behaviors, therefore increasing employability. Through active mentorship and case management, participants are able to learn about themselves, identify future goals, and develop required skills to succeed in the workforce. Participants attend weekly meetings with the program manager and peer groups with fellow participants for support and connections to resources.

Food Scarcity and Food Deserts

Food deserts are defined by the federal government as being located 2 miles or 15 minutes away from a grocery store. Many low-income communities are lacking in sufficient, affordable, nutritious food. Food swamps are referred to as food desert communities with a high density of fast food and junk food (Cantu-Pawlik, 2018).

Residents in low-income communities typically pay more for groceries, spend more time traveling to distant supermarkets, leading to lower fruit and vegetable consumption, increased fast food consumption, and higher childhood obesity. J. Crowe, Lacy, and Columbus (2018) noted a clear association between the presence of

supermarkets and lower obesity rates. Convenience stores and neighborhood fast food outlets, on the other hand, were associated with higher rates of obesity and chronic disease (J. Crowe, Lacy, & Columbus, 2018).

According to the 2017 California Health Information Survey, 37.8% of those living at 200% or below the federal poverty level identified as unable to afford a sufficient amount of nutritious food to feed their family (California Food Policy Advocates, 2019). The same study cited that 38.3% of the population currently utilizes CalFresh, California's food assistance program (SNAP). Even though this may seem like a promising number, many still struggle to regularly provide enough food for themselves and their families due to transportation challenges to the few large supermarkets in the region yet, there is an abundance of liquor stores and small food markets with limited fresh produce at affordable prices. Furthermore, Joassart-Marcelli, Rossiter, and Bosco (2017) conducted a study that revealed only 62% of grocery stores participated in public assistance programs. The few food markets and liquor stores that do accept food stamps usually carry snacks and other less healthy food options than the fresh fruits and vegetables available at large supermarkets and grocery stores. Low-income neighborhoods have one-third as many supermarkets as higher income communities yet have many more fast food restaurants and liquor stores (Ramirez, 2016).

La Maestra's Healthy Foods Program

La Maestra has the following nutrition related programs. The Healthy Choices Food Pantry was opened in 2005 to increase access to nutritious foods for low-income patients of La Maestra Community Health Centers. Collaborations with Feeding America and the San Diego Food Bank allowed La Maestra's Healthy Choices Food Pantry to

distribute over 180,000 pounds of nutritious food products free of charge to low-income patients and their families in 2018 (LMFC, 2019). The organization also operates a community garden and collaborates with several farmers' markets to facilitate the sale of harvested produce and potted plants by families who cultivate plots within the community garden. Others farm the plots for private consumption. Children from the youth program are also engaged in community garden activities for science projects including composting and planting. Seniors in the Generations and Microcredit programs participate in growing herbs and flowers for La Maestra Blossoms, as well as fruit and vegetables to supplement their nutritional intake. La Maestra is committed to expanding the community garden project to improve healthy food options in a food desert.

The Healthy Choices Food Pantry is complimented by the health education program at La Maestra, which offers healthy living classes to assist patients with chronic conditions such as diabetes and cardiovascular disease. Obesity prevention for children and their families is another function of La Maestra's health education program coordinated by licensed nutritionists who are culturally competent. Nutritionists offer recipes with affordable and nutritious ingredients in addition to individual nutrition counseling for patients and their families. Prenatal patients, the elderly, and other patients also take advantage of health education. Classes are open to all interested individuals and are geared towards providing linguistically and culturally appropriate food alternatives and advice.

Physical activity is a component of health education and nutrition counseling for the prevention, screening, and treatment of chronic disease. La Maestra offers exercise, yoga, and gardening classes within safe areas of La Maestra facilities. There are few local

organizations promoting physical activity in secure areas of the community.

Unfortunately, City Heights and other locations in the city of San Diego, where La Maestra sites are located, experience high crime, violence, gangs, and high drug abuse. Safe parks and open areas for children to play are lacking. Seniors are also challenged by the ability to walk freely in low-income communities as they are concerned for their safety.

Community Outreach

In addition to health education, La Maestra currently has an established Promotores de Salud program. The group currently consists of community health educators, all of whom are bilingual. These women are from the communities served and provide care in a culturally and linguistically competent manner. Currently, the promotoras promote clinic services including breast and cervical cancer screenings. In promoting these services, the promotoras also explain other services available at the clinic, such as well-child exams, the importance of obtaining preventive health annual visits, and eligibility and application assistance for public assistance programs. The existing volunteers have the ability to conduct outreach to ethnic populations because the promotoras reside in the same community and are from the same ethnic populations. They have established relationships and existing contacts, and their outreach efforts are tracked each month and reported to the clinic. In 2018, promotoras provided over 38,000 outreach and promotion services, more than half of which were administered to patients that identified as Latino. Cultural liaisons from La Maestra's cultural liaison program are also cross trained in health promotion or "promotora" functions to promote prevention

and screening for chronic disease, build awareness within the culturally diverse communities, and link them to available medical and other social determinants services.

Summary

This introductory chapter has offered a guiding framework for understanding how vulnerable populations are served by La Maestra based on their contextual needs. A background of the populations introduces the reasons that prompt vulnerable populations to seek social determinants services. The comprehensive summary of those services through La Maestra Circle of Care provides a framework to comprehend perceived values identified by the participants in the research study, which they believe have contributed to their improved health and well-being.

The pathways that participants take to garner needed resources is also significant to this dissertation. Chapter 2 explores the bodies of literature that provide an in-depth understanding of why vulnerable populations continue to experience disparities in health and well-being, as well as theories that explain how to improve health care outcomes and quality of life. The literature review provides direction for the methodological development of this qualitative research study, which is guided by the research questions. Chapter 3 identifies the methods used to gather data from the participant perspective on the potential value of the La Maestra Circle of Care model as it pertains to participants' improved health outcomes and factors influencing their quality of life. Chapter 4 presents the findings from the research study according to themes and patterns that emerged from the data. The last chapter, discusses the research findings, provides a summary and conclusion, and offers suggestions for further research.

CHAPTER TWO

LITERATURE REVIEW

This chapter reviews literature that is relevant to the study. There are six sections. The first section offers an overview of vulnerable populations, why they are vulnerable, and how disparities resulting from contextual factors affect their health and well-being.

Research on health care among vulnerable populations typically falls into one of two camps: blame for ill health is placed at the individual level—a blame the victim attitude—advocating primarily for prevention, exercise, and nutrition or blame for ill health is placed at the societal level with social determinants viewed as the cause. Both bodies of literature are examined in this second section.

The third segment of this chapter explores the social determinants of health, such as housing, economic development, food sufficiency, youth development, immigration assistance, and a variety of social services. Social determinants of health are at the forefront of population health agencies in the federal government and abroad in discussions about the root of ill health among vulnerable populations. This section also includes an exploration of the nebulous term *well-being* as the goal for vulnerable populations.

The fourth section describes health care models, which have attempted to address social determinants of health, and their level of integration. This analysis is important to this study because it reviews the degree of implementation of social determinants into the health care sector and reported outcomes to date on resulting improvements to patient health and well-being due to these efforts.

The fifth section of this chapter explores research on social capital theory, specifically its three forms of bonding, bridging, and linking. Because the attributes of social capital have emerged in the exploratory mini studies leading up to this dissertation, this section includes a review of social capital theory, Putnam's (1993) explanation of social capital and the critiques of his theory, and expansions on the theory conceptualizing how social capital can be applied in understanding the field of health care. Research has examined how social capital measures have been applied in different settings, but very few have addressed how social capital concepts may explain factors that support or challenge health care. This dissertation will explore the literature and attempt to determine the ways the three forms of social capital (i.e., bonding, bridging, and linking), as described by Lin (2001), have been found to influence individuals' improved health and well-being.

The sixth section of the chapter describes the process through which vulnerable populations could acquire social capital and the transactional exchange potentially involved in securing social capital for needed resources by vulnerable populations. The section concludes by presenting the framework for this new expanded study by identifying where there are still possible gaps in the literature around the social capital and health, and the exchange of social capital.

Vulnerable Populations

One key body of literature that helps inform this study is the research on vulnerable populations. The Medicaid population is considered the largest vulnerable group in the United States. Medicaid is the largest insurer for over 74 million of the lowest-income, vulnerable people in the United States (Brooks & Whitener, 2018),

representing approximately 16.4% of total health care expenditures. Medicaid insures low-income individuals, individuals with disabilities, and nursing home residents. States receive 50-80% of their respective health care program costs from the federal government, determine which services will be covered, and set the payment modalities for providers of medical services. Populations are typically defined as vulnerable because they do not have the contextual and psychosocial resources that are available to individuals from higher socioeconomic classes when faced with stressors in life (Ahern, Galea, Hubbard, & Karpati, 2008). Numerous population health researchers believe that vulnerable populations are at a higher risk for health-related issues, such as chronic diseases, because of contextual factors embedded in their environment (Cockerham, 2013; Davidson, 2014).

Vulnerable populations are twice as likely to develop chronic diseases than the general population because poverty is directly connected to health disparities (Appleton et al., 2016). Braveman (2006) suggested that health, food, and shelter should be considered human rights as they represent fundamental economic, social, and cultural needs. These resources are derived from wealth, power, and prestige lodged within the social classes. Roffey (2013) stated that these resources often exclude vulnerable populations. She posited that vulnerable populations tend to reside in substandard housing, in federally designated food deserts, and in communities with high crime rates. These populations lack access to rewarding and well-paid employment and access to safe spaces for their children to play or engage in youth programs (Roffey, 2013). Stressors are much more significant for low-income populations, which make them at risk of

developing health issues. Long-term exposure to these stressors and adverse life experiences, including trauma and violence, exacerbate the problem.

I will focus this study on the health and well-being of vulnerable populations that are typically part of the 65.6 billion individuals who are low-income Medicaid recipients (Medicaid, 2019). There is much literature on this demographic because the federal government maintains health care statistics and health care outcomes of Medicaid recipients. The size of the population, the severity of the concern, and the availability of data allow a closer examination as to the reasons behind their health vulnerability (Shi & Stevens, 2010). There have been numerous studies on the health characteristics of vulnerable populations, health problems, and clinical outcome measures. Descriptions of vulnerable populations as defined by the federal government and an overview of disadvantaged populations served by La Maestra were detailed in Chapter 1. These include refugees, immigrants, migrants, veterans, victims of human trafficking, victims of domestic violence, victims of violent crime, parolees, substance abuse victims, homeless individuals, elderly individuals, and other subsets of vulnerable populations.

Health inequities are especially significant among racial and ethnic groups (Hoyert & Xu, 2012). Health equity issues are believed to be complex and multifaceted, involving more than medical services and public health sectors (Diehr, Jordan, Price, Sheu, & Dake, 2017). There is some debate as to why racial and ethnic populations are vulnerable. The research questions guiding this dissertation study focus on identifying factors necessary for vulnerable populations to achieve well-being in the United States. Access to medical services and the provision of health insurance was thought to be the answer 20 years ago resulting in the lack of preventative health services leading to

illnesses (Bradley & Taylor, 2013; Shi & Stevens, 2010). More questions to consider include: Do the causes of illness lie beyond the individual level? Are the causes of poor health only medically related?

Explaining Poor Health Among Vulnerable Populations

There are differing views about where responsibility lies for persistent poor health among vulnerable populations. One group, namely U.S. federal government agencies, believes that the onus of responsibility is on the individual, focusing initiatives on behavior change and prevention (Marmot & Wilkenson, 2006). This victim-blaming argument points to the individual's need to change their behavior for their health outcomes to improve. If an individual's health conditions are perceived by the public as a result of their behavior, like substance abuse, they carry the stigma of sinners versus victims, garnering less compassion from the public (Shi & Stevens, 2010, p.17). The opposing argument is that social conditions have led to increased stress, causing individuals to self-medicate and categorize substance abuse as a disease (Mechanic & Tanner, 2007). The National Institutes on Minority Health and Health Disparities suggested that social stresses cause poor health and conducted studies on the embodiment of social stresses caused by adverse social determinants of health and their direct impact on the body resulting in poor health outcomes (Palmer et al., 2019).

For many years, health care policies in the United States have focused on modifying risk behavior at the individual level, with an emphasis on prevention. Some researchers believe that a shift needs to occur, moving the blame away from the individual level to focus on the root causes at the macro level that influence behaviors (Cockerham, 2013; Marmot, 2007; Rose, Khaw, & Marmot, 2008; Wilkinson, 2002).

Rose et al. (2008) viewed health-related problems as symptoms of root causes within society that are being addressed through a high-risk palliative approach, equating to a “band aid solution,” instead of on equity solutions. Studies have been conducted in countries with national health care to determine if there are causal relationships between socioeconomics and wellness (Davidson, 2014). Davidson’s (2014) findings reveal that as long as there are vast differences between income-levels among social classes, health status continues to be poorer among low-income populations.

Affluent societies have health gradients. Psychosocial determinants of social status or rank are thought to determine the differences in health between social classes (Rose et al., 2008). This might explain persistent poor health status among low income populations residing in England for example, despite a national health care plan which has been in existence for over 60 years. Challenges of access and inability to pay for medical services are addressed through national health programs but do not seem to be addressing the root causes of increased and persistent health conditions among low income populations. The United States spends an increased amount of funding on health care services compared to England, and most economically equally developed countries, yet has historically invested very little funding for social services focused on contextual needs, including nutrition, housing, education, the environment, and unemployment support (Organisation for Economic Co-Operation and Development [OECD], 2017). Many researchers believe this lack of attention to issues connected to health care is the main reason why health outcomes continue to be poor among vulnerable populations in the United States despite increased medical services (Bradley & Taylor, 2013).

Individual well-being is determined by how contextual variables interrelate at different levels of society and social classes. Davidson (2014), Metzler (2007), and others stated that a multidimensional framework is necessary to really understand the complex interdependencies between the individual, systems, and health outcomes. To identify the dynamics of the interdependency theory we must look for a bridge between the sectors and pathways that connect vulnerable populations to resources that reside within the macro level of society.

Several authors have suggested that needed resources for vulnerable populations reside in at the macro level of societies, including those resources which address the social determinants of health. These factors are argued to be at the root cause for why health care outcomes have not improved and have even declined, despite increased government spending of \$3.3 trillion annually for health care, including \$600 billion for Medicaid recipients (Brooks & Whitener, 2018). Individuals living in poverty are more likely to encounter social, psychosocial, and physical factors that are associated with increased morbidity and mortality than populations with higher income levels such as middle and upper classes. The poor lack protective social support or resilience to withstand adverse social determinants of health (Palmer et al., 2019). Minority groups are even more at risk of living in poverty, and the impact is much higher as they are often exposed to these factors over the course of their lives (Holt, 2007). For this reason, initiatives that address the social and economic factors of vulnerable populations are considered more important when creating health care delivery systems. These factors have led to criticism of the health care system in the United States for focusing specifically on medical services rather than addressing structural problems related to

economic, social, and environmental issues faced by vulnerable populations (Brooks & Whitener, 2018). Interventions on the individual behavior level have been the focus in the United States and have guided health policies that center on risk behavior, nutrition, and physical exercise (Bradley & Taylor, 2013; Rose et al., 2008). Unfortunately, evidence from the literature shows that the individual-focused strategy has been proven to be ineffective in meeting the World Health Organization's (WHO, 2012) definition of health as "the state of complete physical, mental, and social well-being" (para. 5).

A Culture of Health Theory: Societal Causes or Social Determinants of Health

When considering the poor health of vulnerable populations, whose fault is it? Those espousing the opposing view, place the blame on societal forces and contextual environments impacting the individual, link health disparities to adverse social determinants of health. Structural functionalist theory emphasizes the importance of social structures that have greater influence on determining health beyond individual behavior (Cockerham, 2013; Golden & Earp, 2012). According to Berkman, Glass, Brissette, and Seeman (2000), "Macro-level structures are formed by an integrated system of different facets of society, formed by norms and values of its inhabitants in order to promote a balanced order, integration and stability" (p. 128). Functional society can be measured by how compliant individuals are to the established social order. Conversely, dysfunctional societies are evidenced by crime rate and disorder. Of note, sickness was thought by Parsons (1963) to be a sign of a dysfunctional social process. Durkheim (1984) made the link to contextual influences through his work on suicide. He found that there are social forces outside the individual's control that affect their health and lead them to commit suicide (Berkman et al., 2000). Although Durkheim (1984) did

not provide the term, it is believed that he was describing social determinants of health. Parsons (1951) took the theory further to embrace medical sociology, still within the structural functional framework following Max Weber's work on sociological factors and suicide (Lazarfeld & Oberschall, 1965). All of these researchers believed that individuals have very little to do with shaping the social process as it relates to health.

Functional theorists provided a great framework to explain why change must be enacted at the structural level but did not address the process through which change occurs, how changes can occur, or the roles that individuals play in the change process. This view speaks to the broader structural issues at the macro level with upstream implications for economics, politics, physical environment, and access to health care services (Palmer et al., 2019). Social and environmental factors including low education, racial segregation, low social support, poverty, income disparities, area level poverty, and neighborhood disadvantage are believed to be linked to the social conditions which create disease and health disparities (Galea, Tracy, Hoggatt, DiMaggio, & Karpati, 2011). Galea et al. (2011) estimated that, of the number of individual deaths in 2000 in the United States, 741,000 were attributed to social and environmental causes, similar in number to the deaths caused by disease, injury, and behavior. These findings led the researchers to advocate for the Public Health Department and each state's Office of Minority Health to focus on expanding the traditional medical service model which concentrates on changing individual behavior to a model that adds social and environmental services (Diehr et al., 2017; Galea et al., 2011).

The WHO (2012) offers a global lens for identifying the primary cause of existing disparities among vulnerable populations. According to the WHO, disparities are caused

by political forces that distribute power, money, and privilege unequally among the various social classes of society in every given country.

People who take the stance that society is responsible for remedying health care inequalities call for a macrosystem shift, to build a culture of health for vulnerable populations to achieve well-being. Such upstream approaches are believed to yield a more significant and lasting impact on reducing health disparities among vulnerable populations. Figure 3 depicts a conceptual framework of factors contributing to the health and well-being of vulnerable populations (Evans & Stoddard, 1990). To accomplish a culture of health, health delivery models would require linking public health to social and environmental disciplines (Braveman, Egerter, & Mockenhaupt, 2011).

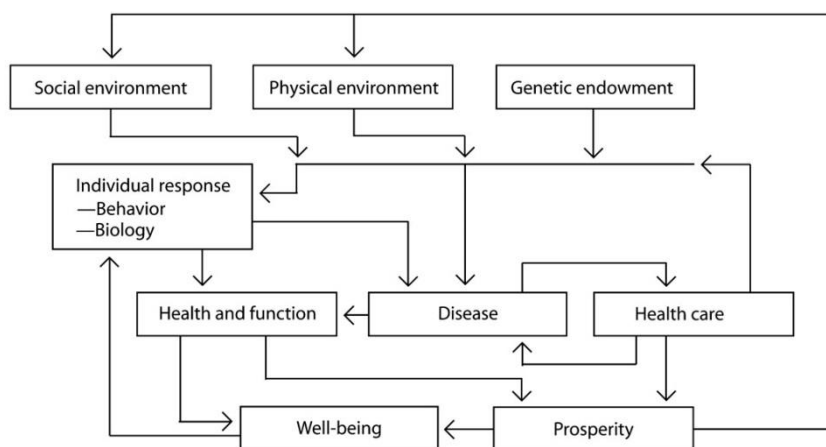


Figure 3. Conceptual framework for patterns of determinants of health. From “Producing health consuming health care,” by R. G. Evans and G. L. Stoddard, 1990, *Social Science Medicine*, 31, 1347–1363. Copyright 1998 by Elsevier Science, Ltd. Reprinted with permission.

There is a disagreement in the literature about where the responsibility lies for implementing services addressing social determinants for vulnerable populations. Diehr et al. (2017) are of the opinion that the Public Health Administration of each state should expand their focus to include social and environmental services. This would require policy changes and designated funds to support nonmedical services through the Public Health Administration of each county. As yet, no such shift has occurred. Braveman and Gottlieb (2014) conducted a study among the state offices of minority health to ascertain the degree of focus on contextual factors for the health and well-being of ethnic minorities in each state. They argued that the responsibility for implementing services that address social determinants for vulnerable populations should reside with the state offices of minority health. The study included 50 states, of which 41 state minority offices responded to the survey. Eighty-nine percent of the activities of state minority offices focused on activities around disease prevention. Fifty-one percent of respondents reported supporting health fairs, health education training, and the provision of materials. Twelve percent of the offices surveyed listed social marketing among their activities, and 11% reported involvement with developing funding initiatives to support additional minority health professions. The highest priority need identified by the Office of Minority Health for ethnic minorities was access to needed health care services. Of the 41 states participating in this study, the top six strategies perceived to reduce health disparities all focused on changing individual risk behaviors (Braveman & Gottlieb, 2014). As such, these 41 states were focused on healthy eating, increased exercise, prenatal care, elimination of substance abuse, mental health, and HIV testing. When questioned specifically about social determinants, officers in the state minority health

offices responded that the most impactful strategies would be through increasing access to care and higher quality education. Braveman and Gottlieb (2014) found that although the responding officers seemed to understand the need for social determinants services, their allocation of time, funds, and activities did not align with their stated beliefs around the need for social determinants services. The researchers concluded that Public Health Administration and Office of Minority Health departments in each state continue to be driven by downstream approaches, focused on disease prevention and education. Until states adopt more upstream strategies, it is unlikely that systemic, macro level changes will occur to incorporate social determinants services.

There is evidence that social determinants of health, these wider social factors, are rising to the attention of policymakers at the national level in the United States, driving initiatives around disease control emerging from the CDC (2016), through their “Healthy People 2020” initiative, and the Centers for Medicaid and Medicare (CMS, 2020). Despite this increased attention, the focus on remedying the poor health of vulnerable populations remains on initiatives that place the responsibility on the individual for improved health and well-being (Mechanic & Tanner, 2007). Such initiatives center on behavior modification and reduction of risk factors, such as smoking, obesity, substance abuse, and other lifestyle changes. These initiatives also do not take into consideration the underpinning societal stressors contributing to risk-seeking behaviors, such as those acknowledged by the United Kingdom or Canada, including socioeconomic status, social connectedness, and equalities in jobs, housing, and social networks (Marmot & Wilkenson, 2006). We see through the literature that the United States prioritizes select social determinants differently than other countries.

At the federal level, the CDC (2016) has defined the social dimension of environment as the economy, employment, education, political, environmental, housing, medical services, governmental, public health, psychosocial and behavioral health services, and transportation with subsets for each category. Subsequently, the CDC issued five social and individual determinants of health centering around biology, genetics, individual risk behavior, social environment, and physical education (CDC, 2016). Biology, genetics, and individual risk behavior are at the top of the list, indicating that the CDC is still focusing its efforts at the individual level while giving some nod to factors in the social environment. Other determinants of health arise from communities, social institutions, and systems at the cultural, environmental, political, and economic levels (Brooks & Whitener, 2018).

The vision established for *Healthy People 2030* by Health and Human Services (HHS), through the Office of Disease Prevention and Health Promotion (2020), focuses on improving health and well-being for all to reach their full potential across their lifespan. The initiative acknowledged the OECD indicator findings that key measures of health and well-being for the United States are below other developed countries, including measures for life expectancy, obesity, and infant mortality. This is despite the United States having the highest GDP spending on health services. The foundational principals driving *Healthy People 2030* are to eliminate health disparities to achieve health equity through health literacy. The overarching goals set forth by the Office of Disease Prevention and Health Promotion (ODPHP, 2019) to achieve well-being include, focus on preventable disease, disability, injury, and premature death by increasing health literacy, promoting healthy behaviors, and engaging political leadership and the public in

designing policies. Though the initiative recognizes the importance of social, economic, and environmental factors impacting health and well-being, the initiative does not describe the process through which social determinants services will be delivered and paid. A nod towards the role of contextual factors in achieving improved health and well-being is all that is reported in the initiative, with no mention of the term social determinants of health.

Health Care Delivery Models Incorporating Social Determinants Services

The Office of Economic Opportunity (OEO) awarded grants for the promotion of health and welfare to Drs. H. Jack Geiger and Count Gibson following the passage of The Economic Opportunity Act of 1964 under President Lyndon Johnson's War on Poverty. The OEO realized that addressing poverty would require the inclusion of health care services for vulnerable populations. The origins of "neighborhood health centers," first established by Drs. Geiger and Gibson, are today referred to as health centers or *federally qualified health centers* (FQHCs). The first neighborhood health centers were funded by the OEO to provide health care services with links to housing agencies, job training, and other social support services for the purpose of economic development (Lefkowitz, 2007). The model quickly expanded to include specialty care in addition to primary health care services and began to attract other subsets of the population (e.g., middle class Americans) in addition to lower income populations. According to Sardell (1989) and other researchers of the health center movement, the American medical profession began to fear losing their market share and lobbied to the federal government to limit neighborhood health centers to only provide primary care services to vulnerable populations with incomes below the established federal poverty guidelines. The

American Medical Association was successful in protecting their market share through the passage of the 1967 amendment to the Economic Opportunity Act (Sardell, 1989). Funding for community health centers then shifted to the Department of Health, Education, and Welfare (HEW) in 1973, with the provision for health centers to only provide primary medical services to vulnerable populations. These approved services included: traditional medical care, dental care, radiology services, laboratory tests, and transportation to the health centers. The payment model was based on a fee-for-service system whereby each service was paid according to a set fee for each respective service. The funding excluded “supplemental services” for health education and social services.

In 1973, President Nixon enacted the Health Management Organization (HMO) Act to control rising health care expenditures in the United States and improve population health (Nixon, 1971). The federal government provided start-up funding to the private sector to expand the HMO model through the formation of provider networks of doctors, hospitals, and other health care providers who accept a set rate of reimbursement for each service provided. These federal initiatives placed even more focus on medical care, to the exclusion of social services. The HMO model was intended to provide health care at a reasonable cost through monthly capitation payments based on the number of individuals assigned to each medical provider for exclusively medical services.

Under the ACA (Patient Protection and Affordable Care Act of 2010) federal health care reform shifted to a new payment system for community health centers. Instead of being paid according to the number of patient visits at set fees per type of visit, community health centers are now paid through a prospective payment system (PPS) of capitation through managed care (Gardner, 2013b). Health centers must contract with

local HMOs to provide services to their patients enrolled in Medicare or Medicaid. Approximately half of all health center patients are enrolled in managed care, resulting in payments for medical care provided through monthly capitation payments based on the number of patients assigned to the health centers from each managed care health plan (Gardner, 2013b). The new payment model shifted from fee-for-service to a set monthly capitation payment regardless of the number of services provided to each patient month by the health center. Social services are not included in these capitation agreements, resulting in health centers only being paid through capitation for providing primary health care services to vulnerable populations according to a set fee each month regardless of utilization. The average percentage of revenue from Medicaid per year, through managed care plans, to health centers across the nation was 44% in 2015 (Lam & Grasse, 2019). As a result, health centers were left with low margins averaging 2-5% in their operating budgets in 2015 (Lam & Grasse, 2019). As such community health centers are challenged with adding nonmedical services without an identified payment system in place.

Federally supported health centers now number 1,700 nonprofit health centers and serve over 28 million low-income patients. The health centers are considered the “safety net” for vulnerable populations to receive primary care services, through increased access to primary care services and reducing the utilization of emergency room visits at hospitals. According to the National Association for Community Health Centers (NACHC), health centers represent an estimated cost savings to the federal health care budget of \$24 billion in savings on an annual basis (NACHC, 2019). This calculation is based on the savings derived from 28 million patients who would be utilizing emergency rooms at local hospitals if health centers were not in existence. According to a study

conducted by Capital Link (2018), the number of health centers conducting at least one social determinant intervention service was 324. Over half of this number represents offering supplemental nutrition services through WIC (Special Supplemental Nutrition Program for Women, Infants & Children). Only 20 of the 1,700 health centers offered job training services, 15 offered homeless services, 10 offered food services, and no center reported offering housing assistance services. Even though health centers are best positioned to offer social determinants services as the “safety net” of the community, very few have expanded their service delivery model to offer nonmedical social determinants. The main reason being, that there is no existing form of payment system.

La Maestra has been able to grow and support nonmedical social determinants services through nonfederal grants and through the clinic’s operating budget. The Board of Directors for La Maestra’s clinic allocates an amount of funds each year to support nonmedical social determinants programs. The Board recognizes the impact of social determinants on the overall health and well-being of its patients and has seen demonstrated value reflected in the HEDIS (health outcome indicators) measures of patient health (see La Maestra’s HEDIS scores in Appendix D). The Board attributes La Maestra’s success on the HEDIS measures to the supportive services offered through La Maestra’s nonmedical programs addressing contextual and social services needs of the patients. The model is sustainable in that the managed care health plans offer incentives to health centers if the HEDIS measures reach acceptable levels. These yearly incentives then fund La Maestra’s support of nonmedical services. Admittedly, the choice to fund nonmedical services is made by the Board of Directors and is not mandated by any regulatory agency. La Maestra’s commitment to improving the health and well-being of

its populations is demonstrated through its mission and the manner in which funds are allocated.

HealthyPeople2020 emerged as a framework to guide the reprioritization of health care reform in the United States in 2010, with a focus on incorporating the social determinants of health and resolving disparities for vulnerable populations (CMS, 2020; Shi & Stevens, 2010). Shi and Stevens (2010) advocated expanding onto HealthyPeople2020, adding a multidimensional approach with the goal of reducing health disparities by focusing on both medical and social determinants, which they believe are drivers to achieve well-being. Shi and Stevens (2010) proposed a model that relies on identifying vulnerability risks by community. Demographics, income, education, and employment rates, as well as behavioral factors and social networks, all determine the levels of risk for vulnerable populations and can predict the health status of individuals within their respective communities (Ahern et al., 2008; Shi & Stevens, 2010). Similar studies corroborate the prevalence of chronic disease, including diabetes, associated with neighborhood-level factors, indicating that socioeconomic and other environmental factors in any given community can increase the rate of chronic disease (Chaikiat, Li, Bennet, & Sundquist, 2012). Unfortunately, CMS has operationalized HealthyPeople2020 by modifying the reimbursement mechanism for health care providers and placing the onus of population health and well-being on the physicians, physician groups, community health centers, and hospitals. This has involved shifting the form of reimbursement or payment to health care providers from what was previously based on volume to one of value (Buntin & Ayanian, 2017; Chernew, 2017). This shift places the responsibility for improving health care onto providers and is directly

connected to how providers will be reimbursed (Chernew, 2017; Spencer, Freda, McGinnis, & Gottlieb, 2016). Value will be determined through performance on established outcome clinical patient measures. If the patients are not able to comply with medication adherence or attend all of the established preventative or chronic illness visits, the providers are responsible. This means less reimbursement to health care providers.

Vulnerable populations face many contextually based challenges. Health care is one of the determinants and is complexly related to other contextual factors such as housing, food insecurity, unemployment, psychosocial, and others. It is unrealistic to expect that a homeless, unemployed patient with a chronic illness will achieve any degree of well-being without the root causes of illness having been addressed. An interconnected service delivery system is needed to link social determinants services together and form pathways for patients (Kaufman, 2017). In essence, the goals set by government for population health are now the prime responsibility of health providers and their patients. We can observe how payment reform has shifted the responsibility for health and well-being to the providers to improve population health. How health care providers are reimbursed is pertinent to this dissertation Providers are directly linked to the health and well-being outcomes of vulnerable populations. We look next at how government prioritizes the order of social determinants to achieve improved health and well-being. The emphasis is still at the individual level by modifying risk behavior.

Government agencies have acknowledged the important role of social determinants and are instituting guidelines for health care providers to capture information in the patient records around these determinants. However, funding to capture the determinants is still not in place, nor has the process to gather the data been

established (CMS, 2013). More importantly, systems have not been developed to address social determinants within the health care realm (Spencer et al., 2016). Partial models are being piloted within health care organizations and social enterprises beyond the collection of social determinants needs. We will now review some of these models as they move further towards integrating health and nonmedical sectors to improve patient health and well-being.

Health Care Reform in the United States offered hope to the millions of Americans who experience health and other disparities daily. The HealthyPeople2020 initiative developed out of the ACA (Affordable Care Act of 2010) to address health disparities among vulnerable populations. The initiative set forth goals to reduce disparities, including the incorporation of social determinants in the overall health delivery system. However, CMS has operationalized the HealthyPeople2020 goals by focusing on collecting data on the social determinants needs of Medicaid and Medicare populations to make a case for the development of a reimbursement mechanism to providers of nonmedical social determinants services. The other two responses by CMS to the HealthyPeople2020 initiative included restructuring the payment methodology to medical providers of Medicaid and Medicare beneficiaries through managed care health plans to coordinate, evaluate, and monitor the provision of medical services. This effort has resulted in shifting the responsibility for patient health outcomes to the providers of medical services through a variety of mechanisms, all with the goal of reducing health care expenditures (Bradley & Taylor, 2013; Brooks & Whitener, 2018). One of the consequences of this shift is that more health care providers are opting out of serving Medicaid and Medicare beneficiaries, leading to increased challenges to access services

from specialty health care providers. As noted earlier, CMS’s Innovation Center is focused on the creation of more payment models that will reduce reimbursement to health care providers even more. CMS is waiting for the case to be made that including nonmedical social determinants services will improve health care outcomes and reduce government expenditures for health care. The case is difficult to make as poor health involves multiple factors, at the individual health level and societal level through environmental disparities.

Conceptual Models

Dahlgren and Whitehead (1991) developed the “rainbow model,” a framework depicting how the range of wider social determinants of health impact individuals. The rainbow model is believed to be the first visual mapping of the interaction between individuals and their social environments with direct impact on their health. This model guided subsequent research into the influence of social determinants on health, as the root causes of illness, and provided a framework for further studies. The position taken by Dahlgren and Whitehead (1991) was that social determinants of housing, education, and employment have more of an impact on health care outcomes than actual medical services or individual lifestyle changes. This visual depiction of the social and environmental factors influencing vulnerable populations, prompted further inquiry into the relationship between contextual social determinants and health status (see Figure 4).



Figure 4. The main determinants of health. From *Policies and Strategies to Promote Social Equity in Health*, by G. Dahlgren and M. Whitehead, 1991, Stockholm, Sweden: Institute for Future Studies. Copyright 1991 by Institute for Future Studies. Reprinted with permission (see Appendix E).

Integrating Social Determinants into Health Care Delivery Models

While government agencies are making process changes to data collection procedures, there are emerging models being piloted in the health care field, incorporating social determinants at various levels of integration. This is important to review as the literature reveals how social determinants of health impact health.

Interventions

Interventions to improve health care outcomes among vulnerable populations have been guided by health policy focusing on changing individual behavior in the areas of risk behavior avoidance, healthy eating, engaging in regular physical exercise, and preventive services. Golden and Earp (2012) conducted a comprehensive study reviewing

157 articles of such health interventions in the United States. The goal of this particular study was to determine how many interventions were implemented at the individual, interpersonal, institutional, community, and policy levels. Findings indicated that two thirds of all interventions targeted only one or two of these levels, with the majority centered on individual behavior, followed by interpersonal levels (Golden & Earp, 2012). There is a gap in health interventional strategies at the structural level to encompass contextual social determinants of health (Durks et al., 2017; Golden & Earp, 2012). This information informs the research questions guiding this review as to why vulnerable populations continue to experience consistent poor health.

Literature shows that structural hierarchy creates social determinants where people are born, grow old, live and work. A strategy of incorporating social determinants into primary health care models is referred to as a “grassroots” approach for physicians, requiring them to see health as connected to contextual elements within patients’ everyday lives. The previously cited study calls for more models with an “upstream” approach, requiring physician practices to take into account the environmental challenges which contextually surround their patients. This speaks directly to the need for physicians to ask about their patients’ social determinants needs (Banger, 2020). This effort will require some “intervention mapping” (Eldredge et al., 2016) to effect desired change within health care practices. Intervention mapping could serve as a systematic approach towards incorporating new mental models around health care service delivery to implement the social determinants of health.

Intervention mapping is a framework based on social cognitive theory and would be useful in facilitating behavior change among health care professionals. Training health

care providers to adopt social determinants into their practice is not addressed much in the literature, with a few exceptions (National Academies of Sciences, Engineering, and Medicine, 2016). New procedures for collecting social determinants of health data are emerging through the CDC, CMS, National Institutes of Health, and other governmental agencies. Federal agencies and think tanks such as the Innovation Center of CMS began advocating for the collection of data on nonmedical needs of Medicaid and Medicare beneficiaries. There is a belief among federal agencies that needs for nonmedical services should be documented and collected to make a case with policy makers and obtain expanded coverage for these nonmedical social determinants' services. The impetus for this approach is to address the highest need and highest cost beneficiaries under Medicaid. According to CMS, the highest need and highest cost beneficiaries, which represent 5% of Medicaid beneficiaries, incur 50% of health care costs to CMS. Despite increased spending for health care, this population has poorer health outcomes than other groups (Spencer et al., 2016). As such, the initiatives by federal agencies, including CMS, have been to adopt alternative payment methods to hold medical service providers accountable for patient outcomes. The responsibility for patient health outcomes has now shifted to the providers through the Affordable Care Act (ACA, 2010) where the emphasis is on demonstrating value of the services rendered to Medicaid and Medicare patients. The provision of medical services is not sufficient. Providers must meet criteria demonstrating improvement in the CMS established health care outcome measures to receive reimbursement.

Shifting the responsibility of health to the provider. HealthyPeople2020 emerged as a framework to guide the reprioritization of health care reform in the United

States in 2010, with a focus on incorporating the social determinants of health and to resolve disparities for vulnerable populations (CMS, 2020; Shi & Stevens, 2010). Shi and Stevens (2010) advocated expanding onto HealthyPeople2020, adding a multidimensional approach, with the goal of reducing health disparities through focusing on both medical and social determinants, which they believe are drivers to achieve well-being. The proposed model relies on identifying vulnerability risks by community. Demographics, income, education, and employment rates as well as behavioral factors and social networks all determine the levels of risk for vulnerable populations and can predict the health status of individuals within their respective communities (Ahern et al., 2008; Shi & Stevens, 2010). Similar studies corroborate the prevalence of chronic disease, including diabetes, associated with neighborhood-level factors, indicating that socioeconomic and other environmental factors in any given community can increase the rate of chronic disease (Chaikiat et al., 2012). Unfortunately, CMS has operationalized HealthyPeople2020 through modifying the reimbursement mechanism for health care providers and placing the onus of population health and well-being on to the physicians, physician groups, community health centers, and hospitals. This has involved shifting the form of reimbursement or payment to health care providers from what was previously based on volume to now, one of value (Buntin & Ayanian, 2017; Chernew, 2017). This change places the responsibility for improving health care onto providers and is directly connected to how providers will be reimbursed (Chernew, 2017; Spencer et al., 2016). Value will be determined through performance on established outcome clinical patient measures. If the patients are not able to comply with medication adherence or attend all of the established preventative or chronic illness visits, the providers are responsible. This

means less reimbursement to health care providers. Vulnerable populations face many contextually based challenges. Health care is one of the determinants and is complexly related to other contextual factors such as housing, food insecurity, unemployment, psychosocial, and others. It is unrealistic to expect that a homeless, unemployed, patient with a chronic illness achieve any degree of well-being without the root causes being addressed. An interconnected service delivery system is needed to link social determinants services together and form pathways for patients (Kaufman, 2017). In essence, the goals set by government for population health are now the prime responsibility of health providers and their patients. We can observe how payment reform has shifted the responsibility for health and well-being to the providers to improve population health. How health care providers are reimbursed is pertinent to this literature review. Providers are directly linked to the health and well-being outcomes of vulnerable populations. We look next at how government prioritizes the order of social determinants to achieve improved health and well-being. The emphasis is still at the individual level by modifying risk behavior.

Government agencies have acknowledged the important role of social determinants and are instituting guidelines for health care providers to capture information in the patient records around these determinants. However, funding to capture the determinants is still not in place, nor the process for delivery (CMS, 2013). More importantly, systems have not been developed to address social determinants within the health care realm (Spencer et al., 2016). Partial models are being piloted within health care organizations and social enterprises beyond the collection of social determinants

needs. We will now review some of these models as they move further towards integrating health and nonmedical sectors to improve patient health and well-being.

Health Care Reform in the United States offered hope to the millions of Americans who experience health care and other disparities daily. The HealthyPeople2020 initiative developed out of the Affordable Care Act (ACA, 2010) to address health disparities among vulnerable populations. The initiative set forth goals to reduce disparities, including the incorporation of social determinants in the overall health delivery system. However, CMS has operationalized the HealthyPeople2020 goals by focusing on collecting data on the social determinants needs of Medicaid/Medicare populations to make a case for the development of a reimbursement mechanism to providers of nonmedical social determinants services. The other two responses by CMS to the HealthyPeople2020 initiative included restructuring the payment methodology to medical providers of Medicaid/Medicare beneficiaries through managed care health plans to coordinate, evaluate, monitor the provision of medical services. This effort has resulted in shifting the responsibility for patient health outcomes to the providers of medical services through a variety of mechanisms, all with the goal of reducing health care expenditures (Bradley & Taylor, 2013; Brooks & Whitener, 2018). One of the consequences of this shift is that more health care providers are opting out from serving Medicaid/Medicare beneficiaries leading to increased challenges to access services from specialty health care providers. As noted earlier, CMS's Innovation Center is focused on the creation of more payment models that will further decrease payments to health care providers even more. CMS is waiting for the case to be made that includes nonmedical social determinants services that will improve health care outcomes and reduce

government expenditures for health care. The case is difficult to make as poor health involves multiple factors, at the individual health level and societal level through environmental disparities. Making the case requires an integrated solution to solve integrated, complex problems, with a better understanding of how the sectors of health and social services could be linked to provide a united approach, including reimbursement for both (Bradley & Taylor, 2013; Brooks & Whitener, 2018).

As we have seen through this literature review, research indicates that medical services alone will not achieve improvement in health status. Nonmedical services addressing contextual issues, social determinants, play a huge part in getting people healthy. Most medical providers do not offer these social determinants, nonmedical services and have not developed linkages with organizations that offer these services. This accountability of medical providers for nonmedical services creates a huge dilemma as CMS is not paying providers for nonmedical services.

Since 2016, when value-based health care reform emerged, there have been numerous pilots initiated in different states to develop data collection models. One such model is the Commonwealth Fund approach to promoting integration of medical and social services (Amarasingham, Xie, Karam, Nguyen, & Kapoor, 2018) through data collection efforts of social determinants needs among patients. Early findings reveal that there is a lack of agreement on the definitions of social determinants of health among states, providers, and health plans. In addition, there is an absence of standardized measures and assessments for social determinants, which creates confusion on how to aggregate the data collected from patients. Many states are starting the data collection process on social determinants with subsectors of the populations and developing

assessment tools. A similar initiative emerged to collect social determinants data among community health centers.

The NACHC (2018) launched a pilot program, “PRAPARE,” enlisting 20 health centers to participate in a program to begin the collection of social determinants data for their patients. Much of the effort is currently centered on expanding electronic health records to capture this data. The mechanism for reimbursing this effort is still pending. Until a reimbursement process is developed for social determinants, services health centers will not make efforts to provide them as there are costs associated with the expansion of nonmedical services.

We see that the collection of data has been the focus of government efforts and not the delivery of services for social determinants. Meanwhile, vulnerable populations continue to fall ill at higher rates than other groups and remain ill, while government determines the best process to collect data on nonmedical needs and holds medical providers accountable for poor health outcomes.

The social theories underpinning the need for change are not made clear and lack appropriate trainings for all levels within the health care system. It would appear that national health governing sites, including the CDC and CMS, equate these changes to rote, procedural, technical changes, similar to the adoption of electronic health records. I believe that this is an adaptive change: one that requires substantial holistic training on the basic principles of social determinants and the reasons why they need to be implemented within the health care sector. This adaptive change is a philosophical alteration of traditional medical training around community health service delivery. The health care sector is not accustomed to relying on other service areas (e.g., education,

housing, unemployment, food scarcity, legal advocacy) as a part of patient care (Bradley & Taylor, 2013). This gap can be evidenced by current medical protocol, patient charts, and standard procedures set forth by the American Medical Association. These observations link back to the British researchers' findings around gaps between individual focused health reform and structure. Marmot (2007), the WHO, the Commission on Social Determinants of Health, and others indicated that theoretical frameworks are missing to address the importance and roles of social networks, communities, institutions, and policies in developing health interventions and measures.

In 2014, CMS funded the Whole Person Care Program (WPW). California elected to participate and funded select counties throughout the state. Counties and health plans were eligible to apply for funding provided that they met the criteria established under the program to address medical, behavioral, and social services. San Diego County was awarded a grant and in turn initiated The Whole Person Wellness (WPW) program in 2016 focuses on at-risk homeless individuals and building case management around this subset of the population (San Diego County, 2016). The focus is on case managing through referral and shared reporting and providing medical and nonmedical services for homeless individuals who are at-risk for chronic illness. Though this is a positive step towards implementing social determinants into the total care of some disadvantaged populations, it is a small pilot targeting only a fraction of the Medicare and MediCal populations in select counties.

There are many concerns with the Whole Person Wellness model for chronically ill homeless individuals from the health practitioner perspective. The first, among many, is that the program is an individual focused, down-stream approach, having little to no

impact on the structural macro changes necessary to address the root issues of homelessness, resulting in another band-aid approach (Rose et al., 2008). The second criticism is that the underlying goal of this pilot is seen to benefit the managed care programs more than the recipients of the services. In other words, the managed care programs have chosen to introduce select social determinants services for their most costly members with the intent to derive savings for the health plans. The third criticism is that the health plans have chosen the most difficult population to include in this pilot, integrating select social determinants services for the first time, instead of implementing the pilot through a more representative subset of the Medicaid/Medicare population. The most daunting challenge to this pilot is that managed care health plans have been entirely focused on coordinating medical services and lack established pathways with community-based organizations providing services in sectors of our society not related to health (e.g., housing, education, food, social services, and legal services). The health plans are relying upon referrals to these nonmedical organizations without providing reimbursement for social determinant services. Consequently, community-based health centers are hesitant to participate in this pilot due to inconsistencies between health plans for: reporting and documentation requirements; patient data management challenges; social determinants terminology; case management and protocols; payment of services rendered. An additional criticism of this pilot is that funding will end in 2020 and thus the resources of time and staffing expended to date by health centers will not continue with no funding to sustain the efforts.

There are many other small initiatives in other states outside California (NACHC, 2018) comprising different care team partners and focusing on a subset of the

underserved population in their catchment service area. A criticism is that much of the decision about program design and the participation criteria is funder driven (Siegal, Winey, Kornestsky, & Mt. Auburn Associates, 2015). Government and, in some cases, private funders determine the priority, scope, and eligibility criteria to receive services and the process by which services are delivered and reimbursed. This is a complex, multidimensional change that requires systems change and is not just about creating new programs (Siegel et al., 2015). There is a disconnect between the identified needs and solutions at the community level and what gets funded, which is decided at the macrosystem level, often without community or individual level input. Some state sponsored pilot programs emerged to begin addressing social determinants by connecting patients through their primary care providers to community-based nonprofits for social determinants services.

Michigan and Washington state governments have initiated collaborative projects to screen for social determinants of health within health centers, using patient referrals to social service organizations to address housing, food, and other determinants of health needs (Byhoff, 2017). Screening practices encompassed 15 core domains, including cultural backgrounds of the patients, which was not found in any national initiatives. Early findings indicate that there are not enough community-based service organizations to meet the demand of the referrals from the health centers (Spencer, Freda, McGinnis, & Gottlieb, 2016). A lack of referrals to affordable and safe housing is one example. A lack of standardized outcome measures is another challenge. The program has not been able to quantify the value of linking health care services with nonmedical social determinants providers. Establishing value is essential in making the case to CMS in order for the

agency to begin reimbursing for nonmedical services around social determinants. According to the Innovation Center at CMS, the case for saving the federal government money and creating value has not been made yet (Bradley & Taylor, 2013). As such, CMS is still searching for models that demonstrate value, meaning that health care outcomes improve, and that health care spending is reduced. Until this case is established, CMS will not reimburse providers for nonmedical social determinants services despite the vast amounts of research and literature that demonstrate the impact of social determinants on health care outcomes yet, Bradley and Taylor (2013) asserted that health care outcomes will not improve until the root causes of illness and disease are addressed through the provision of social services.

In 2018, the passage of the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act allowed managed care health plans that enroll one-third of its members from the Medicaid population to provide social determinants care through supplemental funding (Neuman & Jacobson, 2018; Thomas, Durfey, & Gadbois, 2019). A study of 17 managed care health plans, with an enrollment of 13 million Medicaid beneficiaries revealed three main findings (Thomas et al., 2019). Of the 37 individual participants from the 17 managed care health plans interviewed in the study, all recognized the potential impact of social determinants services on the health care outcomes of their health plans' members. However, there were varying opinions on how social determinants should be addressed, with many respondents voicing concern that social determinants services are outside the purview and capability of health plans (Thomas et al., 2019). The third main finding was that perceptions varied among respondents as to the definition of social determinants and the process by which to

measure the value of providing social determinants service to health plan members. Some of the health plans interviewed in the study were designing nutrition related programs and home modifications to address mobility challenges in response to this supplemental funding for social determinants.

Most of the participants (senior leadership from the health plans) interviewed expressed a lack of clarity on how to establish a return on investment to determine the value of offering social determinants services. Perhaps this confusion can be attributed to the lack of experience among the health plans with providing social determinants services. This finding supports the criticism by community-based organizations about federal initiatives placing the responsibility and coordination of social determinants services in the hands of managed health care plans. The respondents of Thomas, Durfey, and Gadbois's (2019) study described the concern that social determinants were outside of the purview of managed care health plans. This is an arguable point. Managed care health plans have existed within the health sector exclusively and, as such, do not have experience nor collaborations with nonmedical service organizations such as: housing, education, economic development, or food distribution. Their networks are formed with solely health care providers. This fact brings into question the rationale for CMS to place the responsibility of rolling out social determinants services in the realm of the managed care health plans where the purview is not nonmedical services. During interviews I had with CMS and CMS's Innovation Center as part of my advocacy role as CEO of La Maestra, I asked that question. The answers provided were less than satisfactory as the rationale and critique referred to existing delivery models instead of the possibilities for creating new processes. CMS views managed care health plans as coordinators of health

care already, so it is easier for CMS to assign the coordination of social determinants services to the managed care health plans instead of contracting with nonprofit organizations that provide social determinants services. CMS has not explored or chosen multisector approaches in its delivery strategy to address social determinants services. Additionally, the managed care health plans are operating on the agenda of cost savings, which yields them a substantial profit margin.

The literature covered thus far in this dissertation described the motives and results from federal initiatives to fund the creation of managed care health plans, a profit-driven sector, to emerge, adding huge costs to an already expensive health care delivery system in the United States. Cost factors and return on investment drive the determination of value, not health care outcomes. The health care delivery system of managed care has evolved into managing cost (Bradley & Taylor, 2013). As this study focused on San Diego, the state of California's response to this federal initiative on social determinants of health is reviewed.

California Initiatives for Whole Person Care

The California Department of Health Care Services (2020) released funding to select counties to pilot the Health Homes (HHP) program, focusing on at-risk, homeless individuals and enhancing the case management function around this vulnerable population. The HHP initiative is similar to the federal funded Whole Person Wellness Program available to participating states through a waiver program (County of San Diego, 2016). The focus of both the state and federal pilots is on case managing through referral and shared reporting and providing medical and nonmedical services for homeless individuals who are at-risk for chronic illness. Though this is a positive step

towards implementing social determinants into the total care of some disadvantaged populations, it is a small pilot targeting only a fraction of the Medicare and Medicaid populations in select counties. The goal is to identify *health homes* for chronically ill homeless who have a demonstrated pattern of accessing emergency services. The criteria include chronic illness, chronic homelessness, co-occurring mental and substance abuse disorders, and repeated utilization of emergency services. The coordination of the nonmedical services for a subsector of the homeless population with co-occurring disorders is being relegated to the managed care plans, as the managed care plans are the third-party administrator for Medicaid and Medicare. The primary goal of managed care plans is to minimize utilization of emergency room services and other high cost services, which will reduce costs to the health plans, resulting in profit maximization for the managed care health plans.

Social Determinants Models Among Closed Systems

There are exceptions emerging in localities to the adoption of social determinant models in health care planning where the county government also serves as the health plan for the residents. In the instances where county government is the main driver and has the inherent ability to coordinate between its own departments, funding resources are available for social services, eligibility determinations, transportation, law enforcement and medical services, provided that the county operates a hospital or primary care services. An example is the Southwest Texas Crisis Collaborative (STRAC). The mission of STRAC is to minimize emergency care utilization services (STRAC, 2019). The collaborating partners are mostly within the County of San Antonio's system, with some outside partners, including faith-based organizations, food pantries, and housing entities.

In essence, this is a closed system model through the County government. Other closed systems appear to be closer to incorporating social determinants services, as in the case of Kaiser Permanente, an example of a closed health care system where all services along the health care continuum are available only to Kaiser membership. Kaiser Permanente, a nationwide health system, has recognized the impact of social contextual disparities on the health care outcomes of its members who are low-income.

In fact, research has shown that wellness is not achieved through medical visits alone (Shah et al., 2016). Kaiser Permanent studied their patient base and found that social, behavioral, environmental factors were among the root causes of their patients' health problems. This was substantially larger than the 10% of medical causes for their patient visits. Kaiser recognized that one percent or 40,000 out of their four million members in Southern California are responsible for 23% of their total health care spending. These "super-utilizers" will be enrolled in Kaiser's Total Care program, which will connect patients through case management to community resources to address the social determinants of health. This is a positive step towards addressing the social needs of their patients and surpasses the phase of collecting data on social determinants as we saw with government initiatives. However, the Total Care program does not describe the pathways patients will navigate to receive nonmedical services for other determinants of health like employment services, housing assistance, food, and other social services. Also lacking is the referral and case management process through which these interconnected community-based organizations will manage the patients as they access services from all of these various agencies within a new network of care.

We see from the literature that systems and structures are modifying internal processes to screen for and collect social determinants of health data. The issue remains on what to do with this data. The question is how to implement the social determinants services into patient care, ensuring that once needs are identified there are appropriate pathways to access nonmedical services for contextual based needs. Researchers call for a new vision of health including social determinants to allow for collaborations between the medical sector and social services sectors to be formed (Bradley & Taylor, 2013). A recommendation issued through the National Research Council and Institute of Medicine (2013) is that research funding agencies in United States should look abroad for models utilized in other countries to understand factors responsible for health disparities and potential solutions, and innovative models.

International Models Abroad

A model similar to Kaisers Total Care program is being developed in Scotland to evaluate “social prescribing” for patients with high socioeconomic needs. This model incorporates the normalization process theory to measure coherence, collective action, and reflexive monitoring to study the process through which quality of life is achieved as primary care patients are prescribed social needs services (Mercer et al., 2017). A noted limitation of the study, however, is that the data is self-reported through participating organizations in terms of value reported, bringing into question the validity of the data. One key difference between the social prescribing model Kaiser has adopted and the ongoing study in Scotland is that social determinants services are reimbursable in Scotland, whereby they are not in the United States.

The Council of Australian Governments utilized Donabedian's (2005) model of care as a framework in addressing major challenges to health care reform in Australia (Reeve, Humphrey, & Wakerman, 2015). Although similar health care indicators and performance measures for medical services were identified, the model added two other measures. One was a method to evaluate the methods used around access to care, effectiveness, cultural competence of the medical providers, responsiveness, and efficiency. The second difference was to add a measure to evaluate the sustainability of the structure including sufficient health care workforce, and the lineages and referral pathways to and from nonmedical social determinants of care organizations, infrastructure, funding, governance, leadership, and management. The most critical difference between Scotland and Australia, and the United States' health care reform plans is the inclusion of nonmedical social determinants of care for vulnerable populations in the delivery and payment model in Scotland and Australia. Identifying health care indicators with the goal of reducing health disparities is a similarity between the Australian Health Care Reform initiative and CMS's HealthyPeople2020. Through the Australian Health Care Reform, the establishment of referral pathways to and from nonmedical social determinants services was given equal consideration in health care services in an effort to reduce health inequalities of Australia's vulnerable populations.

Population health researchers, Shi and Stevens (2010), are critical of models that focus on general primary health care without taking into consideration the interlocking traits of vulnerable populations. The model proposed by Shi and Stevens calls for abandoning uncoordinated and inadequate approaches that focus on the symptoms rather than the causes of poor health outcomes. These researchers posited that a comprehensive

and integrated approach, addressing vulnerability traits in the community is the most practical model to incorporate. Their theory is based on the belief that individuals with one or more risk factors develop multiple vulnerability traits, resulting in worse health outcomes. The solution, according to Shi and Stevens (2010), is to identify communities with multiple risk factors by searching through the already existing government databases and addressing the ecological challenges that are beyond the individual's control. This multilevel approach shifts the blame away from the individual level and reduces blaming the victim. Literature suggests reasons why focusing on the individual alone is not helpful in achieving better, improved health outcomes and achieving well-being among vulnerable populations.

Increased access to health care services, addressing risk behavior and prevention, and contextual factors are all essential strategies for improving health care outcomes among vulnerable populations. Although the literature provides insight into the root causes of health care outcomes, the solutions presented depend on the elimination of social inequalities. This solution is not attainable from a practical perspective. There must be other strategies to employ besides individual behavior modification and incorporating the social determinants of health. In countries like England, with a national health plan in place for over 60 years, vulnerable populations still exist. Although access to affordable, quality health services is in place, health disparities persist among low-income communities. Services addressing social determinants are more accessible in England as well, yet problems persist for vulnerable populations to achieve equitable health status and well-being.

The literature reviewed in this dissertation has indicated that both individual medical services and other social determinants services are beneficial. Shi and Stevens, (2010) pointed out however that social resources obtained through social ties, as in social capital, are believed to be essential to attaining well-being. To probe further into the process needed to respond to the health and well-being of vulnerable populations, we must look again to the literature to ascertain a definition of the nebulous term well-being (Dodge, Daly, Huyton, & Sanders, 2012).

Well-Being

The end goal of health care management is well-being, which is also a socially and culturally constructed concept as it has various connotations depending on the culture of a group. This section provides an analysis of the definition of well-being from a psychological perspective. The analysis then moves on to review other definitions, contributing factors to achieving well-being, and culminates in further exploration of how integrated factors embedded within geographic landscapes of care are described in the literature to affect well-being among vulnerable populations.

Maslow's (1943) hierarchy of needs is centered on gradient needs which must be met in a sequential process to transcend through a connection of material affluence and the satisfaction of needs. The progression toward well-being starts with physiological needs, leading to protection or security needs. Love and belonging follow, which lead to the satisfaction of the ego and self-esteem recognition. The top of the pyramid is self-transcendence met through satisfying spiritual needs. The theory provides a framework for defining well-being, and it aligns with the goals of social determinants of health.

Many cultures equate well-being with happiness and good health. Seligman's (2012) well-being theory equates well-being with happiness and the ability to lead a meaningful life through engaging relationships and social connections. Researchers suggest that a sense of belonging leads to a meaningful life because it brings a sense of social support, social value, and social identity to pursue collective goals (Hogg, 2009; Lambert, Stillman, Hicks, Baumeister, & Fincham, 2013; Roffey, 2013). This indicates that a social network could facilitate a sense of belonging for vulnerable populations who are marginalized. Through social connectedness with a community-based network, disadvantaged populations might find social support through social identity, which in turn fosters well-being. Studies exploring the operationalizing of well-being and enhancement of healing and health suggest that the physical space can promote social connectedness, through different forms of spatial geography (Fleuret & Atkinson, 2007).

Geographers of health are studying the relationship between spaces and the facilitation of well-being. This refers to physical spaces within vulnerable communities and can include organizations, facilities, or social networks (Andrews, Chen, & Myers, 2014). The prime advantage is that well-being spaces are thought to promote relationship building and connectedness. Social landscapes-of-care is based on a related theory focusing on people-place relationships instead of just interpersonal relationships. Social landscapes-of-care theory is based on the role caregivers hold in the provision of care (Milligan & Wiles, 2010). They provide support, encouragement, and personal attention while delivering the actual service. The term "therapeutic landscapes" defines the healing properties of cultural geographies or social landscapes-of-care. Well-being spaces (e.g., organizations, hospitals, clinics, shelters, social networks) interface with the community

by providing therapeutic care while enlisting feelings of care, belonging, connectedness around common goals. Sociospatial dimensions move beyond the health care realm to encompass social determinants and are thought to lead to well-being (Milligan & Wiles, 2010).

There are four types of spatial landscapes that foster well-being: spaces of capacity, integrative spaces, spaces of security, and therapeutic spaces (Fleuret & Atkinson, 2007). The facilitation of well-being is believed to be engendered through multiple occurrences of these forms of geographic landscapes (Fleuret & Atkinson, 2007). Spaces of capacity address social and physical aspects of a particular space, which can either facilitate or challenge well-being depending on accommodations for individuals who have disabilities, the elderly, and volume. Integrative spaces refer to the social connectedness and networking facilitated through spaces that welcome social and cultural diversity (Gesler & Kearns, 2002). Spaces of security provide visitors with feelings and perceptions of safety against environmental threats and conflict and meet basic needs around health and food security. Therapeutic spaces refer to environments that foster healing through cultural, emotional, and spiritual aspects contained in a given space.

Critics point out that the definition of well-being is not entirely consistent among different cultures. Some cultures use the term well-being to describe a positive feeling that connotes having all of one's physical and material needs met. Other cultures use the term well-being more subjectively to express happiness or to refer to quality of life. Objective well-being is seen to describe contextual factors, such as their living conditions (Cummins, 2000).

Although challenges over the definition of well-being vary among cultures, there is consensus that well-being is a positive state, related to the individual's health status, affected by their contextual environment. According to the WHO (2012), an individual's perception is what measures quality of life and that perception is influenced of culture, values, contextual environment, expectations, and anxieties of that individual. Diener, Oshi, and Lucas (2003) added that the level of education will influence the perception of one's well-being. There are several perspectives found in the literature as to geographical factors which contribute to feelings of well-being. According to Andrews, Chen, and Myers (2014), the geographical location of where health care services are located are paramount to facilitating well-being. Milligan and Wiles (2010) suggest that organizational structure influences relationships of care. Other researchers opined that the level of acculturation (Navas, Rojas, Garcia, & Pumares, 2007), as well as the degree of integration into communities and institutions (Ager & Strang, 2008), are what promotes well-being, specifically among refugee and immigrant vulnerable populations. The integration of culture, combined with the demographic factors of socioeconomic and health status, as well as social capital, all embedded in geographical locations, are thought to drive the promotion of well-being (Veenstra et al., 2005). Several social theories have been offered as explanations for social conditions and their relationship to the well-being of individuals (Carroll & Stanfield, 2003; Lehtonen, 2004; Lin, 2003; Villalonga-Olives & Kawachi, 2015). Social capital is one such theory that, having been used in anthropology, sociology, economics, and psychology, has been less used to understand health and well-being (Hawkins & Maurer, 2010).

My previous pilot studies suggested that social capital could be helpful in understanding the social construction of poor health outcomes for vulnerable populations. I discuss the historical roots of social capital, social capital and health, as well as measures of social capital in the following sections. The last section in this chapter discusses existing models incorporating social determinants.

Historical Roots of Social Capital

Numerous researchers have conceptualized social capital theory and its various forms first developed by Karl Marx (Bourdieu, 1998; Coleman, 1988; Lin, 2001; Putnam, 2000; Szreter & Woolcock, 2004). It is important to understand the initial concept as proposed by Marx to gain insight into how social capital theory has expanded its different forms and how it can be applied to the improvement of health and well-being of vulnerable populations.

The origins of capital theory, as derived from Karl Marx, refer to the imbalance of power and wealth between the social classes. Social inequalities are thought to be embedded within social capital, which determines who is able to benefit from society and who is marginalized. Evidence of social capital includes robust community networks that make up the civic community (McMillan & Chavis, 1986). Civic engagement, civic identity, reciprocity, and trust are all components of social capital, which are found to involve individuals, institutions, and relationships at all levels and help to define the resources that are accessible to them (McMillan & Chavis, 1986).

Because vulnerable populations do not possess equality in power or wealth with individuals from the middle or upper classes, they have comparatively less social capital than other segments of society. Social capital is defined as a theory that explains how

individuals or organizations obtain needed resources through expressive or instrumental action to achieve better outcomes, or “capital captured through social relations” (Lin, 2001, p. 19). Individuals who lack needed resources are thought to be motivated through instrumental action to acquire resources through social networks. Expressive action is defined as measures that individuals take to keep the resources that they currently have. The question then becomes how or if vulnerable populations can acquire and maintain social capital needed to enhance their health status. Disadvantaged individuals from low-income communities lack social networks or pathways to access resources and interactions at the macro level, resulting in minimal social capital (Lin, 2001; Villalonga-Olives & Kawachi, 2015). Social networks are the mechanism through which resources are transferred from the broader society down to the micro level of society. Individuals access social networks and their existing bridges and pathways through the bonding form of social capital processing the resources into social capital. Empowerment, trust, and civic engagement represent some of the tools used by individuals to gain status within society and to access resources. Social networks facilitate the growth of self-efficacy, self-esteem, and a sense of belonging and hope as well as providing the environment through which empowerment can grow.

An unequal distribution of resources and the process involved to secure needed resources align with the foundation of social capital theory. As this dissertation is focused on identifying how vulnerable populations perceive their ability to obtain needed resources to improve their health outcomes and well-being, a discussion follows on social capital and health.

Social Capital and Health

Social capital refers to “the investment in social relations with expected returns in the marketplace” (Lin, 2001, p. 19). Historically, social capital has been analyzed in the economic, political, labor, and community markets by various researchers (Bourdieu, 1998; Campbell, Wood, & Kelly, 1999; Coleman, 1988; Putnam, 2000). Coleman (1988) provided the concept that social capital could be useful in the field of social work and asserted that social capital is a by-product of social networks and support systems through which direct and indirect resources are attainable. Wilkenson (1996) was the first researcher to suggest that social capital could be linked to the field of Public Health through trust at the social level of analysis. Health disparities among vulnerable populations was linked to a low vertical trust in societal structures, including government agencies and, in society, also tied to low participation in voluntary associations (Kawachi, Kennedy, Lochner, & Prothrow-Stith, 1997; Putnam 2000). At the individual level of analysis of social capital and health, numerous studies have demonstrated that low trust is directly correlated with poor self-rated health status (Mohseni & Lindstrom, 2007). Although the idea of social capital has been linked to levels of trust at the individual and societal levels of analysis for health status, the theory has not yet been operationalized to identify the process utilized to exchange resources in the marketplace, resulting in the exchange of social capital for needed resources to improve health and well-being.

Understanding how social capital and its resources are applied to health outcomes may contribute to our understanding of how to improve and maintain health status (Lin, 2001). Social capital as a concept has not yet been applied in the United States to address

social inequality issues. Instead, the United States focuses on individual characteristics to explain inequality rather than examining the challenges faced by deprived communities as a whole (Hawkins & Maurer, 2010). Researchers recommend that the United States consider the influence of social capital in advancing developments in the field of education and social work to provide a clearer understanding of the effects of social relationships and social connectedness on the well-being of its populations (Tracy, 2004). Other countries, including Australia, New Zealand, and Great Britain, have incorporated the ideas that are embodied in social capital theory into their social policies through the allocation of national funding to address social inequality, deprivation, and exclusion challenges among vulnerable populations. There are criticisms, however, of how political agendas have thwarted these efforts by shifting responsibility onto deprived communities directing them to become more self-reliant (Farrell, 2007; Leonard, 2004; Schuller, Barron, & Field., 2000).

According to Lin (2001), social capital is one of two types of capital. The first is human or personal capital, which refers to the resources of an individual that they can use, trade, or dispose of at will. The second form of social capital refers to the resources available through social networks or voluntary associations. Though the resources do not belong to the individual, they can be accessed through connections with others through social networks. If the individual belongs to a high socioeconomic class, more resources are accessible. The poorer the population, the less resources are available (Lin, 2001). Within social capital there are three key concepts that help explain how social capital work. They are bonding (Putnam, 2000), bridging, and linking (Szreter & Woolcock, 2004).

Bonding, Bridging, and Linking Social Capital

Putnam (2000) described the first step in creating social relationships that build capital as *bonding*, which exists exclusively between homogeneous populations with outcomes of social connectedness, trust building, and demonstrations of reciprocity. Bonding is the ability to identify with other similar individuals or connectedness. Building trust and being able to confide with others in the group promote feelings of being supported. Increased self-confidence and self-esteem are outcomes of bonding. *Bonding* is measured by the degree of belonging, trust, reciprocity, and social connectedness that is built at the individual level. Putnam's research on bonding was focused on across-group connections within social networks. He found that reciprocity and solidarity are developed through a sense of belonging. A key attribute resulting from a sense of belonging is that individuals can rely on others for support, emotional security, self-validation, and resilience in adverse situations (Roffey, 2013). Bonding is the accessing of resources from relationships between individuals with similar demographics and socioeconomic backgrounds (Kim, Subramanian, & Kawachi, 2006). An example of bonding among homogeneous populations can be found in a study conducted through Queen's University in which 86% of Irish Catholic households surveyed in West Belfast stated that they depended on neighbors and their community for assistance (Leonard, 2004). The Irish Catholics developed strong bonds and safety nets based on a culture of self-help within their own isolated social networks. However, the ability to seek resources outside of their social networks was not attainable because of an inability to bridge into the larger Protestant society in Northern Ireland. Putnam's (1993) notion of *bridging* was

absent in the Leonard study thereby undermining efforts to create social capital outside their community group (Leonard, 2004).

Putnam's (1993) description of bonding was found to apply in Leonard's (2004) study in Northern Ireland, but the description of bridging did not apply. The insulated Irish Catholic community was not able to bridge social capital as bridging requires the ability to access the wider community to garner resources.

Bridging is the next consecutive form of social capital on the social network's pathway to access needed resources. Bridging is defined as the action of connecting to resources embedded in a social network to draw down resources at the individual level. Briggs (1998) argued that bonding social capital is useful for getting by but bridging social capital is essential for getting ahead (as cited in Putnam, 2000, p. 23).

Disadvantaged communities are described as possessing the bonding of social capital yet cannot attain the bridging aspect to access resources in the broader society (Leonard, 2004; Villalonga-Olives & Kawachi, 2015) Once bridging occurs, *linking* is the next possible vertical step in making contacts with dissimilar individuals to draw needed resources. Linking involves actions taken by the individual to make contact with dissimilar others outside the social network to obtain resources that empower that individual. This could include employment opportunities, improved housing, specialty health care, civic engagement, or other resources at the macro level of society. This action is referred to as linking, where connections are made with contacts accessed through bridging (Ferlander, 2007). These are vertical ties to individuals or institutions of power at the macro level, different from bridging in which there are horizontal ties between individuals or networks with different demographics, different cultures, or who

are unfamiliar. Bridging and linking can build awareness to new ideas, values, and exposure to new ways of viewing the world.

Social capital theory measures social capital by examining the forms of *bonding*, *bridging*, and *linking*. *Bridging* is measured by the individuals' ability to access established pathways through social networks to needed resources in the macrosystem or the wider society (Putnam, 1993). It is the ability to tap into the resources available at the societal level to meet individual and social goals (Lin, 2001; Putnam, 2000). Kim, Surbamanian, and Kawachi (2006) refined the distinction further between bonding and bridging.

An example of bonding, bridging, and linking is found in studies on how social capital was evidenced during natural disasters such as hurricanes, earthquakes, and tsunamis (Hawkins & Maurer, 2010). In the aftermath of disasters, such as after Hurricane Katrina in New Orleans, neighbors helped each other and pooled their resources together to help the community. Bonding occurred among low-income communities hit the hardest by the disaster. They actually met and planned ahead of the hurricane how to respond best to the storm. After the hurricane hit, residents in these devastated communities helped others from their own social networks first, then sought out those who were dissimilar to provide assistance. Many victims were of the same socioeconomic status and many were not. Heterophilous bridging also occurred when people from other racial and socioeconomic backgrounds gave and received assistance. Funds, food, material goods were accessed through bridging from those individuals who had more resources. Organizations from outside the state came in to help with the recovery and restoration efforts from the storm and participate in repairing the damaged

properties in low-income areas. Federal governmental agencies as well as global emergency response nonprofits also came to assist after the hurricane occurred. This was an example of linking, where resources are obtained from outside the community. This form of bridging and linking was evident during the disaster but would not be available during everyday life. Research shows that during times when people are trying to survive during natural disasters, being from the same background, race, or economic status are not prerequisites for engaging in bonding, bridging, or linking. This finding contradicts Putnam's assertion that bonding is evident only among homogeneous populations (Barshaw & Trainor, 2007).

The aspects of bonding, bridging, and linking, as forms of social capital, are possible explanations for the patterns which emerged from the exploratory studies preceding I conducted prior to conducting research for this dissertation. Participants identified value around the social connectedness they experienced as they accessed three or more services through the circle of care model, which led to empowerment and bridging to other resources through established pathways within the social network and community. Examples of linking were also described by the interview participants when they accessed jobs, housing, specialty medical services, and civic engagement from contacts outside the local community, in the broader society or macrosystem.



Figure 5. Pathway to accessing social capital.

Role of Social Networks in Operationalizing Social Capital to Impact Health

Social capital and health discussions focus on specific kinds of social networks or voluntary organizations that operationalize social capital through an integration of micro, meso, and macro levels of participation (Veenstra et al., 2005). Other researchers have described social network levels through horizontal and vertical ties (Ferlander, 2007). Individuals participating in the social networks are at the micro level and form horizontal ties to voluntary organizations, associations, family, friends, neighbors, and colleagues. The social networks themselves represent the meso level, and environmental and political structures represent the macro level of operations of the social network, through which vertical connections are made. The geographical location of these voluntary social networks is paramount to the effectiveness of the social network (Veenstra et al., 2005). Concurrent with geographers of space, social capital researchers assert that the social networks must be in the same geographic environment as the vulnerable populations in order for social capital resources to be effective.

Social capital stems from social networks within communities if high levels of interpersonal trust, norms of reciprocity, and helping others exist for the common benefit of all. Through social networks, the needs of individuals are addressed, and resources are brought into the community (or not) from the macrosystem to strengthen communities (Ferlander, 2007). Resources to programs, support, opportunities, services, are all seen as forms of social capital brought into the community from the macrosystem by local social networks. All of these social capital resources are believed to impact the health and well-being status of vulnerable populations in three different forms. Social capital is believed to impact health through community-based social networks through three main

interventions, according to Veenstra et al. (2005). All three interventions are based upon the premise that social networks exist within the same geographic environment as the vulnerable populations. The three interventions are described here.

The first intervention addresses the compositional health effects of social support, empowerment, social engagement, and bonding for social network members (Berkman et al., 2000). Self-esteem, feelings of being safe, belonging, coping skills, accessing health services, all influence individual behavior positively.

The second intervention provided through social capital speaks to the contextual health effects. Social capital may increase access to the social determinants needs of vulnerable populations, with resulting contextual health effects by connecting them to resources to address issues around housing, employment, food scarcity, environmental hazards, and neighborhood violence. Conceptually the process involves bridging and linking while accessing institutional contacts developed through social networks. Access to these broader resources are found at the macro level of society and involves advocacy and policy, bringing awareness of community-level needs around social determinants that impact health to the wider society (Mohan & Mohan, 2002). Social capital, utilized in this contextual form has a broader reach through advocacy and awareness building activities which could work towards reducing health and economic disparities among vulnerable populations (Kawachi et al., 1997; Wilkenson, 1996).

The third intervention utilizing social capital is believed to influence the collective community through the existence of numerous social networks to combat problems that affect the whole community. This would include environmental issues hazardous to the health of the residents, violence, drug related crimes, and lack of safe

shared space like parks and community centers (Ferlander, 2007; Schuller et al., 2000). Various researchers have stated that increased interpersonal trust, engagement in civil affairs, and reciprocity builds social capital (Hendryx, Ahem, Lovrich, Nicholas, & McCurdy, 2002). These researchers expanded on Putnam's (1993) study among Italian postwar local governments and findings to demonstrate the connection between trust and social capital, specifically as to how social capital can be a predictor of democratic societies and the level of civic engagement within society.

Researchers provide numerous theories on how social capital can impact health and well-being of vulnerable populations. The common themes of how social capital is accessed by vulnerable populations revolve around trust, social connectedness, and the existence of social networks, through bonding, bridging, and linking aspects of social capital theory. The data is rich on explaining why social capital is a positive influence on health status, and theories abound on how the various forms of social capital should improve health and well-being especially among vulnerable populations in disadvantaged neighborhoods. However, there remains a gap. Research is clear that vulnerable populations can access social capital to obtain needed resources through community-based social networks and voluntary associations. What is still missing in our understanding of the relationship between the health of vulnerable populations and social capital is the mechanism for exchanging the social capital from the meso level, or the social networks, for use at the individual level.

Lin (2001) provided a possible theory for how individuals act on either maintaining or acquiring needed resources: expressive and instrumental action. Expressive action is concerned with preserving the resources one has already through

homophilious interactions, or through transactions with individuals at the same hierarchical level. The exchange of resources assumes that similar people who interact with each other more frequently can offer and receive like valued resources. An example of taking expressive action is when an individual seeks out others who are from the same background and socioeconomic level to share confidences. In this transaction, the individual expects to receive support, sympathy, and guidance. Instrumental action is focused on accessing resources that they do not already possess. This form of interaction, or linking, is thought to occur with others who are not from the same background, who live a dissimilar lifestyle, or who are from a higher socioeconomic class with resources desired by the individual. Lin (2001) believed that the individual might not know who the target person is but knows that a connection is sought within a higher structural position.

The theory describes the level of motivation that an individual must have to take either expressive action through bonding or instrumental action through bridging. The exchange of social capital is fairly clear in the expressive action scenario, where there is a transfer and receipt of social capital through bonding. However, bridging and linking social capital assumes that the individual seeking resources is stepping outside their environment. The question then becomes: What will those without the needed resources offer in exchange for the resources they seek? Applying this question to the focus of this study would translate into: What is the mechanism that will allow vulnerable populations to bridge social networks into the macrosystem and acquire resources to improve their health and well-being beyond those resources they can obtain at the micro and meso levels of society? What will they trade at the macro level of society for what they need?

Researchers offer theories on empowerment and social networks as potential answers to these questions.

Israel, Checkoway, Schultz, and Zimmerman (1994) contended that empowerment is the driver for improved health. If individuals feel empowered to participate in the processes controlling their immediate environment and beyond, by having a voice and say in the political realm, they feel that they are part of the outcome. Empowerment leads them across the individual, community, and societal levels. The concepts involved in this process of empowerment are consensus decision making, capacity building, support, mutual respect, and sharing information and power. Empowerment is what motivates individuals to take an active role in their communities through collective action to influence policies, structures, and systems at the macro and ecosystem levels (Israel et al., 1994). There is a similar correlation between populations with higher levels of political power and economic wealth. They have more social capital and have better health than their counterparts in poor communities where social capital is low. Some researchers believe that the concept of empowerment could have a detrimental effect if policymakers try to shift the responsibility to improve health onto disadvantaged communities, encouraging them to become more active in community life instead of increasing budgetary spending on a comprehensive social service model (Campbell et al., 1999). The literature provides the concepts of how health is impacted by agency and structure, respectively.

Network enhancement at the community level, through a bottom-up or grassroots approach, is how social capital is thought to develop. Marmot and Wilkinson (2006) argued that countries whose populations are in the best health are those with the smallest

income differences, as the distribution of social capital and justice within countries is what determines well-being. The basis of the argument is that egalitarian societies are more socially cohesive and supportive of their citizens with a higher level of trust. On the one hand, a stronger community life inherently has less social inequalities. A society fraught with inequalities, on the other hand, experiences higher crime and stress, which reduces the ability of social networks to overlap and work together.

Social capital is a concept that speaks to the interactions between people through systems that support the processes of people and organizations collaborating through the trust of each other to achieve common goals for social benefit. Community-based health relies on civic engagement because it is the pathway through which social interactions and health are united (Campbell et al., 1999; Putnam, 2000). In summary, social capital theory, through bonding, bridging, and linking, suggests how vulnerable populations could potentially access resources through social networks to improving their health and well-being. Lin (2001) and other researchers such as Bourdieu (1998), Coleman (1988), and Berkman (1984), have maintained that social capital can be measured by the resources embedded within social networks. Researchers have also pointed out that social capital can be invested and mobilized to reach goals at the community and societal levels by individuals seeking access to the macrosystem (Leonard, 2004; Lin, 2001; Villalonga-Olives & Kawachi, 2015). This clarification is helpful as it further informs the questions guiding this literature review as to the process and pathway vulnerable populations can travel to obtain well-being. However, the trade offering is still unclear. After vulnerable populations bridge the pathways established by social networks into the macrosystem, what do they have to offer in exchange for needed resources?

Literature provides a potential answer to this question by exploring institutional capital. Social networks are believed to possess the capacity of building institutional capital. It is suggested that institutions accumulate a pool of social capital acquired through collaborations, associations, and partnerships with other shared interests and purpose (Lin, 2001). The cumulative institutional capital is then transformed for use by social network members to access and draw down needed resources. Though Lin offers examples of such transformations in the inception of social movements and revolutions, social networks could transform in a similar manner to institutionalize resources gained from cross-sector collaborations for use in the macrosystem by members of the network. Conceptually, this proposition could be built upon to answer the question of what vulnerable populations have to trade for needed resources once they bridge through established pathways embedded in the social network. Hypothetically, the pooled resources available through the social network are a form of social capital credit for use by its members. Perhaps this is the transactional component of the exchange of social capital that would be used by vulnerable populations to link to institutions at the macro level or wider society. This literature provides a direction for this study.

This study at hand will attempt to determine if the participants experience social capital in its forms of bonding, bridging, and linking and if the participants describe accessing any of La Maestra's collaborating partners for resources to satisfy their needs around social determinants to improve their health and well-being. Another point of interest is whether La Maestra is providing institutional capital that they can draw upon.

Describing various measures of social capital from the literature provides more information as to the source of social capital that vulnerable populations need to

exchange at the macro level to receive resources needed for improved health and well-being.

Measuring Social Capital: Further Insights

Putnam (1993, 1995a, 1995b) created controversy in his attempt to measure what he believed to be a decline of social capital in the United States over several decades. He attributed this decline to lower political participation through the decrease in voting, as well as a decrease in involvement among young people in civic associations.

Unfortunately, Putnam's research contained a few major flaws. The first error was in his analysis of the General Social Survey Data (Greeley, 1997). Putnam used the data for membership in associations and clubs, instead of the amount of time spent volunteering.

Researchers were quick to point out that Putnam used the wrong dependent variable (Greeley, 1997; Newton, 1997). Another criticism of Putnam's research was that he excluded faith-based organizations from the data that he analyzed to determine civic engagement. Putnam defended his choice of criteria by stating that faith-based organizations were not civic-minded. An additional point of contention among the research community was that Putnam blamed the increase of television viewing among young people for the decline of social capital. Many researchers believed that other factors for the alleged decline in social capital should have been considered (Schudson, 1998). Following the controversy and criticism of Putnam's original study, he then expanded on his study and attempted to address some of the main criticisms in following studies (Putnam, 1995a, 1995b). Putnam's further work on social capital (Putnam, 2000) is the most pertinent to this study as he elaborated on the forms of social capital and their qualities.

Measuring social capital and well-being within the medical field is said to be difficult to assess from a public policy perspective as the established measures fall into either morbidity or mortality rates (Fleuret & Atkinson, 2007). Hendryx, Ahem, Lovrich, Nicholas, and McCurdy (2002) attempted to link social capital in local government performance of 22 large cities across the United States with increased access to services in the health care sector. The study's main hypothesis was that access to health care is positively related to the level of social capital present in the community. The secondary argument in the study was that accountability of health care services leads to improved social community capital. Although access to health care is an important factor for improving health, accountability and quality of care are governed by regulatory federal agencies, not the community. Granted, community trust in health care institutions might lead individuals to access more health care services available to the community. However, access to services alone does not lead to social capital in underserved vulnerable communities. This point has already been established by federal agencies that have implemented initiatives around increasing access. The results from Hendryx et al.'s (2002) do not explain why vulnerable populations have not reached desired health care outcomes or well-being. Hendryx et al.'s (2002) study does not address the contextual factors within disadvantaged communities that contribute to health disparities nor does it link social capital to the improvement of health. It does attribute the managed care (HMO) component of health care reform in the 1990s to fostering social community capital but does not address the criticisms of managed care related to barriers patients have experienced due to closed provider networks and pre-authorization requirements (Bradley & Taylor, 2013, p 160). Even if access to care increases social community

capital, the managed care processes, by which members must abide, undermine the proposed access value and ensuing social capital. Hendryx et al.'s (2002) research on social capital in the health sector, through measuring access to care, provided insight useful to this study. However, because Hendryx et al. (2002) did not incorporate the social capital aspects of bonding and bridging which were the main tenets of Putnam's (1993) description of social capital theory we do not know how these processes can affect the social capital of vulnerable populations and the outcomes on their health and well-being.

Although researchers have criticized Putnam's (1993) interpretation of social capital and its outcome measures, several aspects of social capital, such as trust in bonding social capital and bridging through social networks to garner resources from the macrosystem—the wider society, appear to be somewhat helpful in understanding how social capital may affect the health care of vulnerable populations. This study will examine the patterns that may emerge from participant data around trust, social connectedness, empowerment, and social networking and their experience with the Circle of Care. I look specifically at patterns around bonding, bridging, and linking, to gain a deeper understanding of the influence that social capital can have on improving the health and well-being of vulnerable populations.

Is Bonding Social Capital Related to Well Being Indicators?

The literature on well-being, identified social connectedness, social networking, and identifying with others through commonalities of culture, values, experiences are some of the indicators of well-being. Social capital theory, specifically the bonding aspect, is similarly defined. There is a link, therefore, between the ability of individuals to

bond through social networking, identity alignment, and social connectedness and their perceptions of well-being, or subjective indicator of their well-being, or health related well-being (Cummins, 2000; Putnam, 2000). The literature review has also made clear that bonding serves to “get by” but to “get ahead” requires bridging, the second tenet of social capital theory. Bridging and linking involve accessing established pathways and utilizing social capital credit built by others, individuals or organizations, to draw down needed resources, which would address objective well-being indicators or social determinants (Cummins, 2000). The literature has informed the research questions in this study by providing a definition and measurement of health and well-being, as well as mechanisms to obtain needed resources through social capital theory. These mechanisms involve transactions to exchange existing social capital credit from others to draw down needed resources to “get ahead” through bridging or linking social capital. As vulnerable populations do not have access to these needed resources, they can access established pathways to networks into the macrosystem developed by local nonprofit organizations.

Summary

Various authors identified the need for more studies centered on health improvement for vulnerable populations and potential pathways that lead to well-being (Cockerham, 2013; Macaulay, Roy, Donaldson, Teasdale, & Kay, 2017). All of these researchers acknowledge benefits from social capital and the increased sense of belonging, trust, self-esteem, social support, and happiness. Cockerham (2013) expressed the idea that microsystem-level qualitative studies with participant interviews in their communities could shed light on the connection between health and wellness where social capital is available. This research motivates this study to better understand how

social capital may be influencing the outcomes of the individuals that seek health care from an integrated model of care.

This dissertation explores the operationalization of social capital theory and emergent themes to better inform the process through which vulnerable populations access or encounter challenges in the bridging process from their perspective. The literature has guided the formation of the research questions for this qualitative study which focuses on obtaining data directly from vulnerable populations. Perceptions from the participants will inform the research questions by identifying what participants view as beneficial, or not, from accessing La Maestra Circle of Care integrated service model and established networks. The methodology explained in Chapter 3 describes how, through the participant's own words and the meaning they derived from their experiences, accessing integrated medical and social determinants services impacted their health and well-being. The study's methodology will elicit from participants, any useful mechanisms in the Circle of Care model that led them to pathways to secure needed resources, to impact their health and well-being, from a participant lens. This approach might identify the lived experience of what medical and social factors were beneficial to them through the accessing of integrated services through one overarching community-based organization.

The literature surrounding well-being has revealed several key concepts useful to this study at hand. Perception is the key to how well-being and quality of life are measured by the individual, which is subject to change based upon objective well-being indicators. Literature has shown that individual health, social indicators, and the contextual environment impacts individual perception of their well-being, which in turn

influences their health status. The objective well-being indicators, defined as contextual environment factors (SDOH) can change. The research in this dissertation examines which indicators were identified by participants as bringing about desired changes in their health status and well-being.

CHAPTER THREE

METHODOLOGY

The purpose of this study was to gain the perspective of patients and clients of La Maestra as to their experience in obtaining both medical services and the services that address social determinants that are challenging their health. The goal was for participants to identify which characteristics of the La Maestra Circle of Care integrated service delivery model made a positive contribution to their health and well-being. The research questions addressed in this study include:

1. What do patients/clients perceive to be the value of La Maestra's Circle of Care integrated model in improving their health and well-being?
2. How does the perceived value of La Maestra's Circle of Care vary by participants' gender and ethnicity?
3. What strategies does La Maestra's Circle of Care use to address the needs of vulnerable populations seeking health care?

This chapter begins with a description of the two exploratory studies that preceded this research study and the research design used to conduct this study, which was guided by the information gained from the exploratory studies and the literature review. Units of analysis, the sampling strategy, and a description of the study participants are then described in detail. The subsequent section reviews the interview process, including sensitivity to the cultural diversity of the participants. The research sites, and the benefits associated with having conducted the research study in the target community, are also described. The next section concentrates on the data collection process, a priori coding of categories, and how additional categories were formed as new

patterns emerged from the interview data collected for this study. Various forms of data analysis were employed in this study. The rationale for selecting thematic, case, and cross-case data analysis is described. This analysis section proceeds with a discussion about the trustworthiness of the data and the limitations and delimitations of the study. This chapter concludes with a summary of how the research methodology aligned with the literature review to address the research questions.

Exploratory Studies

I previously conducted two mini studies in which participants identified value in accessing multiple services from La Maestra's Circle of Care model, including primary health care and other services that addressed the social determinants that were affecting their health. In the two exploratory studies, participants spoke about finding value with the ease of accessing numerous needed services, the seamless system of inter-referrals, and the cultural competency focus of the services. What I had not anticipated was that participants described a social value in finding others with whom to identify, who shared similar backgrounds and similar experiences and had similar needs. They described the opportunity to belong to a social network at La Maestra where they felt connected to others with similar situations, shared values, goals, and challenges. The participants also spoke about the trust they felt in the staff, who were also from similar backgrounds, and about a welcome feeling and sense of belonging they experienced as they navigated through various service programs in the Circle of Care. They stated that meeting others who had faced similar challenges and adverse prior life experiences gave them hope for their future.

Building trust with the staff gave them the self-confidence to access additional information and opportunities through the established pathways of the Circle of Care and outside La Maestra to the macro or larger health care system and other sectors besides the health sector. The participants spoke about finding validation of their successes because of the ability to reciprocate, contribute to society through volunteering, and become active in their communities through the relationships and resources they had accessed in the social network or social connectedness element of the Circle of Care. Subsequently, the results of the two mini studies led me to utilize social capital theory in developing the interview guide and first cycle coding because this theory suggests that when social connectedness, belonging, trust, self-confidence, hope, empowerment, and reciprocity are present, individuals have the opportunity to better their lives (Lin, 2001). The literature on social capital and its forms of bonding, bridging, and linking, as explained in Chapter 2, provided a lens by which to examine the experiences of participants with the Circle of Care and to understand the transactional exchange of social capital within this health care context.

Research Design

This section describes the research approach, units of analysis, the interview rationale, interview process, observations from the interviews, and the location of the study.

Qualitative Research Approach

The focus of this study was to gain insight into how participants understood their experiences and what value they found from the integration of social determinant services, specifically the cognitive interpretation of the participants' experiences with the

integrated model. I chose a qualitative research approach because this approach allows for a deeper investigation into the participants' experiences. A quantitative approach to these research questions would have been helpful if the goal of the study had been to count or sort the types of services accessed by the participants or if it sought to survey a broader group of health care recipients. This study was focused solely on La Maestra and was designed to examine more closely the lived experiences of the clients who sought help.

A qualitative research approach allowed me to gain insight into how participants understood their experiences with the integrated Circle of Care model and their perspectives on how social capital, particularly the notions of bonding, bridging, and linking impacted their health and well-being. A deeper dive into the participants' thought processes, how they described their interpretations of the effect of their experiences through the integrated model on their health status and well-being, was all essential information needed for this study. The sequence of steps in the research design is depicted in Figure 6.

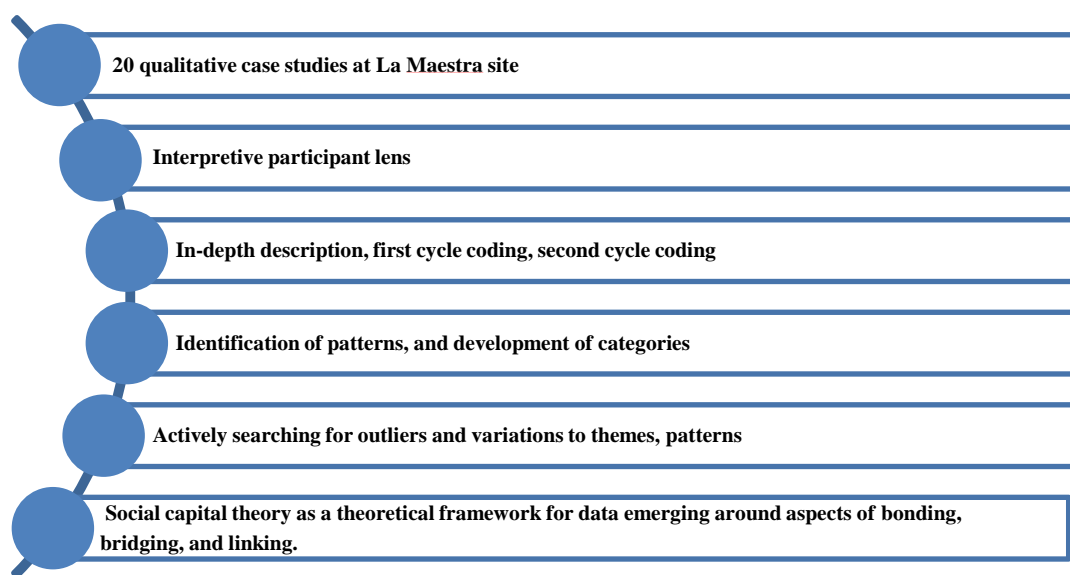


Figure 6. Research design.

Units of Analysis and Participant Selection

The units of analysis in this study are the patients and clients who participated in La Maestra's Circle of Care. I included interviews with six unit directors in my sample of 20, as they were formerly patients or clients. I also included the data from the three patient and client interviews previously conducted as part of the exploratory mini studies. The focus of the earlier mini studies was to identify any value they derived from accessing three or more services from the Circle of Care model. Participants in both mini studies valued social connectedness, belonging, identification with the staff and other patients. Using these factors, I searched the literature to gain more insight into how these factors connected to previous research on social connectedness through social networks. My search led me to some of the major concepts included in explanations of social capital and explanations as to how social capital can better the lives of individuals.

In this dissertation, I expanded the inquiry of the participants from the mini studies and, using their electronic patient records and client database, I identified those patients who had accessed a minimum of three or more program services from the La Maestra's Circle of Care model. The resulting list of potential participants was extensive. The query revealed thousands of patients and clients who met the criteria of having accessed three or more services from services areas in the Circle of Care (an interesting finding on its own). To further refine the list down to a more manageable number of potential participants, I enlisted the assistance of staff to identify a cross section of participants from the six major service areas of the Circle of Care: health care services, economic development services, housing, legal assistance, food and nutrition, and youth development. Staff identified 14 additional eligible participants using the criterion-based

selection process. There were no patients or clients who abstained from the offer to participate. This sampling resulted in 14 more patients or clients who agreed to participate in the study after the lay summary and consent forms were reviewed, signed, and collected.

Six unit directors also participated in the study who had previously been clients, bringing the total number of participants to 20. I included the data from three director interviews in the previous preliminary studies who greatly added to the research data because they provided an additional lens about patient and client experiences: context over time. They have been with the organization for many years and were part of the development of many of the service units. They also have had direct contact with patients, clients, staff, and outside collaborative community-based organizations for numerous years. The directors added a perspective first as a client and then second as a director observing and interacting with current clients. Directors also shared pertinent examples of feedback from patients and clients relating to bonding, bridging, and linking forms of social capital.

Four of the 20 participants indicated that they preferred to have a translator present during the interview to fully communicate. Others spoke in Spanish during the interviews or in a mixture of Spanish and English. I am fluent in Spanish, so I was able to fully comprehend their answers and idiomatic expressions used. As the majority of the participants were not born in the United States, I made every attempt to tailor the in-depth interviews to be culturally sensitive in that I also spoke in Spanish when needed and provided translators for other language and cultural interpretation.

Interview Rationale

The focus of this study was to capture the participants' interpretations of the values that they derived from the health and well-being from multiple interactions with the Circle of Care model. Through two exploratory studies participants identified value in the availability of comprehensive social determinants of health services through one overarching organization. Participants had also spoken about the benefits they derived from social connectedness through the social network characteristic of the model. In this study, I wanted to understand how social capital relates, if at all, to the improved health and well-being from the perception of the participants. I chose to delve into the participants' perspectives instead of trying to determine the relationship between the Circle of Care, social capital, and health outcomes. Subsequently, I looked for evidence from participants of the characteristics of social capital. I expected that participants would report favorable outcomes after accessing services through the Circle of Care based on the results from the two exploratory studies, but I did not know how much of an impact the social connectedness and social network, including staff, at La Maestra would have on their well-being.

To establish a baseline of how participants perceived their health status and overall well-being before they obtained services through La Maestra, I tailored the open-ended, in-depth interview questions (Merriam & Tisdell, 2016) to elicit information about their prior lives, adverse experiences, and needs before accessing services through the Circle of Care. It was important to gain a clearer understanding of the social determinants that influenced their need to seek help at La Maestra. I examined the process through which participants accessed three or more services. The interview questions were

designed to assess the value participants gave to the Circle of Care model and better understand how their efforts to seek health related services were related to their backgrounds and their current lives. I wanted to explore the intersectionality between social capital, health, and well-being in vulnerable populations, as defined through the interpretive lens of the participants (see Appendix F for Interview Questions).

Research Sites

The study took place on the premises of La Maestra Community Health Centers, a federally qualified health center, and La Maestra Foundation, which offers social determinant services around economic development, housing, social services, immigration and legal assistance, human trafficking, youth empowerment, community garden food pantry, and re-entry services. These two nonprofit organizations (La Maestra Community Health Center and La Maestra Foundation) form La Maestra Circle of Care, located on the same two blocks in City Heights, San Diego. The interviews were conducted at La Maestra, within the same community where participants reside, as were the two preceding exploratory studies. By conducting the interviews at La Maestra, potential challenges of transportation and translation were eliminated. Participants were already familiar with the site where the interviews occurred, adding a level of comfort, which facilitated participation in the interview process. Many of the participants, in this current study and the two preceding mini studies, appreciated the trust relationships with the staff and the organization more generally. I believe that their willingness to participate in this study was assisted by their existing level of trust with the staff and the programs.

Interview Process

Participants were asked to describe the needs that led them to access services and the types of services they accessed. All of the participants answered these questions and offered the experiences that led them to seek care. They described their challenges and journeys as they sought resources to improve their health and well-being. The two exploratory studies and the literature guided the development of the interview protocol. Each of the 20 cases consisted of one interview and one post-interview meeting to review the interview transcripts and member check. In the instances where translators were used, the translators were asked to review and verify the accuracy of the transcripts. I had originally allotted a 2-hour interview time per participant. Most of the interviews were conducted within the 2-hour time period. The second meeting consisted of reviewing the transcripts for accuracy and completeness; it also provided me the opportunity to ask clarifying questions. Often, the process required editing the transcripts twice before the participants were satisfied because they wanted to add information that had come to their minds after our first meeting, such as correcting the sequence of their visits or identifying additional services they had accessed but had not been recalled during the interview.

I offered light refreshments and ensured confidentiality by selecting an office space free from outside interruptions and sound muffler devices outside the doors, frequently utilized to avoid being overheard by adjacent offices. The restroom was located directly adjacent to the office where the interviews were conducted. These efforts were very useful as they signaled to the participants that they could speak freely without the risk of being overheard. All of the participants gave lengthy answers and offered a plethora of information to inform the research questions. Most of the interviews were an

hour and a half to two hours in duration, as were the interviews from the mini studies. The interview transcripts ranged from 15 to 27 typed pages per participant. I allowed the participants to follow their thought process when providing descriptions and historical accounts and then guided them back to the topic at hand by consulting the interview guide.

Observations

As my goal was to obtain as much information pertinent to this study, I wanted to make participants feel as comfortable as possible and build trust between the participants and me, the researcher.

Through observations and participant comments, it became evident that the participants were pleased to be asked about their experiences and life events leading up to accessing services through La Maestra Circle of Care. The participants voiced their happiness in sharing their stories and welcomed the opportunity to be heard in detail. Their demeanor was open, willing to share, and willing to be part of this study although five of the participants declined to be recorded. Two self-identified as mental health patients and were concerned about being recorded. As a result, I took copious notes, which I transcribed the same evening to ensure that I remembered all of the nuances, nonverbal communication, and observations from the interview, in addition to the content. I used analytic memos, quotes, and observations and followed up with the participants for clarifying questions.

The participants spoke of the stigma of mental health issues still existing and voiced shame from having mental health problems. I realized that, in their cultural community, being known for mental health issues is still a challenge even though they

are in the United States, which, generally, does not ostracize individuals for having mental health issues or for seeking mental health services, at least not formally. Other participants who declined being recorded were in the process of obtaining their residency status and did not want to risk having any of their comments falling into the hands of Homeland Security, even though I assured them that the recordings would remain only in my possession.

Enlisting interpreters for the interview process was essential to communicating and translating cultural nuances during the interviews as participants spoke several different languages. English was the second or third language for most of the participants. Some were comfortable with their English proficiency and others accepted the offer of translators. The interpreters translated the conversations, which was important, by providing the interpretation of cultural beliefs and how they influence participant perspectives. There are always issues with translation, but, to the extent possible, the translators captured the perspectives of the patients and clients. These same participants emphasized greatly the value of having cultural liaisons at La Maestra available to them. One patient noted, they “understand me and the problems I had in my country, in the refugee camps and now in this new country.” Because the staff came from similar experiences and backgrounds, they felt that the staff did not adversely judge them, and they felt supported.

The unit directors were very cooperative and agreed to participate because this study falls within their scope of work. The unit directors provided patient and case file records to corroborate the number of services that patients and clients accessed. These resources were helpful to the study because the participants often forgot to mention the

entire list of services they obtained. The directors also offered case management notes about referrals and examples of many other patients and clients who accessed services through their respective units. The directors brought an additional level of observation to this study, as they had previously been at the same level of need as the patients and clients. The directors also obtained services through La Maestra's Circle of Care. The directors brought an additional level of insight to the study, detailing their own journey towards health and well-being through many years of accessing services and helping to expand the Circle of Care. Instead of a 3- to 5-year experience with La Maestra's Circle of Care, which most of the patient and client participants have, the directors offered their perceived value over 10 years or more. The directors were proud to have emerged from the patient base, accessed job training, advanced their education, and attained leadership positions as directors in the organization.

Through the conversational interviews, participants spoke without constraint and elaborated on their experiences as they navigated through the integrated model. Participants identified and prioritized perceived values associated with social capital (i.e., social connectedness, increased self-esteem, trust, and reciprocity). Additional values were identified related to the role of culture in their understanding of the process and the cultural competency of the staff. Interviews addressed the research questions on how the Circle of Care integrated model facilitated their health care outcomes of feelings of well-being and revealed participants' opinions of how expanded services could be added to the model.

Triangulation of Data Collection

The study used triangulation to capture data through various means, including qualitative data from conversational interviews, observations, and participant charts and files. According to Merriam and Tisdell(2016), collecting multiple sources of data in a research study serves to increase the internal validity. The data needed for this study included contextual, perceptual, demographic, and theoretical information. Data were collected through 20 qualitative case studies selected from the electronic health records and program files. A total of 14 patients and clients were chosen based on their access of three or more services through La Maestra Circle of Care. In addition, six directors representing the main programs in the model participated in the study. I triangulated the data between open-ended interviews, observations, the use of quotes, and patient or client charts to validate the data.

The data collected was informative in answering if their experiences were influenced in any way by their gender or ethnicity. I also actively sought data that were nonconforming to the patterns emerging (Merriam & Tisdell, 2016). Follow-up questions provided more information and further clarification.

Analysis of Data

This section describes the data analysis process for the multiple case study. The first stage consisted of a deep level of analysis into each case followed by the second stage of cross-case analysis (Merriam & Tisdell, 2016). Each participant in this study was considered a case. Within-case and cross-case analysis allowed for emergent concepts and themes to surface with sensitivity to the tenets of social capital theory (Gioia, Corley, & Hamilton, 2012). Though this study was designed to identify data related to social

capital theory and its forms of bonding, bridging, and linking, new themes emerged in response to the research questions on participant perceived values of the holistic model. For example, new themes arose around the empowerment of participants through alignment with the staff and the culture and institutional capital.

Coding

I proceeded to code all of the data, allowing patterns to emerge that generated themes in response to the research questions about the value participants identified from the integrated service delivery model, La Maestra Circle of Care. In addition, the data revealed additional factors from the patient and client perspectives, which impacted their health and well-being. Analysis of interview data allows for a priori coding of the qualitative data into categories (Saldana, 2016). The information gleaned from the exploratory studies led me to develop these initial headings of categories. First cycle coding used the theoretical codes that emerged from the two previous mini studies around the bonding, bridging, and linking forms of social capital. The second level codes were derived from these current interviews. Participants who identified the values of social connectedness (i.e., identifying with the populations, reciprocity, and trust) were placed into the bonding category. The bridging category included participant interview data that identified value around referrals to additional social determinants resources obtained through La Maestra's Circle of Care. Participants who identified value from resources accessed through La Maestra's network with collaborating partners in the macrosystem were included in the linking category. Additional codes were assigned for adverse prior life experiences, number and type of services accessed through La Maestra Circle of Care, gender, and ethnicity. Additional codes were developed to highlight participant

identification of values around the staff, including cultural liaisons. This process allowed me to identify patterns in the data and develop categories that led to the themes that emerged from the interview data (Charmaz, 2006). Similarities and differences among the interview data then became apparent (Coffey & Atkinson, 1996). An example of this comparison was the transactional exchange of social capital, specifically how participants accessed social capital and then reciprocated through civic engagement.

I used chronology to order and organize the data according to the participants' first entry into the Circle of Care, by gender, and ethnicity. The participants' description of their social determinants needs coincided with their navigational pattern through the various units in the Circle of Care. The participants' social determinants needs resulted from prior adverse experiences of the participants.

My goal was to identify theories emerging from the data about the phenomenon of the cumulative value of the Circle of Care model and the process or pathways followed by the participants. I used open coding in first cycle coding (Saldana, 2016). I used both margins of the interview transcript pages to record simultaneous coding as the data were indicating that it could be categorized under more than one code. I did experience an overwhelming amount of data that could be used, but, after grouping the codes according to patterns, I eventually ended up with categories of codes that fit under the categories of demographics, baseline social determinants needs, prior adverse life experiences, and access patterns to services by gender and ethnicity. The second cycle coding focused on evidence of social capital: bonding, bridging, and linking emerging from the interview data. Well-being indicators and data regarding staff and cultural competency was also coded.

Thematic Analysis

Thematic analysis assisted in the process of organizing the categories according to major themes emerging from the data. Thematic analysis allowed analysis of each case study through assigning codes, identifying patterns, and assigning categories (Glesne, 2011).

Following the within-case and cross-case analysis, I employed thematic analysis (Glesne, 2011) to interpret participant understanding of their experiences before, during, and after accessing the multiple services. Participants described their specific needs and experiences before accessing services, which provided a baseline of needs. Then, the participants described the social value they identified as beneficial to their feelings of increased well-being emanating from trust, connectedness, belonging, and cultural alignment with staff and other patients and clients. This data aligned with the bonding form of social capital theory. Data around the participants' accessing resources through the social network of the Circle of Care was grouped into the theme of bridging social capital. The participant data around accessing resources in the macrosystem, outside La Maestra, through established pathways to agencies collaborating with La Maestra was grouped into the linking theme. Data reflecting the participants' perceptions of their quality of life was placed into the theme of well-being indicators.

Thematic analysis is a research technique that provides a process to organize and make sense of the participants' experiences, identifying the commonalities through patterns, themes, and differences in how participants interpret their experiences (M. Crowe, Inder, & Porter, 2015). Gender, ethnicity, and age were theme subgroups to gain an understanding if these factors influenced the values identified by the participants of

their experience with the Circle of Care. This form of analysis opened the inquiry for a deep description of the data and guided the direction for delving deeper into understanding why patients and clients were motivated to seek services in the first place and their perceptions of the value in obtaining multiple services through one overarching organization.

After analyzing the interview data, I regrouped the categories to note relationships between the established categories noting common themes among the cases. Participant identification of similar values obtained from the Circle of Care, including bonding, bridging, and linking, were brought together and labeled according to dominant themes around social capital theory (Charmaz, 2006; Crowe, Inder, & Porter, 2015). The cultural competency of the staff and the intersectionality of service delivery model of the Circle of Care were also common themes.

The process of data analysis facilitated constant comparison between the cases (Eisenhardt & Graebner, 2007) and highlighted emerging themes responding to the research questions in this dissertation aligning with social capital theory (Charmaz, 2006).

Within Case and Cross-Case Analysis Design

Social capital theory was the theoretical framework I used to analyze the interview data. I also employed an inductive or bottom-up approach to allow new theory to emerge from the data. Once the data was coded and themes and theories emerged, I tested the theories across subsequent interactive interviews through an inductive approach (Merriam & Tisdell, 2016). I analyzed the interview transcripts and quotes to capture how the participants' responses supported or challenged the themes that had emerged

from the analysis of previous interviews. I then employed relational analysis to explore the relationships between the concepts that emerged from the data (Merriam & Tisdell, 2016).

Creating a conceptual map was incredibly instructive, as it helped me to identify relationships between the cases and repeating themes. Through numerous re-organizing exercises, it became clear that the data were very rich. I began to query the data as to how participants determined the value of the cumulative services in the Circle of Care model and how the data related to social capital

The data analysis sought to discern the influence of compositional and contextual factors of social capital that influenced participants' health and well-being (Veenstra et al., 2005). This cross-case analysis design facilitated the examination of the emerging contextual and cultural idiosyncrasies that shaped the participants' understanding of their health status and well-being such as: commonalities emerging around interpretation of culture as shared experiences rather than shared ethnicity, and the definitions of well-being centering around social connectedness.

Within-case and cross-case analysis design allowed for comparing themes across the 20 patient and client cases (Merriam & Tisdale, 2016) around social capital theory. The analysis lent itself to an in-depth examination into the individual cases, the participants' backgrounds, life experiences, their contextual needs before seeking services, and the experience of the participants as they accessed multiple services through the La Maestra Circle of Care. Commonalities, distinctions, and variations emerged among the cases (Glesne, 2011).

A within-case analysis facilitated the grouping of data by looking at the different views of participants on core issues (Merriam & Tisdell, 2016). The within-case form of analysis fit the study, with a focus on the participants' experiences and identification of value of the Circle of Care integrated model related to their health and well-being.

Cross-case analysis grouped together answers looking at the different values identified from each participant according to the categories (Patton, 1990). This process was followed by an analysis of how each participant expressed the layering of factors that culminated in their understanding of the value they identified from their own personal experience with the Circle of Care (Merriam & Tisdell, 2016). These forms of analysis fit the study which focuses on the participants' experiences and understandings about the Circle of Care's integrated, holistic model. Through cross-case analysis, I identified re-occurring themes and patterns across the cases using thematic analysis and continuously comparing the data in the key conceptual categories, according to gender, ethnicity, and age. Explanatory overarching concepts began to emerge through constant comparison of cases that resulted in commonalities among the participants (Corbin & Strauss, 2008). Cross-case analysis allowed me to compare each of these main theoretical concepts and delve deeper into the case data for differences between the cases.

The resulting data from participants' interpretations of their contextual environment and added an expanded knowledge of the effect of multilayered social determinants on their health (Suddaby, 2006) through the transactional exchange of social capital.

The results of the study provided insight into the current debate about responsibility for the ill health of vulnerable populations. Although this study is limited in

size and not generalizable, it provides an opportunity to gain a greater understanding as to how integrated care can help ameliorate the persistent health care challenges of vulnerable populations.

Trustworthiness

I used member checking to increase the trustworthiness of the data collected from the interviews during a second meeting with the participants and translators. Methods were triangulated to build trustworthiness, helping to interpret the data and identify gaps and contradictions. Triangulation of participant interview data, observations, patient and client chart data, and case management logs strengthened the trustworthiness of the emergent findings (see Figure 7).

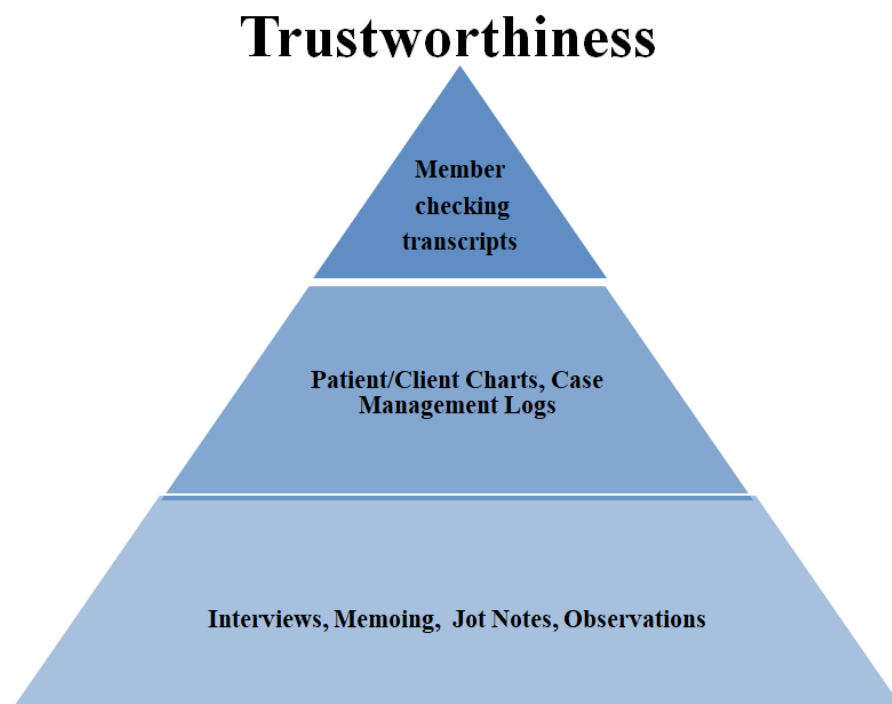


Figure 7. Triangulation of data collection.

Although this study is not generalizable, the results could be transferrable to other settings through the use of detailed descriptions of the findings with quotes from the participant interviews, patient and client chart documents, and observations to inform other investigations of social capital and health (Merriam & Tisdell, 2016).

Positionality

My position, as one of the founders of La Maestra 34 years ago, places me in an insider position because I share similar past challenges with the participants in this study. In 1986, La Maestra was formed to help applicants applying for residency in the United States through the Immigration and Reform Act of 1986. Amnesty related services included English as a second language, immigration application assistance, and classes on civics and American history. From there, other contextual needs emerged from the student base of over 12,000. These included adult and children's literacy, economic development, vocational English as a second language, computer literacy, housing assistance, and social services. The students were from culturally diverse, immigrant, and refugee backgrounds, recognized in this study as vulnerable populations. The programs expanded to meet health care needs, establishing La Maestra Family Clinic in 1990. The clinic now handles over 248,000 patient visits per year.

From a personal perspective, I can identify with the needs of the populations of focus in this study. My mother is a refugee from the former Yugoslavia. She and her family were one of many refugees to come through Ellis Island in 1949 after escaping the war-torn Croatian coast and living in a refugee camp as a child. My mother, her two sisters, and her mother had to flee Zara, Yugoslavia by hiding under fishing nets and navigating through islands occupied by the enemy to reach the shores of Italy. My

mother's father was a guerrilla fighter against Tito's communist regime and lost communication with his family for 10 years. After fleeing from execution attempts in Zara, Yugoslavia, he served with the Allied Forces and gained sponsorship from a U.S. general to bring his family to the United States. Because my grandfather was from a communist country, the government delayed his citizenship application for 11 years, during which time his movements, mail, and activities were under surveillance. The family experienced constant anxiety and uncertainty, not knowing if they could establish roots or if they would be displaced again. They experienced health problems but did not have access to services for medical care, mental health care, food, or housing. They lived in government housing for a few years until the city condemned it. Through social networks, my grandfather found work on the tuna boats in San Diego. He studied to be an electronic engineer, securing the position of chief engineer with the West Gate Plaza and Little America corporate buildings in San Diego. He advocated for the engineers he supervised who were working around asbestos and deafening machinery. He was responsible for unionizing the workers. As was our custom, each week we shared a meal during which time my grandfather would share his views on social injustice, human rights issues, political discussions, and conversations about the disparities. As a child, those discussions did not resonate at the time, but I did comprehend his passion for helping others and fighting injustices. We continued those stimulating interactions until 2005 when he passed away.

My father died when I was 1.5 years old. He had Hodgkin's disease. His family, unlike my mother's, came from a culturally diverse background. He was a fifth-generation American with family from the Midwest who had migrated from the Dust

Bowl to San Diego in search of work and better opportunities. My great-grandfather was the sole provider for an extended family for many years, living in Section 8 housing on Market Street, when I was born. Health care was only accessed for emergencies as there was no money to purchase health care policies. In those days, preventative care screenings were not accessible. Moreover, families took care of their own members with home remedies, and they dealt with mental health issues as best as possible.

Both sides of my family were poor but resourceful, hardworking, and loving people. During my childhood, family members and stepfathers who surrounded me could have greatly benefited from a variety of culturally competent services. There were no such services available to help meet with the medical, mental health, domestic violence, substance abuse, food scarcity, employment, and housing needs that I witnessed growing up. Perhaps my background prepared me for the path in life that has led me to develop programs for vulnerable populations. I am deeply appreciative to have had my family as mentors throughout my life, sharing their faith, traditions, values, hopes, and love for me and others. I have a strong faith in God, whom I believe has led me to my purpose in life.

As the CEO and co-founder of La Maestra Amnesty Center, La Maestra Community Health Centers, La Maestra Foundation, Community Redevelopment Centers, and Community Health Imaging Centers, and many community-focused initiatives, including the Circle of Care, I am heavily invested in the continuous development of the organizations and their missions. The outcomes of this study provided direction for further development of the integrated model. The perceived value identified by the participants have elucidated how the model can be improved to further enhance and facilitate the pathways for vulnerable populations to make strides towards

realizing a meaningful life through improved health and well-being. I believe that I was able to minimize my subjectivity during the research study process through reflexivity. Journaling throughout the research study allowed me to make notes of my feelings and emotions immediately after each interview. Reflexivity provided an opportunity to record my reactions and thoughts on a separate document, which signaled to me that my thoughts and feelings were separate from the participant interviews. The reflexivity process encouraged my objectivity through remaining mindful of the separation I wanted to achieve as the researcher from the data provided by the participants. A goal of this dissertation is to continue enhancing the service delivery model. I anticipate continuing to share this integrated model along with the new information gathered from this study with other community health centers across the nation and with federal agencies developing policy to improve health and well-being for vulnerable populations.

Limitations and Delimitations

Due to time constraints, this study did not focus on capturing the participants' experiences accessing similar services outside the La Maestra Circle of Care because the area of interest in this study is on the value of an integrated model. For this reason, the participant selection criteria required that participants accessed at least three different service areas in the La Maestra Circle of Care. However, if participants mentioned accessing services outside of La Maestra, in connection with their perceived value, the information was included in the findings.

I anticipated that, as I interviewed participants, I would hear their experiences echoing similar events in my life, as disclosed in the positionality section. By practicing reflexivity, I was aware of my subjectivity in an insider-outsider stance (Merriam &

Tisdell, 2016) during the interviews and kept a journal on how the information I heard triggered my emotions and my personal experiences. In interpreting the data, I was mindful to focus on the participants' lens of how they understood their experiences and life events and the inter-subjectivity of all involved in this process. Glesne (2011) described this process as practicing "highly disciplined subjectivity" (p. 147) and not generalizable, in that each interview and the interpretation is unique to that participant and to the researcher inter-subjectivity.

Summary

This chapter described the methodology of the research study, from the design framework to the steps to identify, collect, code, and analyze the data. The literature review preceding this chapter and the exploratory studies served to guide the selection of each step of the research. This study offers the perspectives of vulnerable populations as they identify the value derived from accessing social determinants of health through an integrated model. Connections were made to the forms of social capital: bonding, bridging, and linking. The emerging theories focused on social ties and social networks as impacted by culture and staff. The synthesis of the data is the process that culminates in research findings. The findings and discussion of the research study follow in Chapters 4 and 5, respectively.

CHAPTER FOUR

FINDINGS

This chapter presents findings from this research study conducted with 20 participants who accessed three or more social determinants service units through La Maestra Community Health Centers. La Maestra is the organization and the Circle of Care refers to the integrated social determinants service delivery model created by La Maestra. The findings are structured around a framework that begins with participant demographics and a description of the self-reported adverse prior life experiences, which prompted the participants to seek services through La Maestra. The framework of findings then continues with an explanation of the intersectionality of social determinants services that participants accessed through the Circle of Care. The next section of the framework lays out the values participants identified from their experiences at La Maestra as they relate to their health and well-being. The values identified are categorized into the areas of services, staff, and the three forms of social capital: bonding, bridging, and linking. The next section focuses on how institutional capital and culture supported participants' needs. The chapter concludes with participants' descriptions of their current quality of life.

Participant Demographics

The majority of the participants in this study are in their 50s (47%), with 25% of participants in their 40s. Twenty percent of the participants are in their 30s. Ten percent of the participants are in their 70s, and 5% are in their 20s. The median age of the participants is 42 years old. Participants identified their ethnicity as 60% Latino(a) or Hispanic, 15% Caucasian, 10% African, 5% Laotian, 5% African American or Black, and

5% Burmese. The participants self-identified as 60% female, 35% male, and 5% transgender. The participant who self-identified as transgender elected to be included in the female gender category for the remaining findings.

Participant Demographics for Socioeconomic Indicators

A baseline measure of participants' socioeconomic status before accessing services at La Maestra is included here as well as the change in the indicators of employment, income levels, housing, social-psychological status, and medical insurance coverage after accessing services through La Maestra Circle of Care.

Employment Status

The participants were asked about their employment status before and after accessing services through La Maestra Circle of Care. The unemployment rate among the participants was 75% before accessing services. After accessing services through La Maestra, participant unemployment decreased by 60%, and the number of participants who were employed full-time increased from 25% to 65%. This shift represents a 40% increase in full-time employment. Of the 15% of participants who remained unemployed after participating in La Maestra programs, one participant was permanently disabled, and two were homemakers raising small children. There was no significant difference reported in the unemployment rate across genders.

None of the participants were self-employed before they entered programs at La Maestra. This number increased to 20% of participants owning and operating their own businesses after participating in La Maestra's Microcredit program. Overall, there was a reported increase of 60% in economic development among participants after accessing

the Circle of Care model. The Microcredit program criteria focused on women's empowerment so there were no men reported in this category.

Income Status

Of the 20 participants, 90% self-declared as low-income before they began programs through La Maestra. The number of participants in the low-income bracket decreased by 45% after participating in job training and placement services through La Maestra Circle of Care. Ten percent of participants reported their income to be in the middle income range before engaging in La Maestra programs. This number increased to 50% during their participation in the organization's programs. None of the participants self-identified as being in the high income bracket before entering into programs offered through La Maestra. This number increased to 10% after accessing programs and services at La Maestra. There was no significant difference in the income status across genders or ethnicities for participants in either the low income category or for those that elevated to middle income status. However, those participants that reported an increase to high income earners were predominantly males of Latino, African American, Caucasian, and African ethnicity.

Housing

Before entering services in the Circle of Care, a combined total of 50% of participants reported being homeless, equally experienced by gender. Of that number 15% were in transitional housing, 5% were in shelters, 5% were living in their car, and 25% were living on the street. Of the 50% of participants who were homeless, 45% became renters and 5% became homeowners after accessing services at La Maestra. Forty percent of participants identified as renters before they came to La Maestra, equally

divided between the genders and ethnicities. That number increased by 35% after participants' engagement in the Circle of Care. Only 10% of participants owned their own home before accessing services, all male. This percentage increased to 25% after participating in programs through the Circle of Care, inclusive of both genders but predominantly male.

Well-being Indicators Before and After Accessing Services

Participants reported on their well-being before and after accessing services through La Maestra. The most commonly reported needs mentioned by participants related to their well-being were isolation, mental health, behavioral health, and urgent medical needs.

Isolation. Seventy percent of participants reported feeling isolated before they accessed services through La Maestra, with equal distribution among genders and ethnicities. The percentage dropped to 0% after participants engaged in the Circle of Care.

Mental health. Mental health issues were reported by 55% of participants before seeking services through La Maestra. While male participants described mental health issues, they did not seek mental health services with the same urgency as female participants. The percentage of reported mental health issues dropped to 20% after accessing services in the Circle of Care. Of that 20%, all were female due to persistent challenges resulting from their experiences from domestic violence and human trafficking.

Behavioral health. Twenty-five percent of the participants reported having behavioral health issues before entering the Circle of Care, with a drop to 0% after receiving services through La Maestra. The gender distribution was predominantly male.

Urgent medical needs. Ninety percent of participants stated that they experienced urgent medical care needs before accessing services through La Maestra, with a decrease to 0% after receiving services through La Maestra. This well-being indicator was reported by only female participants.

Medical Insurance Coverage

Eighty percent of participants were medically uninsured before seeking services through La Maestra at an equal rate between the genders. Twenty percent of participants were already enrolled in medical insurance plans but were under-insured, meaning that not all of their medical needs were covered through their insurance. Of the 80% of uninsured participants, 65% were enrolled in medical coverage through La Maestra's eligibility programs, with both genders attaining medical coverage. Fifteen percent of participants remained uninsured due to ineligibility for qualification in state or federally sponsored medical coverage programs and inability to afford the cost of private health care insurance. Those who remained uninsured were all female. Though uninsured, those participants still received services at La Maestra.

Prior Adverse Life Experiences

Participants explained the importance of having access to the intersectionality of services that responded to their needs. Figure 8 depicts the prior life challenges, which prompted participants to access services through La Maestra Circle of Care. All respondents experienced one or more of those traumatic experiences. Males reported

more trauma related to gang life, substance use disorder, and violent crime. Mental health issues, human trafficking, domestic violence, and lack of legal status were more prevalent among the female participants. Trauma/loss from war, homelessness, childhood trauma, and sexual abuse was equally reported by both genders. All ethnicities were equally affected by these traumas, with the exception of gang life.

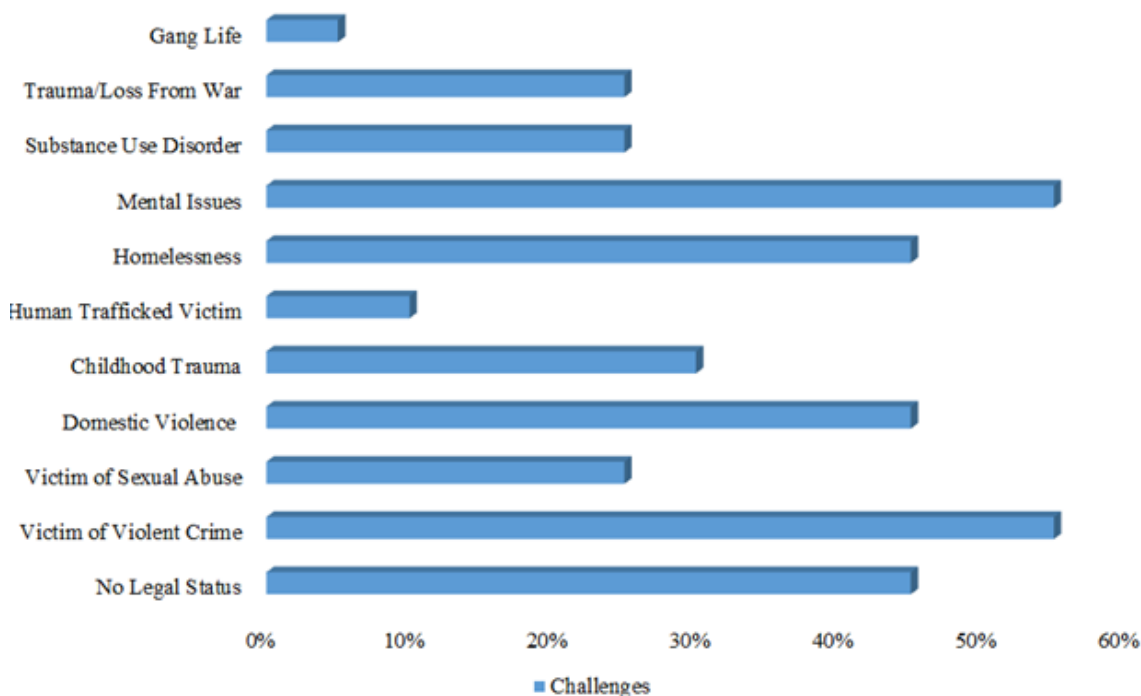


Figure 8. Percentages of prior life challenges among participants.

As presented in the data, the most common issue mentioned by the participants that caused them to seek out support was mental illness. Emilia shared,

I thought I was going crazy with all of the memories from my past experiences. I needed to talk with someone. I had so many triggers every day and had to keep reminding myself that I was now safe from the beatings and cruelty. . . . I also had to find help to file a visa application with immigration to be able to remain in this

country. There was no way I could return to Mexico after two documented assassination attempts against me.

Carolina also shared her experience of abuse that caused her to seek mental health help.

I was lost in this country. Even though I came from Tijuana, a border town, and visited often, when I came to live in San Diego, it was a totally different story. So, when I came here to live, I faced a very difficult personal situation . . . months after I moved to San Diego from Tijuana that my marriage fell apart. I didn't know anything. I was now here and couldn't return to Mexico because we had sold all of our properties in Mexico, and he [my husband] kept the money. My husband told me that I was on my own and that he wasn't going to give me money or any help. I didn't know what to do and had no support system.

(Carolina)

Other respondents' comments indicated the need for mental health services.

Nicole explained,

My anxiety came from twenty plus years of addiction and living on the streets and canyons, losing my children and my self-esteem. . . .Violence was something that I came to know a lot through sexual abuse, domestic violence, and criminal violence. . . . I didn't know how I could even start putting my life back together but was committed to getting out of that drug cycle. When I did, my memories were hard to deal with. I also knew that I had a lot work to do to make amends to my kids and family. Even though I knew what my goals were, it still caused me anxiety.

Eva shared why she chose mental health services to be the first unit she accessed in the Circle of Care.

The first time I came here to La Maestra was to see the psychiatrist. I took off all of my clothes and ran around. I was out of my mind. I came from Burma and then was in the refugee camp in Thailand for 10 years. I had to flee Burma because of the military troops that were after me and my village. It was very traumatic for me. I was pregnant and had to give birth alone in the jungle. It was the rainy season, and I got very sick. There were other horrible things that happened. My brothers were killed in front of me. I couldn't eat or sleep and became crazy. . . . I am still on medication. (Eva)

Each vignette highlights the complexity of needs faced by the participants, caused by adverse traumatic experiences in their past. The severity and complexity of their resulting needs required numerous social determinants services.

Robert, Mark, and Carolina shared that they were all homeless, although for different reasons, and all needed to find work. Robert explained, "I was unemployed. I was homeless. I was ready to go rob another bank." Mark also shared he was homeless and had family members who were homeless. Mark had just completed drug court and was mandated to transitional housing as a condition for his release. He heard about the transitional housing at La Maestra and applied. Mark stated that he was done with being homeless and using drugs. The transitional housing program allowed him to comply with the court order, transition out of homelessness, and begin working on his future.

Carolina described her situation with homelessness,

I had just gone through a divorce and was left without any money or housing or credit. He [my husband] wanted me to be under his control. He didn't want me to do anything without him. I said that if I'm here in San Diego I need to learn more English. . . . My husband said "no, you don't need that, you have me." I insisted, so I signed up. My husband wanted me to have the cell phone right next to me on the desk, and he would call me every 15 minutes. If I didn't pick up he would make a big deal over that. So I had to stop going to school. It made me think about my situation. He wanted to decide what we were going to do, where we were going to go, what we were going to eat, everything. I couldn't live like that.

Participant descriptions of their prior adverse life challenges provide background information as to why they sought services at La Maestra. The next finding describes all of the service units they accessed through the Circle of Care.

Participant Access to Social Determinants in Circle of Care by Gender

Figure 9 captures all of the service areas that participants accessed in the Circle of Care. This finding is essential because it suggests that services needed by participants are those who would address social determinants services offered through the Circle of Care. The data does not reflect the number of visits by participants to each of the service units.

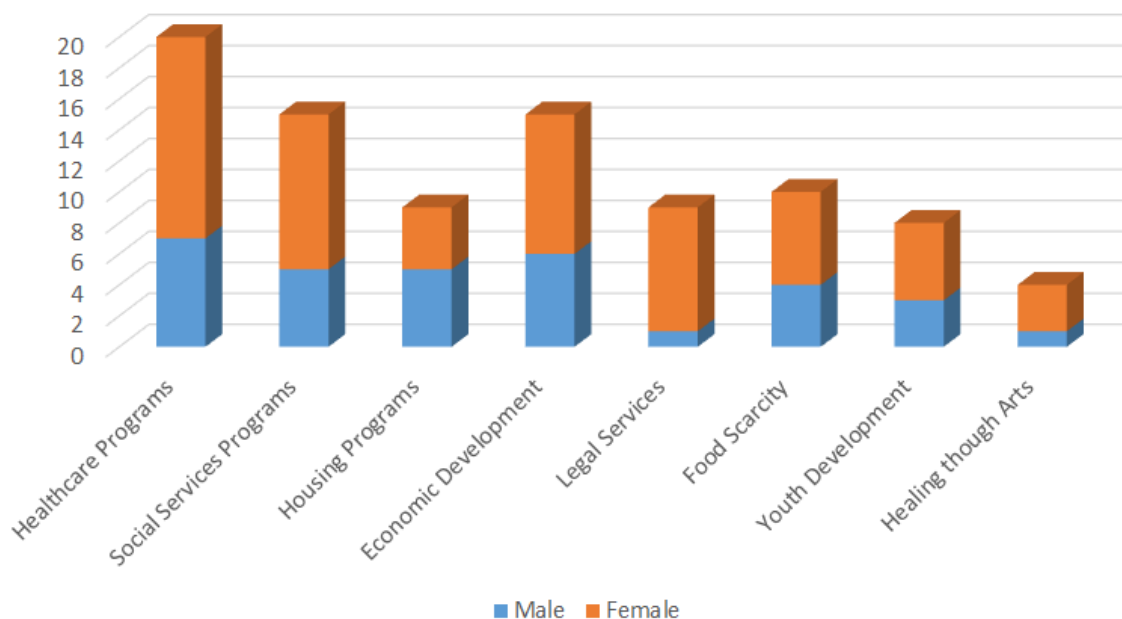


Figure 9. All social determinants services accessed by participants, by gender.

All participants accessed health care services. Fourteen participants (70%) accessed social services and economic development services. Nine participants (45%) were provided food pantry services. Eight participants (40%) obtained housing assistance services and visited the legal services unit. Seven participants (35%) engaged in the youth development unit, and three participants (15%) attended the Healing Through Arts unit. The data supports the argument that vulnerable populations need health care support, but they also have many contextually based needs requiring numerous social determinants services, not just health care services. Program director participants reflected on the range of social determinants services that patients and clients accessed through the Circle of Care. Carolina, Program Director of the Human Trafficking Assistance Unit shared, “All of the clients in the Human Trafficking Assistance Unit have a variety of survival needs like medical, counseling, shelter, food, clothing, jobs, personal and family safety, then

immigration and social services.” Dr. Maldonado also described his perspective on the numerous service units his patients access, stemming from their needs.

They [patients] will oftentimes access the pharmacy, imaging, laboratory, optometry, food pantry, mental health, behavioral health. . . . They also go to Microcredit classes, the Generations Youth Program, and other nonmedical services. . . . I know the Circle of Care works and helps and the families have been impacted in a very positive way. (Dr. Maldonado)

Participants described their decisions to choose which unit to access first. Most of them based their decision on which social determinant was of priority to them at the time.

Others mentioned that they had heard of a particular service unit from the community and were not aware of the other social determinants units at the time they first entered the Circle of Care.

First Access to Circle of Care by Gender

Figure 10 illustrates that eight participants (40%) first entered into the Circle of Care through economic development services, of which 63.5% were male and 35.5% were female. The next most frequently accessed service was health care. Six participants (30%) accessed health care services first, all of whom were female. Ten percent of participants made their first access into the Circle of Care through the Healing Through Arts Unit, 50% of whom were female and 50% were male. Five percent of participants accessed housing services as the first service unit received in the Circle of Care, all of whom self-identified as male. There were no participants who first accessed social services or food security in the integrated model. The Youth Development Program was the first unit accessed by 5% of participants. Only female participants chose to access this

service first. Of the 20% of participants who entered into the Circle of Care through the Legal Services Unit first, 100% were female. The findings reveal that only female participants accessed health care services, legal services, or youth development services first. There were no female participants who entered the Circle of Care through the housing services first. By contrast, the majority of male participants interviewed in this study chose to first access the economic development, housing, and the Healing Through Arts units first.

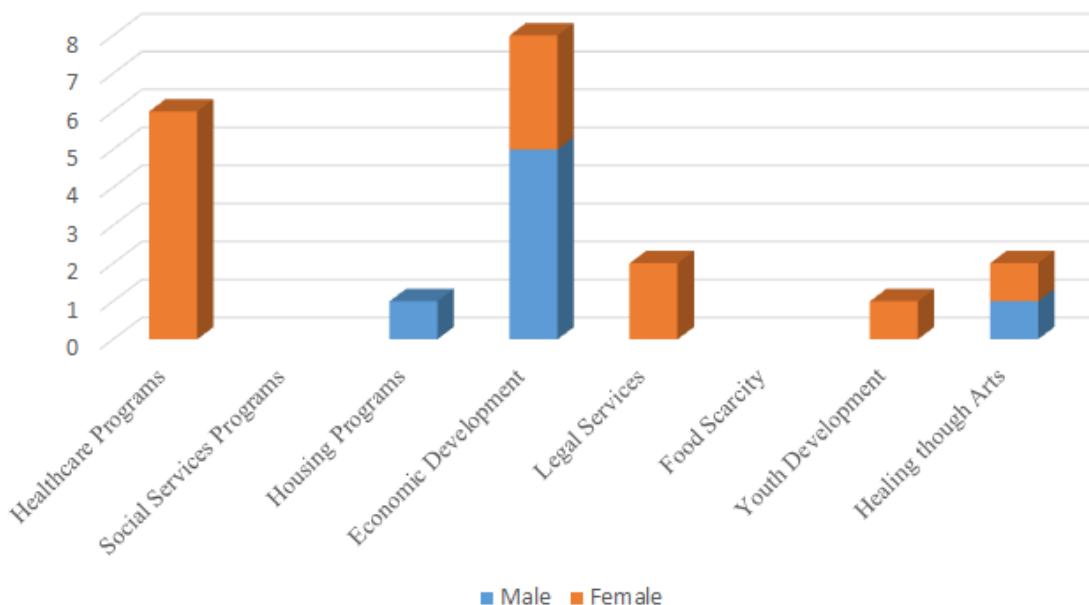


Figure 10. First access to Circle of Care by gender.

There was no significant difference between respondents based on ethnicity. Nicole and Mark shared their reasons for why they chose a particular service unit to access first in the Circle of Care. Nicole reflected,

I knew that I had a lot of needs that I had ignored for many years. I was in my addiction and didn't put my health as priority. Then I decided once and for all to recover and stay in recovery; I started to take care of all of the things I had neglected. But I didn't know where to start, what I would qualify for or even what was available. . . . I grew up in this country, and English is my native language. Still, it is very difficult to navigate the system. . . . When I first went to the art and music program, I found out about other services at La Maestra. I knew I had to go to medical and dental, but it took me time to do that. I had to work myself up to it, build my courage. I felt ashamed about my past. . . . When I got to know people there, it gave me the confidence to seek help for my other needs. I saw people worse off than me, and I just bucked up and took advice and made appointments. From there I really started addressing my health, my legal issues and continued working on my recovery.

Nicole realized that she had many layers of need but was faced with barriers of shame about her past. The support and social connectedness she felt through her experience in the art and music unit gave her the confidence to seek help with her other complex needs.

Mark described why he chose to access the transitional housing program first in the Circle of Care.

As I started to go to a lot of NA [Narcotics Anonymous] meetings, I started building a support group. One of the guys from the transitional housing was in that support group. . . . For me, I had just finished drug court, and I knew that I was done using. I wasn't clear on what my future was going to be, but I knew that I didn't want to use anymore and wanted to stay connected to NA. I didn't want to

be homeless, or in jail again. . . . I applied for the transitional program and then went for the other services that I needed. (Mark)

These two examples provide insight into how participants chose to enter the Circle of Care and how the resulting support, encouragement, social connectedness, and trust they come to feel assists them in accessing other social determinant services.

Values Identified by Participants on Services

Participants identified what they valued most from La Maestra’s Circle of Care (see Figures 11–15). The findings are grouped according to the following values: the organizational qualities of the Circle of Care that they felt contributed to their improved health and well-being and other values which are categorized as bonding, bridging, and linking—the three forms of social capital identified by participants as provided by La Maestra.

The five organizational qualities that were the most mentioned values specifically pertaining to services included: comprehensiveness of services in one place, cultural competency of the services, location of services, safety, and enabling services of translation and transportation. Figure 11 reflects the commonly identified values by gender regarding the services through the Circle of Care. Appendix G further defines the five values mentioned by participants by the ethnicity and age of the participants.

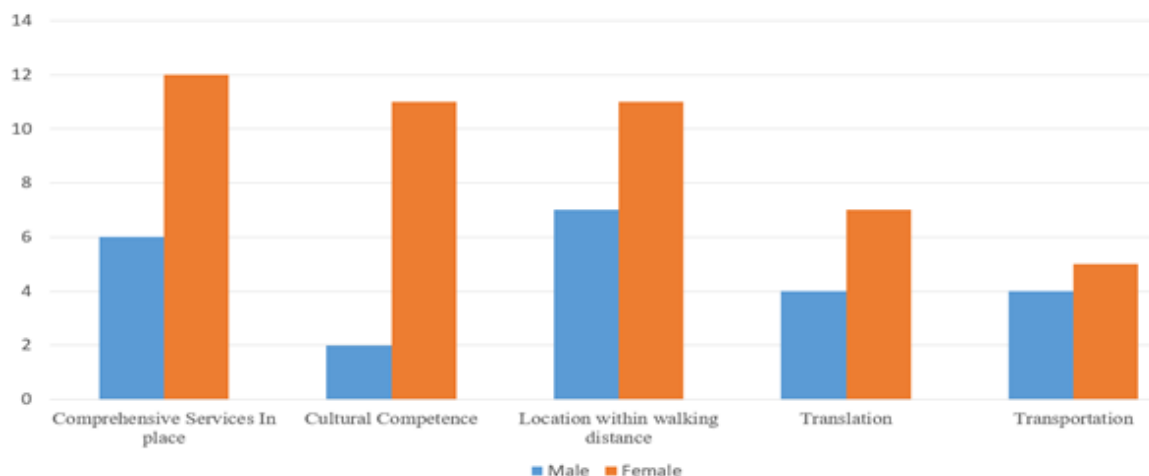


Figure 11. Service characteristics valued by participants, by gender.

Interview participants identified five common aspects of the services which they perceived to be of value to their well-being. Ninety percent of participants spoke about the benefit of comprehensive services in the Circle of Care, which includes direct medical services and nonmedical social determinants of health services. There was no significant distinction by gender in the value of comprehensive services. Participants identified value in the integrated structure of the comprehensive model, which gave them access to needed services. The cultural diversity of the staff and clients in the units was identified by participants as important in that this made them feel welcome and gave them a sense of belonging. They valued the availability of translation because it was essential for participants to communicate with their providers and other staff. Culturally competent health education and materials were also identified as instrumental to participants. Translation capability and culturally competent materials were of value to all participants regardless of gender and to all ethnicities except for Caucasians and African Americans. The location of the services, within their community of residence, was an additional value as many lacked means of transportation, and some participants voiced concerns

about their personal safety in venturing outside their immediate community using public transportation. This value was equally mentioned by both genders and all ethnicities.

The comprehensiveness of social determinants services was perceived by participants as valuable in that their numerous contextually layered needs were met. Carmela, a program director and a former client, described the value she identified for her clients to be able to access comprehensive social determinants services through one organization, without which her clients would not have been able to endure the process of accessing services through disparate organizations.

I have over 120 open cases of human trafficked victims. Aside from needing assistance with their immigration applications, they need safe shelter, they need food, mental health, dental, and mental health services. If we didn't have all of these services here, I really doubt that the human trafficked and domestic violence clients would make it through the process. (Carmela)

Erika explained how she was able to benefit from the comprehensive services through one organization,

After I went to medical services, I went to the eligibility services unit. They told me about the Microcredit program [economic development] with the classes, the jewelry making, and sewing classes too. All of these services in one place really helped me a lot. . . . I think that it would have been helpful for me to know about all of the services that are available when I first went to the medical services unit.

Integrated Model

The integrated structure of the comprehensive services through one organization was identified as a value and perceived by participants to provide a supportive network.

Norma described how services within her community enhanced her feeling of belonging and well-being. She shared that “They [services] are all close by and I feel welcome. Everyone knows me and that makes me feel good, like I belong here and have a place here.” Similarly, Rosa described how the integrated model helped address her complexity of needs through comprehensive services.

I was living in my car with my two young sons for two years, moving from parking lot to parking lot trying to hide from my husband who had trafficked me and had threatened to kill me and my children. My youngest son had reoccurring asthma attacks. The hospital referred him to La Maestra clinic. During my son’s medical visit, I started crying and told the doctor that I had a lot of anxiety and felt depressed. The pediatrician referred me to counseling [Family Wellness Unit]. I described my situation, and the counselor immediately called the human trafficking assistance program at La Maestra. The director walked me over, and I was able to talk with her right away. She helped me and my two boys to get into a shelter and apply for an immigration visa for human trafficked victims. My case took a long time. Meanwhile, my sons and I went to more medical services, optometry, dental units, and counseling. Then, my sons attended the youth development program, and I attended the Healing through Arts program, all at La Maestra. Our lives changed so much. (Rosa)

Dr. Maldonado, another director of the program who works with many clients, provided an example of the benefits of an integrated model.

What really helps them [patients and clients] long term is the support from the infrastructure that is behind them to get them out of addictions and learn new

strategies to cope and take control of their lives within the structure and societal rules that we all live by. Like the yoga, naturopathic doctor, the classes, all help a lot to help patients become their own advocate and heal. (Dr. Maldonado)

He also identified value in the integrated comprehensive services as an overarching organization for enhanced patient care. Dr. Maldonado said,

Here [at La Maestra] the convenience factor for our patients is even more important. What I am trying to illustrate is that we have the ability to just see the patients and co-manage among our providers from our respective units.

Having a supportive network was identified as a value equally among genders and ethnicities.

Empowerment

One of the main values mentioned by clients was the sense of empowerment they derived from being at La Maestra. Mark and Carolina reflected on the feelings of empowerment they gained as they continued to access the services they needed through the integrated Circle of Care model. Mark shared,

I was able to start seeing the doctor again and take advantage of all of the resources here. I was living in the transitional housing at La Maestra and was in the work program. Then, I was able to see the eye doctor, and I have a dental plan that I am actively working on. I was able to go and get physical therapy too. . . . I am very grateful for the structure here.

Carolina explained her perspective of how comprehensive services through one organization promotes empowerment.

I would say that in the Circle of Care there are so many things that empower. Not only for women. Children and adults are empowered too. Coming to La Maestra is not just coming to the doctor. Like when patients and clients tell me about their situation, I start thinking of all of the services that they can go to in order to get better and heal like counseling, medical, immigration services. We offer many opportunities and resources. (Carolina)

All participants spoke about a sense of empowerment as a result of participating in the supportive network.

Culturally Responsive Services

Fear of not being able to communicate with medical staff is a barrier to accessing health care services. The majority of interview participants mentioned that translation services offered through cultural liaisons at La Maestra were extremely valuable. Translation services were mentioned by all ethnicities except Caucasian and African American. Both genders found equal value in translation services. The ability to communicate during medical and other social determinants services was essential to enabling the participants to progress towards improved health and well-being. La Maestra hires cultural liaisons to give feedback to the staff and providers about the patients' cultures, their concerns, and how clients understand what they are being told about their health and wellness. Cultural liaisons educate other staff about cultural beliefs, traditions, and backgrounds. Dr. Maldonado explained the value of these cultural liaisons for the patients,

They are really important because if the providers don't understand the patients' beliefs they might not know how to interact respectfully with other cultures or

understand the challenges that patients might have with following the prescribed treatment plans. Our providers want to learn about all of the other ethnicities we serve and how to best interact with them.

The ability to communicate through cultural liaisons brought a feeling of being understood. Eva described why she found value in translation and how translators facilitated her transportation needs,

Maybe at other places they will not understand me [language] or what my background is [refugee). . . . I went to Family Wellness Service, Pharmacy, Medical, Dental, Optometry and the Food Pantry. . . . I see many people from all over the world going to the all of these units.

Mary also explained the benefits of having translators available who shared her background to facilitate her care. She shared, “I feel more comfortable using the translators. They understand me and my background. I would not be able go to many different places to get my services [because of the language differences].”

Lilly’s reflection confirms the essential role of translation services for her mother to be able to communicate and be an active participant in her treatment plan.

My mom doesn’t speak English that much so the staff at La Maestra clinic was very helpful, patient and kind with her. . . . My mom doesn’t speak Spanish well either, so the staff were very understanding of that. . . . She speaks Mixteco. They took the time to spend with her, explain things to her. (Lilly)

Eva, an elderly refugee patient from Laos, described why she found value in the supportive services of translation and transportation.

The cultural liaisons helped me and translated and arranged for my transportation to the [specialty medical] visits. . . . The driver was very nice. He was from Somalia, and I felt comfortable riding with him. All of the staff is from many different cultures and that makes me feel welcome. . . . I see many different people from different cultures coming for services. I can't speak to all of them but know that we are all the same in needing services. (Eva)

Director Carmela confirmed that "All of my clients in the human trafficking assistance unit . . . all need translation."

Transportation

Many participants lacked their own means of transportation. Patients and clients reported difficulty in navigating through San Diego County's insufficient public transportation. Traveling by bus often requires numerous transfers and takes an inordinate amount of time. Carmela, Director of the Human Trafficking and Domestic Violence Programs (under the Legal Advocacy unit) shared,

The clients are so fearful and with good reason. Many are still hiding from their perpetrators so waiting at the bus stops is dangerous for them. I see a lot of value in having the services all through one organization.

Robert described his circumstances as

a learning process and still is about what all La Maestra offers. When I moved into the Transitional Housing in 2010, I had no clue, and no car . . . food pantry . . . medical services, mental health, legal and immigration services . . . substance abuse programs, and others were accessible to me. . . . I wish I had known about all of the services when I first went to La Maestra.

Eva benefited from transportation services as well. She shared, “I have all the services I need here. I cannot drive and am afraid to get lost going on the bus around the city.”

Lilly shared how the proximity of the social determinants services to her home increased her access to care and reduced her anxiety.

It [medical services] was close to where we live so we could walk. Getting to those doctor’s appointments were pretty easy. . . . And it’s [Legal Advocacy Services] is right over here, a few houses down! It was easy to find, and they said they could help me and take my case. . . . After I got the DACA, I had to renew it three times, and La Maestra’s Legal Advocacy unit helped me each time. It is wonderful, and it put me at ease because I don’t have to travel far away for my appointments. I don’t drive so being close by really made it doable for me. It’s right here. If I ever have any questions, it’s just a 15-minute walk from my house so it really puts me at ease, my emotions and my mind at peace. (Lilly)

Brigida described why she valued being able to walk her elderly mother to services within the neighborhood, “I always was afraid to take my mother outside the house on the bus anywhere because I didn’t want immigration to stop her and send her back to Mexico.” Mary also shared the value she found in the location of the services and the cultural competency of the staff.

I was walking and I saw it [La Maestra] and my health plan recommended it to me because it is in my neighborhood and the staff speaks my language [Laotian]. . . . I went in one day and learned that many Laotian patients are here. So, I felt that this clinic would be good for me. (Mary)

As the Director of the Human Trafficking and Domestic Violence Programs, Carmela provided a more organizational perspective regarding the value of translation and transportation. She explained that

The issue is that all of my clients have transportation challenges. The public transit system takes so long, and it's dangerous for the clients to be sitting and waiting at the bus and trolley stops. They are already fearful and with good reason. . . . Language and cultural diversity is also a big deal. Oftentimes, the other organizations are not familiar with the cultures and don't have the capacity for language translations.

The value of transportation services was noted by all participants.

Location and Safety

Many participants identified the importance of being able to access social determinants services within their community. Participants spoke about concerns for their safety when traveling outside their immediate community for various reasons and found value in accessing services in close proximity to their homes. Nicole, for example, expressed a lot of concern about her safety due to living on the streets for 20 years—a situation she described as very dangerous. She explained,

I never knew what to expect or when I would be attacked. I knew that living in addiction had a big price. Being physically assaulted was one of them. . . . People have to feed their addiction, and they lose their reasoning. I needed a safe and supportive environment to help me.

La Maestra provides that environment for her.

Director Carmela heard a lot about the value recipients obtained from accessing services within the same geographic location as their homes. She explained that

Safety is a big issue for my domestic violence and human trafficked patients.

Oftentimes, they are still hiding from their perpetrators and do not want to be traveling around a lot waiting at bus stops going to services in different parts of the city.

La Maestra is able to provide a location that is safe, and the fact that all services are in one location means that vulnerable individuals can minimize their exposure to risk. All participants spoke to the value of centrally located services within their community.

Cultural Diversity of Environment

The majority of participants identified the value of the Circle of Care model by pointing to the cultural diversity of both the staff and patients which creates a welcoming environment. Participants from all ethnicities and genders reported that cultural diversity was comforting to them and of value. Peter, a refugee from the Sudan, likened the interactions between diverse cultures within the units to “the United Nations.” The diversity created a sense of a community where he felt he belonged.

Eva, a patient, described a feeling of comradery between different cultures because of shared needs and backgrounds. She acknowledged, “I don’t know how to speak to different languages, but we are all the same.” Patients’ comments were confirmed and elaborated upon by the staff, who work daily with patients and clients in the Circle of Care service units. John, a marriage and family counselor, offered his perspective as to the value of cultural diversity for patients and clients by pointing to the feeling of comfortableness that the organization engendered. This feeling came in part

from the culturally sensitive resource materials that were made available to patients and clients. He explained how patients feel welcome when they see that the organization is responsive and prepared to communicate with them through verbal and written means.

We have educational material in their languages and have the cultural liaisons from the different cultures to explain to the patients about eligibility for insurance coverage, about the services and the treatment plans, the prescriptions, social services and transportation, and many other services. (John)

Carmela, who is also a director, shared why her clients and patients feel at ease as they receive services through the Circle of Care by pointing to the cultural diversity of the staff that assists them. She explained,

When the patients come to their first visit, they see us, the staff, from many different countries. I believe this makes them feel relaxed and welcome. They have anxiety about coming to their first visit and don't know how they will be received and treated. They look for the staff they can relate to and who can facilitate their care. They come from all parts of the world and all walks of life. They are refugees, immigrants, veterans, victims of domestic violence, victims of violent crime, human trafficked victims, homeless, people with substance abuse issues, and mental illnesses.

Mark, a client from the transitional housing unit who volunteers with the homeless outreach program, described his experience in relating culturally to others through his background and experiences.

I think that it helps tremendously to have a connection point with people. . . . Like when I do outreach with the homeless. They relate to me because I was homeless

too. My opinion on that is not to offer a handout but a hand up and to make that connection and not judge them. (Mark)

Patients benefit from this sense of “co-membership” that exists between them and staff. Co-membership refers to human connection stemming from similar social identities (Erikson & Schultz, 1982). In this context, co-membership applies to staff members, who share similar social identities with the patients and clients, becoming advocates for patients in accessing institutional resources. The higher the degree of co-membership, the more likely that staff will assume the advocate role.

Values about Staff

Participants also identified common values about the staff in the units of the Circle of Care. Figure 12 depicts the 10 most commonly mentioned staff characteristics, by gender, that participants felt contributed to the health and well-being of patients and clients. Appendix G shows the breakdown of values around staff, as voiced by participants, according to gender, ethnicity, and age. However, there was no significant difference based on gender, age, or ethnicity.

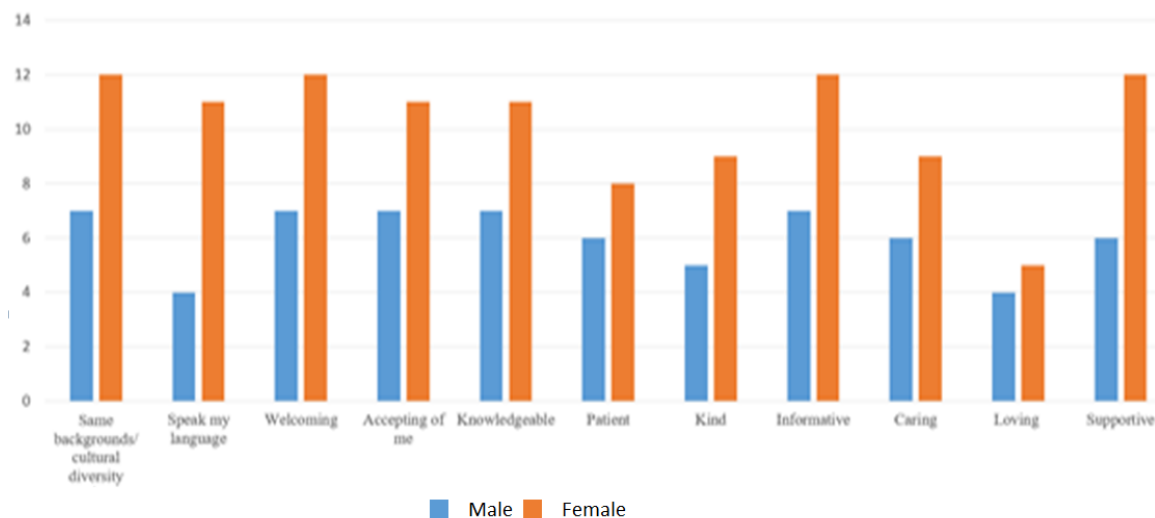


Figure 12. Qualities of staff valued by participants, by gender.

Supportive Staff

Participants report the characteristics of staff that enhanced social connectedness and feelings of belonging. The staff and the organization provided support through facilitating these social ties. Norma shared, “Well, my self-esteem has certainly improved through the classes and the support and the social ties I have with others here including the staff.” Erika, a client of the Microcredit unit concurred by saying,

The people I have met here, like the staff have made so much effort to help me and others to succeed with their dreams and skills so they can have a better life.

You can move sea and land to get ahead if you have support and guidance. I have received that from the staff here.

Marty shared his perspective of the benefit of cohesiveness and interrelationships with staff, which engender patient feelings of welcomeness and belonging. He explained,

So, there are times when it is very rough to get back into civilian life after serving in the military, like it’s hard to fit in the same life they came from before the experience in the military. I didn’t have too much of a struggle with this transition because I had my family who became my focus. Like I said, I’m still connected to the Navy community. I came to La Maestra and joined a big family. We know each other well and have built strong relationships with others that share our values. . . . We know about each other’s kids, families, enough to build trust and enjoy working together. It gives the patients a sense of comfort to know that the staff is really operating as a united team to help them because they share values where serving others is priority. They also feel welcome and feel hope that their condition will be better in the future.

Cultural liaisons really helped establish that connectedness and feeling of welcomeness. Eva, a patient, explained,

I felt welcomed here because the cultural liaisons, from the staff at La Maestra, were here to help me. They speak my language and others and came from the same experiences as I did so they understand me and can help me. . . . Staff helped me and translated and arranged for my transportation to the visits. My cultural liaison also came to my house to visit me once each week for 3 years. . . . Staff at La Maestra and my [Burmese] community also helped me to get better.

Director Dr. Maldonado offered his perspective on the value of the staff for patients by emphasizing in particular how selecting staff with backgrounds that are similar to the patients really facilitated the support patients needed. He stated,

They [staff] are the model! We get staff from many cultures. A lot of them or their families, or one generation back, have gone through the same wringer, the same traumatic backgrounds as the patients they help to heal here at the clinic. In fact, the staff continues to face challenges here like domestic violence, economic issues, deportations of family members, housing issues because they are of the same population as the patients and live in the same communities. They interact with the patients outside of the clinic too because they belong to the same ethnic communities. The staff relates and empathizes with the plight of the patients at all of our sites. Each clinic site has a different composition of ethnicities.

Marty, a director of the dental units and Navy veteran, concurred, citing the insider perspective as key.

The staff feels that the organization has a family atmosphere, does not have a corporate feel. . . . The staff is committed . . . and, from the same populations they serve. The staff relates to the challenges that the patients have as they are from the same cultures and feel empathy for people from similar situations. (Marty)

John, another director who works a lot with patients in the Family Wellness (mental health) unit, explained that even when staff members do not share the same background, they go out of their way to take steps that instill a feeling of belonging. He explained,

When new patients come into the Family Wellness Unit [mental health unit], I am the first person that they see. I speak with them and determine what their needs are. I welcome them, and they feel great that I give them the attention they deserve. Even though I may be from a different culture than they are from, they connect with me. They respond to me because they can feel that I care. They have my complete attention.

Director Carmela shared her perspective of how the cultural sensitivity of the staff enhances the value to patients and clients.

Here at La Maestra, we have a pool of cultural liaisons from the different populations we serve. So they translate but, more importantly, are familiar with the cultures and religions; so they educate us as well about challenges. . . . They are also trained in HIPAA and confidentiality and have the training to know that there are sensitivities and know their parameters about giving advice and translating exactly. (Carmela)

Cultural liaisons are facilitators of communication and understanding between patients, clients, and staff. As valued staff members, cultural liaisons serve as conduits, enabling the exchange of information through the translation of language and culture.

Social Capital

Social capital is “the goodwill available to individuals or groups. Its source lies in the structure and content of the actor’s social relations. Its effects flow from the information, influence, and solidarity it makes available to the actor” (Adler & Kwon, 2002, p. 23). It was clear from patient and administrator interviews that one of the main values of La Maestra’s Circle of Care was the social capital it created for participants. Social capital refers to resources embedded in the network, which are passed on to clients and can be traded for additional resources or support (see Chapter 2 for a full discussion of social capital). There are three main forms of social capital (i.e., bonding, bridging, and linking) that were provided to La Maestra’s clients. Participants’ examples of each form of social capital are depicted in Figures 13–15. Tables G3–G5 in Appendix G illustrate the findings by gender, age, and ethnicity of the participants.

Bonding refers to interrelationships among individuals who share similar norms, beliefs, and backgrounds within a social network. Social capital bonding refers, in general, to actions that occur between individuals that build transactional effectiveness due to the sharing and exchanging of resources (Lin, 2001) with an emotional or instrumental purpose. Participants pointed specifically to the support they received in building social connectedness, trust, and psychological capital, all of which contributed to their ability for reciprocity or exchange of social capital.

Bridging are the practices that an organization takes to give clients the ability to obtain additional resources, usually by the creation of pathways established through a network of support. Examples of how La Maestra provided the bridging form of social capital include referrals, a seamless system, case management, and the actions of cultural liaisons. Each of these organizational arrangements facilitated the process of bridging.

Linking is the action of helping clients access resources outside a network, among dissimilar others, for the purpose of expanding opportunities and resources. The findings related to the linking form of social capital were evident in La Maestra's practice of providing education, housing, economic development, advocacy opportunities, specialty medical services, law enforcement agencies, and the courts system.

Bonding Social Capital

All participants across age, ethnicity, and gender had numerous comments relating to the importance of bonding and their experiences in the Circle of Care. Bonding resulted through relationships with similar others. Intrinsic resources of bonding social capital have been described by researchers (Lin, 2001; Putnam, 1993) to include: social connectedness, trust, increased psychological capital, support system, empowerment, and reciprocity. Figure 13 captures the values mentioned by participants related to bonding social capital. Identifying with others, belonging, and feeling welcomed and accepted represent the social connectedness aspect of bonding. A supportive system and feeling cared about are also evidence of bonding because they speak to trust. Participant comments about increased self-esteem, self-worth, and self-confidence relate to psychological capital, aligning with the definition of bonding. Actions of giving back to society, helping others, and volunteering indicate reciprocity,

another characteristic of bonding. There were no distinguishable differences by gender, age, or ethnicity in identifying this value.

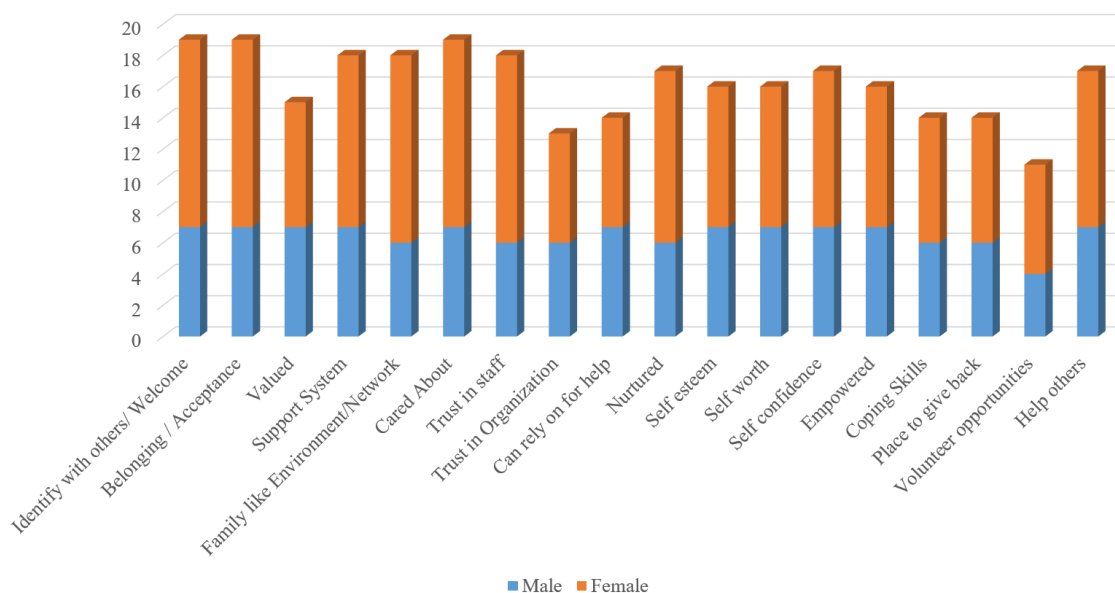


Figure 13. Bonding social capital by participants.

Social connectedness. Evidence of bonding was primarily explained by participants when they described the support system that allowed them to socially connect with each other and with staff in ways that would facilitate improvement of their health and well-being. Participants described characteristics of social connectedness as gaining feelings of belonging, identifying with others, and developing a support system.

Mary, a long-term patient, shared her feelings of belonging and social connectedness,

I like to come here with people I know and that are from my country. . . . They understand me, and I can walk here. The people are very friendly, and I feel comfortable here. I feel comfortable with other people I see here because there are people from all cultures and my own here.

This feeling of connectedness was also expressed by Robert. Because other patients shared similar past life experiences, he felt he had a network or community of individuals

to which he could related. It made life “easier.” The bonding that occurred at La Maestra gave Mary and Robert a sense of well-being that allowed them to move forward. As a director, Carolina saw her patients and clients gaining a sense of belonging at La Maestra that allowed them to “feel comfortable in accessing other services when they are told about them because they already feel like they belong here at La Maestra.” The ability to identify with others through common backgrounds or shared ethnicity promoted a sense of belonging and facilitated trust building.

Mark gained encouragement from this shared sense of belonging. He explained,

I had issues growing up because I was always teased because I looked different than my family. So, growing up it was a problem because I am Black, and I didn't look Black. . . . It has been a constant problem in my life, especially when I was young. I felt like I needed acceptance. If I hung around people that were White, they didn't know that I was black. Then my family teased me because I looked White. So I had an identity crisis going on. . . . The guy I met from Chicago was a Blood, so we were Bloods. . . . I wondered why I was putting my life on the line for a gang that I wasn't even part of. . . . Sometimes people are having identity crisis or come from bad homes and worry that they won't be accepted so they follow the footsteps of their brothers or cousins. . . . Here [La Maestra], I identified with people who had experienced many of the challenges that I faced in my life, like involvement with gangs, problems with substance use disorder, and being incarcerated. I met a lot of people at La Maestra who were in my shoes before, and they are still doing good. That gave me a lot of encouragement.

Being able to build relationships with people that had similar backgrounds built trust. It also built a sense of sharedness and connectedness, which in turn built a level of empowerment and courage that was previously absent.

Director Carolina, who was previously a client, spoke of the impact of being able to identify with others and the courage she gained from this experience when she joined the Microcredit unit as a client. She shared,

I first went to the La Maestra Microcredit meetings that were in Chula Vista at the time. The very first time I entered into the meeting, I felt like I belonged. I saw all of the ladies there. Maybe it was because of everything I was going through at the time. That evening every one of the ladies in the group shared her story. It was amazing! I felt at that moment that I can make it. . . . I found the courage through the Microcredit program. There were examples of ladies who learned how to form their own business and make a better life for themselves here. I can tell you from the bottom of my heart, the Microcredit gave me the courage to change.

Carolina was encouraged by other women in the Microcredit unit who shared similar experiences with her own when she first joined the program. She identified with the group, and this encouraged her to learn how to start her own business and become financially independent. There was no difference by gender or ethnicity in how participants reported the importance of social connectedness.

Trust. Increased trust in others within the network is a characteristic of bonding social capital. Participants described the trust they felt in staff and the organization as a whole. Lilly, a patient and client in the youth development unit, shared,

Just by going through the medical services made me trust them to then go seek help for mental issues and dental. I didn't have that added problem of what they might think about me. . . . Already being a patient in their system gave me a feeling that I was accepted and part of the organization.

Erika also described how trust in the staff from one unit motivated her to access other units in the Circle of Care. She stated, "I already felt comfortable with La Maestra for medical services where I felt at home and welcome, and knew the staff, so it was very easy for me to go to these other units." Detailing how the reputation of La Maestra builds trust with patients and clients, Marty explained,

La Maestra is a brand name now and has been in the community for over 34 years providing very comprehensive services even beyond medical. It's a recognizable name with local and national agencies, government, organizations, and community members. The staff feels like they are giving back. They are working for an organization that looks out for people, like the Navy. I believe in fate. I'm where God put me. I like what I do and get satisfaction knowing we provide services to people that need it the most. It's like a common feeling we all have.

Established feelings of trust led participants to feel that they could rely on others for help and to feel cared for and nurtured through the social connectedness that had been created. Participants identified these intangible benefits as valuable to their enhanced well-being. Lilly shared,

I came here [Youth Development Program], because this is the one place where I could get away from it all, all of the sadness. . . . There was love and support here.

I felt love and support here. That is what I needed. . . . Without me telling people my life story, I could feel that there are people who care here and wanted me here. Erika also felt she was able to make progress due to the staff's guidance and mentoring. She shared, "I had been stuck and didn't know what to do. . . . Then with the classes and support at La Maestra's Microcredit program, I was able to make some great progress with my understanding of the business functions and responsibilities." Mary provides an example of how support from staff facilitated her bridging social capital, "They had everything I needed . . . and, I had a cultural liaison from the clinic there with me to help me go to all of the services I needed at La Maestra. . . . I felt cared for."

It is clear that trust in the staff and the organization motivated the participants to carry through with obtaining additional recommended services and engendered the process of bonding. Trusting others in the network served to crystallize social connectedness and belonging, forming a support system. There was no difference by gender or ethnicity in how participants reported the importance of trust.

Psychological capital. Increased self-esteem, self-worth, empowerment, and coping skills, all intrinsic resources of bonding social capital, were reported by participants as benefits from the social connectedness they experienced through the Circle of Care. In some cases, patients described it as improving their psychological well-being. Norma shared,

My experience with the Microcredit program has pulled me out of my depression. . . . I have a great support group at the Microcredit program. . . . I see now the opportunities for me to continue learning and growing and having a good life as well as a means to support myself through my business.

Irma described the psychological value she derives from being part of a social network stating, “I feel like the people here are my family. We all know each other well and are supportive of each other. We care about each other. . . . I feel empowered and involved.”

Brigida shared about the importance in knowing “that we have people that care about us. I always look forward to coming to the programs and services and seeing my friends here. . . . I know so many people here.”

Erika explained that the social support aspect of La Maestra’s Circle of Care model has increased her self-esteem and self-confidence. She stated,

I feel like I have reached a milestone in my life now with the classes and the program. . . . Most of all I think what has helped me is that I feel support from the group here at La Maestra. Being part of the group has given me confidence that I can succeed, and my self-confidence has improved a lot too. . . . I want to succeed for myself and for my children, to be a model for my kids. That is really important to me.

Participants reported that through increased self-esteem and self-confidence they learned coping skills which was of value to them. Lilly explained,

After a few months going to see the counselor, I felt like I could control my crying and get a handle on my emotions. I learned how to see what was bothering me and signs of when I was tensed up, and the therapist gave me the tools to use so when I feel overwhelmed, I can help myself deal with issues and emotions.

Building psychological strength led to feelings of empowerment. Carolina described feeling empowered because other members of the Microcredit unit created the social

connectedness she needed. She continued to excel and eventually became the Director of the Microcredit program.

I found my motivation from the Microcredit group to go to the organizations outside La Maestra that I was referred to. . . . I found out that the other ladies' eagerness motivated me. They had less formal education than I did and they were so committed to getting ahead. I thought "if they can make it, then I can make it." I found strength from the group. I went to all of the Microcredit program courses and meetings. From that moment, I really engaged. (Carolina)

There was no visible difference in gender or ethnicity among participants describing the value they derived from increased psychological capital.

Reciprocity. The social connectedness, identification with similar others, feelings of belonging, and trust that developed from bonding social capital led to participants exchanging their social psychological capital for other types of more capital. They had an improved state of being able to reciprocate; that is, participants were in a better position to build additional capital. This was evidenced by the comments made by the majority of the participants who talked about their new found ability to give back through volunteering and that being able to do so gave them more pride and self-esteem. Being able to reciprocate was described by participants as validation that they had reached well-being status to be able to give back and help others.

Peter described his experience accessing services through La Maestra, and how being part of the network helped move him from surviving to thriving.

My wife and I have a very strong faith which we have tried to impart to my children. They don't know true hardship as they have grown up in this country, at

least not the trauma that my wife and I experienced. They did have a lot of challenges though, as we have always been poor. . . . When I came to this country, I was only able to help myself and my family as we were focusing on survival. Now I help others. That is proof to me that I am doing OK.

Other participants provided additional examples of how they helped others and why reciprocity was important to them. Brigida shared that because she now knows a lot of the staff and patients, she always “helps others who have trouble carrying their food or who come to us with troubles asking for advice on all kinds of things like their housing or who have trouble finding work or with their families.” Robert also explained how he gives back.

I think that having all of these services at La Maestra at the same location, and integrated staff from so many units, including substance use disorder, transitional housing, and behavioral health services has helped me to stay engaged in volunteering in NA. It just seemed like part of my recovery over fourteen years.

(Robert)

Volunteering has become valuable to Norma’s well-being. She shared that “I have been a volunteer, part of the Promotora de Salud program since 2015. . . . I feel so good at being able to help the community with health education.” With these opportunities to volunteer and give back to the community, these patients and clients demonstrate how the actions of the Circle of Care program helped them gain additional capital. All participants described reciprocating.

Empowerment through a support system. A support system is one of the resources offered to participants of La Maestra, and being able to rely on others for help

was noted by participants as empowering. All participants described the value of a support system. Director Carolina, a previous patient, explained,

I can see them [patients and clients] be able to deal with and overcome their problems. They have the motivation to try and find resources because the social network here at La Maestra empowers them and is supportive. They feel stronger to face challenges they will have in the future.

Mark, a patient and transitional housing resident, also identified value in the network that La Maestra helped to construct. He saw others who have succeeded in overcoming challenges similar to the ones he is facing, which gave him the support and encouragement he needed.

There is a great network and support group here. I talk to staff and others, and I go to an NA book study group every week with a friend here. I do go to him and others about things that I want to share and need advice about. I do like the fact that there are people here that have seen things that I have seen in my life, and they have come out of it and are doing good, still doing good. (Mark)

Norma also shared the value of being part of a network that created social connectedness, with opportunities to share information and provide support.

The Microcredit program at La Maestra offers me classes on how to start the business, develop the business plan, and of course be part of the support group where we talk and share about how our plans are developing and the steps we are taking. We also share what's going on in our lives. . . . So it feels good to be part of this group. (Norma)

Estella explained that being connected to others with similar experiences changed her from someone who felt abused and isolated, “a childhood of ridicule, child and sexual abuse,” to feeling accepted and welcome. She needed to feel accepted and be able to relate to similar others in the group to dispel the feeling of isolation. Estella stated that feeling accepted gave her the courage to seek the additional services she needed to heal. Because patients and clients were provided opportunities for bonding, they began to thrive. They began to engender a sense of trust in themselves and others, building the capital they needed to improve their lives.

Erika and Lupe both recounted how they felt empowered, first by giving back in their community, and then by linking to other volunteer opportunities outside their immediate community. While Erika volunteers every Friday at schools, Lupe helps women in other communities “make appointments for their mammograms . . . I feel so good at being able to help them.” Peter, also stated how his volunteering within his community expanded to link to nationwide advocacy efforts for humanitarian causes abroad.

I have been very involved with establishing sports programs for the youth in the Sudanese community here in San Diego for many years. I am also very much involved in trying to be part of the peace building initiatives in South Sudan and have traveled there numerous times. I am also very involved with the nationwide effort to promote peace in South Sudan. (Peter)

Emilia described the similar value she derives from sharing resources with others—resources to which she now has access through La Maestra. She shared,

What keeps me going is to focus on advocating for the needs and rights of the Trans community, even the Elder Trans. . . . We have meetings every Friday at La Maestra. We have ten classes on “Ending The Game” which is identifying and getting out of trafficking, with supplemental counseling, and rental assistance.

It is clear from the interview data that the bonding form of social capital is fostered through social connectedness, psychological capital, empowerment, and a support system. Trust is a facilitator of bonding through interconnectedness and relationships that are formed through the bonding phase. Once empowered, participants continue to seek resources for additional social determinants needs and are able to engage in reciprocal relationships—the exchange agent of social capital.

Bridging Social Capital

Bridging opportunities are the practices that an organization takes to give clients the ability to obtain additional resources, usually through the creation of pathways through a network of support. Bridging occurred when participants had gained the psychological capital and empowerment through the bonding phase to reach beyond the immediate trusted support group to access additional social determinants services. Figure 14 provides the most commonly mentioned elements participants felt contributed to their ability to bridge to other needed resources. The total number of comments made by participants, relating to bridging, was translated into four main themes indicating what La Maestra does to help clients bridge to additional resources, thus gaining additional social capital: referrals, seamless system, case management, and cultural liaisons. Appendix G provides a more in-depth picture of the data findings across participant ethnicity, age, and gender.

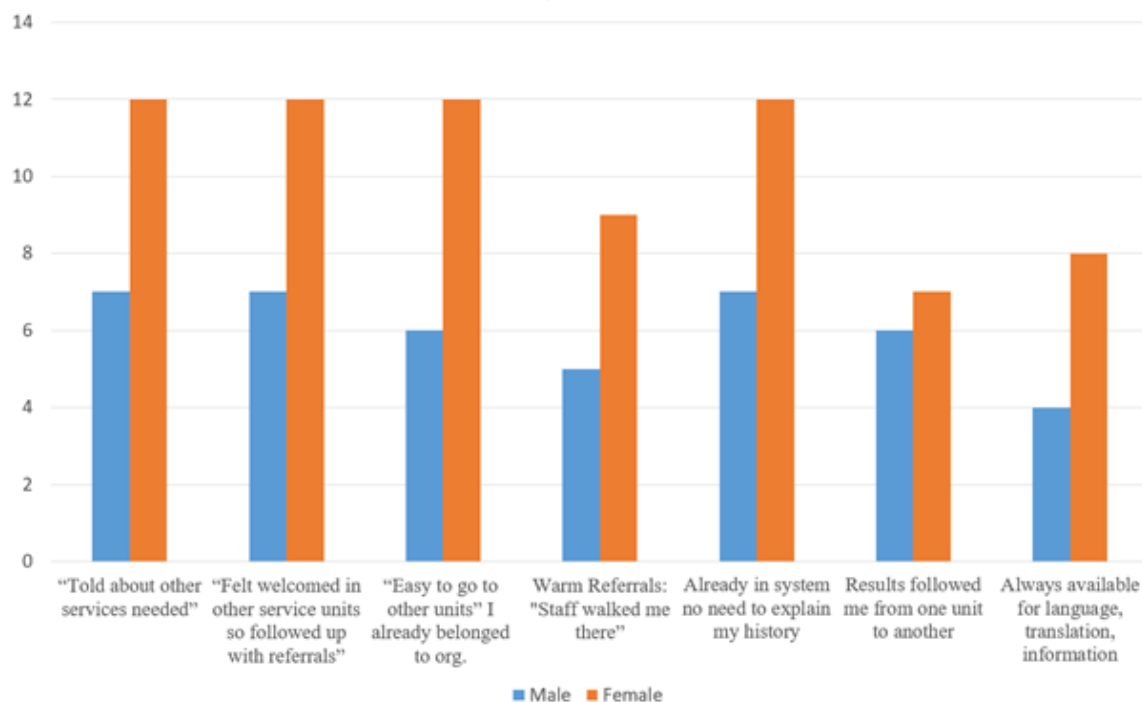


Figure 14. Bridging social capital by participant.

Each participant reported on being able to bridge to at least five service units. For example, participants who accessed medical services also went to dental, mental health, optometry, lab, imaging, and other services within the health care realm of the Circle of Care. Likewise, participants who accessed human trafficking assistance, which is in the legal advocacy unit, also accessed immigration assistance, in the same unit.

This study was concerned with determining how many different units in the Circle of Care were accessed by participants to assess if the services were useful to the participants. This study was not concerned with the number of visits each participant made to each unit. All participants described bridging to other units within the Circle of Care regardless of age, ethnicity, or gender.

Trust in the staff and in the process was already present during the bonding phase of social capital. Armed with empowerment and a support system, participants were able to follow up on recommendations and guidance to seek additional services outside of their immediate support group, formed through the first unit they accessed in the Circle of Care. Several strategies were used by La Maestra, including referrals.

Referrals. The participants' bridging process was facilitated and coordinated through referrals. One of the main features of the Circle of Care is an integrated referral system for bridging or referring patients and clients to other services within the Circle of Care. The mere availability of resources is not sufficient to ensure that participants will access them. Engagement in the referral process is encouraged by the integrated feature of the Circle of Care model. Feeling comfortable in accessing other units because of their experience with the Circle of Care allowed patients like Lilly to bridge to other services that were referred by the first unit she accessed. She explained that by already having a trusting relationship with the staff in the first unit she accessed, trust was carried over and motivated her to access other needed services.

The staff at the after-school program told us that La Maestra also has a clinic right down the street. So, my whole family went there, my siblings and my mom and me. All of us. I already knew people here at the Youth Development Program so I felt comfortable going to other units. (Lilly)

Robert shared his fears in accessing services from other units and why he was able to overcome his anxiety when the referrals to other service units were offered.

The fourth unit I went to was dental, and it was really hard for me to go. My teeth were in awful shape, either missing, broken or cavities. . . . The last time I had

dental work was in prison. They had scared me so much because they just pull teeth there. They say, “yeah, we fix that” and pull them out. . . . I was 20 years in custody. . . . It took me 3 years at La Maestra before I went for the dental work. I already had a lot of trust with the staff and the organization for me to go there and let them see my awful teeth. (Robert)

Norma also shared why she felt comfortable accepting the referrals she received from the first unit she accessed through the Circle of Care.

When I came to the medical clinic at La Maestra 10 years ago, I heard about the Microcredit program. . . . I then went to the immigration assistance unit, the food pantry, the sewing classes, the painting classes, jewelry making classes. I already felt like I belonged at La Maestra as a patient, then as a member of the Microcredit program, so I felt really comfortable, and it was easy for me to go to the other units. (Norma)

Lupe described she had the ability to bridge to other needed service units because other units at La Maestra had brought speakers into the service she was accessing. She explained that they talked,

about human trafficking, domestic violence, and substance use disorder. These are hard things to ask for help with. Then the women make the contacts right there in the program and feel supported in going to those other units for help, including me. . . . This changed my life.

Referrals to other social determinants service units within La Maestra are successful because, according to Dr. Maldonado, “Whenever we say to go to a program within La Maestra, they most often have had a good experience and will be more apt to

go.” Trusting relationships also helped patients like Rosa feel more comfortable in seeking help from other service units. She explained she had the courage to seek services from other units to which she was referred because she had confidence in La Maestra.

I was so nervous about my situation and knew that I needed help. I had confidence that I would be helped. I followed every referral to the other service units and felt more supported and cared for along the way. I was able to take care of so many needs for myself and my children. (Rosa)

Another aspect of the organization that helped with bridging was the organizational arrangement of La Maestra, specifically its seamless system and case management approach to care.

Seamless system and case management. In addition to accepting referrals from staff that participants trusted, participants explained that they also felt comfortable taking advantage of the referrals because of the ease of interacting with La Maestra’s seamless referral system. Nicole shared,

I knew that the referrals were sent through requests through the computer system at the clinic. . . . All of my data was already in the system, so I didn’t have to fill everything out each time. I only needed to renew my data and update it. It’s hard and painful to have to repeat my information all of the time because my past always catches up to me. People in recovery have a lot of guilt and shame. If I had to go for medical, dental, mental services to providers I didn’t know, I would have to repeat my story each time as they need it for my medical history and mental/behavioral history. . . . Just the thought of having to go through this ordeal to get the services I needed might have stopped me.

Several participants spoke to the shame and guilt they carried about their past. Referrals through a shared practice management system among the units of the Circle of Care eliminated the need to re-register in each unit, thereby removing the barrier of repeating traumatic past events.

Director Dr. Maldonado explained the challenges of developing software to capture the nonmedical social determinants services during patient visits but also the importance of capturing this information. Patient visits are entered into the electronic health records (EHR) for health care services. The EMR software is not built out to capture nonmedical social determinants services. He described La Maestra's process and lessons learned from a practitioner's perspective, to achieve the capturing of both medical and nonmedical social determinants services.

I know that the providers were making the attempt to enter the nonmedical data on Quickbase years ago when the software was first implemented. We were already entering data in the electronic patient record software system and the chronic disease software program. We had a lot of trouble keeping up with this task, even with scribes to help providers. So Quickbase fell by the wayside. We just relied on the cultural liaisons and referral clerks to do the referrals. There just wasn't enough time to keep up all three systems. . . . Finally our IT figured out how to capture this social determinants data on our EHR [Electronic Health Record]. This whole process took a few years. . . . Otherwise, our providers would not be entering the social determinants data except under the "notes" section and the information would be buried. (Dr. Maldonado)

He explained the value for patients of being case managed throughout social determinants units housed within one organization. Case management of patients throughout all social determinants service units is essential to enhance timeliness of care, especially with patients who are in crisis. The process requires keeping track of referrals generated, visits generated from referrals, “no shows,” follow-up appointments, outcomes, and coordination between units of service.

Here is an example of a client who had a lot of medical needs as well as mental health needs related to the abuse and sexual assaults. During our first five sessions, it was hard to get all of the information I needed. She would just cry for long periods of time. I collaborated with the counseling unit to help her get through this. The case lasted over 3 years until she got to the point of feeling functional and somewhat safe. Her children were also affected and underwent counseling and tutoring. They attended the La Maestra Youth Program and started socializing with other children more and were happy participating in activities. My client joined the “Healing through Arts” program also at La Maestra where other victims of rape and trauma attend. She was willing to accept the services for herself and her children because she already had established a feeling of trust with the units and felt welcomed. (Dr. Maldonado)

Dr. Maldonado further explained how technology and a seamless system were of value to the patients. He added,

As all of the units were part of the same “Circle of Care” model, I was able to keep track of my client and her children and provide the needed background information to the other units she accessed to promote a seamless experience as

my client transitioned between the units. She did not have to retell her traumatic background each time she sought other services through the same model.

Marty spoke to the value of the integrated service model in that the patients can be case managed throughout numerous service units; that is, each individual's needs can be assessed, enabling us to send them to the unit that can help them. For example,

Our dentists sometimes diagnose serious medical conditions that the patients had no idea they had. Then we refer them to their medical provider if they have one, or else send them over to one of our medical clinics right away. Our dentists have caught really high blood pressure and been able to alert the patients to conditions that they never knew they had. Or they see signs that point to diabetes. We also have dental patients with severe chronic diseases and are on medications. Or the elderly that have co-existing medical conditions as well as social service needs like housing and food. Or victims of domestic violence who have had fractures to their face, and or jaws, that need to be referred to our other units to get other services to help them. Each group presents their own special complications. Malnutrition during childhood also affects the teeth. Like our refugees that spent years in refugee camps or were starving in their countries. We refer and case manage all of these cases and consult a lot with our medical service units, mental health providers, pharmacists, and social service unit to make sure that these patients get into these other units right away. (Marty)

The characteristics of a seamless system enhance participants' opportunities to take advantage of additional services that they need because duplicate registration functions are eliminated, including eligibility screening. Carmela, the Director of the Human

Trafficking Assistance Unit, described the value she has observed on behalf of her human trafficked clients who are case managed through numerous services in a seamless system, in one organization.

A challenge is that every time a client has to go to another organization, they have to retell their story and try to qualify for the services for eligibility from that organization. Then I have to find out what happened, and if the client received the services and do the case management with outside agencies. This adds a lot of complication and time and anxiety for the clients. . . . Even if there are other organizations that help on these cases, I am the one that case manages them for years. I make sure that they get where they need to go and figure out what else they need and how to work with other units. This would be really hard if I had to coordinate with six or more outside agencies just to meet the needs of each victim. (Carmela)

Ease in accessing numerous needed services, addresses the complexity and degree of needs by participants, and it is facilitated through a seamless data management system. Patients and clients are more likely to follow up on the referral process if they feel comfortable navigating through numerous service units. Mary identified value in the single registration function of the software used by the Circle of Care units. She stated, “I did not have to give all of my information again. They had all my information already.”

From a medical provider’s perspective, Dr. Maldonado identified value for his patients in integrated services because there is increased access to care, warm “hand off” referrals for patients in crisis, and facilitation in case management functions. He explained,

When we [medical providers] refer our patients that need to access mental health services that same day because they are in crisis or are going through an adjustment disorder, or crisis and their situation is getting worse, we can call our colleagues in the mental health unit and explain directly to them what is going on. Sometimes the mental health providers even come downstairs to do an immediate evaluation of the patient, whether it is in general practice, pediatrics, walk-in, OB [obstetrics]. It has tremendous value, not just because of the warm hand-off of the patient within a trusted environment, but because there is immediate intervention for the patient's benefit. So there is fluid communication between different levels of providers to confer on the best strategy moving forward. Sometimes the cases are really complex and severe. This makes a world of difference.

Dr. Maldonado described another benefit of the seamless system component of the Circle of Care model. It adds to the level of trust and comfort of the patients and clients—the knowledge that their confidential data is managed securely as they navigate through the numerous social determinants services in the Circle of Care.

Communication flows and it makes it easy because we are physically close and can communicate through our email, which is HIPAA compliant as all of our units are on the same electronic health records program under La Maestra. We send everything securely so there are no issues or concerns. (Dr. Maldonado)

The integrated seamless system of care gave clients the feeling of being supported. Through a network of caring and trusted relationships, participants gained the motivation to take advantage of new opportunities and resources. Many participants found value in the feeling of being supported and identified this element of their

experience in the Circle of Care service units to be a key factor in being able to improve their well-being. Erika described how feeling supported and being able to rely on others for help through difficult transitions was extremely valuable to her. She shared, “When I came here [USA], I wanted to change my life, have a better quality of life. I knew that I would need to learn new skills to make those changes. . . . With support, people can do anything!”

Robert also described the element of support as contributing to his sense of well-being. He shared, “I have a support system here. If I have problems I’m not afraid to say ‘Hey I don’t know how to do this.’ And I know that we have people here that can lead me in the right way.” The staff also gave their perceptions of the Circle of Care and the value of the integrated system. Marty, the director of dental operations explained how his patients, clients, and the rest of the staff are supported in the Circle of care model.

The staff is a vast network of ethnicities and cultures, like people sharing common values. The organization is a support system. I’ve seen that the organization fosters the culture of looking and analyzing any challenges and is expedient in collectively coming up with solutions like programs and services. That’s how the “Circle of Care” was developed, it responds to what the community needs.

(Marty)

Participant examples of how they bridged social capital spoke to how trust facilitated their process. Another key strategy engaged in by La Maestra that gave participants social capital was the practice of linking.

Linking Social Capital

The third form of social capital is linking. Participants found value in their ability to reach outside of their social network to obtain resources to “get ahead.” While bonding and bridging were described as within organizational strategies used by La Maestra to enhance support for their clients and empower them to make progress, linking was described as the vehicle to advance their position in life and create future successes by connecting La Maestra clients to resources outside the organization.

Participants indicated the sectors they had linked to through established pathways developed by the Circle of Care. Figure 15 indicates the number of times participants mentioned accessing resources outside the Circle of Care through La Maestra’s established collaborations and networks in multiple sectors of society. The most commonly mentioned examples of organizations that La Maestra helped clients link to are categorized into six groups: education, housing, economic development, advocacy opportunities, specialty legal, and specialty medical.

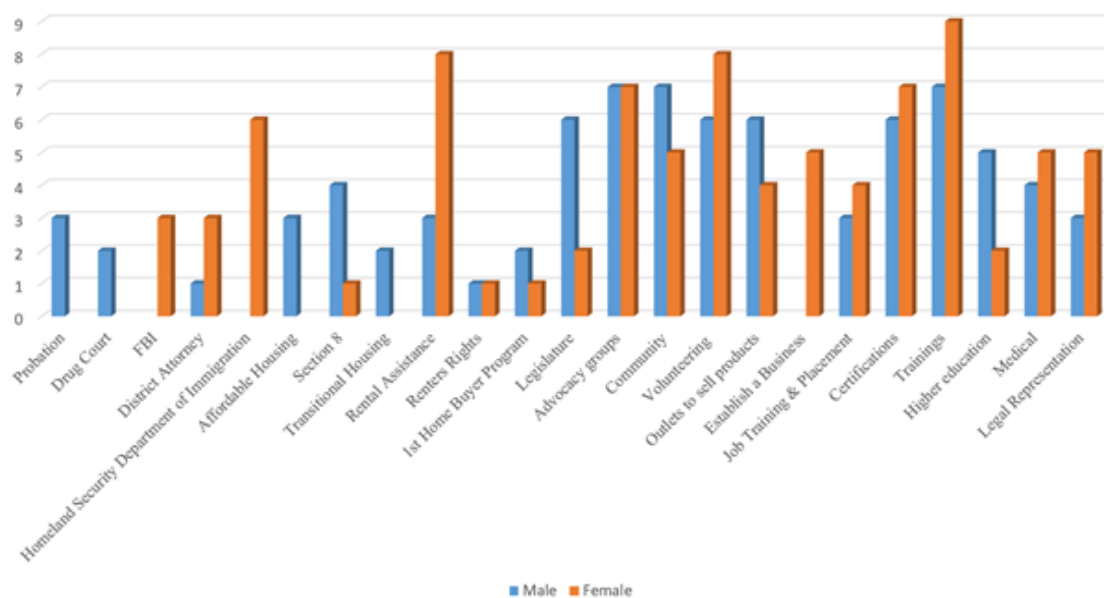


Figure 15. Linking social capital by participant.

The findings indicated that there were gender differences in linking to probation, drug court, affordable housing, and transitional housing through La Maestra. A possible reason for this difference is that the transitional housing services in the Circle of Care only houses men referred from Drug Court and probation. Two of the women participants had also been in custody, transitional housing, Drug Court, and probation before entering into the Circle of Care. Age also differed as participants described their linking patterns. Elderly participants did not link to outside agencies for probation, Drug Court, or transitional housing. There were no significant differences in the linking patterns between ethnicities. Appendix G expands on findings related to linking by ethnicity, gender, and age.

Education. The ability to link to certification, training, and higher education was mentioned by participants as a way to improve their lives and their well-being. Nicole shared that after she “healed,” using resources through the bonding and bridging phases of social capital, she was able to link to resources that allowed her to “get ahead” through her new job skills. She explained,

I recently started interning at the print shop and took classes on graphic arts through the community college. I love designing flyers, menus, brochures, all kinds of promotional materials. I discovered that I am good at it. That makes me feel really good. I look forward to each day now because I feel like I have a purpose. I now have a say in designing materials for the same programs that helped me to heal. How cool is that? I still have a long journey ahead, but I am happy to be able to be on that journey.

Through Nicole’s linking experience we see that she was able to succeed for her own personal advancement and also to benefit the collective. Nicole found value in being able to apply her newly acquired graphic arts skills to improve program materials for the service units that had helped her heal. This is an example of the transactional exchange of social capital through linking.

Eva described how being able to pursue citizenship status through education was of value to her and her well-being by linking to adult school. She shared, “La Maestra recommended me to go to citizenship classes and English as a second language classes. I am happy to go to classes.” Other participants linked their experiences with education to employment. Lupe, a member of the Microcredit unit, explained how linking to advanced training and certification helped her improve her business. She viewed this opportunity as a way to support her family.

I am part of a group that meets for one month now that is held in the commercial kitchen and learn how to get their food handlers license and learn the basics about how to prepare the food to sell in their businesses. These classes are very helpful and supportive for the women and their families. (Lupe)

Mark also shared that the linking opportunities available through the Circle of Care enabled him to obtain the education he needed to prepare for future job opportunities. He explained, “The main thing being part of the ICR program [transitional housing at La Maestra] was that I was able to tap into more resources and educate myself more like CPR certification, motivational interviewing, and the Sober Living Coalition.”

Participants mentioned that they connected their education to employment through La Maestra’s network partners. Carolina described the various collaborative

partners she linked with in the Circle of Care to gain the skills she needed for economic development.

I found out about where to go to further my education through the Microcredit program . . . I started going to Adult School and signed up at Southwestern College. I also took every single training and class that the Microcredit program offered through La Maestra like mental health training, doula training, jewelry design, financial literacy, health home environment . . . all the trainings, even the trainings that were offered through the organizations that La Maestra partners with like Casa Familiar, PCI. (Carolina).

Participants' linking social capital opened pathways to education and employment, facilitated through La Maestra's dense network of collaborative partners.

Housing. Participants described how they obtained improved housing conditions because La Maestra had connected them to their collaborative partners. Brennan described the power he experienced in changing his housing situation from being homeless to becoming a homeowner. La Maestra helped Brennan realize the opportunity to own his own home by linking him to a First Time Home Buyer program.

I really understand the need for housing having been in and out of temporary housing [homeless] for the last three decades myself. I was sent to a First Time Home Buyer program through La Maestra and I now own my own home.

(Brennan)

Brigida, a patient and client at La Maestra, described how she was also able to link to improved housing conditions. She stated,

Staff at La Maestra convinced me that I could qualify for Section 8 housing as a senior. They helped me to complete the applications, go through the interviews and qualify for Section 8. It was a long process, but I made it.

Peter, a refugee from the Sudan, described linking to housing for his family. He explained that,

Finding adequate and safe housing was a nightmare because of lack of housing and the size of my growing family. . . . I obtained help with this issue from the community housing assistance organization and Habitat for Humanity that La Maestra sent me to.

Adequate, safe, and affordable housing is one of the social determinants that participants viewed as essential to their well-being. The examples provided by the participants demonstrate the linking phase of social capital as it relates directly to their improved sense of well-being.

Economic development. The majority of interview participants spoke about the value they received from Circle of Care administrators in linking them with outside organizations to gain assistance with economic development needs. Job training and job opportunities were noted as essential to the participants' well-being. The linking form of social capital was described by participants as "life changing" experiences.

Brennan, once homeless and struggling with recovery from substance use disorder, shared his experience of linking to outside economic development agencies that are collaborative partners of La Maestra. In his explanation of how those agencies helped him to change his life, Brennan shared,

Through being involved with ICR [transitional housing], I found out about job training for CAARR [California for Addition Recovery Resource] which is now called CCAPP [California Consortium of Addiction Programs and Professionals].

I got my certificate to do alcohol and drug addiction counseling. . . . So this was an economic development program that helped me, again through La Maestra.

Similarly, Peter described how “My job training also came from La Maestra where I started to train as an intake counselor for the economic development unit, and then I was placed in an organization referred to me by La Maestra.”. Job training was essential for Peter to secure employment. There are other pre-requisites to employment, including obtaining legal status.

Deferred Action for Childhood Arrivals (DACA)) status allows qualified students to continue their studies in the United States and work through a temporary immigration status. Lilly shared how La Maestra’s Legal Advocacy Unit helped her obtain this legal status, enabling her order to work and providing the opportunity to earn income to support her family.

I am a DACA recipient, so I can work, and I have a social security number. I don’t get all of the benefits that residents or citizens get, but it’s better than nothing. I have the freedom to move around, study, and work. La Maestra Legal Advocacy Unit helped me with my DACA application and helped me renew it three times so far. Without DACA, I wouldn’t have been able to work and help support my family. (Lilly)

La Maestra helped patients with career advancement by linking them with collaborative partners for training and job placement. Mark was previously in the

transitional housing program for recovery from substance use disorder. His linking experience provides insight into how he derived value from obtaining resources by bonding with staff at La Maestra and linking to certification training and a job in his field of interest. Mark stated,

I already had a plan that I wanted to become a drug and alcohol counselor. I talked to people here who have changed their lives. She told me what I needed to do and said that she would supervise my hours I needed in order to get the certification and help me get a job. . . . I ended up getting the certification and hired as a registered substance abuse counselor.

John, a former refugee and now administrator at La Maestra, shared his perspective on the value patients and clients obtain by linking to La Maestra's extensive network of collaborating organizations.

La Maestra has offered training and internships to prepare people with no marketable skills. I would classify them into two groups. The first group received the training and job placement services and moved on, using their new skills to support themselves and their families. That is where the many collaborations La Maestra has with other organizations has benefitted the community. These partners have employed people trained through La Maestra in many fields. The second group got help as patients, became stable, and got work within La Maestra. (John)

For Norma, using La Maestra's network of partners resulted in additional outlets to sell her business products. She described,

I signed up for a garden plot in La Maestra’s Community Garden and planted Epasote, Radishes, Tomatoes, Squash, Ruda, and Wanxota. . . . Wanxota is an herb that grows in Mexico City, Puebla, and Guerrero. I then sell the plants because they are organic at health fairs La Maestra participates in, where I also sell my jewelry. . . . I also learned through financial literacy classes in the Microcredit unit about the need to prepare taxes for my business, and I am so proud of myself now that I have been able to file the taxes and pay the taxes for my business.

These linking practices enabled Norma to expand on her business plan by developing products and establish her company. Lupe also described how linking to outside agencies brought her value, stating “Through the Microcredit program, I was invited to events which I could market the products I was selling in my business. . . . I found out about meetings at La Maestra and through other partner organizations in the community.”

Linking social capital also provided opportunities to develop businesses. For example, Erika shared, “I am looking forward to having my own business so the Microcredit program is teaching me about how to start the business and manage it. . . . Some of these classes are through other organizations [that La Maestra linked me to].” Likewise, Irma shared the value she derived from linking to outside agencies and organizations to develop her business.

What also really helped me was the guidance on how to get my business license. . . . People that I had talked to before coming to La Maestra had told me that it wasn’t possible for me to get a business license because I had no immigration status. Here at La Maestra, I learned that this was not true. I was really happy to

find this out and get help with the process. . . . I felt like the Director here lifted me out of a hole and showed me all of the programs and services through other organizations so I could bring income in to support my family through my business. (Irma).

Participants valued the ability to link social capital to obtain education, find employment, and start their own businesses.

Specialty legal. Access to specialty legal services, outside the parameter of the legal services unit at La Maestra, was of importance to numerous participants.

Participants described value they found in linking to specialty legal services through La Maestra's network for: political asylum and other immigration applications, criminal record expungement to be able to pass the background checks for employment, representation at court hearings, family law cases, housing disputes, and other legal services. Often, clients link to La Maestra from outside agencies and then link again to other collaborating partner organizations. Carmela explained,

They [clients] in the Legal Advocacy Unit are referred by outside organizations that we have collaborations with throughout San Diego County, sometimes even further. These are law enforcement, social service agencies, and shelters. The majority are referred by other departments within La Maestra. So some clients come from the Microcredit Unit, the Family Wellness Unit, and of course, from the medical service. I, in turn, refer the clients coming into the Circle of Care through referrals from outside agencies to La Maestra's immigration services to further explore if they qualify for any immigration petition. If they need specialty legal services, as in the cases of political asylum, I refer them to nonprofit legal

organizations with that specialty. If they already have an attorney that has taken their case, I then start providing them with referrals to get them the resources they need and counseling, medical, shelter and so forth. . . . Oftentimes, they are in need of restraining orders and many other intervention safety services.

Brennan spoke about his need for expungement legal services and how this process enabled him to achieve a sense of well-being and acceptance by society. He shared,

I had need for legal services to try and expunge my record. Heard about La Maestra's Legal Advocacy Program. I went to the office, told my story, and was referred again to an office through the court. I have almost taken care of everything there, and it makes me feel like I have become a full citizen again, with my rights restored. It made me feel free, and there is no price I can put on personal freedom.

In a similar way, Mark described how La Maestra's efforts to link him with law enforcement agencies, correctional facilities, and the court system facilitated his process to re-enter society after serving time in the correctional system. He explained,

There are a lot of people in transitional housing here being sent by Drug Court, MHS, other correctional facilities, courts, and treatment programs. . . . I was in that situation and now I am renting. . . . La Maestra's transitional housing program works with these agencies.

Participants described the value they obtained from linking social capital to access specialty legal resources beyond the network at La Maestra.

Specialty medical. Patients at La Maestra often encounter the need to be seen for specialty medical services, outside the scope of service at Maestra. Referrals are made by

La Maestra providers. Patients experience challenges in following up on those referrals for a variety of reasons, including language and transportation barriers, difficulty in navigating the authorization process through insurance coverage plans, and inability to pay if not insured. Participants shared the value of linking to outside specialty medical services through La Maestra's partners. Quotes from interview participants indicate that their linking was motivated through the support provided by La Maestra. For example, Eva shared,

I went to a specialist at the hospital for OB/GYN for a medical procedure. My cultural liaisons at La Maestra help me all the time with getting approval from my insurance to go to specialist and the hospital. They arranged for my transportation and translated for me.

Robert also spoke about support from La Maestra as a motivator to seek specialty medical services. He explained,

I have been referred by La Maestra to other medical specialists like orthopedics, for my knee which I'm going to now. . . . I would have never been willing to go because I worry about going for the operation because of the meds they will give me. I worried about getting them in my system again after so many years clean. But now I feel like I have a great support system here at La Maestra and in Narcotics Anonymous.

Brennan shared his linking experience to specialty medical procedures and how, with La Maestra's support, he was able to cross potential barriers to access urgent medical intervention.

My primary care doctor at La Maestra referred me to dental, lab, imaging, optometry, liver specialist, and imaging . . . to start with. The imaging discovered that my appendix was ready to burst, and I had been having symptoms which I ignored. They sent me to the emergency room with two CDs of the CT scan they had done at La Maestra. The orderly at the hospital lost one, but luckily I had the second one which the surgeon looked at and immediately scheduled me for emergency surgery. Who knows what would have happened if I had not brought those two CDs with me? (Brennan)

Participants had many medical needs beyond the scope of practice at La Maestra. They found value in linking to specialists for procedures and operations through La Maestra's network.

Participant Duration in the Circle of Care

The length of time the patients in this study accessed La Maestra's services helps to better understand the potential benefits they received from bonding, bridging, and linking. Figure 16 shows how long each participant engaged in the Circle of Care. This finding is important in that it gives some indication as to the social connectedness the participants experienced in La Maestra.

Years in Circle of Care

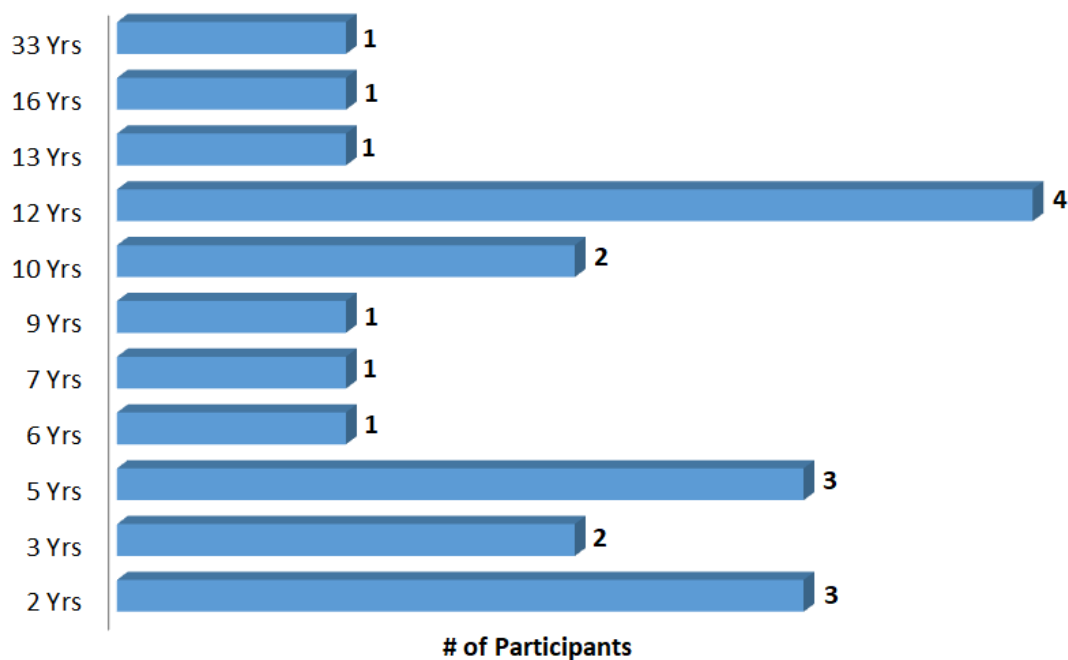


Figure 16. Years in Circle of Care.

Nine of participants have been active members of the Circle of Care social network for 10 years or more. This speaks to their level of engagement and the continued support and resources they derive from being members of the Circle of Care for themselves and their families. Participants' longevity in the Circle of Care network also reflects the layers of needs that challenged participants.

Current Quality of Life Indicators

Participants defined their quality of life or current well-being after receiving services and support from La Maestra. The top 15 indicators identified by participants to assess their quality of life at the time of their interviews are illustrated in Figure 17.

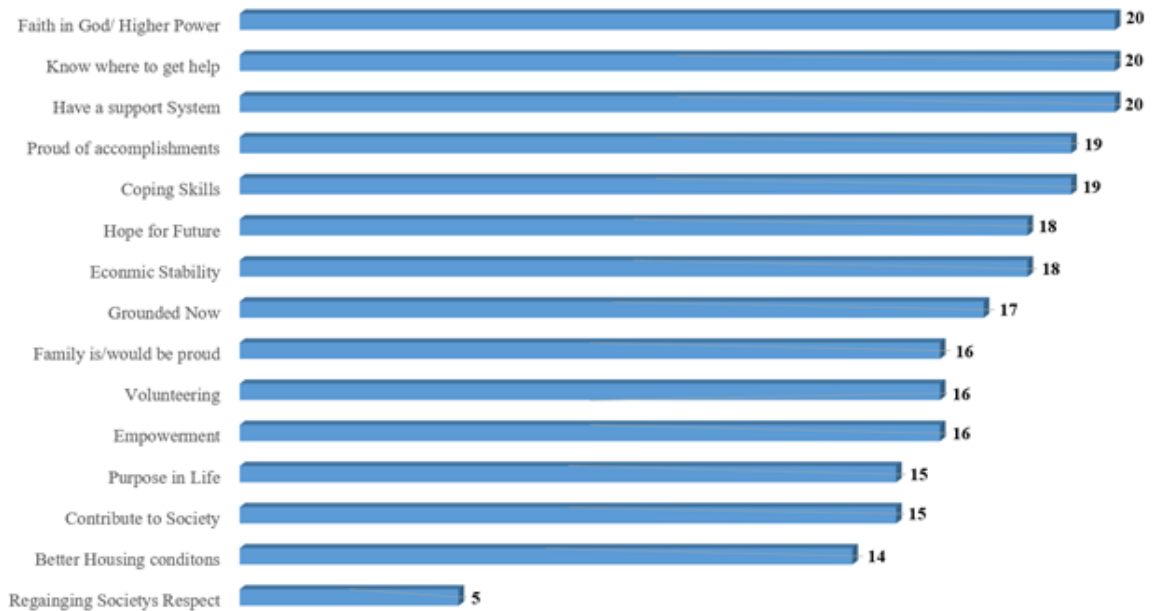


Figure 17. Current quality of life indicators of participants.

All of the participants stated that they felt their lives were enriched through their faith in God or a higher power. For example, Mark spoke about his spiritual development and the connection to well-being. He explained,

Life has drastically changed for me for the better. I have my spirituality. I do have a conscious contact with my higher power. I pray for guidance. I remember just being one of those “in need” prayers when I needed something or to help me out of something. Now I pray to God for strength to make the right decisions. And I like to thank Him a lot for my blessings. “Gratitude is attitude.” Sometimes I may forget the things and blessings that I have, so I have to play my tape through to remember my blessings. I have a lot of things to be grateful for.

Participants also offered examples of what has contributed to their sense of well-being, aside from improved health status. Many of the indicators point to characteristics

of social capital: support system, coping skills, empowerment, reciprocity, economic and housing stability, and an increased self-esteem and psychological capital. They expressed pride in themselves and their achievements.

Brennan shared, “my parents who died in an accident when I was 13 would be proud of me now.” Brennan’s pride in being able to overcome addictions and homelessness for over 30 years was an indicator for him of his well-being. For Norma, her improved health was indicative of her well-being status. She explained, “My health now is great. I used to have a lot of health problems and experienced depression. . . . I have many opportunities and feel happier and more freedom to try new experiences and learn continuously new things.” Even Erika explained the measures that indicate to her that she is doing well. She shared,

I believe that the quality of my life is much better now. I am involved socially much more, and I have people that I know and feel comfortable with to ask for guidance. I feel like I have support here at La Maestra. . . . I learn a lot about different topics that help me and my family through the guest speakers and events through the Microcredit program that empower women.

Carmela, the director of human trafficking assistance unit, described well-being indicators she witnesses in her clients, achieved through social connectedness, self-esteem, support, and reciprocity. She stated,

I know that the clients feel like they have an entire team working together on their health and case. They don’t feel alone anymore. That gives them an incredible feeling of comfort and support which leads them to feel well. They start having confidence and hope that their lives will get better and start growing roots,

getting involved in community activities and socializing with others through the organization, like the support groups and arts, exercise, nutrition, and even get into civil activities. They start giving back to the community, and it makes them feel great because it means to them that they have overcome their adversities enough to help others. Their focus is not anymore survival, its doing well and being active members of society.

This was echoed in Emilia's remarks about her well-being indicators including the ability to rely on a supportive, caring network. Emilia shared,

I know that whatever faces me in the future, I have a huge new family that loves me for who I am and cares about me and my family. It's like I found a big, extended family where I belong. Just knowing this gives me the confidence to keep trying and take opportunities.

Throughout the interviews, participants described their indication of well-being as derived from the support of a social network, affirming their sense that they are now doing well and positioned to help others.

Reciprocity Through Advocacy

The numerous examples provided by participants of bonding, bridging, and linking, gave clients the benefit, the exchange value, and the social capital to progress in their lives personally and professionally and to become advocates for others. La Maestra's network gave them advocacy opportunities to have a wider reach and support more people.

Mark shared that he found value in linking to advocacy activities and groups through his involvement with La Maestra's transitional housing program and behavioral health department.

Because of the transitional housing, having a place to live and having a job as part of the recovery program, I was able to go to meetings and participate in my recovery. I've been able to advocate for more resources for families who are coping with mental health illness, like transportation and food. Those resources are what I needed when I was caring for my mother during her periods of mental health crisis. (Mark)

Robert shared the advocacy and volunteer efforts he is involved in for re-entry. He mentioned,

I do a lot of volunteer work and advocacy for NA. I'm involved with a couple of different activities. . . . I go into the jails. We take meetings into the jails to share our strength, experience, and hope. I'm like the best speaker, and I do my best sharing there. Cause these guys walk in, like real tough, then I share my story, and then all of the sudden they are listening and coming up to me after and thanking me. I sure get a lot more out of it than they do. And as corny as it sounds, that is how I stay clean, by helping others. I am also on the activities committee. . . . Then I run a study group every Tuesday.

Emilia also described the advocacy activities she got involved in and how being able to advocate for others aligns with her purpose in life. For Emilia,

What keeps me going is to focus on advocating for the needs and rights of the Trans community, even the Elder Trans. . . . We have meetings every Friday at La

Maestra. We have ten classes on “Ending The Game,” which is identifying and getting out of trafficking, with supplemental counseling, and rental assistance. We have many partner organizations that work with us on these classes.

Erika spoke about her environmental advocacy efforts with the schools and neighborhood clean-up groups. She wants “to support my community and help make it better. I volunteer at the schools then participate in neighborhood activities like street cleaning and other activities.”

Brennan described his volunteering activities among populations who are experiencing similar adversities that he went through and how being able to help others reflects his well-being. The growth cycle of social capital is demonstrated through Brennan’s description of how he linked and now is bringing resources to others in the homeless community. Brennan was on the streets, homeless, for 30 years before achieving recovery, and, as he is now giving back, he described,

As a volunteer I have joined an outreach team through La Maestra which goes to help the homeless once per week. We are joined by the PATH program, MacAllister Institute, Salvation Army Feeds, PERT (Psychiatric Emergency Response Team), the Veterans Administration, Friend of a Friend, Law Enforcement, the Volunteers of America, and other programs. La Maestra takes its mobile medical/dental/optometry clinic, and we all meet at various homeless sites once a week throughout the city. We pass out flyers ahead of time, and the homeless know where we will be as we often go to the same sites. Its amazing work, and each week we are able to help so many people who are less fortunate than we are with many needed services. Some even get off the street into recovery

programs. I feel blessed to be part of this work and see people connect to the help that they need at that moment. They might not be ready for all of the services but at least connect to a few and maybe the next time will accept other kinds of assistance. This is true Community Health in action!

Likewise, Mark shared how he gives back to the community, which allowed him to expand his advocacy efforts. He explained,

I was volunteering in outreach programs for the homeless. I am also involved with volunteering through Narcotics Anonymous, and I am looking into starting a nonprofit to support family members of people with mental health issues by building awareness for support services like food, transportation and a supportive network.

Participants found value in being a voice for others on social justice issues, educational reform, re-entry strategies, substance use disorder, gender rights, environment, and mental health issues. Participants expressed how advocacy and volunteering allowed them to reciprocate and furthered their feeling of empowerment and well-being. Reciprocity was described by all participants as valuable to them.

Institutional Capital

The last group of findings highlights how institutional capital is created through the actions taken by La Maestra's staff and the benefit of this capital on participants. Institutional capital refers to the organizations' success in building capacity (i.e., knowledge, quality, collaborations, trust). Commonalities across participants' comments indicated how institutional capital has been created over the last 34 years and how it accounts for their ability to provide additional social capital to their clients and improve

their health and well-being and the well-being of the wider community. For example, Marty shared,

The staff is a vast network of ethnicities and cultures, like people sharing common values. The organization is a support system. I've seen that the organization fosters the culture of looking and analyzing any challenges and is expedient in collectively coming up with solutions like programs and services. That's how we have the "Circle of Care" model because it responds to what the community needs. . . . The organization also encourages and supports staff to get more training, education and they get promoted. The staff come and stay. They feel comfortable with the work environment and feel proud to be a member of this organization. The staff knows they are making a huge impact on patients' lives. They see how big we are now.

The continuous professional growth of the staff as well as the integration of the Circle of Care model and its responsiveness to community needs has facilitated a supportive network that increasingly deepens the work and is able to spread its impact.

One of the main reasons for the growth in institutional capacity is the emphasis on culture. As described earlier, cultural liaisons, translators, and overall empathy for the complex needs of all, has built a structure, a set of arrangements that responds to the needs of the very diverse population of clients. However, hiring a staff that shares similar backgrounds and experiences with their clients has been key. Dr. Maldonado described its importance, stating

I think that at the end of the day, it's the love for people and doing something actionable to improve their lives. I think that at each level, everybody at the

organization has either experienced trauma or has family that had to cross the border . . . all of these things that we continue to see our patients and clients experience. We are able to relate to them. Not just sympathize but we empathize with them. Empathy is at a deeper level. I remember my mom telling me that they had to sleep in little homes with really thin walls, and it was very cold. When families tell me about their housing issues, I can sympathize, empathize with them to a certain extent. Even though I was preserved from that, it is not very far from me. I think that all of us in this organization have had these experiences.

John echoed the importance of cultural alignment between staff and patients. He shared, Well, I know the populations we serve very well and know that the services offered through the “Circle of Care” have been created to address their specific needs. The fact that the staff here is from all of the units of service are from the populations that we serve is a big deal. It’s a welcoming environment and healing because people who are in need see others that were from similar walks of life that have been able to overcome their adversities.

He explained that La Maestra’s staff is somewhat unique. Many share the same background as their clients. Carmela relayed why she aligned with the mission of La Maestra and joined the staff. She explained,

I feel passionate to help people because I also was someone who came to this country seeking refuge. I escaped from Peru because the government attempted to assassinate me. I came here illegally with my family and was homeless, with kids, and did not have any resources. I was a lawyer then judge in Peru and enjoyed a very fulfilling life. Then I was assigned a case involving the incumbent President

of Peru. Then the trouble started. Luckily, I was able to escape, and my family sent me the proof I needed to apply for political asylum. I did not even know that I could apply for political asylum. It was a long process, and I faced many of the same issues that my clients deal with. I swore that if I could get my life back together, I would dedicate my life to helping others. So I understand, feel compassion for my clients and many others who will never qualify for any immigration status because they do not have the necessary proof to satisfy immigration. We all start again, with nothing. Actually, less than nothing because we have faced trauma and adversity than has to be addressed before we can start healing.

Participants provided many examples of how invested the staff are in their healing process. Eva described how staff goes beyond their expected job duties to support patients and clients particularly the cultural liaisons. She explained that “she [my cultural liaison] came to my house to check on me once each week for 3 years . . . on her own time. She and my Burmese community also helped me to get better.”

The organization has established a strong reputation in the community, and they are able to build on the social capital that they have cultivated. Dr. Maldonado spoke specifically about the trust that La Maestra has established, saying,

I think it is a well-known fact . . . more importantly La Maestra has created such a great reputation in the community and a name for itself, here locally and even beyond. If you couple the fact that the provider has such a good relationship with the patients and the families along with La Maestra having such a good reputation in the community, through their own experience or hearing it word of mouth from

others, they are more likely to go. Also because La Maestra has intentionally built such strong relationships and made great strides within the different population subsets. The staff speaks so many languages because they are reflective of the diverse cultures that La Maestra serves. That says a lot. Patients are willing to meet me at that level and at the organizational level. And the name and the brand itself speak loudly and they are attracted to that.

The creation of a strong collaborative network across sectors brings additional resources to the patients and clients in terms of improved health status and well-being. Dr.

Maldonado added,

As an active participant in the community and among our peers, we also are keeping high standards and going about providing these services in accordance with the regulatory agencies and expectations of the public. So we play the game and play by the rules. That brings a high level of validity to the work we do, among the structural forces that we have to satisfy. It definitely adds to the reputation of the organization. Of course, we work with the police, ICE, the correctional facilities, the universities, hospitals, county, state, federal agencies, and other community organizations from all sectors. We are team players and government, community, and patients recognize that. We have an awesome reputation among all levels of society. We are not just known as an excellent medical facility but as providers of other social determinants. It is palpable among all of our staff that we are unique in that we encompass services that address numerous needs. We constantly train new staff and re-emphasize the nonmedical programs we offer and why that is integral to our model and how it impacts

positively the patient health care outcomes and their well-being. This is done through providing updates, meetings, trainings, and orientation.

The staff's role in creating the integrated model was further explained,

The staff actually helped to create the model of the Circle of Care and how it continues to develop because of the bilateral communication . . . so [the organization is] connected and well-grounded in the trends and needs of the subsets of the clinic's population. I think that is one of the main reasons it is so successful here at La Maestra. So it might be difficult in some FQHC's [Federally Qualified Health Centers] in other parts of the nation to implement the Circle of Care without having the cultural diversity of the staff, or the cultural liaison model in place first. (Dr. Maldonado)

Identifying new cultures moving into the community helps the Circle of Care remain responsive to their needs. Peter shared,

La Maestra built a very strong relationship with the Sudanese refugee community, when we first arrived in San Diego in 1998. La Maestra met with the leaders of our community and invited us to come to the health care services at La Maestra. More importantly, La Maestra provided them with job training and job placement. Right away, La Maestra started hiring Sudanese also. What other organization in San Diego hired five Sudanese right away? So my community witnessed La Maestra's mission to help everyone in the community.

Dr. Maldonado explained further that the Circle of Care model is really the secret sauce. It is an organization's attention to all of the social determinants of health. He stated,

I'm sure that they have different populations at other FQHCs, but there are commonalities that can be addressed through the same model which is pertinent in all low-income communities across the nation. A similar approach would work because the needs are still the same. Like mental health, it cuts across socioeconomic levels. We are from "the hood" and for "the hood," very grassroots. We know what to look for and know our people.

This data demonstrates that La Maestra's institutional capital has been built through the staff and that they reflect the populations they serve. Alignment with staff through shared backgrounds, cultures, norms, and beliefs, creates connectedness and trust. The organization continues to be responsive because staff members are embedded within the populations served and are part of the decision making for future programs needed by the community. Their strategic plan has facilitated the spiraling, (acceleration), of social capital for patients, clients, and staff. Members of the board of directors and staff are hired from the community that La Maestra serves. Data has shown that cultural diversity of staff and cultural responsiveness of program materials serves to attract and retain members of the community in La Maestra's network.

Culture

Throughout the participant interviews, the word "culture" was referred to repeatedly by both genders and all ethnicities. Participants pointed to the value they derive from the cultural diversity of the staff and patients at La Maestra, the cultural competency of the services, and how cultural diversity enhanced their experiences. Bonding, bridging, and linking strategies facilitated their journey and created a culture that moved them towards improved health and well-being.

Robert found comfort in the culture at La Maestra. He stated, I align with people I am comfortable with, so I identify with people here [La Maestra] and with people from NA [Narcotics Anonymous]. In NA, we have different groups with a mix of people [ethnicities] that I hang out with. . . . We have common bonds from experiences we have in common. That is how I would describe my culture now, not based on my ethnicity.

Peter also shared how La Maestra created a welcoming culture. In his experience,

When you have to flee, as in my case as a refugee, I had to find another group to fit into. I had to adopt a new group. I would no longer fit in if I went back to South Sudan. Life has changed me and my family and community. So we looked for new places and groups to align with. Part of our process was identifying with the values, beliefs, norms of others, despite the diverse ethnicities. Our situational, contextual needs pushed us to seek help and direction and services from organizations that we thought could assist us.

John agreed that La Maestra exuded a culture of acceptance and support. He explained,

I would say that culture is what people identify with, like values, beliefs, and commonalities. I think that ethnicity is one way to define culture. Another way is to describe a group of people that have been through similar situations and are facing similar challenges. Like victims of domestic violence, human trafficking, refugees, immigrants, homeless, veterans, people released from correctional facilities. I think that La Maestra through its “Circle of Care” has a culture of its own. . . . It’s the opportunity for acceptance and a support organization to all cultures and walks of life. It benefits all who seek the many comprehensive

services. The integrated nature of the model provides a primary culture for people who have left their previous social network. The integration of services gives them the support through ability to build relationships with numerous staff, other patients, clients, and the bigger society. When you leave your country, your community, your support system, you have to try and find another social network. I believe this becomes the new primary culture.

Participants defined the culture at La Maestra as inclusive and diverse, referring to ethnicities and backgrounds. The culture that La Maestra has created has proved helpful in supporting improved health and well-being. It has motivated, encouraged, and supported through various strategies opportunities for these participants. Peter described why he thinks that the culture at La Maestra has been conducive to his acculturation process and necessary in achieving well-being. He shared,

In order to acculturate and grow roots, we have to become members of our new society in this country. This means finding work and helping our children assimilate in their schools. We can't remain isolated as we won't survive. We look for new places and groups to align with. Part of the process is identifying with values, beliefs, and norms, despite the diverse ethnicities. My situational, contextual needs pushed me to seek help and direction and services from organizations I thought could assist me. . . . I have identified with a new primary culture. I have identified with a new primary culture which is the culture at La Maestra. My ethnicity is my secondary culture. My being a refugee is another subculture, which is the culture at La Maestra. My ethnicity is my secondary culture now.

The role of culture was noted many times by participants when describing their feelings of belonging to the network at La Maestra and their healing process through bonding, bridging, and then linking to “get ahead” and advance their future opportunities.

Summary

The interview data was rich and clearly indicated the values these participants derived from their experiences with the integrated social determinants services in the Circle of Care. The participant demographics and prior adverse life experiences before accessing care through the Circle of Care showed why participants needed the services. They indicated a complex layer of needs that were addressed through the social determinants services at La Maestra. The Circle of Care model provided the participants with social determinants services and a supportive social network that gave them the resources they needed.

Gender analysis revealed that 65% of the participants were female and that their first accessed services were different than those reported by men. This ratio aligns with the health center data across the nation. Participants across all ethnicities, genders, and ages in this research study reported finding value in the cultural diversity of the patients and staff and the cultural competency characteristic of the service delivery model. Participants’ comments emphasized the importance of the cultural alignment they felt with the staff, specifically their social identity and the co-membership that helped to attract them to access services and remain engaged in the network. Trust was engendered through alignment to similar others, through shared backgrounds, and similar needs. Trust was generated from the bonding strategies of La Maestra, which built social connectedness, psychological capital, and gave participants the ability to reciprocate. The

supportive system, which offered them a place to belong and feel cared about, gave them the courage to bridge to other needed services within the Circle of Care and garner additional resources, further strengthening their resilience, health, and well-being. Once empowered, participants were able to take advantage of the bridging opportunities offered by La Maestra, expanding their social capital as they gained even more opportunities from the resources of multiple service units with which participants had engaged. Empowered by the experience of bonding and bridging social capital, participants felt prepared and supported to venture beyond the social network at La Maestra to link to resources offered by collaborating agencies and organizations in La Maestra's network. La Maestra's dense network of partners, spanning across numerous sectors in the wider society, offered participants the opportunity to find jobs, improved housing conditions, and resolutions to legal issues and medical challenges beyond the scope of practice at La Maestra.

The ability to engage in reciprocal relationships resulted in a sense of well-being. Participants reported the value of being able to engage with and give back to others through advocacy opportunities. They explained that advocating for others was an indicator to them of their well-being and quality of life. They expressed that their lives were meaningful, as reciprocity at a collective level gave them a purpose, self-respect, and pride in their achievements. Moreover, participants described feeling respected by society.

Chapter 5 will draw on relevant research to interpret the findings in this chapter, provide an analysis of the main findings, and answer the research questions posed in this

dissertation. Implications of this study and recommendations for future studies will also be addressed.

CHAPTER FIVE

DISCUSSION AND CONCLUSION

This dissertation was a qualitative research study conducted at La Maestra Community Health Centers and La Maestra Foundation over a 1-year period following two mini studies that had been conducted at the same site. La Maestra is a nonprofit community-based organization which provides services to low-income populations. As a federally qualified health center (FQHC), La Maestra provides a wide range of primary health care and specialty services for vulnerable populations. The medical services are integrated with other social determinants of health: economic development, housing, youth development, legal, immigration, food pantry, community garden, eligibility, and other social services. The Circle of Care is the multisectoral model La Maestra has developed over 34 years.

Criteria for participant selection in this study involved identifying 20 patients or clients who had accessed three or more social determinants service units in the Circle of Care. Six of the participants were previous patients who had advanced to administrative director positions within La Maestra. These participants provided an additional perspective about patient and client experiences: context over time. This qualitative study triangulated data by including conversational interviews, observations, and document analysis of participant charts and files. This multiple case study consisted of a deep level of analysis into each participant case followed by a second stage of cross-case analysis (Merriam & Tisdell, 2016). Within-case and cross-case analyses allowed for emergent concepts and themes to surface with sensitivity to the tenets of social capital theory (Gioia et al., 2012). Themes emerged helping to explain participants' experiences around

the importance of social connectivity, social networks, and social capital with cultural alignment and trust as key facilitators in accessing both instrumental and intrinsic resources.

The study identified theories emerging from the data about the phenomenon of the cumulative value of the Circle of Care model and the process or pathways followed by the participants to seek the help they needed. The study also sought to define the transactional exchange of social capital that was facilitated by the Circle of Care professionals. Gender, ethnicity, and age were disaggregated to gain an understanding of how these factors influenced participants' experiences in accessing services within the Circle of Care.

The primary research questions which guided the research methodology for this study were:

1. What do patients or clients perceive to be the value of La Maestra's Circle of Care integrated model in improving their health and well-being?
2. How does the perceived value of La Maestra Circle of Care vary by participants' gender and ethnicity?
3. What strategies does La Maestra's Circle of Care use to address the needs of vulnerable populations seeking health care?

This chapter describes the main findings of this research study which speak to the instrumental and intrinsic resources that participants found valuable in accessing numerous service units in the Circle of Care. Instrumental resources refer to comprehensive services and access to information, contacts, and referrals obtained through the integrated service delivery model. The cumulative value or intrinsic resources

participants identified from the social network at La Maestra are presented through a social capital framework. The intrinsic resources were described by participants as social connectedness, empowerment and feelings of accomplishment through the three kinds of social capital: bonding, bridging, and linking opportunities. The ability to contribute to society was how participants measured their own progress towards well-being.

Participants provided measures of what well-being means to them and gave examples of how the structure, the leadership, and the norms of La Maestra's network facilitated their access to social capital resources within and beyond the Circle of Care.

Vulnerability Threshold of Participants

The participants in this study meet the definition of vulnerable because they did not have the contextual, physical, and psychosocial resources that are available to individuals from higher socioeconomic classes when faced with stressors in life (Ahern et al., 2008). Vulnerable populations are at a higher risk for health-related issues, such as chronic diseases, because of contextual factors embedded in their environment (Cockerham, 2013; Davidson, 2014).

One might assume from the literature that all vulnerable populations experience the same level of disparity or resulting threshold of needs for social determinants services. The study at hand contributes to an expansion of the definition of vulnerable populations by bringing awareness to the complexity of needs and the interlocking layers of challenges to be considered in developing effective strategies for improvement in their health and well-being.

Poor is Poor

This study also revealed no difference among genders, ages, or ethnicities in regard to frequency or type of incidence of prior adverse life experiences or adverse social determinants experienced by the participants. An unexpected finding was that poverty is the main determining factor for participants' overlapping challenges.

Prior Adverse Life Experiences Resulted in a Need for Social Determinants Services

The participants described multiple adverse life events and overlapping adverse social determinants, creating an urgency to seek comprehensive services to address their complex needs. Literature on intersectionality theory provides insight into the complex layers of needs that affect health and well-being. Crenshaw (1989) first raised awareness on how race and gender created complexities in marginalized populations. Subsequently, additional demographics of ethnicity, socioeconomic status, immigration status, educational background, and age were added as indicators of social disparities among vulnerable populations (Bowleg, 2012). Intersectionality theory in health research seeks to identify each of these layers of inequalities, taking into consideration the composition of communities to develop strategies for improving population health (Bauer, 2014).

A visual depiction of the layers of challenges described by the participants in this study is in Figure 18. Participants in this study reported having intersecting layers of health care, contextual, and psychosocial needs, resulting in what they described as “just surviving.” They relayed they were aware of their wide range of needs that needed to be taken care of before they could start feeling well. Accessing the necessary pathways that led to improved health and well-being was reported as essential by these participants.

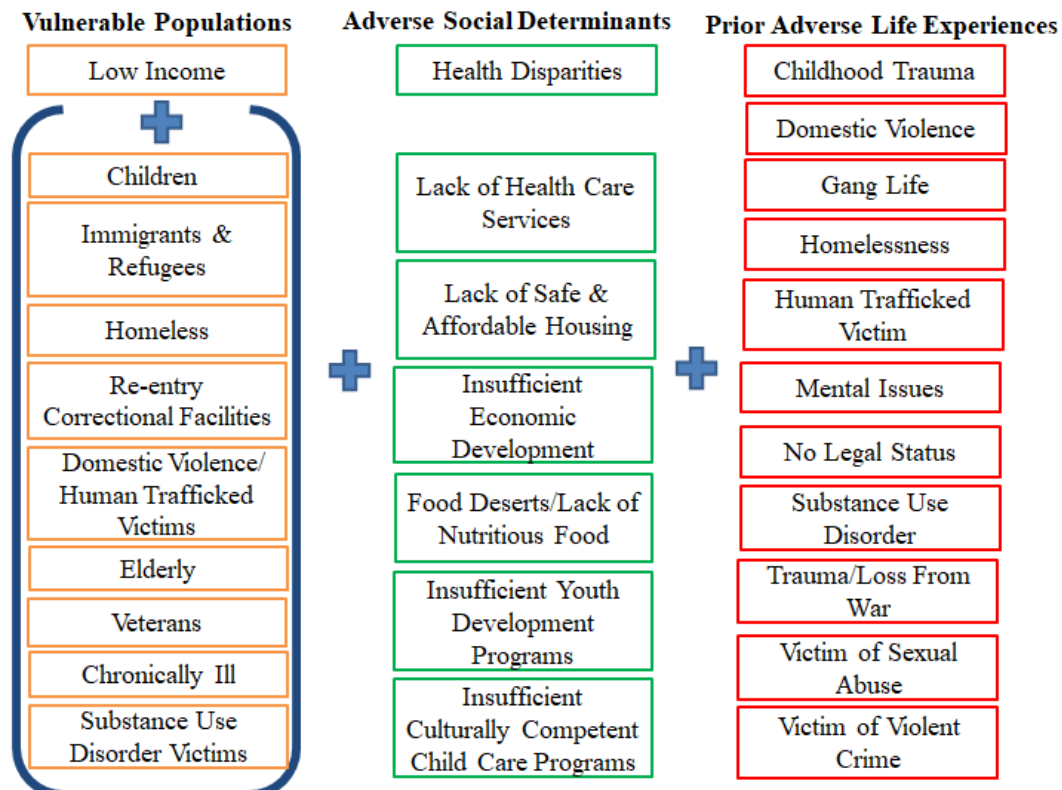


Figure 18. Vulnerability threshold of participants with overlapping challenges.

Circle of Care Model: Integrated Social Determinants

The Circle of Care model is La Maestra’s strategy to address vulnerable populations’ health care and well-being by integrating social determinants services into an FQHC setting. “Social determinants of health are conditions in the environment in which people are born, live, learn, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks” (ODPHP, 2020 p. 1). Social determinants services are essential to the health status and well-being of vulnerable populations (Davidson, 2014; Marmot, 2007; WHO, 2012).

The services offered through La Maestra’s Circle of Care were responsive to the interlocking participants’ needs. As depicted in Figure 18, participants in this study reported experiencing interrelated adverse contextual challenges in addition to traumatic

life experiences before seeking services through the Circle of Care. Participants found value in the social determinants services offered through La Maestra's Circle of Care, evidenced by their utilization of five or more service units. All participants accessed health care services: 70% utilized social services and economic development, 45% food pantry, 40% housing and legal assistance, 35% youth development, and 15% Healing Through Arts (adults and youth). The percentage of female participants who accessed housing might have been higher if the transitional and sober living programs were not exclusively for men at the time. However, assistance in finding safe, affordable housing was received by a third of female participants. This study did not include participants under the age of 18. The youth development program is available to individuals between the ages of 5–23. This might explain why only 15% of participants in this study accessed this program.

The participants described value in the Circle of Care's integrated approach with resources in the service areas that participants needed. The social determinants services that participants obtained through the Circle of Care addressed co-existing layers of needed resources, spanning across a variety of sectors (La Maestra, 2020). Participants found value in being able to obtain these services through one overarching organization to address their adverse social determinants needs.

Social Determinants Services

Integrated Model Responds to Overlapping Needs

There were slight gender differences in the service areas that were accessed first. Male participants tended to access economic development, housing assistance, and Healing Through Arts units first, then proceeded to access health care, legal, and food

scarcity units. Male participants commonly mentioned that they tended to delay accessing dental and medical services until their need was urgent. A few male participants mentioned the fear of pain, preventing them from first accessing dental services. Female participants tended to enter the health care services first, followed by legal and immigration assistance, Microcredit, and youth development, respectively. A few of the participants stated that they were unaware of the totality of social determinants services offered through the Circle of Care model when they first accessed services.

These findings provide evidence of how adverse social determinants interfere with medical interventions unless social determinants are addressed through a comprehensive approach. Participants offered examples of how contextual environmental challenges negatively impacted health outcomes. One such example was offered by Dr. Maldonado in regard to childhood asthma exacerbated by poor living conditions. Patients experience higher incidents of asthma because the living environments have many triggers for asthma (e.g., old carpeting, poor or no ventilation, overcrowding, infestation of rodents, fleas, cockroaches, and lack of heat). These contextual issues present challenges for treating patients with chronic disease as Dr. Maldonado is not able to address them, even though they are the root of many of his patients' problems.

Researchers have criticized the health care system in the United States for failing to comprehensively address and pay for social determinants services. According to Bradley and Taylor (2013), the health care delivery system in the United States encourages over prescribing medications, surgeries, and imaging instead of addressing the root causes of illness, which are social determinants. However, attention to adverse social determinants impacts health status. An example of how chronic allergies, including

asthma, is exacerbated by substandard living conditions is provided by Dr. Maldonado who sees patients with severe allergies. According to accepted medical policies and procedures, he prescribes allergy medications. If, after the course of medication, the allergies persist, patients are referred to allergy specialists, according to protocol. The patients then go through more screening, tests, medication, and expense, yet their conditions persist due to living in substandard housing conditions, in cars, or in homelessness. The conditions where patients live, sleep, work and play are hazardous to their health and the root cause for asthma and allergies.

Integrated Model Responds to a Variety of Contextual Needs

An analysis of the contextual challenges reported by the participants in this study provides insight into why vulnerable populations required social determinants services. Poverty, years of enduring disparities, and adverse traumatic events exacerbated their health and well-being conditions. The findings indicate that poverty is the main culprit of the participants' circumstances resulting in trauma to their body, mind, and spirit. Ninety percent of participants self-categorized in the low-income bracket before accessing services through the Circle of Care, with equal reporting across genders and ethnicities. Individuals living in poverty are more likely to encounter social, psychosocial, and physical factors that are associated with increased morbidity and mortality compared to populations with higher income levels such as middle and upper classes (Bradley & Taylor, 2013; Braveman, 2006; Mechanic & Tanner, 2007; Palmer et al., 2019; Rose et al., 2008). Low-income populations lack protective social support or resilience to withstand adverse social determinants of health. Minority groups are even more at risk of

living in poverty, and the impact of adverse contextual challenges are much higher as they are often exposed to disparities over the course of their lives (Holt, 2007).

Participants indicated they needed job training opportunities. Without marketable skills, they were unable to gain steady employment. Without employment, they were unable to support their family causing undue stress and mental and behavioral health issues, further compounding their medical conditions. Lack of legal status also impacted the ability to earn income and become self-supportive and interfered with the well-being of the participants in this study. These contextual challenges are just some of the participant examples of adverse social determinants of health, which affected their health status and required an integrated health solution.

Researchers have suggested that needed resources for vulnerable populations reside at the macro level of societies, including those resources which address the social determinants of health. These factors are argued to be at the root cause for why health care outcomes have not improved and have even declined, despite increased government spending of \$3.3 trillion annually for health care, including \$600 billion for Medicaid recipients (Brooks & Whitener, 2018).

Individual behavior level interventions have been the focus in the United States and have guided health policies that center on risk behavior, nutrition, and physical exercise (Bradley & Taylor, 2013; Rose et al., 2008;) rather than addressing structural problems related to economic, social, and environmental issues faced by vulnerable populations (Brooks & Whitener, 2018). Key measures of health and well-being in the United States are below those in other developed countries despite higher health care spending that is higher than in other OECD member countries (OECD, 2017). The United

States has historically invested very little funding for social services focused on contextual needs, including nutrition, housing, education, the environment, and unemployment support (OECD, 2017). Many researchers believe this lack of attention to issues connected to health care is the main reason why health outcomes continue to be poor among vulnerable populations in the United States despite increased medical services (Bradley & Taylor, 2013).

Researchers are among those who have advocated for policy implementation of a multidimensional framework to really understand the complex interdependencies between the individual, systems, and health outcomes and provide bridges between the sectors and pathways that connect vulnerable populations to resources that reside within the macro level of society (Davidson, 2014; Mechanic & Tanner, 2007; Metzler, 2007). La Maestra's Circle of Care model utilizes such a multidimensional framework with established bridges through its network to numerous sectors at the macro level of society. The fields suggested for inclusion by Mechanic and Tanner (2007) are health care, education, economic development, and community development. La Maestra's Circle of Care model has established bridges with these sectors and also includes bridges with housing, youth development services, law enforcement, the judicial system, and food adequacy services.

Circle of Care Strategy Incorporates Cultural Sensitivity

Participants remarked that they felt drawn to the environment in the service units from their first visit. As they described, this was mainly due to observing other patients and clients that were culturally diverse (i.e., similar ethnicities and backgrounds). This respect for creating a culturally diverse environment allowed participants to identify with

others similar to themselves who were also accessing services, making them feel a sense of belonging, connectedness, and identification with others. The feelings of welcomeness they described helped address their concerns about isolation. Ninety percent of participants had reported experiencing isolation before coming to La Maestra.

The culturally diverse environment created by La Maestra also promoted feelings of connectedness among the directors who participated in this study. The directors described how they also value the sense of belonging, comparing it to a family environment full of relationships with each other and the patients. They listed the commonalities found in their past, backgrounds, and cultures with those of the patients. Directors described how their values are aligned with the organizational purpose and feel empowered and fulfilled through the work they do serving others. They were able to describe the direct impact of the compassion, empathy, efforts towards helping patients, transformation of clients, and progress shown by staff towards patients' well-being. The directors likened their own backgrounds, struggles, and acculturation process to those experienced by the patients, the clients they serve. This cultural dynamic in La Maestra is driven by the cultural competencies around ethnicities, backgrounds, languages, and religions. The directors benefitted as patients and, when promoted to their staff positions, created a culture through the Circle of Care that led to transformative growth over time for their patients. To further promote a welcoming environment for diverse cultures, La Maestra has made a concerted effort to integrate culturally familiar aesthetic elements in each service unit which incorporate open design concepts, cultural community art, colors scheme of the units, and patterns in flooring, reception counters, and cabinetry. They added new programs and services to the model to support this overarching culture.

Culture is a set of cognitions shared by members of a social unit (O'Reilly, Chatman, & Caldwell, 1991). Individuals seek social identity that brings meaning and connectedness and classify themselves into social categories. Congruency between individuals' values and those of the organization are the root of the person-culture fit as described by the participants in this study. Crystallization is when there is agreement on values among the members and the organization (O'Reilly et al., 1991). Social connectedness, belonging, and cultural alignment were values reported by all participants in this study. Culturally competent services address the fear many patients have of not being able to communicate with medical staff, which creates a barrier to accessing health care services. The majority of interview participants mentioned that translation services offered through cultural liaisons at La Maestra were extremely valuable.

Seamless Referral System Provides Benefits to Participants

Participants in this study pointed to the benefits of a system of integrated services that allowed information to be shared between units within the same model, facilitating case management functions throughout numerous units. There is also evidence from participants that accessing services at disparate organizations creates fragmented services, which can complicate the patient/clients' pathway. The Circle of Care model enhances access, facilitates case management, and reduces the stress for the patient/client because they do not have to repeat their story. Reliving their past traumas causes feelings of humiliation each time they seek access at outside organizations or fear of not meeting criteria required to receive services. La Maestra serves all low-income applicants, regardless of income, immigration status, age, ethnicity, or gender.

Participants referred to the ease of accessing other units within La Maestra's Circle of Care model through an internal referral strategy. Reference to the effectiveness of "warm hand-off" referrals was mentioned by participants to describe how helpful it was being accompanied by staff from one unit to another to ease the access process, especially when patients were experiencing a mental health crisis. This referral strategy of using a "warm hand-off" was also found to be effective when patients were referred from free clinics to FQHCs (Hughes, 2016). Hughes (2016) described that access to services is not enough; there are challenges of language, eligibility, transportation, and case management to address.

The findings validate that there are enormous barriers facing vulnerable populations around access to care. La Maestra's model allows patients and clients to access the network of integrated services through any service unit. In other words, there is more than one door through which individuals can access services. The Circle of Care integrated model was credited by participants for breaking down their access challenges because they were registered one time with the organization. An additional access barrier reported by participants was transportation.

La Maestra's Services are Located in Low-Income Communities

The location of the services was also a key finding in this study. The value of the Circle of Care services can be understood through spatial capital theory which combines the geographic location of the Circle of Care and its role in facilitating access to services (Marcus, 2010) within the same communities where the participants reside. La Maestra sites are in low-income communities in San Diego County.

The majority of the participants found benefit from being able to walk to the service units from their residences. Transportation barriers were reduced and concerns for personal safety were perceived to be mitigated. As many of the participants had been victims of various forms of assault, they found comfort in the proximity of the services. Others were concerned with venturing outside their community for services for fear of being apprehended by Border Patrol. A few of the participants had been stalked by perpetrators of domestic violence and human trafficking. Those participants also expressed significant value in their ability to access services in their own neighborhoods where they had social ties to those they could rely on for help.

Staff Facilitated Participants' Health and Well-Being

The participants' experiences were connected intrinsically to the benefits derived from the staff. They reported feeling cared for, listened to, and supported with services, which they identified as a value to them. Egnew (2017) described how identifying vulnerabilities of patients, including contextual challenges, through deep listening and care is the philosophy of integrated care. Integrated care is the underlying philosophy upon which the Circle of Care was constructed by La Maestra to address health care and well-being of the vulnerable population served.

In addition to the purposeful connections made by staff, patients also noted the importance of the cultural diversity and competency of staff as key to supporting their health and well-being. They described cultural diversity as people from similar backgrounds and ethnicities. Participants valued the ability to identify with staff from similar walks of life who shared like values, traditions, and languages. Cultural alignment

with staff was a key motivator for participants to engage in the services at La Maestra and remain engaged.

Participants reported value from cultural liaisons that helped them through the various units of service. La Maestra created and implemented the MTCL strategy as a core component throughout all of the service modalities to ensure representation of the cultures served by La Maestra. These liaisons educate staff on cultural nuances, beliefs, values, and traditions that impact receptivity to services. Additionally, they provide translation of languages for patients and clients. Cultural liaisons are included in focus groups to inform future program development and customer service initiatives at La Maestra. They translate health education into many different languages with an emphasis on the culturally acceptable delivery of the materials, serve as promotoras, serve on focus groups within the community, and provide leadership with insight into the needs of their respective cultural communities. This finding aligns with the literature on cultural competence. Hanley (1999) stated that a marker of cultural competence in organizations is whether they employ people that resemble the populations being served and adopt culturally relevant service models to better meet the needs of the populations. Ager and Strang (2008) described social connection between groups as social bridges, social bonds, and social links with language, cultural knowledge, safety, and stability as facilitators of those connections.

Relationships with staff also helped patients feel hopeful regarding their own future. Having previously experienced some of the same challenges, staff were well-positioned to help participants find needed resources to improve their quality of life and serve as a hopeful example to those who are still facing complex challenges. Hope theory

research from the field of positive psychology (Snyder, 2002) suggests that when persons are able to select multiple pathways towards their goals, especially when faced with stress and challenges, they find it easier to adjust, build resilience, and excel more at personal growth and change, leading to positive mental health and well-being (Shorey, Little, Synder, Kluck, & Robitscheck, 2007). These participants were clear that the culturally competent, caring, and empathetic staff helped them advance and gave them hope. Co-membership theory also helps to understand this finding. Co-membership refers to human connection stemming from similar social identities (Erikson & Schultz, 1982). In this context, co-membership applies to staff who share similar social identities with the patients and clients, becoming advocates for patients in accessing institutional resources. The higher the degree of co-membership, the more likely that staff will assume the advocate role.

The findings demonstrated that there was indeed an enhanced value resulting from the structure of the model around the cumulative benefit of integrated services through one organization. The cumulative value of culturally competent services and staff creates a bond, a social connection to the supportive network in the Circle of Care. Through trust, these relationships build hope, foster resiliency, and provide the opportunity to build coping skills, self-esteem, and reciprocity.

Cumulative Value of the Circle of Care: Social Capital

A story began to emerge to describe how participants became socially connected through relationships they built during their experiences accessing services through the Circle of Care. Participants highlighted the importance of building trust relationships with staff and other patients, aligning with similar others, and the valuing of reciprocity.

Participants spoke to the value of a supportive network. Empowerment gave participants the motivation and courage to engage in bridging social capital by following prescribed referrals to access other social determinants services to “get by.” In describing their journey towards health and well-being, participants mentioned how they linked to resources outside the Circle of Care through established pathways created by La Maestra. Collaborative agencies, organizations, and partners helped participants draw down resources to “get ahead.” These descriptions led me to social capital theory and its three forms of bonding, bridging, and linking. Participants reported receiving intrinsic resources through bonding and bridging social capital from their experiences in the Circle of Care. Identity alignment, trust, hope, support, belonging through social connectedness, and opportunities to give back were all identified by participants. These intangible resources represent bonding social capital. Resources from bridging social capital reported by participants included increased psychological capital, self-efficacy, increased self-esteem, resilience, personal growth, empowerment, and reciprocity. This finding aligns with social capital theory. According to Szreter and Woolcock (2004), the framework of social capital theory provides insight into the importance of social cohesiveness in the provision of health care services.

Social Capital

Social capital is “the goodwill available to individuals or groups. Its source lies in the structure and content of the actor’s social relations. Its effects flow from the information, influence, and solidarity it makes available to the actor” (Adler & Kwon, 2002, p. 23). It was clear from patient and administrator interviews that one of the main values perceived from La Maestra’s Circle of Care was the capital it created for

participants. Social capital encompasses instrumental and intrinsic resources embedded in a social network, which are passed on to clients and traded for additional resources or support. There are many definitions of what social capital is, its sources, how it is operationalized, and its benefits (Bourdieu, 1998; Coleman, 1988; Lin, 2001; Portes, 1998; Putnam, 1995b). Participants' engagement in social capital through La Maestra is best understood through Lin's (2001) multidimensional framework, believed to best apply to the field of social work. The framework provides an understanding of how the participants operationalized social capital through bonding, bridging, and linking. Through a social work lens, Lin described social capital as "resources embedded in one's network or associations . . . accessible through direct and indirect ties" (Lin, 2001, p. 56). Lin's multidimensional interpretation of social capital is useful in understanding the findings from this study relating to the Circle of Care's multisectoral network, which offers social capital resources to vulnerable populations.

La Maestra's Network Engendering Social Capital

La Maestra was described by the participants of this study as a social network. They voiced that their feelings of belonging, social connectedness, and cultural alignment to others in the network at La Maestra came from shared beliefs, shared backgrounds, and shared norms. According to Adler and Kwon (2000), shared norms and beliefs are essential characteristics of social networks.

Cultural alignment as a facilitator of social capital for participants. I had expected culture (i.e., beliefs) to be mentioned by the participants in the context of the culturally diverse environment at La Maestra and of the staff. I also anticipated their definition of culture to be based on their ethnicity and country of origin. However, I was

surprised to hear participants defining their culture based on lived experiences (i.e., refugees, immigrants, recovery community, veterans, or survivors of human trafficking and domestic violence). Many of the participants' definitions of culture spoke to their social ties, not to their ethnicity. As they described their beliefs, values, and norms, it became clear that they self-identified primarily with similar individuals who had similar life experiences, rather than alignment by ethnicity. Participants' descriptions of cultural alignment with others became increasingly prominent as they identified the importance of identifying and socially connecting with others in the network and building trust. Cultural alignment and trust facilitated their experiences through the bonding, bridging, and linking forms of social capital.

An example from the literature to understand the facilitating role of culture in social capital is provided by Hall (2006) who stated that life experiences are what determine primary culture and alignment with a specific group or network. Hall (2006) stated that cultural alignment is not necessarily based on ethnicity, race, language, country, or religion as a priority. When individuals are uprooted from their social and cultural place in the world as they know it, they experience a crisis in identity (Hall, 2006). My participants described experiences and events as defining their primary culture. The value of cultural alignment for participants coincides with the literature as 70% of the participants in this study are immigrants and refugees.

Trust as a facilitator of social capital. Participants stated that trust relationships between themselves and the staff enhanced progress towards their health care objectives through communication, information gathering, and referrals. Participants spoke about how the trust built with staff in one service unit carried over to other units they accessed.

They mentioned that they already felt a sense of belonging in the social network and had experienced beneficial results. When speaking about why they followed up on referrals to partnering agencies in the macrosystem, participants said that they trusted staff to guide them and advise them to the resources they needed.

Trust in the La Maestra organization was a value assigned by participants in this current study. The participants spoke about the reputational capital from La Maestra's long standing presence in the community of over 34 years. They described that the community trusted the organization because of long-standing services and programs that were well-known. Reputation and years of experience providing services are, in part, responsible for engendering trust (Cohen & Prusak, 2001). According to McCauley and Kuhnert (1992), trust is also derived from the established relationships of the organization.

Trust is described in the literature as a source of social capital (Nahapiet & Ghoshal, 1998) in that believing in others will produce desired results. My research shows that trust is a facilitator of social capital. Trust was reported as incrementally built through participants' experiences in the Circle of Care social network—in other words, through tacit knowledge (Smeldund, 2008). As participants accessed additional units of service, their trust increased. Participants stated that trust was challenging for them because of their prior adverse life events. Research confirms that trust is affected by one's individual past experiences (Bicchieri, Duffy, & Tolle, 2004) and is a focal determiner of social capital among refugees and immigrants (Fukuyama, 1999; Gambetta, 1988; Putnam, 1993). In other words, the absence of trust can interfere with immigrants and refugees engaging in social networks and accessing resources of social capital.

Reciprocity as the norm. Reciprocity is when an individual receives something and that individual returns the favor (Burger, Horita, Kinoshita, Roberts, & Vera, 1997). Participants in this study described how they were self-motivated to give back to their community and to the wider society but not because it was required or expected. They mentioned how their prior adverse life events had sensitized them to the plight of others and wanted to contribute to others' healing and well-being. In fact, most of the participants described this desire to be their life's purpose now. Reciprocity drives the acquisition and leveraging capabilities of participants through each form of social capital in bonding, bridging, and linking.

Social network increased opportunities to engage in reciprocity. The participants in this study voiced the values they derived from La Maestra's dense network. Half of the participants reported being active members in La Maestra's social network for 10 years, representing a range from 2 to 33 years. This speaks to their level of engagement and the continued support and resources they derive from being members of the Circle of Care for themselves and their families. Participants' longevity in the Circle of Care network also reflects the layers of needs that challenge participants.

Coleman (1988) stated that dense social network structures have more opportunities for reciprocity, more trust building capacity, and a higher commitment to the community. The density of the network, combined with the facilitators of social capital, cultural alignment, and trust, contributed to the participants' access to needed instrumental resources and intrinsic resources of social capital. I had expected the research findings to indicate that services offered were useful to the participants. What I had not expected was the overwhelming value participants reported deriving from the

transactional strategies La Maestra provided that built social capital—capital that could be exchanged for even more capital. Participants identified that the ability to reciprocate because of the bonding, bridging, and linking forms of social capital was of great value to them. They felt that their ability to reciprocate was an indication of their improved well-being status. The next section presents findings related to the three forms of social capital: bonding, bridging, and linking.

Participants Benefit from Bonding Social Capital

All of the participants described feelings of welcomeness, acceptance, and belonging to a support system. A supportive system and feeling cared about are also evidence of bonding, as is trust. Intrinsic resources of bonding social capital have been described by researchers (Lin, 2001; Putnam, 1993) to include social connectedness, trust, a support system, and reciprocity.

Social support is dependent on the nature of relationships and social interactions within the network (Findler, 2000). Social capital is more likely to occur with the sharing and exchanging of resources if the relationships are strong (Lin, 2001). Bonding is categorized as connectedness to other similar individuals within the network who share similar backgrounds, beliefs, demographic characteristics, and values (Byrne, 1971; Byrne, Clore, & Smeaton, 1986; Tajfel & Turner, 1986). Benefits, or intangible resources obtained, include an increased sense of belonging and an identification with others, which facilitate accessing resources to allow participants to “get by” (Putnam, 2000). During the bonding form of social capital, participants described actions of giving back to society and helping others. Examples provided included sharing food they had cooked, donating clothing, volunteering in the food pantry, helping elderly, sharing recipes and patterns to

sew, teaching children songs, reading to children, teaching others how to search the internet, and a variety of other volunteer activities within the first unit of service they accessed.

Participants reported feeling happier through their connectedness with a group at a micro level. They described how they began to feel hopeful that their situation in life would improve as they met others who had experienced the same challenges and had advanced from surviving to thriving. Participants explained that they were then motivated to engage on a wider scale. They were referring to other units within the Circle of Care. Participants felt supported by the group, and trusted advice to seek additional needed resources through bridging.

Participants' Engagement in Bridging Social Capital

Participants in this study described their experiences of venturing to other units for services within the Circle of Care because they felt encouraged and supported by relationships formed in the network. Participants described how their self-esteem, self-worth, and self-confidence, acquired during the bonding form of social capital, facilitated them to bridge to other services units, which could be understood as between-group connections (Lancee, 2010).

According to Szreter and Woolcock (2004), the bridging form of social capital is not spontaneous and must be created. The researchers explained that vulnerable populations experience complex disadvantages, including isolation from needed resources. The bridging form of social capital gave participants additional instrumental and intrinsic resources. Given the expanded connectivity through bridging, participants reported learning of even more opportunities to reciprocate.

Examples of participant reciprocity during the bridging form of social capital occurred in the Circle of Care and in the immediate community. These volunteer activities included homeless outreach activities, environmental clean-up in neighborhood, giving art workshops in youth development program, and conducting yoga and Zumba classes for seniors. Engagement in reciprocity, the exchange of social capital through bridging, was reported as even more satisfying to the participants than during the bonding form of social capital; they could see their efforts now benefitting multiple service sectors across the Circle of Care network. Benefits from reciprocity through bridging were reported as empowering. These resources through bridging provided participants with validation of their contributions to the collective (Cattell, 2001). Szreter and Woolcock (2004) described bridging social capital as occurring between similar individuals. Though the participants in this study were culturally diverse, their degree of contextual needs and backgrounds were similar.

The acquisition of coping skills and self-efficacy throughout the bonding and bridging forms of social capital were described as prerequisites by the participants to link to farther reaching resources. Coping skills and the ability to rely on others in the network was identified as a value by participants. The more relationships they formed and the more resources accessed enabled them to learn coping skills to deal with challenges. This was described as building resilience. Participants reported increased psychological capital (i.e., self-esteem, self-confidence, coping skills) which in turn enhanced their resilience to deal with challenges. Psychological resilience is thought to develop through positive relationships, and alignment with others who share the similar values is formed (Vogelgesang, Clapp-Smith, & Osland, 2014). The findings related to how participants

experienced bonding and bridging forms of social capital align with the literature.

According to Lin (2000), bonding occurs first before bridging and linking.

Empowerment, increased self-confidence, self-efficacy, and a strong support system gave participants the courage to venture outside La Maestra's network to link to farther reaching resources to "get ahead."

Participants' Examples of Linking Social Capital

Socioeconomic outcomes reported by participants derived from their linking social capital included securing full-time employment; securing safe, affordable housing; specialty medical and specialty legal services; higher education, job training, and certification programs; and advocacy opportunities.

After accessing services through La Maestra, 100% of participants stated that they had a medical home at La Maestra. There was a 60% increase in participant economic development by attaining full-time employment or starting their own business. Of the 90% participants who classified themselves in the low-income bracket, 45% achieved a middle-income level. Fifty percent of participants reported being homeless at the time they first accessed services at La Maestra. At the time of the interviews, 45% had become renters and 5% homeowners. The remaining 50% of the participants were able to improve their living conditions through housing assistance programs. Participants reported value in leveraging capacity to increase their returns of social capital through the linking form of social capital. Examples of linking included higher quality employment, improved housing accommodations, expansion of self-owned businesses through increased loans and number of outlets where they sell their products, further education, specialty medical procedures, and court related proceedings.

The Effects of Linking on Participant Well-Being

The exchange of social capital occurred during the participants' ability to give back through efforts with farther reaching returns for larger collectives at a societal level. Now connected with consortia sized advocacy groups, participants engaged with statewide, national, and even global social movements addressing social justice. The benefits of well-being reported by participants included pride in themselves, seeing themselves as contributing members of society, self-respect, feeling respected by others, finding purpose and meaning in life, happiness, engagement with numerous networks, more fruitful and rewarding relationships. All of these were indicators participants listed as measures of their improved health and well-being. Activities through civic engagement could be seen as giving back social credit in the form of social capital as individuals who are now empowered through bonding, bridging, and linking are reciprocating in kind, contributing resources back into the network for the benefit of others.

This analysis has also highlighted the exchange process by which social capital credit is given back to the network of La Maestra for use by others seeking needed resources. Researchers have referred to this effect as a cascade effect (Emery & Flora, 2006). There is evidence of this effect in how participants trade up the forms of social capital through accessing needed resources and giving back (i.e., reciprocity) through each of the three forms of social capital (i.e., bonding, bridging, and linking). Participants expressed how their sense of well-being increased through giving back to others.

Participants Identified Well-Being Indicators

Wellness, to the participants meant finding a support system and network, feeling a sense of belonging with others who accepted them, feeling supported and cared about,

and finding a place to help others through volunteering or helping others—the altruistic form of reciprocity. To each of the participants these benefits were huge. They said it meant that they were not in survival mode any longer. They were now in a position to help others, which signified to them that they were well. Participants' increased self-esteem and empowerment led them to contribute to society.

The value and effectiveness of the Circle of Care model is in the measurement of the resources accessed by the individual and through the collective experience. According to Cattell (2001), collective action through solidarity brings hope and can improve quality of life. Physical health outcomes and technical challenges were aided through the services. A holistic healing occurred through the support system that had guided and nurtured them through their healing process. The opportunity to find their place, develop marketable skills, contribute to society, and regain their self-worth were all identified as the prime benefits of the Circle of Care. This speaks to a larger process, a collective and dynamic energy, a grounded feeling with opportunity, and hope to continue advancing in their new lives. This was a higher value, identified by the participants, which spoke to their reality. It prompted me to delve deeper to capture data regarding participants' understanding of the how they measured their progress from their cumulative experiences at La Maestra.

The participant interviews provided insight into their process of addressing contextual challenges as well as trying to heal from prior adverse life events. Participants shared the interlocking layers of daily challenges they had faced, leading to feeling dismayed at what seemed to be insurmountable obstacles. They described feeling totally alone in their turmoil and incredible relief at finding services to address their immediate

adverse social determinants needs. Through social connectedness with the staff and other patients at La Maestra, they described feeling relief in meeting others who had shared similar backgrounds and in the knowledge that they now had people they could ask for guidance and advice. Participants were very descriptive of how they interpreted their journey towards healing, the challenges they resolved, and those that still remain. The main difference now, according to participants, is that they have a social network with many resources, both instrumental and intrinsic. They described what well-being meant to them, which revolved around how they feel about themselves and how they believe others view them.

Access to opportunities to give back through bonding, bridging, and linking social capital was reported by participants as a key value through engagement with the social network at La Maestra. Their rich descriptions explained how they traded up social capital from the bonding phase to bridging and linking. The transactional exchange of reciprocity in each of the three forms of social capital strengthened participants' hope for additional advancement and well-being. The cycle of social capital described by the participants followed a sequence of bonding, bridging, and linking as participants first needed to feel belonging, establish trusting relationships, and gain self-confidence and empowerment to link to resources in the macrosystem. According to Stets and Burke (2000), optimal outcomes for agency well-being is when individuals are connected at the micro, meso, and macro levels of their social interactions. This research confirms that participants reached increased well-being by connecting with resources through bonding, bridging, and linking to socially connect at all three levels.

Conclusion

This is a story of goodwill, which defines social capital according to Adler and Kwon (2002). Participants were first attracted to services because of their needs based on prior life adverse events were compounded by overlapping adverse social determinants. Through cultural alignment and social identity, provided by the culturally responsive environment at La Maestra, trust started to build with staff in the first service unit they accessed. Trust incrementally increased as participants developed relationships with staff who shared similar backgrounds, beliefs, norms, languages, and goals. Staff, who were once at the patients' level of hardship and had excelled, created hope for participants for their own advancement. Feelings of welcomeness, identification with the group, support, and caring are all characteristics of the bonding form of social capital. Through bonding, participants engaged in the network at La Maestra. Participants described utilizing the network resources for instrumental purposes, to satisfy their immediate needs of social determinants services (i.e., health care, food, economic development, housing, legal assistance, immigration assistance, social services). Opportunities for reciprocity were available through La Maestra's social network. Through altruism, and because they had been sensitized through prior adverse experiences to the plight of others, participants were motivated to give back, stating that they started feeling better through helping others. The cycle of being helped and helping others provided participants with a sense of increasing well-being. The common social capital process participants described in bonding, bridging, and linking appeared to be sequential. However, other patients and clients at La Maestra may have had a different trajectory. These participants valued the trust they had with the staff, built early on when they accessed the first service unit.

Figure 19 depicts how the participants in this study experienced the process of social capital.

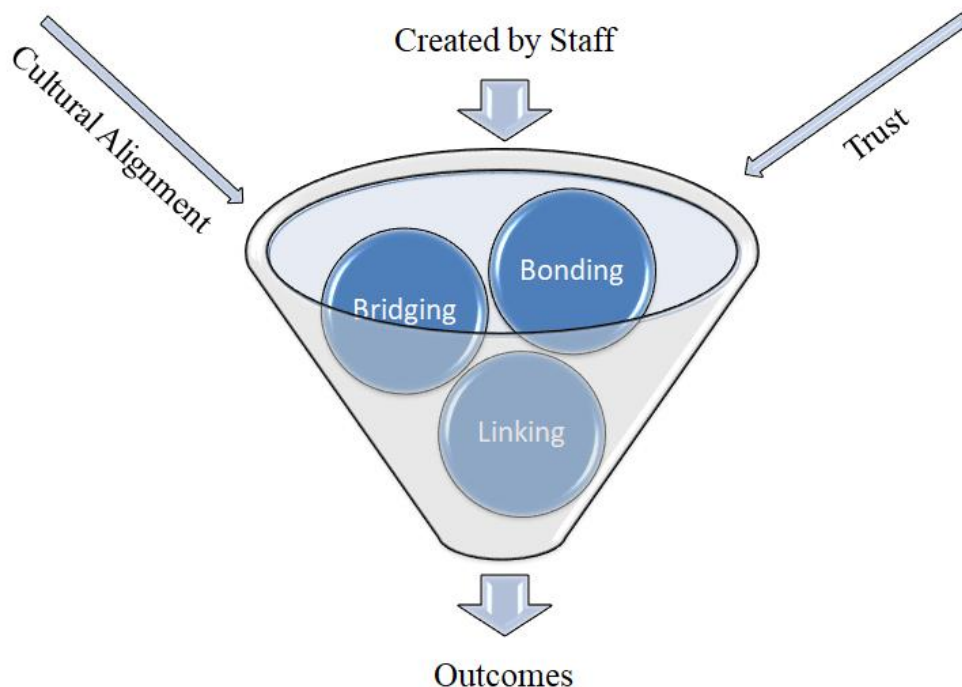


Figure 19. Social capital process of participants.

The trust that participants established in the first unit they accessed carried over into the resolution of other social determinants needs. Participants trusted staff advice and followed up with referrals, engaging in the bridging form of social capital to other service units that provided them access to yet more instrumental resources. The structure of La Maestra's Circle of Care model allowed for bridging as service units span across numerous social determinants sectors (e.g., health care, economic development, housing assistance, legal assistance services, immigration assistance services, food scarcity, substance use disorder, youth development) which promoted a sense of healing. During

the bridging form of social capital, participants reported value in obtaining intrinsic resources of psychological capital (i.e., self-esteem, self-confidence, and coping skills) which contributed to their feelings of well-being.

The integrated, holistic approach of the Circle of Care model was of benefit to the participants in this study. The features of the model mentioned as important to the participants included comprehensiveness of services through one overarching organization and enhanced access to services which were in participants' communities, addressing concerns of safety and access. Participants valued the cultural component of the MTCLs, materials, and diversity of the caring and supportive staff. All of these supportive elements of the model facilitated a seamless system (i.e., easy to navigate from one unit to the next, with patient/client registration already in the system). Increased self-efficacy, empowerment, and coping skills were reported by participants. Participants identified these key elements as the motivation to reach outside the social network in the Circle of Care through the linking form of social capital in pursuit of opportunities to secure higher quality employment, improved housing, creation and expansion of self-owned businesses through increased loans and number of outlets where they bring to market their products, further education and certifications, opportunities for advocacy, and resolution of legal issues among dissimilar others in the wider society. These are examples of linking social capital provided by participants regarding the instrumental and intrinsic resources of social capital they were provided through La Maestra. La Maestra continues to strengthen its network by collaborating across service sectors; partnering with service organizations, agencies, for-profit corporations at the local, state, and

national levels; and making more resources available to network members. The dense network at La Maestra offered opportunities for advancement.

The study design elicited data useful to answer my research questions. The importance of social connectivity through the social network at La Maestra appeared to be the connection between the overarching themes in the data. The connections between these overarching themes of overlapping needs, cultural alignment, trust, and reciprocity are the main findings of the study, which also address the research questions. Participants shared what was useful and valuable to them and, often, to their family members who also sought help from the Circle of Care model. They spoke of their interactions, new concepts, and the friendships and connections they made to access resources outside their immediate community. The interview questions guided my ability to delve deeper into the participants' social ties within the social network and the resources they were able to draw down. The sequence of questions provided a pathway for participants to give voice to the cumulative impact of the integrated Circle of Care model and the value they derived from it (i.e., access to resources and giving back) at each level of bonding, bridging, and linking. Participants remain actively engaged in the social network at La Maestra, continuing to access farther reaching resources while simultaneously bonding and bridging. This research demonstrates that the cycle of securing and replenishing social capital is dynamic and continuous. La Maestra's dense multisectoral network continuously offers new opportunities by adding collaborative partners with additional resources for La Maestra's network members.

Implications for Action and Advocacy

My research shows that improved health and well-being among Medicaid and Medicare populations can be facilitated through a delivery model which integrates social determinants into primary health care services. This is important information towards achieving population health and reducing health care costs for patients who have health complications due to their contextual environment. Achieving wellness serves to reduce the social injustices that these populations contend with daily. Comprehensive social determinants services offered through welcoming environments with culturally aligned and caring staff are conducive to their healing process, engender feelings of empowerment, and lead to social connections within the larger community.

Social capital spirals, as does its resources, through repeated interactions, reinforcing social connectedness. This concept implies that disparate services from different organizations would not foster social capital at the same rate as sequential interactions within the same organization. Additionally, the implications of this research indicate that organizations must be committed to continued cultural competence (i.e., ethnicity, backgrounds, values) demonstrated through staff representation of the patients and clients served by the organizations. Organizations with a multisectoral approach have greater capacity to develop a dense network of collaborative partners, resulting in increased resources for network members. This network will increase the linking opportunities through integrated solutions and established pathways, enabling access to farther reaching resources for the well-being of vulnerable communities, as well as consistency and sustainability for the collaborating organizations.

Moving forward, this study provides insight into how other mission driven, community-based organizations could be charged to help vulnerable populations in developing integrated service models to further assist disadvantaged communities in improving health and well-being. At a time when FQHCs across the nation wrestle with increasing responsibilities, changing payment methodologies, and policy uncertainties affecting their vulnerable populations, they are also challenged with demonstrating value for population health. Making the case to prove value through improved health outcome measures requires that adverse social determinants affecting the health of their patients be addressed. The question then becomes which sector should be responsible for assuming the responsibility for bringing social determinants services to vulnerable populations. My research tells me that FQHCs (i.e., medical homes) are best positioned to coordinate social determinants services as they already have built trusted relationships with patients. This research study has brought to light how essential trust is, especially among populations with layers of intersecting needs stemming from adverse prior life experiences. Whether FQHCs add social determinants services to their scope or establish contractual relationships with existing community-based organizations providing social determinants services, health centers already serve as networks within vulnerable communities. The findings in this study underscore the importance of a holistic, integrated care philosophy for organizations serving vulnerable populations with attention given to the importance of social connectedness to community-based networks. This strategy allows for populations opportunities to access resources through social capital. The role of leadership is very important in promoting an integrated philosophy, as evidenced by the directors in this study. The leadership at La Maestra emerged from the

vulnerable populations served and developed in conjunction with the growth of the grassroots organization.

This study offers insight into the impact of adverse life experiences of vulnerable or marginalized populations and the resulting degree of need for social determinants services. Findings suggest that trauma-informed care screening in all primary health care visits for prior adverse life experiences, such as those described by the participants in this study, would better support these individuals. Though adverse childhood experiences (ACEs) screening tools are available through the State of California Department of Health Care Services (2020) for pediatric and adult patients (www.acesaware.org), they are not sufficient to identify their needs. The participants in this study shared their overlapping contextual needs resulting in part from traumatic life events that are not captured on these screening tools or from the complexity of their various needs. A recommendation is for trauma-informed care screening tools to be implemented in other social determinants service units or organizations that are not health care providers to identify at-risk youth and adults who can be referred for appropriate care. Individuals might not divulge this information during health care visits but might share traumatic life events with staff in other social determinants units. Participants in this study shared that they first spoke about their prior adverse life experiences in other units first, not during medical visits. For example, several participants in this study shared personal information of being victims of domestic violence, human trafficking, or experiencing substance use disorder when they were in Microcredit support groups, the legal assistance unit, transitional housing, and youth development programs. Once La Maestra's staff

identified individual need, they were then able to offer a “warm hand-off” to the appropriate service units.

Another recommendation is for the life events screening tool to be tailored to fit the populations being screened. For example, ACEs might not capture the trauma involved with deportations, seeing family members or others killed in front of them, being blackmailed by the “coyotes” and gangs on this side of the border, and so forth. This recommendation points again to the need for integrated service delivery systems to meet a variety of physical, contextual, and psychosocial needs.

Implications for the fields of health care and social work require demonstrating the value of integrated models of care for vulnerable populations that expand across numerous sectors (e.g., health care, social services, housing, economic development, education, legal assistance, youth development, food scarcity). Making this case requires an integrated solution to solve complex overlapping challenges, such as those revealed by the participants in this study. Exploring how the sectors of health and social determinants services could be linked to provide an integrated approach, including reimbursement for both, was suggested by various researchers in the literature (Bradley & Taylor, 2013; Brooks & Whitener, 2018). Currently, there is no payment methodology in place for providing social determinants services for Medicare, MediCal patients from CMS except for health care services. Several nationwide managed care health plans are participating in pilot programs funded by CMS to determine if providing some social determinants services for the highest utilizers of inpatient and emergency services will result in cost savings. Unfortunately, managed care health plans have not established linkages or networks with any sector except health care services. CMS is currently concerned with

just collecting data around the social determinants needs of patients enrolled in Medicare and Medicaid but has not yet established a model which tests the referrals, linkages, or reimbursements for these additional services. Sustainability is essential to the continuance of providing social determinants services. To date, La Maestra Community Health Centers has supported the development and expansion of social determinants services through its operational budget and grant solicitation. This study confirmed the ongoing need for increasing this effort which requires a regular ongoing payment source for social determinants services. Currently, the only social determinants services with payment methodology in place are for health care. The commitment of the leadership at La Maestra, including the Board of Directors, is necessary for the integrated model to continue to exist.

Academic Implications

Based on this current study, intersectionality theory could be further expanded to include prior adverse life events and adverse social determinants as social disparity indicators for a more complete understanding of the overlapping layers of complexities challenging vulnerable populations.

The literature on social capital and its three forms, bonding, bridging, and linking, is robust. Most of the research on social capital has been in the fields of economics, sociology, and social work. This study contributes to the sparse literature on the effects of social capital when applied to the field of health, specifically for improving health and well-being in vulnerable populations.

Network structures and forms most conducive to facilitating social capital are plentiful in the literature. This study contributes to the current debate on dense versus

sparse networks. In this study, the dense network formed by La Maestra provided resources identified by the participants as valuable to their advancement.

Recommendations for Future Studies

Future studies could further inform the need to address overlapping, contextual needs of vulnerable populations in other geographic areas for care providers to respond effectively through integrated service delivery strategies. Future studies could analyze cost savings to the health care system through addressing core issues of social determinants at the primary care level through FQHCs. Another recommendation for future research is to study and recommend standardized quality and outcome measures for integrated care of health services and other social determinants.

The ability to fully test the model was limited due to the inability to accept women and children into the current transitional housing program at La Maestra. Code requirements present these limitations due to the age of the buildings. The current transitional housing buildings are not conducive to housing children or accommodating women separately from men. Future research studies would be more complete with data from all genders residing in transitional housing programs.

Another informative future study would be to develop a business model for FQHCs interested in adding social determinants services, by intentionally developing these services internally or by establishing collaborative agreements with other nonprofit, community-based organizations. Integration of data management for social determinants services into the FQHCs electronic health care record system would also be part of this business model as well as reporting functions to demonstrate value. Sustainability for the

expansion into social determinants services is another feature of the business model which could be studied.

Generalizability

The sample size of this study only involved 20 participants. Although the sample size was small, there could be similarities between the characteristics of these vulnerable populations and other low-income communities in different geographic areas. The findings demonstrated that poverty was the common indicator of vulnerability among the participants in this study. There could be a strong possibility that other low-income communities would benefit from the integrated Circle of Care model and the structure of the social network as La Maestra has developed. Furthermore, other low-income communities would possibly benefit from opportunities to leverage resources of social capital and trade them up, which was identified as beneficial to participants in this study.

Limitations

Due to time constraints, this study focused on a sample size of 20 participants. The location of the study and the adverse social determinants could be influenced by contextual factors. La Maestra, the site of the study, is located in a border zone and has been a resettlement zone for refugees. Over the last 40 years, refugees from Asia, Africa, and the Middle East have either been placed in San Diego or have moved to San Diego through secondary migration. Additionally, the area has been impacted due to the high volume of immigrations from Mexico, Central America, Haiti, Cuba, and South America. Vulnerable populations in other geographic areas in the United States could comprise different ethnicities and cultures. There could be different county policies and programs in other geographic areas that offer more social services to residents of disadvantaged

communities, such as safe and affordable housing, better public transportation infrastructure, and county owned and operated hospitals. In other words, context matters.

Positionality

I have a vested interest in this study. My background of spending 34 years co-developing an integrated model responsive to the community needs has provided me with an insider position. I also share similar backgrounds and prior life adverse events to those experienced by the participants in this study. My interest in this research topic was driven by a life-long desire to improve the lives of those who are marginalized in our society and find solutions to help vulnerable populations achieve well-being. This study provided more insight into how the Circle of Care model can be further enhanced to provide yet more opportunities for healing. Several participants indicated that they were unaware of the numerous services available after they accessed the first service unit. This information was difficult for me to hear as access to care is one of the overarching goals of La Maestra. As a result, La Maestra has now initiated a welcome packet for all new patients and clients with details of how to access all Circle of Care services and resources. This study provided me with insight on how to enhance the caring and supportive system at La Maestra, which empowers individuals to improve their circumstances in life while integrating and contributing to society.

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APPENDIX A

Mission Statements



Mission Statement

The mission of La Maestra Family Clinic, Inc. is to provide quality health care and education; to improve the overall wellbeing of the family; bringing the under-served, ethnically diverse communities into the mainstream of our society through a caring, effective, culturally and linguistically competent manner, respecting the dignity of all patients.



Mission Statement

La Maestra Foundation's mission is to "provide and support advocacy and community services that improve the overall well-being of low-income, culturally diverse individuals and families in San Diego and guide them along the path to self-sufficiency"

APPENDIX B

La Maestra Sliding Scale 2020

Sliding Fee Scale

It is the policy of La Maestra Family Clinic, Inc. to provide essential health care services regardless of a patient's ability to pay. Discounts are available based upon household income and family size for patients without health insurance and for patients with third-party insurance that does not cover, or only partially covers, fees. The eligibility for discounts is updated at least annually using the Federal Poverty Level guidelines (FPL) below. Additional discounts may be available to patients who meet criteria or state or county-funded indigent care programs. Additional discounts are dependent on availability of funds. Patients may apply for a discount at any time.

To apply for eligibility for Sliding Fee Discounts, please fill out the Sliding Fee Application in the patient registration packet available at the front desk.

2020 Federal Poverty Level (FPL) Guidelines

| Family Size | FPL 0-100% | FPL 101-133% | FPL 134-150% | FPL 151-200% | FPL 201-300% |
|-------------|------------|--------------|--------------|--------------|--------------|
| 1 | \$12,760 | \$16,971 | \$19,140 | \$25,520 | \$38,280 |
| 2 | \$17,240 | \$22,929 | \$25,860 | \$34,480 | \$51,720 |
| 3 | \$21,720 | \$28,888 | \$32,580 | \$43,440 | \$65,160 |
| 4 | \$26,200 | \$34,846 | \$39,300 | \$52,400 | \$78,600 |
| 5 | \$30,680 | \$40,804 | \$46,020 | \$61,360 | \$92,040 |
| 6 | \$35,160 | \$46,763 | \$52,740 | \$70,320 | \$105,480 |
| 7 | \$39,640 | \$52,721 | \$59,460 | \$79,280 | \$118,920 |
| 8 | \$44,120 | \$58,680 | \$66,180 | \$88,240 | \$132,360 |

* For families/households with more than 8 persons, add \$4,480 for each additional person.

APPENDIX C

City of San Diego Income Limits 2019



CDBG INCOME LIMITS*
FOR CITY OF SAN DIEGO
(Effective 06-28-19/Published May 2019)

| HOUSEHOLD SIZE | EXTREMELY LOW INCOME LIMITS (0-30% of median) | VERY LOW INCOME LIMITS (31-50% of median) | LOW/MODERATE INCOME LIMITS (51-80% of median) |
|----------------|--|--|--|
| 1 | \$0 - \$22,500 | \$22,501 - \$37,450 | \$37,451 - \$59,950 |
| 2 | \$0 - \$25,700 | \$25,701 - \$42,800 | \$42,801 - \$68,500 |
| 3 | \$0 - \$28,900 | \$28,901 - \$48,150 | \$48,151 - \$77,050 |
| 4 | \$0 - \$32,100 | \$32,101 - \$53,500 | \$53,501 - \$85,600 |
| 5 | \$0 - \$34,700 | \$34,701 - \$57,800 | \$57,801 - \$92,450 |
| 6 | \$0 - \$37,250 | \$37,251 - \$62,100 | \$62,101 - \$99,300 |
| 7 | \$0 - \$39,850 | \$39,851 - \$66,350 | \$66,351 - \$106,150 |
| 8 | \$0 - \$43,430 | \$43,431 - \$70,650 | \$70,651 - \$113,000 |

**Income limits are set by HUD and are subject to change*

APPENDIX D

La Maestra Healthcare Effectiveness Data and Information Set (HEDIS) Report 2020

| | Feb-20 | Goal |
|--|--------|------|
| Percentage of diabetic patients whose HbA1c levels are less than 8 percent, less than or equal to 9 percent, or greater than 9 percent. | 94% | 80% |
| Percentage of adult patients with diagnosed hypertension whose most recent blood pressure was less than 140/90. | 75% | 73% |
| Percentage of women 23-64 years of age received one or more Pap test to screen for cervical cancer. | 77% | 67% |
| Percentage of children who have received age appropriate vaccines on or before their 2nd birthday. | 54% | 50% |
| Percentage of individuals age 18 years and older who have received a screen for substance abuse such as (AUDITC, AUDIT or SBIRT) during the 3 years prior to the measurement within the measurement year | 70% | 70% |
| Percentage of pregnant women beginning prenatal care in first trimester. | 75% | 72% |
| Percentage of low birth weight infants born to prenatal care patients. | 10% | 5% |
| Percentage of patients age 3 to 17 years who had a visit during the measurement year and who had Body Mass Index (BMI) Percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year. | 89% | 70% |
| Percentage of patients age 18 years or older who had their calculated Body Mass Index (BMI) documented at the last visit or within the last six months and, if they were overweight or underweight, had a plan documented. | 93% | 60% |
| Percentage of patients age 18 years and older with a diagnosis of CAD prescribed a lipid lowering therapy during the measurement year. | 74% | 60% |
| Percentage of patients aged 18 years and older who were discharged alive for acute myocardial infarction (AMI) or coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) or had a diagnosis of ischemic vascular disease (IVD) during the measurement year or prior year who had documentation of use of aspirin or another antithrombotic | 85% | 55% |
| Percentage of patients age 50 to 75 years who had appropriate screening for colorectal cancer | 72% | 50% |
| Percentage of patients aged 12 and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented | 62% | 70% |
| Percentage of patients age 18 years and older who were screened for tobacco use at least once during the measurement year or prior year AND who received cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user. | 97% | 95% |
| Percentage of newly diagnosed HIV patients who had a medical visit for HIV care within 90 days of first ever HIV diagnosis | 0% | 50% |
| Note: The new metric goals were updated June 5th 2019 | | |

Note. Clinical measures and DM performance. (The low birth rate measure captures only patients delivering in January and February 2020. By the end of 2020, the low birth rate measure is projected to be less than 5%.)

APPENDIX E

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Dahlgren-Whitehead Model

Info <info@iffs.se>

To: Zara Marselian <zmarselian@sandiego.edu>

Mon, Aug 26, 2019 at 2:25 AM

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-----Ursprungligt meddelande-----

Fran: Zara Marselian
<zmarselian@san-diego.edu>
> Skickat: den 26 augusti
2019 00:02
Till: Info <info@iffs.se>
Amne: Dahlgren-Whitehead Model

Hello. I would like permission to publish the image of the Dahlgren-Whitehead model in my dissertation. I am currently a doctoral student at the University of San Diego. My topic is on the role of social determinants of health in improving health care outcomes and well-being among vulnerable populations. I am devoting a section of the dissertation for describing holistic models integrating social determinants of health. I believe that in addition to describing the conceptual framework of the Dahlgren-Whitehead model, adding the visual image of the model would be most helpful to the readers.

I would greatly appreciate guidance as to the process to obtain this permission as I am aware that the image is under copyright.

Thank you,

Zara Marselian

APPENDIX F

Participant Interview Question Guide

Interview Guide for Participants

1. How did you hear about La Maestra?
2. What kind(s) of assistance were you needing at the time? Why?
3. Did anyone refer you to La Maestra? If so, was it a friend, or an organization?
4. What program did you first contact at La Maestra?
5. What services did you receive?
6. Did you feel welcome by the staff? Did the staff speak your native language?
7. Were you referred to other services at La Maestra? If so, when and where were you referred? How were you referred?
8. Did you feel comfortable with the staff at the second unit? If so, can you describe what helped you feel at ease? If not, what could have been different to make you feel more comfortable?
9. What services did you receive in the second unit?
10. At what point did you go to a third unit? How did you find out about the services offered in the third unit?
11. Did you feel comfortable interacting staff in the third unit? If so, what made you feel that way? If not, what could have been different to make you feel more comfortable?
12. Did the staff speak your native language in the third service?
13. Did you find any benefit in being able to access these three services through

La Maestra instead of going to different organizations?

14. Did you access any other services at La Maestra or do you plan to? If so, please describe.
15. Did you feel that you were able to build trust in the staff in these three or more units]
16. Do you believe that you can trust the staff about private issues or call on them if you need help? If so, can you please describe what makes you feel this trust? If not, what could help you feel more able to build this trust?
17. Have you made friends with any of the staff or other patients since you first came to La Maestra? If so, can you describe how making friends with them has made you feel?
18. Has any of the staff referred you to agencies or organizations outside of La Maestra? If so, can you please describe who and for what purpose?
19. How do you feel about your life now? Has there been a difference between how you feel about your life now than when you first came to La Maestra? Please describe.
20. How would you evaluate your health now? Has there been an improvement in your health since you first accessed services at La Maestra? If so, what do you attribute that improvement to?
21. How would you describe the environment at La Maestra?
22. Have you ever belonged to any groups, associations or faith-based organizations? If so, when did you join? Can you describe them?

Interview Guide for Directors

1. What is your perception of the experience of patients/clients that come through your unit about the value they receive from the La Maestra Circle of Care?
2. Did you observe how patients/clients *felt* interacting with staff in the unit? If so, did the interactions appear to be positive? If so, what factors do you think made it positive?
3. Did you observe the patients/clients feeling comfortable with speaking and confiding in the staff? If so, please describe.
4. Do you feel that the patients/clients gained value from the ability to access multiple services through La Maestra? If so, what do you believe the value was?
5. Have you observed any friendships formed by the patients/clients in your unit between other patient/clients or staff?
6. Which cultures and languages are spoken through your unit?
7. What value do you believe that the clients/patient derive from staff being from diverse cultures?
8. Do you believe that the patients/clients in your unit believe that their health and well-being has improved from accessing three or more services through La Maestra? If so, can you please give examples?
9. When your unit refers patients/clients to other service units in La Maestra, do the patients/clients go? If so, what factors do you believe contribute to this?

10. Has your unit made referrals to patients/clients outside La Maestra? If so, where and for what reason?
11. Can you describe the environment in your unit that the patients/clients experience when they first walk in? How do you perceive them to react to this environment? What factors, if any, do you perceive add or detract from their comfort level?
12. What factors do you believe contribute to trust building between staff and patients/clients in your unit, if any? Do you believe that patients/clients feel a connection to La Maestra? If so, please describe. If not, why?
13. What feedback have the patients/clients in your unit offered, if any, about their experience accessing other services in different units at LaMaestra?

APPENDIX G

Participant Data Disaggregated by Gender, Age, and Ethnicity

Table G1

Characteristics of Services of Value to Participants, Disaggregated by Gender, Age, and Ethnicity

| | African | | African American | | Burmese | | Caucasian | | Laotian | | Hispanic | |
|-------------------------------------|---------|---|------------------|---|---------|--------|-----------|----|---------|--------|------------------------------------|---|
| | M | F | M | F | M | F | M | F | M | F | M | F |
| Services | | | | | | | | | | | | |
| Comprehensive services in one place | 50, 42 | | 43 | | 55 | 59, 58 | 34 | | 70 | 55, 45 | 39, 34, 48, 42, 79, 20, 36, 43, 57 | |
| Cultural competence | 50, 42 | | | | 55 | | | | 70 | | 39, 34, 48, 42, 79, 20, 36, 43, 57 | |
| Translation | 50, 42 | | | | 55 | 59 | | | 70 | 45 | 34, 79, 20, 48, 36 | |
| Transportation | 50, 42 | | | | 55 | 59 | | | 70 | 45 | 34, 39, 57 | |
| Safety | | | | | | | | 34 | 70 | 45 | 34, 39, 79, 20, 57 | |
| Location within walking distance | 50, 42 | | 43 | | 55 | 59, 58 | 34 | | 70 | 55, 45 | 42, 43, 57, 39, 79, 20, 48, 36 | |

Table G2

Qualities of Staff Identified by Participants as Valuable, Disaggregated by Gender, Age, and Ethnicity

| | African | | African American | | Burmese | | Caucasian | | Laotian | | Hispanic | |
|--|---------|----|------------------|---|---------|-------|-----------|---|---------|----|----------|---------------------------------|
| | M | F | M | F | M | F | M | F | M | F | M | F |
| Staff | | | | | | | | | | | | |
| Same backgrounds/ cultural diversity experiences; They understand me, where I come from what I've been through. | 50,42 | 43 | | | 55 | 58,59 | | | 34 | 70 | 45,55 | 36,42,43,57, 34,39,79,20, 48 |
| Speak my language | 50,42 | | | | 55 | | | | | 70 | 45,55 | 36,42,43,57, 39,34,79,20, 48 |
| Welcoming | 50,42 | 43 | | | 55 | 58,59 | | | 34 | 70 | 45,55 | 36,42,43,57, 39,34,79,20, 48 |
| Accepting of me | 50,42 | 43 | | | 55 | 58,59 | | | 34 | 70 | 45,55 | 36,43,57,34, 39,79,20,48 |
| Knowledgeable | 50,42 | 43 | | | 55 | 58,59 | | | 34 | 70 | 45,55 | 36,42,43,57, 34,39,79,20 |
| Patient | 50,42 | | | | 55 | 58,59 | | | 34 | 70 | 45 | 36,57,34,39, 79,20 |
| Kind | 50,42 | | | | 55 | 59 | | | 34 | 70 | 45 | 34,43,57,39, 20,48,36 |
| Informative | 50,42 | 43 | | | 55 | 58,59 | | | 34 | 70 | 45,55 | 34,42,43,57, 39,79,20,48, 36 |
| Caring | 50,42 | 43 | | | 55 | 59 | | | 34 | 70 | 45,55 | 34,39,79,20, 36,57 |
| Loving | | | | | 55 | 58 | | | 34 | | 45,55 | 34,39,20,57 |
| Supportive | 50,42 | 43 | | | 55 | 58,59 | | | 34 | 70 | 55 | 34,43,39,79, 20,36,48,42, 57 |

Table G3

Participant Experiences with Bonding Social Capital, Disaggregated by Gender, Age, and Ethnicity

| | African | | African American | | Burmese | | Caucasian | | Laotian | | Hispanic | |
|----------------------------------|---------|----|------------------|---|---------|--------|-----------|---|---------|----|----------|------------------------------|
| | M | F | M | F | M | F | M | F | M | F | M | F |
| a. Social Connectedness | | | | | | | | | | | | |
| Identify with others/Welcome | 50, 42 | | 43 | | | 55, 58 | 59, 34 | | | 70 | 55, 45 | 42,43,57, 20,48,36, 34,39,79 |
| Belonging / Acceptance | 50, 42 | | 43 | | | 55, 58 | 59, 34 | | | 70 | 55, 45 | 42,43,57, 20,48,36, 34,39,79 |
| Valued | 50, 42 | | 43 | | | 55, 58 | 59, 34 | | | | 55, 45 | 48,43,57, 39,79,20 |
| Support System | 50, 42 | | 43 | | | 55, 58 | 59, 34 | | | 70 | 55, 45 | 48,36,42, 34,39,79, 57,43 |
| Family like Environment/ Network | 50, 42 | | | | | 55, 58 | 59, 34 | | | 70 | 55, 45 | 20,48,36, 42,39,34, 79,43,57 |
| Cared About | 50, 42 | | 43 | | | 55, 58 | 59, 34 | | | 70 | 55, 45 | 34,39,79, 57,20,48, 36,42,43 |
| Kind | 50, 42 | | | | | 55, 59 | | | 34 | 70 | 45 | 34,43,57, 39,20,48, 36 |
| Informative | 50, 42 | 43 | | | | 55, 59 | 58, | | 34 | 70 | 45, 55 | 34,42,43, 57,39,79, 20,48,36 |
| b. Trust | | | | | | | | | | | | |
| Trust in staff | 50, 42 | | 43 | | | 55, 59 | 59, 34 | | | 70 | 55, 45 | 43,57,20, 48,36,42, 34,39,79 |
| Trust in Organization | 50, 42 | | 43 | | | 55, 58 | 59, 34 | | | | 55 | 20,48,34, 39,79 |
| Can rely on for help | 50, 42 | | 43 | | | 55, 58 | 59, 34 | | | 70 | 55, 45 | 20,48,36, 43,34,39, 79,42 |
| Nurtured | 50, 42 | | 43 | | | 55, 58 | 59, | | | | 55 | 20,48,57, 34,39, 43 |
| c. Psychological Capital | | | | | | | | | | | | |
| Self esteem | 50, 42 | | 43 | | | 55, 58 | 59, 34 | | | | 55, 45 | 48,36,42, 57,34,20, 48 |
| Self-worth | 50, 42 | | 43 | | | 55, 58 | 59, 34 | | | | 55, 45 | 36,42,43, 57,34,20, 48 |
| Self confidence | 50, 42 | | 43 | | | 55, 58 | 59, 34 | | | | 55, 45 | 20,36,42, 43,34,39, 79,57 |

| | | | | | | | | |
|----------------------------|-----------|----|----|-----------|----|----|-----------|---------------------------------|
| Empowered | 50, 42 | 43 | | 59, 58 | 34 | | 55, 45 | 20,48,36,4 3,34, 39,42,57 |
| Coping Skills | 50, 42 | 43 | 55 | 58 | 34 | | 55, 45 | 20,48,43, 34,39,57 |
| d. Reciprocity | | | | | | | | |
| Place to give back | 50, 42 | 43 | | 59, 58 | 34 | | 55 | 20,48,57, 36,39,79,43 |
| Volunteer Opportunities | 42 | 43 | | 58 | 34 | 70 | 55 | 39,20,48, 36,43 |
| Help others | 50, 42 | 43 | 55 | 59, 58 | 34 | | 55, 45 | 39,79,20, 48,36,42, 43,57 |

Table G4

Participant Identified Features in the Circle of Care Model Facilitating Their Bridging Social Capital, Disaggregated by Gender, Age, and Ethnicity

| | African | | African American | | Burmese | | Caucasian | | Laotian | | Hispanic | |
|--|---------|---|------------------|---|---------|--------|-----------|---|---------|---|----------|------------------------------|
| | M | F | M | F | M | F | M | F | M | F | M | F |
| Referrals | | | | | | | | | | | | |
| “Told about other services needed” | 42, 50 | | 43 | | 55 | 59, 58 | 34 | | 70 | | 55, 45 | 34,39,79,20, 48,36,42,43, 57 |
| “Felt welcomed in other service units so followed up with referrals” | 42, 50 | | 43 | | 55 | 59, 58 | 34 | | 70 | | 55, 45 | 34,39,79,20, 48,36,42,43, 57 |
| “Easy to go to other units” I already belonged to org. | 42, 50 | | 43 | | 55 | 59, 58 | 34 | | 70 | | 45 | 34,39,79,20, 42,57,43,48, 36 |
| Warm Referrals: “Staff walked me there” | 42, 50 | | | | 55 | 59 | | | 70 | | 55, 45 | 34,39,79,20, 48,36,57 |
| Seamless System | | | | | | | | | | | | |
| Already in system no need to explain my history | 42, 50 | | 43 | | 55 | 59, 58 | 34 | | 70 | | 55, 45 | 34,39,79,20, 48,36,42,43, 57 |
| Case Managed | | | | | | | | | | | | |
| Results followed me from one unit to another | 42, 50 | | | | 55 | 59, 58 | | | 70 | | 55, 45 | 34,39,79,20, 57 |
| Staff/ Cultural Liaisons | | | | | | | | | | | | |
| Always available for language, translation, information | 42, 50 | | | | 55 | 59 | | | 70 | | 45 | 34,39,79,20, 48,57 |

Table G5

Participant Examples of Linking Social Capital, Disaggregated by Gender, Age, and Ethnicity

| | African | | African American | | Burmese | | Caucasian | | Laotian | | Hispanic | |
|-------------------------------|-----------|---|------------------|---|---------|----|-----------|----|---------|---|-----------|-----------------------------|
| | M | F | M | F | M | F | M | F | M | F | M | F |
| Education | | | | | | | | | | | | |
| Certifications | 42, 50 | | 43 | | | | 58, 59 | 34 | | | 45 | 39,20,48,36, 42,43 |
| Trainings | 42, 50 | | 43 | | | | 58, 59 | 34 | | | 45 | 39,20,48,36, 42,43 |
| Higher education | 42, 50 | | 43 | | | | 58, 59 | 34 | | | 45, 55 | 43,57,39,79, 20,48,36,42 |
| Housing | | | | | | | | | | | | |
| Affordable Housing | 42, 50 | | | | | | | | | | 45 | |
| Section 8 | 42, 50 | | | | | | 58 | | | | 45 | 79 |
| Transitional Housing | | | 43 | | | | | | | | 55 | |
| Rental Assistance | 42, 50 | | 43 | | | 55 | | | | | | 34,57,39,20, 48,36,43 |
| Renters Rights | 50 | | | | | | | | | | | 79 |
| 1st Home Buyer Program | | | | | | | 58, 59 | | | | | 57 |
| Economic Development | | | | | | | | | | | | |
| Establish a Business | | | | | | | | | | | | 48,36,42,43, 57 |
| Outlets to sell products | 42, 50 | | 43 | | | | | | | | | |
| Job Training & Placement | 42, 50 | | | | | | | 34 | | | 55 | 39,79,20 |
| Advocacy Opportunities | | | | | | | | | | | | |
| Legislature | 42, 50 | | | | | | 58, 59 | | | | 55,45 | 20,57, |
| Advocacy groups | 42, 50 | | 43 | | | | 58, 59 | | | | 55,45 | 39,20,48,36, 42,43,57 |

| | | | | | |
|--|-----------|----|-----------|-------|-----------------------------|
| Community | 42, 50 | 43 | 58, 59 | 55,45 | 39,20,48,36, 42 |
| Volunteering | 42, 50 | 43 | 58 | 55,45 | 39,79,20,48, 36,43,57,42 |
| Specialty Services | | | | | |
| Medical | 42 | | 55 58 | 45,55 | 39,79,57,70 |
| Legal Representation | 42 | | 58 | 45 | 34,39,20,48, 57 |
| Law Enforcement Agencies | | | | | |
| Probation | | 43 | 58 | 55 | |
| Drug Court | | 43 | | 55 | |
| FBI | | | | | 34,39,57 |
| District Attorney | | | | 45 | 34,39,57 |
| Homeland Security Department of Immigration | | | | | 79,34,39,20, 48,57 |

Institutional Review Board Clearance



Mar 28, 2017 2:06 PM PDT

zara marselian
Sch of Leadership & Ed Science

Re: Expedited - Initial - IRB-2017-53, Integrating Social Determinants of Health Services into a Primary Healthcare Setting: A Mini-Study to Begin to Determine the Process, Impact and Perceived Value of La Maestra's "Circle of Care" model.

Dear zara marselian:

The Institutional Review Board has rendered the decision below for IRB-2017-53, Integrating Social Determinants of Health Services into a Primary Healthcare Setting: A Mini-Study to Begin to Determine the Process, Impact and Perceived Value of La Maestra's "Circle of Care" model..

Decision: Approved

Selected Category: 7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Findings:

Research Notes:

Internal Notes:

Note: We send IRB correspondence regarding student research to the faculty advisor, who bears the ultimate responsibility for the conduct of the research. We request that the faculty advisor share this correspondence with the student researcher.

The next deadline for submitting project proposals to the Provost's Office for full review is N/A. You may submit a project proposal for expedited or exempt review at any time.

Sincerely,

*Dr. Thomas R. Herrinton
Administrator, Institutional Review Board*

*Office of the Vice President and Provost
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