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Behavioral Health Leadership Perspectives on the Transition to Medicaid Managed Care

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Walden University
2020

Abstract

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MS, St. John Fisher College, 2006

BS, Keuka College, 2004

Doctoral Study Submitted in Partial Fulfillment

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Doctor of Psychology in Behavioral Health Leadership

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Abstract

Healthcare and behavioral healthcare reform are sweeping across the United States to improve health outcomes, increase client satisfaction, and to decrease healthcare expenditures through statewide transitions to Medicaid managed care (MMC). Leaders of behavioral health organizations face significant challenges when implementing wide scale organizational change. A case study design was used to explore senior leaders' experiences with transitioning from a fee for service environment to MMC at a behavioral health organization, which operates in the Northeastern region of the United States. The Baldrige excellence framework was used as a conceptual lens to assess the organization's effectiveness in key factors. Senior leader interviews ($N = 7$) and analysis of the organization's archival data were used to inform the study. Senior leaders identified preparation, communication, and marketing assisted in strategic readiness and capacity for organizational change. State delays and regulation changes in MMC implementation, decreases in reimbursement rates, and staffing issues impacted implementation of MMC. These findings were aligned between senior leader interviews and archival data. Recommendations included documentation of senior leader decisions, creation of an organizational strategic action plan for significant changes, capturing outcome data, diversifying funding sources, and implementing workforce satisfaction surveys. Senior leader insights can be used to inform the behavioral healthcare field of challenges encountered and strategies used to implement an MMC transition to improve the lives of individuals served and effect positive social change.

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Dedication

This doctoral capstone is dedicated to my daughter, Olivia, and my husband, Mark. Olivia, at the age of 11, served as a mini-research assistant; she highlighted journal articles, categorized research, role played qualitative interviews, and helped me check every reference in this study. May the love of learning always spark joy in her life.

Mark sacrificed many activities, including coaching soccer, to step into the lead parenting role countless times over the past three years so I could complete this doctoral program. His endearing support never wavered, and for that, I am forever grateful.

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Thank you to my family, friends, coworkers, and mentors for standing by me through the past 3 years as I pursued a life-long goal. I could not have succeeded in this process without their support.

Thank you to the study participants for their time, dialogue, transparency, and dedication to the human service field. I would like to express my sincerest appreciation to the senior leaders at the behavioral health organization for allowing me to complete my study at the agency and to have full access to pertinent information which, in turn, could benefit the field of behavioral healthcare reform.

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Section 1a: The Behavioral Health Organization

Introduction

A nonprofit behavioral health organization (BHO) in the Northeast region of the United States was the subject of this case study and will be referred to as the BHO Partner Site (BHOPS) throughout this doctoral capstone study. The BHOPS delivers an array of services and programs in more than 15 counties and has been in operation for more than 40 years. The BHOPS's mission is to provide a comprehensive array of services to best meet the community's needs while maintaining accountability for empowering individuals to meet their individualized goals, according to the BHOPS's website. The BHOPS provides services to adults, children, and families across their lifespan. Categories of service provisions include home and community-based behavioral health services, residential services, habilitation services, and educational services. According to the agency's website, services occur in individual or group settings, which vary by program and needs of individuals served. The agency is experienced in providing health-related services, such as residential care, as well as nonhealth-related services, such as after school programs.

The majority of the services at the BHOPS are funded by Medicaid through contractual partnerships with state government entities, according to public financial statements and the agency's website. The programs involved in this study's exploration of senior leaders' experiences of the Medicaid managed care (MMC) transition are provided within the children's behavioral health services programs, which include

therapeutic foster care (TFC), health home care coordination, 1915c waiver programs, and home and community-based services. MMC is a model of healthcare reimbursement and health service management that focuses on managing healthcare services through private health insurance organizations instead of state run Medicaid (Palmer, Marton, Yelowitz, & Talbert, 2017).

Practice Problem

Behavioral healthcare reform is defined as changing a health delivery system to better meet the mental health and substance abuse needs of individuals and communities (Swartz & Morrissey, 2012). While healthcare reform is underway across the United States, behavioral healthcare reform is not often prioritized among reform initiatives (Bao, Casalino, & Pincus, 2013). A BHO implementing reform often finds challenges specific to the mental health field and subcategories of this population, such as children's behavioral health (Huffman, Brat, Chamberlain, & Wise, 2010). Hall, Kurth, Chapman, and Shireman (2015) presented similar findings in the adults with long-term disabilities population during a statewide transition from Medicaid to MMC. Thus, it is important to explore organizations' experiences with behavioral healthcare reform from a systems perspective to improve future reform implementation for the agency and to provide valuable lessons learned to the behavioral health field.

Healthcare reform in the United States has shifted to focusing on the triple aim goals of healthcare: (a) improving health outcomes for patients, (b) increasing patient satisfaction, and (c) decreasing healthcare costs (Lown, McIntosh, Gaines, McGuinn, &

Hatem, 2016). Many states across the country have transitioned health and behavioral healthcare services from a Medicaid fee-for-service (FFS) environment to MMC in an effort to improve the management of healthcare in alignment with the triple aim goals (Owen, Heller, & Bowers, 2016). Preliminary results of MMC indicated a decrease in unmet health needs across several populations, including children with complex care needs (Bright, Kleinman, Vogel, & Shenkman, 2018; Owen et al., 2016). Evidence of improvements in access to healthcare support the purpose of MMC transitions.

Effective leadership is a key factor for successful organizational change (Brown, 2011; Lussier & Achua, 2016). Aarons, Sommerfeld, and Willging (2011) studied the impact of a statewide behavioral health transition in safety-net institutions (SNIs) and found that transformational leadership was related to lower staff turnover rates and improved organizational transition success. Huffman et al. (2010) discussed the importance of health policy decision-makers and stakeholders to understand the impact of MMC with the unique and complex needs of the children and youth population across the United States. The researchers posited the necessity of state and organizational planning for a smooth transition to MMC for this population (Huffman et al., 2010). Hall et al. (2015) presented similar findings in the adults with long-term disabilities population during a statewide transition from Medicaid to MMC. Burson, Cossman, and Cain (2013) reflected on the experience of failed MMC implementations, which were common in the United States in the 1990s and early 2000s. Years of preparation for MMC by states and

organizations were met with frequent modifications to proposed regulations, which required organizations to be adaptable while sustainable (Owen et al., 2016).

In order to avoid the challenges other organizations have experienced with their transition to MMC, it is important for BHOs and its leaders to be prepared for healthcare reform. An ever-changing regulatory environment puts the organization's capacity for transformation to the test (Burns, Bradley, & Weiner, 2020). Nonprofit organizations rely on various financial and nonfinancial factors, such as leadership, service offerings, and fiscal management, as the key to effectiveness and sustainability (Iwu, Kapondoro, Twum-Darko, & Tengeh, 2015). The addition of significant healthcare reform calls for a high level of organizational capacity for change.

The experiences of senior leaders in a nonprofit BHO in the midst of implementing state-mandated behavioral healthcare reform, specifically a transition from Medicaid FFS to MMC, were the focus of this study. Research questions that guided this doctoral study included the following:

1. What are the experiences of senior leaders in preparing and implementing the MMC transition?
2. How do senior leaders prepare the agency, clients, and workforce for significant healthcare reform?
3. How do senior leaders address challenges and implement strategies to meet the demands of state-mandated behavioral healthcare reform?

4. With hindsight in mind, what would senior leaders change about their preparation or implementation of the MMC transition?

Specifically, these questions assisted me in investigating how senior BHO leaders prepare to transition to the MMC system. This practice problem aligns with challenges faced in organizations experiencing similar healthcare reform (see Hall et al., 2015; Huffman et al., 2010; Williamson et al., 2017).

Purpose

The purpose of this qualitative case study was to explore the BHO's readiness and implementation of the MMC transition from a leadership perspective. The BHOPS's children's behavioral health services were in the midst of a transition from an FFS environment to an MMC environment. The services impacted by this transition included TFC, health home care coordination, 1915c waiver programs, and home and community-based services. Approximately 300 to 450 recipients under the age of 21 with behavioral health issues were initially impacted by this transition. How the leaders of the BHO responded to the MMC transition may provide insight on how to improve organizational processes during times of change or healthcare reform.

Conceptual Framework

This study is grounded in the conceptual structure of the Baldrige excellence framework (National Institute for Standards and Technology [NIST], 2017). The Baldrige excellence framework provides a comprehensive systems-based assessment of organizational dynamics by exploring seven key factors of management and leadership:

leadership, strategy, clients, workforce, operations, results, and measurements, analysis, and knowledge management (NIST, 2017). When these key factors are in place and working harmoniously, organizational excellence can be achieved. Organizations that use the framework want to achieve results that align with their mission and achievement of strategic objectives. The Baldrige excellence framework and organizational systems theory complement one another, as systems and processes impact one another in an organizational setting (Brown, 2011; NIST, 2017). In this study, I used the conceptual framework to assess the agency's approach to organizational change.

Sources of Evidence and Data Collection Strategies

I used semistructured interviews of senior organizational leaders as a primary source of data collection regarding the phenomenon of the MMC transition. Semistructured interview questions were aligned with key criteria from the Baldrige excellence framework (see NIST, 2017). Additionally, secondary data sources consisting of documents and media resources from internal and external sources were used. Secondary data sources specific to the organization included leadership reports, leadership meeting minutes, financial reports, memorandums, formal emails, survey results, assessment results, outcome measures, and correspondence. The states' government websites and the state's selected MMC transition consultant organization were the most significant sources of external secondary data, per review of these websites and their resources. These sources contained reports, presentations, regulations, and manuals regarding the MMC transition.

Interview questions used as part of this study included the following:

1. What role do senior leaders play in the transition to MMC?
2. What role does the agency's vision and mission play in the transition to MMC?
3. What are the most significant internal challenges the organization faces in its attempts to implement the MMC transition?
4. What are the most significant external challenges the organization faces in its attempts to implement the MMC transition?
5. What strategies have been successful or unsuccessful in implementing the MMC transition?
6. How has the organization prepared the workforce for the MMC transition?
7. How has the organization prepared clients for the MMC transition?
8. How will the organization measure the effectiveness of MMC?
9. How has the organization planned, either formally or informally, to address the MMC transition? If there is a plan, how often is the plan reviewed and with whom?
10. What are the key factors in ensuring organizational change is effective?
11. Reflecting on the MMC transition, what, if anything, would you change in the beginning stages of preparation or implementation of the transition?

Significance

The United States' quality of healthcare is deficient compared to other developed countries, which is compounded with the chronic health conditions and premature death

rates of people with chronic mental health issues (Davis, Stremikis, Squires, & Shoen, 2014; National Alliance on Mental Illness, 2018). Barriers to accessing behavioral healthcare and wraparound services for children and adolescents have been a long-standing issue in the United States (Coldiron, Bruns, & Quick, 2017). Youth with chronic serious emotional disturbances account for the majority of behavioral health services expenditures, leaving minimal resources to address emerging behavioral health symptoms (Coldiron et al., 2017). It is believed that if managed care, including coordinated care and quality service provision, is successfully implemented, evidence of improvement will be seen in greater access to services, lower healthcare expenditures, improved health outcomes, and increased patient satisfaction, as Davis et al. (2014) found in other developed countries around the world.

Children with behavioral and emotional health issues have complex healthcare needs (Coldiron et al., 2017). Youth in foster care have an even greater risk of chronic behavioral health issues, including emergency room visits and hospitalizations, associated with abuse, neglect, displacements, frequent moves, and the exposure of chronic complex trauma (Bright et al., 2018). If the triple aim goals can be attained for children with serious emotional disturbances and youth in foster care, it is hoped their chance of having lifelong chronic health issues could be decreased or at least better managed. The potential social change of successfully implementing MMC in behavioral health organizations would be improving the quality of life for youth and extending their years lived through increased access to healthcare and improved health outcomes.

Ultimately, treating and rehabilitating youth's mental health symptoms before adulthood could decrease the need for mental health treatment as an adult (Asselmann, Wittchen, Lieb, & Beesdo-Baum, 2018).

Senior BHO leaders' experiences with transitioning children's behavioral health services from Medicaid to MMC were explored. The MMC transition also expanded services across the organization's service region, which required an increase in staffing and programming. The MMC transition significantly changed stakeholders, reimbursement rates, regulations, programming, staffing, and outcomes for the organization. The BHOPS and its staff, who comprised the setting and participants of this study, were tasked with implementing the required changes effectively to sustain programming and the organization through a rapidly changing external environment. Thus, the main focus of the study was on executive level decision-making, readiness, and navigation of this significant change.

Researchers have documented successes and challenges of implementing significant healthcare reform and posited the importance of effective leadership for organizational success and sustainability (Aarons et al., 2011; Williamson et al., 2017). Stanhope et al. (2017) posited the importance of organizational readiness to effectively implement change. In this study, senior leaders provided a unique perspective into their experiences of organizational leadership while the phenomenon of the MMC transition was occurring in real time. Senior leaders' reflections of the organization's readiness and implementation activities during the transformation provided a contemporaneous

assessment of behavioral healthcare reform from a nonprofit leader perspective. This unique perspective is believed to fill a gap in the current literature, as many MMC transitions have focused on the adult population (Holtrop, Potworowski, Fitzpatrick, Kowalk, & Green, 2016; Huffman et al., 2010; Williamson et al., 2017). The successes and challenges of one organization's transition can inform the practices and progression of another organization's transition, which makes this study relevant and valued not only to this study's BHO but to other organizations implementing healthcare reform around the country.

Summary and Transition

The aforementioned scholarly evidence supports this study's purpose of exploring organizational change from a leadership perspective. The senior leaders provided insight into the organization's implementation of the MMC transition as the primary source of data for this study. The practice problem, navigating behavioral healthcare reform at the organizational level, is a challenge many BHOs face (Hall et al., 2015; Huffman et al., 2010; Williamson et al., 2017). Exploring the practice problem through the Baldrige excellence framework provided a systems overview of how one organization's senior leaders implemented a statewide behavioral healthcare transition. The social change significance of the study not only focuses on assisting BHOs in exploring how to effectively implement MMC and manage significant organizational change but for youth and families to procure the benefits of increased access to care and improved health outcomes.

In the next section of this study, I present the BHOPS's organizational profile, providing an overview of the organization's services, leadership, vision, workforce, clients, results, strategy, and knowledge management. In the organizational profile, the foundation of how the organization operates is established. In the subsequent sections of this study, I detail a comprehensive assessment of each Baldrige excellence framework's organizational key factor, review the methods and procedures for data collection and analysis of senior leaders' experiences, and discuss key findings and recommendations for the BHOPS's senior leaders.

Section 1b: Organizational Profile

Introduction

Behavioral healthcare reform requires substantial planning for organizations to effectively implement change (Huffman et al., 2010; Stanhope et al., 2017; Williamson et al., 2017). However, many organizations are faced with challenges when undertaking large scale organizational change (Brown, 2011). The purpose of this study was to explore the experiences of senior leaders responsible for planning and implementation of the MMC transition. A comprehensive overview of the organization's service offerings, structure, operations, strategy, financial profile, governance, and leadership provides a foundation to view the organization through the conceptual lens of the Baldrige excellence framework to explore the practice problem.

The nonprofit BHOPS, founded over forty years ago, delivers an array of services and programs in 15 counties. As reviewed on the BHOPS's website, the organization provides over 50 distinct programs that can be summarized within the following categories: children and family services, TFC, residential services, home and community-based services, educational programming, habilitation services, childcare services, and care coordination. The BHOPS provides services to adults, children, and families across the lifespan. The majority of the services at the BHOPS are funded by Medicaid through partnerships with state government entities, as noted in annual agency financial reports. Financial information of the BHOPS can also be publicly accessed through the GuideStar website, a search engine and overview of nonprofit annual tax returns named 990s

(GuideStar, 2019). Partnerships between states and nonprofit organizations are common delivery systems for mental healthcare in the United States (Ott & Dicke, 2016; Swartz & Morrissey, 2012).

Organizational Profile and Key Factors

The organizational profile is the first part of a comprehensive Baldrige excellence framework assessment (NIST, 2017). The organizational profile provides the foundation of an organization's purpose and daily operations. The organizational profile is reviewed within the Baldrige excellence framework's seven key factors of organizational distinction. In subsequent subsections, I review each key factor in accordance to operations at the BHOPS. Information gathered for the organizational profile was found on the agency's website, public newsletters, public financial statements, internal administrative and program manuals, and employee resources.

Healthcare Service Offerings

Each of the BHOPS's programs serve to meet the needs of the community, per the organization's mission, as reviewed through the organization's website. The organization has a positive reputation at local, regional, and state government levels for quality care and compliance as evidenced by state and federal audit reports, client satisfaction surveys, and semiannual agency newsletters. The behavioral health programs involved in the MMC transition accounted for approximately 20% of the organization's staffing and 22% of the organization's annual budget, as reported in quarterly board reports at the time of data collection. The children's behavioral health programs are a cornerstone of

the organization's success and sustainability, per the senior leader report. Within the past decade, the organization's children's behavioral health services have tripled in census, as well as geographic location of the services offered, per the organization's administrative directory and financial statements.

Children's Services

The existing children's behavioral health programs involved in the MMC transition included (a) TFC, (b) health home care coordination, (c) 1915c waiver programs, and (d) home and community-based service programs, according to the BHOPS's service offerings within the Children and Family Services Department, per the agency website. Newly expanded services as a result of the MMC transition are discussed in later sections in this study.

1. TFC is provided throughout the service region. TFC provides a specialized program to youth in foster care with special needs, per the agency website. The TFC program trains and certifies foster parents to care for these children in their agency-approved homes. The BHOPS specializes in serving hard to place children, especially teenagers, according to the 2019 TFC program service guide. Approximately 30 to 40 children are served in this program, per BHOPS program census data report. This program was carved out of the MMC transition until 2020, as recorded in state memos. However, many youth in care also receive the services listed below.

2. Health home care coordination, also known as a *medical health home*, is a federal model to integrate healthcare, mental health and substance abuse care, and social needs (Holtrop et al., 2016). A health home is not a physical place but a conceptual clearinghouse of an individual's total care coordinated and integrated by a care coordinator professional (Monti & Rosner, 2015). Davis et al. (2014) reviewed the positive impact of care coordination on health outcomes from a global perspective. Eligibility to receive health home care coordination includes receiving Medicaid and having chronic health conditions, developmental disabilities, a serious emotional disturbance, HIV/AIDS, or complex trauma, as noted in state eligibility criteria. This service was first offered to children in the state in 2016. Before the MMC transition, approximately 100 children were served in this program, as evidenced in BHOPS program census reports.
3. The Social Security Act of 1965 created 1915c waiver amendment programs to allow specialized healthcare services, funded by Medicaid, for individuals with chronic conditions and disabilities, with the goal of preventing hospitalizations and institutional levels of care (Hoverstadt, Smith, Reininger, & Arcari, 2013). To receive these services, youth must be at imminent risk of hospitalization or a higher level of care and a Medicaid recipient. The 1915c waiver array of services ranging from nine to 14 services including crisis management, skill-building, and care coordination provided highly intensive

wraparound services to assist in preventing the need for hospitalization or a higher level of care (Hoverstadt et al., 2013). The BHOPS has provided four children's 1915c waiver programs, with one program dating back 2 decades. The BHOPS served approximately 200 children across these waivers before the MMC transition, per BHOPS program census data report.

4. Home and community-based services were recently unbundled from the 1915c waivers to better meet the needs of the community, per state presentations. Services can include skill-building, crisis avoidance, intensive in-home supports, employment services, parent advocacy, peer advocacy, habilitation, and crisis services, as reviewed in the BHOPS's program brochure and website.

Vision, Mission, Philosophy, and Values

Nonprofit organizations use vision statements to indicate the long-term goal of the organization, while a mission statement provides information on how an organization will operate to meet the vision (Nicol, 2014; Srinivasan, 2014). An organization's effectiveness in exemplifying its vision and mission can assist in managing and implementing successful organizational change (Bryson, 2018). The BHOPS highlights its vision, mission, philosophy, and values via website, program sites, and newsletters. The 2019 BHOPS's website describes those elements that comprise the operating philosophy of the organization (see Table 1).

Table 1

BHOPS's Vision, Mission, Philosophy, and Values

Element	Content
Vision	Recognition for quality services that support the goals of individuals served.
Mission	Provide a wide array of services to meet the needs of the community. Empower individuals to meet their identified goals.
Philosophy	Respect the importance and power of individual choice.
Values	Empowerment, quality, compassion, collaboration, and integrity.

Note. Information gathered from the BHOP's 2019 website.

Organizational Core Competencies

An organization's core competencies are unique offerings or qualities of the agency or service delivery that set the agency apart from other organizations (Burns et al., 2020). Core competencies assist the organization in obtaining a competitive advantage (NIST, 2017). The BHOPS's core competencies include quality services, dedication to ethical compliance, and strategic insight. The BHOPS is steadfast in maintaining compliance with internal and external standards and regulations. These core competencies are evidenced in the BHOPS's audit reports from various state entities and internal compliance reviews. The organization's commitment to these competencies provides a competitive advantage in its field, as referral sources, families, local, and state partners have sought service delivery from the BHOPS due to its exemplification of these competencies. The organization uses its core competencies as a competitive advantage

for strategic insight into the future of service delivery, per review of managers' meeting minutes and internal memos. The BHOPS's core competencies are directly related to the mission and assist the organization in achieving the mission and vision.

Delivery of Healthcare Services

Healthcare services are delivered by per diem, part-time, and full-time employees. Employees provide services on-site, in family homes, and in the community. The BHOPS employs over 700 individuals, who span the organization's service area, according to the agency staff directory. In general, most employees are assigned a regional site, whether they work within an on-site program or in the community. A majority of the organization's healthcare services are delivered through Medicaid funding through contracts with state agencies. Other programs are operated under grant funds, local county contracts, and subcontracts, as noted in public financial statements.

State and federal Medicaid dollars primarily fund the children's behavioral health services through state contracts, which is a typical funding stream and partnership for nonprofit agencies (Ott & Dicke, 2016). Previously, services were delivered in an FFS manner under traditional Medicaid, per annual budget documents. The MMC transition will move these services from FFS to a value-based payment (VBP) delivery system over the course of several years, as is common with MMC transitions across the country (Wagner, 2014). Implementing a value-based service delivery system is part of the country's triple aim goals of healthcare (Wagner, 2014). Evidence-based results from other countries implementing this delivery system show a correlation to the triple aim

goals of healthcare: improve care quality, increase client satisfaction, and decrease costs (Lown et al., 2016). This significant shift in care delivery and funding requires the organization to adapt its operations, workforce, and strategy to meet the needs of the MMC transition while simultaneously continuing to meet the needs of its clients through quality service delivery.

Workforce Profile

Recruitment and retention of staff practices are crucial to the effectiveness of an organization (Heneman & Milanowski, 2011). As aforementioned, the BHOPS employs over 700 staff who work in a variety of settings across fifteen counties. Positions include full-time, part-time, relief, and temporary staffing. Salaried (exempt) positions and hourly positions (non-exempt) are offered. Foster parents are considered subcontractors for the organization. According to job descriptions, education requirements for positions range from entry level to professionally licensed mental health providers or other licensed professionals such as registered nurses. Operating over 20 regional offices and 10 residential sites, the agency requires significant staffing to maintain the property and operations. Maintenance employees, nurses, childcare aides, teachers, occupational therapists, physical therapists, transportation staff, information technology staff, trainers, financial staff, and administrative support staff sustain the organization's operations. This information was gathered from the BHOPS's internal organizational chart and the *Administrative Manual*, which is a manual containing general policies and procedures for the agency.

Benefits

Benefits for the workforce play a significant role in recruiting and retaining employees (Purdon, 2018). According to the company's website, the BHOPS provides an array of benefits. Full-time employee benefits include two choices of medical insurance plans, dental insurance, vision insurance, flexible spending account (FSA), and life insurance. The medical plans offered are characterized as traditional full coverage and high-deductible. Fulltime and part-time employees are offered short-term and long-term disability, supplemental insurance, tuition reimbursement, and paid time off.

Purdon (2018) posited the importance of employees understanding how their employer-provided benefits complement employee's financial compensation. All employees have the opportunity to access the Employee Assistance Program, profit sharing, 401(k) options, and credit union membership. Paid time off includes vacation, supplemental vacation, personal, sick, and bereavement days. The BHOPS's Administrative Manual indicates the observation of seven holidays. However, residential and on-call crisis staff continue to work through these holidays as needed, per the Administrative Manual, and receive one and a half times their pay rate to work on an observed holiday. Tuition reimbursement for part-time and full-time who have worked at the agency for over a year is offered up to $2,000 per year for courses that are related to the employee's field, reported in the Administrative Manual.

Lanham, Rye, Rimsky, and Weill (2012) posited that expressing gratitude within the workforce may predict less burnout and turnover in the mental health field. The

BHOPS has a specific committee dedicated to the recognition of staff and agency event planning. The BHOPS provides employees with small gifts of gratitude throughout the year. These tokens of appreciation range from cookies delivered to all regional sites, gift cards to local coffee shops, or staff outings for free or discounted rates. Annually, employee milestones and achievements are celebrated at an employee recognition dinner, as reviewed in the Administrative Manual.

Senior Leadership Workforce Profile

Effective senior leadership is positively related to organizational capacity for change among the workforce (Yasir, Imran, Irshad, Mohamad, & Khan, 2016). Thus, senior leadership roles will be discussed below and further elaborated in the leadership profile. According to BHOPS's job descriptions, The chief executive officer (CEO) of the BHOPS oversees the senior leadership team consisting of six executive-level positions. These positions include chief financial officer (CFO), two executive vice presidents of operations (EVPs), chief human resources officer (CHRO), chief compliance officer (CCO), and chief public relations officer (CPRO). The chief operating officer (COO) recently retired after 30 years of service to the BHOPS. The COO's position was not replaced. The EVPs took over COO responsibilities, per job descriptions, and internal memos. These positions range from a bachelor's degree with decades of experience in their field to master's level executives. The CEO has a professional doctorate and 4 decades of experience in the human services field. The CEO provides supervision to each member of the leadership team and holds senior administrative leadership meetings,

termed *admin meetings*, biweekly. The EVPs oversee all program operations. One EVP oversees the director of children's services. Additionally, the leaders of the finance, transportation, human resources, information technology, and training departments work in tandem to promote program operations, as reported in the Administrative Manual.

Board of Directors

The BHOPS's board of directors (BOD) consists of 12 community members with diverse education and experiences within the community. The BOD consists of six women and six men, according to the agency website. The BOD meets monthly with the senior leadership team to review the status and upcoming changes within the organization, including a review of financial data and outcomes, per BOD meeting minutes.

Children's Services Department Workforce Profile

Although this study focuses on the senior leadership's experiences with the MMC transition, it is essential to have a thorough overview of the workforce in the department at the center of the MMC transition. The Children's Services Department is comprised of over 130 employees ranging from relief to full-time positions, as reviewed in the department's employee roster. There are two basic categories of direct care employees in this department: care coordinators and service providers, per the Children's Services offerings, as indicated on the agency website. Care coordinators are responsible for overseeing the physical, behavioral, emotional, and social care and wellbeing of their assigned youth and families (Monti & Rosner, 2015). Service providers are responsible

for delivering services to assist in skill acquisition or rehabilitation, per job descriptions for this position.

According to the 2019 BHOPS's staffing plan, in the TFC program, six full-time (exempt) care coordinators maintain a caseload of six youth. Youth in care with serious emotional disturbances, developmental disabilities, and medical fragility require intensive support and coordination, per TFC program manual. Bright et al. (2018) posited that youth in foster care have complex medical needs, especially youth with mental health diagnoses, hence the low staff to youth case ratio. The foster care coordinators supervise the foster homes and work closely with the youth's treatment team.

According to the TFC program's staffing plan and foster home roster, staff members in this program are based out of the agency's headquarters and one regional office but cover a wide geographic region to complete home visits with families and foster homes, meet youth in schools, and attend provider meetings. Foster homes are spread throughout the geographic region of over a dozen counties, per foster home demographics internal agency reports. For example, a foster care coordinator may have six clients in four different counties. The foster care coordinator utilizes their regional or assigned office to complete paperwork, attend meetings, and clinical supervision. Approximately 65% of foster care coordinators' time is spent attending to foster homes, visitations, and travel, as reviewed in annual foster care time studies. This information was gathered from the BHOP's TFC program staffing plan and 2019 TFC program service guide, which describes the service offerings and staffing of the program.

In the health/medical home care coordination program, approximately 30 full-time care coordinators are salaried (exempt) and have a caseload of 12 to 35 youth depending on the youth's level of need. Staff in this program is based out of the agency's headquarters and five offices within the service region, but also cover a wide geographic region of fifteen counties, to meet with families and providers. Care coordinators minimally require a bachelor's degree in human services or a related field with 2 years of coordination experience. Several master's level staff also provide care coordination. The salary for this position depends on the employee's education and experience. This information was gathered from the care coordination program's staffing plan, job descriptions, and the agency's website. However, the typical salary for a care coordinator/child social worker at the BHOPS is below the national average salary for child social workers (Bureau of Labor Statistics, 2018).

The BHOPS employs several full-time, salaried, care coordination supervisors with a supervisor to staff ratio of one to seven, as indicated in the program's policies and procedures, which aligns with government recommendations reported in program manuals. Supervisors of the care coordination program provide regular supervision to staff, documentation review, collaboration with local community resources, and quality and compliance oversight of their share of the program. The full-time, salaried, manager of care coordination provides supervision to all care coordination supervisors, overall management of the health home care coordination program, and collaboration and promotion of services through stakeholder engagement. The position requires a

bachelor's degree with a minimum of 4 years of coordination and 1 year of supervisory experience. The current manager of care coordination has a master's degree in nonprofit management and leadership, over fifteen years of experience, and five years of supervisory experience. This information was gathered from job descriptions and the manager of care coordination resume.

Service providers deliver home and community-based services to youth and families in a twelve county region, as noted in the program's census and demographic reports. Most service providers are mobile and are not assigned office workstations, but are assigned a regional office to complete documentation, trainings, and participate in supervision in designated mobile work areas. Service provider positions significantly vary depending on the needs of each community. These hourly (exempt) positions are relief (0 to 30 hours per week) or full-time (35 to 40 hours per week). Before MMC transition activities, caseloads ranged from three youth (relief service providers) to 14 youth (full-time service providers), as reported on program census reports, staff caseload reports, and internal memos.

Education requirements range from entry level staff with high school diplomas to licensed mental health professionals, as reviewed in service provider job descriptions. Education and experience requirements for these positions are dependent on state regulations, per policies and procedures and state regulation manuals. According to the BHOPS's directory of service providers pre-MMC transition, approximately 50 service providers, 16 full-time, and 34 relief, provide services to approximately 200 youth in a

twelve county region. The mobile workforce utilizes various technologies to meet the demand for contemporaneous documentation. Most full-time service providers are assigned a laptop or data-enabled tablet to complete documentation requirements, per review of the service provider technology assignment list. Full-time service providers are provided with an agency cell phone, as indicated on the directory of service providers. Service providers receive supervision from service provider supervisors, per the program's policies and procedures. Contrasting from the care coordination program, there is no supervisor to staff ratio for service providers, as reviewed in state program manuals. Service supervisors oversee approximately 15 to 25 service providers, per the department's service provider directory.

According to job descriptions, Licensed counselors are a specialized subset of service providers in the Children's Services Department. Licensed counselors were recently hired as part of the state's expanded service array under the MMC transition, per senior leaders' report, to be further discussed in subsequent sections. Licensed counselors provide in-home counseling, evaluations, and crisis services. Counselors must maintain a professional license in the mental health or social work field as well as have at least 1 year of experience. It is important to note although job titles and programs in the department may vary, there are two distinct roles of direct care providers. Direct care staff are either providing services or coordinating care, which is a key distinction, as reviewed in Table 2.

Table 2

Children's Services Department Workforce

Job title	Description
Care coordinators	Provides comprehensive management of emotional, social, and healthcare for each youth and family.
Licensed counselors	Provides diagnostic and clinical assessments, as well as individual, family, and group counseling for youth through age 21 in the home, school, and community.
Service providers	Provides rehabilitative and habilitative services to youths and families in the home, school, and community.

Note. Information was gathered from the Children's Services policies and procedures and job descriptions.

Clinical supervisors provide clinical supervision to the counselors and management of the counseling services program. As reviewed in job descriptions, clinical supervisors also oversee two revamped and expanded services as part of the MMC transition, to be further discussed in subsequent sections. There is no supervisor-to-staff ratio limits for licensed counselors, according to state regulations.

The youth services manager is responsible for the oversight of the supervisors, as well as the management of the programs. The job description for the youth services manager indicates education and experience requirements for the services manager is a minimum of a bachelor's degree with 4 years of experience and at least 1 year of supervisory experience. The current youth services manager has a master's degree in public health administration and over a decade of experience with specialized children's services, as reviewed in the manager's resume. The director of children's services

oversees the managers of TFC, care coordination, and youth service provision. The director of children's services is responsible for the general operations of the department.

Workforce Training

A comprehensive list of more than 30 unique internal trainings are offered at the agency either as required or elective**,** per job descriptions, the Administrative Manual, the Employee Handbook, and the training department's curriculum calendars. Some trainings include first aid/CPR, Therapeutic Crisis Intervention, cultural competency, trauma-informed care, team building, safety in the community, mandated child abuse reporting, strengths-based approach, and supervisory training**.** The training department meets as needed with program managers to ensure training needs are met, per internal memos. The training department develops trainings as needed, such as staff development and team-building workshops for foster care staff, as evidenced in internal memos. All employees at the agency are required to have workplace (sexual) harassment training on an annual basis as mandated by a statewide policy. Supervisory training topics include workplace harassment, worker's compensation, the Family Medical Leave Act and short-term disability, and counseling and disciplinary action, per the Administrative Manual and training calendars.

All Children's Services Department staff must pass an online course in mandated child abuse reporting before they are able to provide direct services, as required by program policies and procedures that align with statewide expectations for direct care providers. Additionally, background clearances, including child abuse and criminal

history checks, are also required before services, per job descriptions. The training department at the BHOPS consists of two full-time trainers and one part-time trainer. The two full-time trainers have been employed at the BHOPS for over thirty years, according to annual staff recognition award recipients lists.

Therapeutic Crisis Intervention

Pioneered by Cornell University (n.d.), Therapeutic Crisis Intervention (TCI) is an evidence-based training, used worldwide, focusing on preventing crisis and safely de-escalating crisis in youths with special needs. The full 4- or 5-day training includes physical interventions, which is required per state regulations for TFC staff, per the 2019 TFC policies and procedures. A 2-day TCI modified course, without physical interventions, has been used in the past to train care coordinators and service providers. The BHOPS currently has four internal TCI trainers, one of which is based out of a regional office.

Assets

The BHOPS's assets are comprised of real estate, vehicles, equipment, technology, and workforce. Information reviewed in this subsection was gathered through the agency's 2019 asset and equipment reports maintained by the Finance, Transportation, and Information Technology Departments. The BHOPS maintains a 27,000 square foot headquarter facility, 30 regional offices, and 10 residential sites. Several of the residences are owned, while most of the physical plant assets are leased. A building management team is responsible for the maintenance of local residences and

offices, while leasers assist the building management team in the upkeep of regional offices more than 90 minutes away from the headquarters.

The working capital cycle reveals how an organization manages daily cash flow, balances assets and liabilities, and can indicate whether or not the organization has sufficient funds for its expenses (Zelman, McCue, Glick, & Thomas, 2014). The BHOPS's 990 financial filing documents show the organization's major financial data categories from 2017 (GuideStar, 2019). This information can be used to evaluate the organization's financial health as well as current working capital. Total property and equipment assets amount to $3.5 million. Total assets, including cash investments, total $25.6 million, as reviewed in internal financial statements.

The organization's 2017 assets were more than the organization's liabilities. Thus, there was sufficient working capital to maintain the organization's operations. The current ratio (current assets/current liabilities), at the time of data collection, was 4.22, per financial reports. A ratio of more than one indicates the organization is able to pay off current debt and maintain operations (Zelman et al., 2014). These results indicate the organization is able to meet current day to day operations and financial obligations even if a catastrophe occurred.

Additional physical assets include a fleet of over 80 agency vehicles and substantial office equipment. The fleet of vehicles is spread across the service region at regional offices and residences. Vehicles are used to transport clients and residents to appointments or meetings, as well as staff travel to meetings, visits with clients and

families, or trainings. Handicap-accessible vans are used to transport clients to the BHOPS's day habilitation programs for adults with developmental disabilities, per vehicle asset reports.

Technology assets include two virtual privacy networks (VPNs), a large internal secure data server with adequate network space, a web conferencing system, a multitude of computers, laptops, tablets, office phones, cell phones, smartphones, commercial copiers with scanning capabilities, fax machines, and projectors. The agency pays for an electronic health record (EHR) to document healthcare delivery for most health-related programs within the organization. Initial implementation of an EHR system was to meet requirements of the Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009 to streamline and integrate care through shared documentation within an agency and within local systems (Furrow, Greaney, Johnson, Jost, & Schwartz, 2018).

At this time, the EHR only interacts with one Regional Health Information Organization (RHIO). An RHIO is a clearinghouse for medical, dental, mental health, and substance abuse service information on each client served. The integration of this data, with client or representative consent, aims to improve the quality of care and avoid duplication of care through shared and integrated information (Burns et al., 2020). Children's services programs use these assets as well as external electronic record systems, which is common to be required by state and federal government entities (Burns et al., 2020).

Regulatory Environment

The BHOPS operates within many regulatory environments from the local, state, and federal levels, per the Administrative Manual and program policies and procedures. While all departments, leaders, supervisors, and staff are responsible for compliance, the leader of agency compliance is the CCO. According to the Administrative Manual and senor leader reports, the CCO has a separate and direct reporting line to the CEO and BOD. The CCO maintains the Corporate Compliance Manual and oversees the completion of annual compliance training**,** as reviewed in the Corporate Compliance Manual and the Administrative Manual.

At the federal level, the BHOPS complies with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to protect the privacy of patients' health-related information (Furrow et al., 2018). HIPAA policies and procedures are listed in the Corporate Compliance Manual on the organization's internal shared drive. Additionally, the organization's HIPAA compliance policies are posted on its website for public viewing. The BHOPS is considered a "hybrid entity," which provides healthcare services as well as non-health-related services. The BHOPS must maintain firewalls to ensure the health-related information is not disclosed or shared with employees or programs that are not considered healthcare services**,** according to the agency's website. Thus, health-related data within the Children's Services Department is not shared and cannot be accessed by staff from non-health-related programs, such as the BHOPS's childcare

programs. At any point, health-related information is disclosed within HIPAA standards, the organization is required to log each disclosure of information.

Federal and state regulations for 501(3)c nonprofit organizations are followed by programs, leaders, and the organization's finance team. The BHOPS participates in regular financial audits to maintain nonprofit (tax-exempt) status. An annual full agency financial audit is completed by independent auditors, per the Administrative Manual.

The Department of Labor's (n.d.) Occupational Safety and Health Administration (OSHA) federal regulations establish standards for employers to provide safe working conditions for employees. All new hires at the BHOPS complete OSHA required safety trainings upon hire and on an annual basis. The agency provides safety policies and procedures which are posted at all sites and available to all employees. Each job description at the BHOPS, signed by employees, includes the OSHA typical working conditions category for the position. The BHOPS provides similar training to staff and supervisors regarding the Family Medical Leave Act, as noted in the Administrative Manual.

The BHOPS follows Medicaid service delivery, documentation, and billing regulations as mandated by the Centers for Medicare and Medicaid Services (CMS) and the Office of Inspector General. The BHOPS operates within seven state departments focusing on health and human services, which provide the main oversight for the TFC, health home care coordination, and home and community-based services programs. The BHOPS maintains articles of incorporation, authority to board certificate, operating

certificates, program licenses, subcontracts, formal county contracts, and approval letters to operate services, per review of these documents.

Organization Governance

The BHOPS's articles of incorporation and bylaws review the established governance structure and processes, which is aligned with general nonprofit governance (Ott & Dicke, 2016). As previously mentioned, the BOD consists of 12 members. The agency does not have established term limits for board members. Thus, several board members have served the BHOPS for more than 2 decades, per board member profiles.

The CEO reports directly to the BOD. The BOD is responsible for ensuring the CEO is continually aligning with the agency's vision, mission, philosophy, and values (Tschirhart & Bielefeld, 2012). The BOD is responsible for the annual performance evaluation of the CEO and is at the helm of choosing a new CEO when necessary (Johnson & Rossow, 2019). As aforementioned, the CCO maintains a direct reporting line to the BOD to comply with regulatory requirements.

The full BOD meets nine times a year with the senior leadership team to review the operations, finances, strategy, upcoming changes, compliance, and outcomes, per senior leader reports, which is similar to the responsibilities within boards across the country (Johnson & Rossow, 2019; LeRoux & Langer, 2016). Board meetings typically last 1 hour in length, follow an agenda and formal quorum procedures. Similar to other Boards around the country, the BOD does not meet in June, July, or August (Johnson &

Rossow, 2019). Members of the BOD also comprise special governance committees that also meet primarily on a monthly basis, such as the executive committee.

Organization Leadership Structure

The BHOPS maintains a traditional hierarchical structure, according to the internal organizational chart, job descriptions, the agency website, and the Administrative Manual, which reviews internal reporting structures. The BHOPS's CEO is the executive administrator who formally oversees a level of senior executives of operations and administrative functions, including the CFO, CCO, CHRO, CPRO, and the EVPs. The two EVPs manage department directors, three in total, including the director of children's services. The director of children's services oversees three program managers. The program managers oversee frontline supervisors, approximately 13 supervisors. The frontline supervisors oversee direct care staff. The organizational structure has been maintained in a traditional format, in part, to meet state regulatory conflict-free firewalls, also termed as *silos*, to comply with the CMS (2015).

The BHOPS maintains a set of policies and procedures which require top-down management as well as shared decision-making, as evidenced in the Administrative Manual. Several decisions need approval at various levels of leadership in the structure. For example, purchases under $500 require the approval of the manager and director. Purchases over $500 require the approval of the manager, director, and EVP. Purchases over $1,500 require the approval of the manager, director, EVP, and CEO. Most major

decisions at the BHOPS are made at the executive level, such as expansion of services or organizational restructuring.

Shared Decision Making and Collaboration

Shared decision-making provides a high learning environment for all employees, managers, and administrators, which is positively correlated with organizational effectiveness (Burns et al., 2020). BHOPS program units are given autonomy to make decisions within its program or group. Department and program-specific decisions are made within the leadership teams of work units of the department and program. Each program maintains its own set of policies and procedures aligned with agency, regional, state, and federal regulations. Care coordinators and service providers review policies and procedures on an annual basis. Staff meetings for each program provide an opportunity for staff and leaders to share feedback on the processes and practices. This collaboration often leads to revisions of policies and procedures to best meet the needs of the workforce and clients, while also maintaining necessary regulatory requirements. Policies and procedure changes are reviewed by the CCO on an annual basis, per the Administrative Manual.

Burns et al. (2020) indicated collaboration within a healthcare organization is a key factor for organizational effectiveness and patient outcomes. Collaboration at the BHOPS is encouraged vertically and laterally, as evidenced by agency committees with employees from a cross-section of the organization's departments, quarterly manager meetings, and weekly agency-wide update emails. Although two of the programs in the

Children's Services Department, health home care coordination and 1915c waiver programs, require a silo approach of reporting lines per state and federal regulations, all program supervisors within the department regularly meet to communicate updates, problem-solve shared cases, and share decisions in department matters. Every other week, the supervisors and managers of each program participate in a leadership meeting with the department managers and director of children's services. The purpose of the regularly scheduled meetings, as reviewed in meeting minutes, is to share decision-making within the teams, address any policy or procedure changes, share information across the reporting silos, problem solve shared cases, and maintain consistency of management within the department. Supervisors from regional sites join the leadership meetings through video and audio webinars. This information was gathered from leadership meeting minutes.

Information regarding communication in this department was gathered from the BHOPS's meeting minutes, program manuals, training checklists, and internal memos. Consistent communication between and within the Children's Services Department occurs with regular staff meetings, leadership meetings, access to meeting minutes and policies and procedures, internal memos, project committees, and family team meetings, in which this information was gathered. All staff within the department receive biweekly or weekly individual supervision or group supervision with their direct supervisor. Supervision provides an opportunity to review challenging cases, work performance, progress, and outcomes. Care coordinators and service providers connect several times a

month to review shared cases, progress, and outcomes. This communication can occur informally through HIPAA compliant email, phone calls, or in-person meetings, per department policies and procedures.

Clients

The BHOPS has over 50 distinct programs, each serving a specific population of clients. The BHOPS uses the term *individuals* instead of *clients*, per agency communication and agency website. But for purposes of this study, the term *clients* will be used to describe individuals receiving services from the BHOPS to align with preferred behavioral health terminology (Costa, Mercieca-Bebber, Tesson, Seidler, & Lopez, 2019). Clients include infants, children, youth, adolescents, young adults, families, adults, and natural supports. Because a majority of the agency's funding is from Medicaid sources, most clients are eligible for Medicaid through below poverty line income levels or chronic illnesses (CMS, n.d.a.).

Clients are served through the agency in various population units. According to program descriptions found on the agency's website, child care programs serve infants and children up to the age of 12. Whereas, residential homes serve children over the age of five with serious emotional disturbances to adults with chronic intellectual developmental disabilities. Each program was either established or expanded to serve a specific population of clients to meet a community need. An example of a program adapting to community needs is the TFC program. The program was originally established to meet the need of approximately 10 to 15 youth with special needs in foster

care, per the program's initial proposal to the state. Over the years, the demand for specialized foster care services to address the growing epidemic of mental health and substance abuse issues among adolescents has increased the need for specialized foster care (Bright et al., 2018). This trend required the agency to invest in hiring and training staff and foster parents to meet the needs of this growing population, including youth with gang involvement. The growth in the TFC program census, as reviewed in demographic and census reports, in serving this population led to the agency expanding the TFC program, including expansion into an urban setting.

The Children's Services Department of the BHOPS in this study serves clients, children and youth, from birth to age 21. The TFC program is more likely to serve newborns compared to other programs within the department. Previous to the Affordable Care Act of 2010, most mental health programs in the state only covered youth up to the age of 18 (Furrow et al., 2018). Young adults, aged 18 to 21 were falling through the cracks of traditional mental healthcare, too old for the children's mental health system and too young, developmentally, to benefit from services geared towards adults (Altman, O'Connor, Anapolsky, & Sexton, 2014). The BHOPS is able to serve transitional age youth (18 to 21) in each program of the Children's Services Department, per program descriptions on the agency's website.

Families

In addition to children and youth, families and natural supports are also served through the Children's Services Department. Family involvement in behavioral health

services is positively correlated to an improvement in the mental health wellness of children (Burton, Cohen, & Jain-Aghi, 2014). Families are widely defined within state governmental entities to include caregivers, natural supports, or non-fictive kin (CMS, n.d.b.). The broad definition of *family* allows creativity in service provision and the ability to meet youths and families' needs, according to the CMS (n.d.b.) Person and Family Engagement initiatives. The BHOPS's website and newsletters highlight the importance of supporting families through service provision and care coordination.

Demographics

The Children's Services Department does not require programs to collect data on client race, ethnicity, or religion, as these are not required fields in electronic health records, and this information could not be found consistently in other reports. However, the TFC program's connection to a statewide database of all foster youth prepopulates the race and ethnicity as this demographic information is gathered from youth's county department of social services caseworker. The agency's headquarters are located in a small city bordering a similar-sized city with surrounding rural areas. According to the 2010 census, people identifying as White/Caucasian make up 84%, and African-Americans make up approximately 9% of the population in and around the agency's headquarters, which is over the United States average of White/Caucasian people of 77% and under the United States average of African-American people of 13% (United States Census Bureau, 2019). However, African American youth in the BHOPS's TFC program accounts for approximately 50% of the youth placed, indicating disproportionality, per

TFC demographic and census data. This finding is common among foster care programs across the country, which is being addressed in a myriad of ways, through implicit bias training to blind child welfare removals (Pryce et al., 2019). On average, 3% of the population served near the agency's headquarters identify with Hispanic, Asian, or multiple races.

In the past 5 years, the BHOPS expanded services to an urban setting, in which demographics of the population are much more diverse with race percentages of 40% African-American, 36% White, 18% Hispanic, 3% Asian, and 4.5% of people identifying as more than two races (United States Census Bureau, 2019). The TFC program's demographics of youth in care in this service region show an increase in alignment with the regional demographics, as reviewed in the 2019 TFC program census data report, which contains demographic information for current and past youth.

All programs maintain a database of the client's birth gender and date of birth to match their health insurance information in the EHR. Referral forms in the Children's Services Department do not include race, ethnicity, or religion data. Some referrals for services include copious demographic information in supporting documentation from referral sources, however, this information is not required to access services, per agency referral forms. Clients in the Children's Services Department are served in rural, suburban, and urban areas, as evidenced by the counties served via the agency's website.

The Children's Services Department has experience in working with LGBTQ clients. The TFC program has experience in working with transgender and gender-fluid

youth, per the 2019 TFC program service guide. Serving this population with respect, dignity, and support is crucial to building rapport with clients (Singh & Harper, 2013). A culmination of these experiences and cultural competency training provides clients with a safe, affirming, and supportive space when services are provided. Many areas or offices at the BHOPS's regional sites or headquarters maintain visible equality or safe-space signs. If a youth identifies as transgender or gender-fluid, staff will utilize the preferred pronouns of the youth. The department's new clinical assessment includes *preferred pronoun* as a category to be completed during an initial intake for services.

Determining Ongoing Needs

Client needs are gathered through semiannual satisfaction surveys hand-delivered to each family or sent via mail. Surveys are also conducted via phone if needed. Families and youth complete separate surveys. Surveys are collected confidentially and kept with the Compliance Coordinator. Internal aggregate survey data and comments are shared with staff and leaders in a detailed report. The results of surveys provide programs the ability to reflect on feedback and improve processes. In addition to these internal surveys, families also participate in satisfaction surveys delivered by state partners. For concerns or grievances, all families and youth are provided with client rights, agency and state grievance process procedures, and contact information of program managers. This information was gathered from department policies and procedures.

Stakeholders

Stakeholders include community members, churches, schools, city council members, local judges, local legislators, county officials, law enforcement, and businesses. Stakeholders have vested interests in the agency's services in the community, per the agency's semiannual newsletters which highlight collaborations with the community and agency events. The headquarter of the BHOPS is located in the same small city in which an international Fortune 500 company is based. This corporation partners with many local nonprofit agencies to ensure the needs of its employees are met, as well as needs of the overall community. The large corporation has a publicly established commitment to diversity in its workforce, which has increased diversity of race, ethnicity, and religion in the city's population, according to the corporation's website. The corporation has sponsored mental wellness fairs and children's services fairs. This corporation is the typical site for the agency's annual fundraiser, as it is one of the only venues large enough for the agency fundraiser.

Partners

The BHOPS provides contracted services regionally and statewide, according to the agency's website. Thus, key external stakeholders include state and local government partners and oversight agencies, per review of contracts, letters, emails, and senior leader reports. Stakeholders also include other provider agencies in the region and state. State partners are continually engaged with the BHOPS's senior leaders and the workforce with regular quality audits, monthly individual meetings, monthly statewide webinars,

formal guidance document issuances, phone calls, and emails. The BHOPS's workforce and senior leaders communicate with state government partners through required monthly, quarterly, and annual reports, incident reporting, emails, phone calls, and teleconferences. County Departments of Social Services and Mental Health Clinics contract with the BHOPS for the provision of various services out to the BHOPS, as reviewed within respective contracts.

Insurance Companies

Medicaid remains the number one payer of funds to the BHOPS, per agency financial statements and 990 tax filings. Preparation for the MMC transition required the BHOPS to secure contracts with seven managed care organizations (MCO), as standard practice across the country (Stanhope et al., 2017). Relationships with MCOs as primary payers of Medicaid funds for the MMC transition established MCOs as financial stakeholders (Zelman et al., 2014). The BHOPS's senior leadership, directors, managers, and the finance team began to create partnerships with each MCO through various communication methods, per review.

Suppliers

According to agency asset reports, financial statements, and the Administrative Manual, the BHOPS's collaborates with suppliers to ensure quality services can be provided in the Children's Services Department and throughout the agency. Suppliers include a global office supply company that not only assists in furnishing regional offices but offers free and fast shipping for office supplies. Additionally, a global technology

company provides the agency with computers. Another global technology company provides smartphones and tablets to staff in various departments. These technology pieces allow staff to be either office based or mobile. A nation-wide data communication company provides office-based phone services. A global cellular data company provides cellular service. The flexibility in each position due to the technology resources assists staff in meeting their job duties (Burns et al., 2020).

A fleet of over 80 vehicles is provided through a partnership with the state on a discount program for nonprofit organizations, per review of the agency vehicle asset report. Throughout the rest of the agency, residential and educational programs rely on additional suppliers for food, educational supplies, and medical supplies. For the adult residential facilities, medical suppliers of adaptive and assistive equipment and accessibility modifications are vital to ensuring clients can lead a quality life. This information was gathered from the Administrative Manual.

The BHOPS supports local businesses through the purchasing and contracting of goods and services. Local pharmacies provide medication for individuals in residential services. Local grocery stores provide food and toiletries for all programs in need. Local lawyers and financial firms provide legal and financial oversight for required independent auditing. The agency relies on responsive landlords when renting or leasing office space for regional offices, per internal memos. This information was gathered from the Administrative Manual.

As reported in financial statements, internal emails, and the agency's website, the BHOPS's services, programs, career opportunities, recruitment of foster parents, and events are promoted through various local media outlets. Television, radio, newspaper advertisements, local media design companies, local billboard companies, and locally targeted social media are primary promotional sources. The agency's website maintains promotional and educational material that connects directly to social media accounts.

Organizational Background and Context

The organizational profile provides a comprehensive overview of the BHOPS's operations, governance, leadership, workforce, and assets. These key factors working in tandem are required to lay the foundation to prepare for effective organizational change. This section will begin by reviewing the changes to existing services to meet the regulations and requirements of the MMC transition. As previously stated, the organization's practice problem is how it will prepare and implement the MMC transition from a senior leadership perspective, acknowledging other nonprofit organizations and health systems around the country have struggled with this transition (Hall et al., 2015; Huffman et al., 2010; Williamson et al., 2017). To understand how the BHOPS will effectively implement MMC for children's behavioral health services, it is essential to understand the organization's competitive position and strategic planning abilities (NIST, 2017).

Restructuring Services for MMC Transition

Restructuring and expanding services to meet statewide regulation changes have been challenging for many private, public, and nonprofit organizations (Huffman et al., 2010; Stanhope et al., 2017; Williamson et al., 2017). To review, the BHOPS's services involved in the children's behavioral health transformation to MMC include the TFC program, 1915c waiver programs, health home care coordination, and home and community-based services. Various state entities interpreted the 1915c waiver amendments differently, which resulted in the operation of several distinctive 1915c waiver programs for children based on their prescribed population category: foster care, mental health, developmental disabilities, and medical fragility, per state presentations. Each of these programs differed in service offerings.

The MMC transition merged these 1915c waivers into one consolidated 1915c waiver to streamline access, standardize services across populations, and prepare for a VBP system. The merger also established stricter conflict-free firewalls between service provision and care coordination (CMS, 2015). An exception to the merger was care coordination. The coordination service was removed from the 1915c waivers and placed into the health home care coordination program. The new census of the health home care coordination program moved to over 300 children at the time of its MMC transition, with an anticipated 450 children to be served within the first year post-MMC transition**,** per internal estimates derived from the number of ongoing referrals received and projecting a growth rate of a census.

The consolidated 1915c waiver program was recently implemented at the BHOPS and serves approximately 200 youth. At the same time these 1915c waiver programs were merging, several of the most utilized services were removed from the waiver array and placed into the state plan as a Medicaid entitlement service. This change in service structure and design was to provide services earlier in a child's life to avoid mental health diagnoses or worsening of diagnoses, in response to the federal Early Periodic Screening and Diagnostic Treatment policy (Rosenbaum, 2017). These services included skill-building and intensive in-home supports. Additionally, a new service was established in the state plan: in-home clinical counseling. Eligibility requirements for these services were decreased from *level of care* to *medical necessity* to expand these services from approximately 7,000 youth to approximately 175,000 youth across the state, according to a projection from a state presentation from 2014. This increase in eligibility is aligned with the expansion rates of other states, depending on the degree of expansion (Antonisse, Garfield, & Rudowitz, 2018). Medical necessity is currently defined at the state level as the need for a service to prevent or halt the worsening of behavioral health symptoms or mental health diagnoses (see Markus & West, 2014).

To provide the new state plan services, the BHOPS was approved through a state designation process, per review of the agency's designation letter from the state. In the first year of implementation, the BHOPS was expected to provide these new state plan services to approximately 300 to 400 children, a combination of youth from the waiver programs as well as community youth who did not have access to these services prior to

the MMC transition, based on internal community need assessments and projections reviewed in internal emails. Additional children's services in the state plan are expected to premiere within the next year, as noted in the state's MMC transition website.

To understand how the agency prepared to implement these significant changes, it is vital to understand the agency's competitive position and strategic plan. The significant restructuring of services for special populations moving from FFS to MMC has caused difficulties and challenges for organizations across the country (Hall et al., 2015; Huffman et al., 2010; Williamson et al., 2017). Thus, it is imperative to understand the organization's competitive environment to gain strategic insight into how these significant changes may be implemented.

Competitive Environment

According to a state government report from 2012, there were over 12,000 healthcare and social assistance nonprofits in the Northeast state in which the BHOPS operates. Nationwide, the largest category of nonprofits is human service and healthcare agencies (Ott & Dicke, 2016). The BHOPS is considered a large nonprofit with an operating budget of over 25 million dollars and employs over 700 people, according to internal financial documents and public 990s. Ott and Dicke (2016) consider a nonprofit's size by assessing the budget and number of employees. According to a state provider list, there were over 150 existing agencies designated to provide children's behavioral health services expanded by the MMC transition. Additionally, there were over 100 nonprofit agencies in the state providing TFC. The BHOPS has shown

continued growth over the past four decades through expansion in service and clients served, per comparison of past and recent financial statements and agency reports. The growth rate is aligned with national growth in the nonprofit sector (McKeever, 2018).

Competitive Position

The BHOPS's competitive position is to remain a high performing agency and expand services as the growing market share allows, per senior leader reports and internal emails. *Managers' meeting* occurs on a quarterly basis and all managers, directors, and executives across the agency meet at the agency's headquarters to discuss the status of the agency's services, review upcoming agency changes to operations, finances, or leadership, discuss market trends within behavioral healthcare, review legislative efforts, and discuss achievements and challenges. These meetings serve a specific purpose: effectively communicate and network with leadership throughout the agency, maintain transparency within the agency, and promote a system's view of operations instead of siloed departments. This information was gathered from senior leader interviews and managers' meeting agendas and meeting minutes. Transparency and effective communication from senior leaders is positively associated with an organization's capacity to adapt and change (Lussier & Achua, 2016). Board meetings are also used to discuss topics as listed above. The BHOPS's competitive position is aligned with the agency's vision and mission to provide quality services that meet the community's needs, per the agency website.

The BHOPS uses core competencies and core values of quality, compliance, and responsiveness to develop and maintain its competitive position. Frequent market evaluation is crucial to the assessing current and future needs of the community (Zelman et al., 2014). The BHOPS provides services in fifteen counties; thus, the agency must stay abreast of variations in regional healthcare and human service markets, urban versus rural needs trends, and gaps in services through the region. Strong collaborations, marked by consistent and transparent communication with state and community stakeholders, provide the BHOPS with key information regarding trends in the market and needs in services, according to senior leader reports and managers' meeting minutes.

Once the competitive environment is assessed, the BHOPS must deliver responsive and quality services to maintain a competitive advantage (Brown, 2011). To gain and sustain a competitive advantage, the BHOPS focuses on preparedness and ongoing training, per managers' meeting minutes. Training to become familiar with new services or maintain an advantage on current services stems from systems readiness (Stanhope et al., 2017). For example, the BHOPS's leadership must be invested in competitive advantage and the work necessary to maintain the advantage. Support departments such as finance and human resources must also have up to date information on the agency's status to ensure readiness from its departments (Bryson, 2018). The public relations department works with program operations to create and maintain adequate marketing through mediums to reach the intended population and stakeholders, according to a senior leader. Then, operations must be ready to implement high quality

services. When these systems work synchronously, a high performing system is exhibiting organizational excellence (NIST, 2017).

Competitive Environment Changes

Pre-MMC transition, the BHOPS was designated as the sole provider of children's mental health 1915c waiver services in several counties of the service region, as reviewed in a state directory of waiver services and waiver brochures. At most, the agency was in competition with one other agency for 1915c waiver services in all other counties, per public state provider lists. The MMC transition led the way for additional agencies to be designated to provide home and community-based services, aligning with other states in expanding Medicaid services with Early Periodic Screening and Diagnostic Treatment policy (Rosenbaum, 2017). Thus, the competitive environment for 1915c waiver programs went from approximately 50 agencies statewide to over 150 agencies. Market saturation was a possible concern to the agency. To maintain a competitive advantage, the BHOPS planned to use its core competencies and experience in service provision to market services to the community. Readiness to provide the expanded services was given years of planning at the BHOPS, according to managers' meeting minutes. Stanhope et al. (2017) posited that large nonprofit agencies were more likely to attend and participate in ongoing trainings for the MMC transition compared to small or medium sized agencies. The researchers posited that their finding may be due in part to large agencies having the resources to invest in the time, travel, and costs associated with statewide trainings.

Strategic Context

The BHOPS's strategic context can be summarized through a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis. Bryson (2018) posited the importance of conducting a SWOT assessment when organizations are preparing for change. The strengths and weaknesses of a SWOT assessment capture internal factors, while opportunities and threats review external factors that may impact the organization's efforts or goals. A SWOT assessment may assist in the organization in identifying gaps in services, areas for improvement, and areas of competitive advantage (Bryson, 2018). The BHOPS's SWOT information was gathered from managers' meeting minutes, quarterly workforce turnover reports, leadership meeting minutes, including a SWOT analysis of the Children's Services Department conducted in September 2018, internal memos, and correspondence.

The BHOPS's strategic context is captured in the following SWOT categories:

1. Strengths: The BHOPS was prepared to provide an expanded array of children's behavioral health services on-time. The BHOPS serves close to 400 children in the community. The agency maintains a comprehensive benefits package for employees. The BHOPS employs fiscally prudent practices and is financially sound, allowing for the agency to support new endeavors.
2. Weaknesses: High turnover in the direct care staff field and at the BHOPS can impact the utilization and quality of services. The organization's CEO is retiring midyear, and the COO retired last year. The loss of experience and

expertise could affect the ability for the agency to adapt to changes depending on preparedness. Gaps in communication between departments can lead to ineffective implementation of new services.

3. Opportunities: The BHOPS has a positive reputation in the community. The BHOPS has active collaborations with community stakeholders and policymakers. The BHOPS must collaborate with new stakeholders, such as MMC organizations.
4. Threats: New competitors in the field. The agency experiences ever-changing state regulations. Low reimbursement rates for services were implemented post-MMC transition. The possibility of changes or a repeal of the Affordable Care Act.

Bryson (2018) posited that organizational weaknesses can impact external threats, and strengths can impact opportunities. As aforementioned, a weakness of staff turnover can impact the quantity and quality of service provision. In turn, a lack of quality service provision could impact the agency's reputation and allow competitors to gain an advantage in the field. Likewise, strengths of the agency, such as its core competencies, lay the foundation for establishing opportunities for growth and meeting the triple aim goals of healthcare in alignment with the agency's vision, mission, and values.

Performance Improvement System

A performance improvement system describes an organization's plan for continuously improving the quality of services (NIST, 2017). The BHOPS's performance

improvement system includes a wide array of quality components embedded into the agency's practices supported by HIPAA and the principles of the Sarbanes-Oxley Act of 2002 (Furrow et al., 2018; Ott & Dicke, 2016). The Sarbanes-Oxley Act developed ethical and best practice business principles that mainly applied to private corporations, with some principles applying to nonprofit governance and fiscal management (Ott & Dicke, 2016). A corporate compliance program, as documented in the Corporate Compliance Manual, ensures all programs operate within local, state, and federal regulations. Annual training regarding the compliance program is conducted with all employees who provide health-related services. Client satisfaction surveys are conducted semiannually in the Children's Services Department. As aforementioned, the results of these surveys, which were reviewed for this study, are aggregated, discussed with leadership, reviewed in staff meeting, and lead to policy changes when necessary. Internal policies and procedures are reviewed and updated annually by managers, per program policies and procedures.

Internal compliance audits for programs that bill Medicaid or MMC are completed quarterly by quality assurance specialists free from conflict of program operations, reported in program policies and procedures. The results of internal audits are also reviewed with senior leadership and staff. Items of noncompliance are corrected, and the manager writes a plan of corrective action for the program to indicate the steps the program leaders will take to prevent noncompliance in the future, per the Administrative and Corporate Compliance Manual. Financial audits are completed internally and through

an independent external auditor aligned with the Sarbanes-Oxley Act of 2002 (Ott & Dicke, 2016). Multidisciplinary committees at the BHOPS meet monthly or quarterly, including the safety committee, compliance committee, and the incident review committee. These committees provide perspectives from across the agency.

The BHOPS does not have agency-wide outcomes aside from the goals and aspirations of the vision and mission statements, per senior leader report. Each program maintains individual outcome expectations, which can be set internally or through a service contract, as noted in program manuals and policies and procedures. Program operations managers are responsible for meeting set outcomes, according to their job descriptions. An example of an outcome from the TFC program is: 80% of youth in the program will avoid a higher level of care or hospitalization. This outcome is measured quarterly, and the results are sent to local county child welfare departments that have requested data on this outcome. Currently, there are no outcome goals in the Children's Services Department directly tied to reimbursement. The triple aim healthcare goals are significant outcomes to achieve (Lown et al., 2016; Wagner, 2014). As behavioral healthcare services transition to MMC and VBPs, outcome measurement will have financial implications (Wagner, 2014). It appears outcome measurement will be viewed in a different manner, out of necessity, when VBPs become a reality for the BHOPS. Next, operational definitions will be reviewed as a guide to understanding key terms in this study.

Operational Definitions

Adolescent: "A young person developing into an adult" (Merriam-Webster, Incorporated, 2019).

Admin meeting: A biweekly gathering of the BHOPS's senior leaders in the CEO's conference room, per senior leader reports.

Affordable Care Act: A historic law passed in 2010, which expanded healthcare to millions of Americans and opened the door for reform in the behavioral healthcare field by recognizing the importance of behavioral health through funding and special initiatives (Furrow et al., 2018).

Behavioral healthcare reform: Changing a behavioral healthcare delivery system to better meet the needs of individuals and communities (Swartz & Morrissey, 2012).

Behavioral health organization partner site (BHOPS): A large behavioral health, nonprofit, human service agency that served as the site for this doctoral capstone project.

Behavioral health organization (BHO): Generally, an agency that provides mental health, behavioral health, or substance abuse treatment services to individuals. Synonymous with safety-net organizations (Stanhope et al., 2017).

Care coordinator: An employee of the BHOPS who focuses on managing the medical, emotional, and social healthcare of individuals (Holtrop et al., 2016).

Capacity for organizational change: The degree to which an organization's workforce, values, operations, and leadership align to support organization-wide readiness and implementation change (Buono & Kerber, 2010; Burns et al., 2020).

Clients: Individuals receiving services from the BHOPS (NIST, 2017). Synonymous, in this study, with youth, youth in care, individuals, children, families, and adults.

Fee-for-service: Reimbursement at a flat rate for a service regardless of quality or outcomes (Zelman et al., 2014).

Leadership meeting: A biweekly gathering of all supervisory staff in the Children's Services Department, per meeting minutes.

Level of care: To have a qualifying behavioral health diagnosis, developmental disability, or chronic illness that severely impacts functioning putting a client at risk of hospitalization, higher level of care, or institutionalization (Hoverstadt et al., 2013).

Managers' meeting: A quarterly gathering of all BHOPS managers, directors, and senior leaders to review agency updates, state regulation updates, strategy plans, and agency events. The meeting is led by the CEO, but all of the leadership are able to discuss agenda items, per meeting minutes, and agenda items.

Medicaid: A safety-net funding source and insurance program through state and federal money to support families of low income or individuals with chronic health or behavioral health needs (Zelman et al., 2014).

Medicaid managed care: Medicaid funds managed by private insurers to direct healthcare costs and quality of care (Palmer et al., 2017).

Medicaid managed care transition: The movement of services, programs, payments, and regulations, from a Medicaid FFS environment to a managed healthcare

insurance system focused on improving the quality of healthcare and decreasing healthcare costs (Lown et al., 2016; Palmer et al., 2017).

Medical necessity: A determination made by a licensed mental health professional or medical professional, acting within their scope of practice, which indicates a client needs specific care or services to prevent the onset or worsening of a behavioral health diagnosis or behavioral health symptoms, as defined at the state level (see Markus & West, 2014).

Service provider: An employee of the BHOPS who assists individuals and their families in addressing behavioral health issues through evidenced-based delivery of services (Hoverstadt et al., 2013).

Stakeholders: Individuals or groups with a vested interest in the agency or services provided by the agency (NIST, 2017). Stakeholders can include but are not limited to clients, partners, suppliers, workforce, community members, legislators, and organizations.

Transition age youth: Individuals between the ages of 18 and 21 (Altman et al., 2014).

Triple aim goals of healthcare: An initiative to improve patient health outcomes, improve patient satisfaction, and decrease healthcare costs (Lown et al., 2016).

Youth: A broad term depicting all individuals under the age of 21, according to state program manuals. Synonymous with children.

Youth in foster care: Individuals under the age of 21 who are in the care and custody of a social services or child welfare department of a county or state (Bright et al., 2018). Synonymous with youth in care, foster youth, foster care youth.

Value-based payments: Reimbursement initiative of managed care organizations positively correlated with high-quality outcomes due to quality service provision (Stanhope et al., 2017).

1915c Waiver Programs: Established from the 1965 Social Security Act, additional services and programs funded through Medicaid for individuals with chronic illnesses to prevent institutionalization (Hoverstadt et al., 2013).

Summary

The overview of the organizational profile and organizational background and context establish an overview of how the BHOPS operates and governs. The broad overview of the organization's key factors associated with the Baldrige excellence framework included service offerings, service delivery, leadership, workforce, clients, results, strategy, and knowledge, and data management within the context of the BHOPS's competitive environment and strategic insight regarding the MMC transition (NIST, 2017). Organizations around the country have reported difficulty in making such a significant transition within their healthcare systems, that it is important to assess the BHOPS's key factors to organizational effectiveness in relation to the MMC transition (Hall et al., 2015; Huffman et al., 2010; Williamson et al., 2017). Section 2 of the

doctoral study moves from a broad overview to a comprehensive assessment of these key factors in relation to the practice problem.

The transition to MMC through the lens of senior leaders' perspectives requires a thorough review of the BHOPS's approach to leaders and strategy. Section 2 reviews the sources of information and data used to assess the organization. Additionally, a comprehensive overview of scholarly literature regarding the practice problem is reviewed. Methods of how data was obtained and analyzed in this study is discussed in-depth in this next section.

Section 2: Background and Approach–Leadership Strategy and Assessment

Introduction

The transition to MMC through the lens of senior leaders' perspectives requires a thorough review of the BHOPS's approach to leadership, strategy, and clients as key Baldrige excellence framework (NIST, 2017) factors presented in this section. In Section 2, I review the sources of information and data used to assess the organization. Additionally, a comprehensive overview of scholarly literature regarding the practice problem is reviewed. An in-depth discussion of research methods and procedures, analytic strategy, ethical practices for this study, and validity and reliability are included in this section.

A transition from a Medicaid FFS reimbursement environment to a managed care and a VBP environment is the direction in which healthcare in the United States is moving, in part based on the varying evidence of the successes of managed care systems (Bright et al., 2018; Stanhope et al., 2017). Many organizations face challenges when implementing statewide changes to systems of care and reimbursement structures (Williamson et al., 2017). The purpose of this study was to explore a behavioral health organization's transition from FFS to MMC from the perspective of senior leaders in the organization. In this section of the doctoral study, I review the literature of MMC, healthcare and behavioral healthcare reform, and organizational change. Additionally, sources of evidence used and data collection for this case study pertaining to the BHOPS and study topic are identified. Further assessment of the BHOPS's leadership strategy,

clients served, workforce, operations, and strategy are explored in-depth in relation to the practice problem.

Supporting Literature

Literature Searches

A thorough review of literature is crucial to the foundation and structure of research studies, whether qualitative or quantitative (Ravitch & Carl, 2016). Multiple sources of scholarly literature were used for the purposes of this case study. A majority of research regarding the topic of MMC, MMC transitions, and organizational change were collected through searches in the Walden Library databases, specifically searches in the Thoreau database, which is a general database that collects research from broad subjects such as management, psychology, healthcare, and education.

Keywords used to search the topics of this case study included *healthcare reform, behavioral healthcare reform, Medicaid managed care, fee-for-service, value-based payments, organizational change, leadership, children, adolescents, foster care, youth, quality, transition,* and *triple aim health goals*. These keyword searches often included two to three keywords using the Boolean search technique. Scholarly articles were exclusively reviewed by selecting the "peer-reviewed scholarly journals only" option.

Upon initiating a review of scholarly literature in 2018, articles from 2012 to the present date were sought. However, due to a lack of research and the need to understand previous trends in MMC, the search results were expanded to the year 2010; this did yield a credible study that documented a statewide MMC transition specifically for children

(Huffman et al., 2010). Supporting literature was gathered over the course of 2018, with additional searches in 2019 revealing new scholarly articles related to the topic of this case study. Additionally, textbooks on the topics of healthcare management, financial healthcare management, healthcare law, leadership, nonprofit organizations, organizational development and change, and strategic planning were used to support key foundations of healthcare reform and organizational change theories and history.

Literature Review

Healthcare Reform Needs

The United States spends approximately 18% of its GDP towards healthcare costs, the highest of developed nations, yet places last in the quality and efficiency of healthcare (Davis et al., 2014). The purpose of healthcare reform is to improve the quality of care while decreasing healthcare costs (Furrow et al., 2018; Lown et al., 2016). Davis et al. (2014) researched the effectiveness of integrated care and universal coverage in other countries with more efficient healthcare delivery systems than the United States.

However, the United States is a complex healthcare environment, meaning one-size-fits-all healthcare models have been determined to be insufficient in addressing the country as a whole (Burns et al., 2020; Furrow et al., 2018). While federal initiatives and policies adopted after the passing of the Affordable Care Act have provided additional incentives to try new models of healthcare while expanding access to coverage and services across the country, states maintain a portion autonomy in deciding what healthcare models to use, the degree of expansion of Medicaid, how to integrate care, and

whether to participate in individualized state demonstration projects (Furrow et al., 2018; Hoverstadt et al., 2013; Stanhope et al., 2017).

Behavioral Healthcare Reform

In the United States, traditional health care reform took precedence over behavioral healthcare reform (Bao et al., 2013). Chang, Cohen, McCarty, Rieckmann, and McConnell (2015) noted that behavioral healthcare reform lagged behind traditional healthcare reform in implementation in the State of Oregon, with substance abuse treatment reform lagging further behind behavioral healthcare reform. The field is beginning to colocate mental health clinics within primary care clinics to integrate care, but more integration than just proximity is needed (Chang et al., 2015).

The lag in behavioral healthcare reform was not for lack of necessity. In fact, behavioral health expenses have increased the most over time compared to other healthcare expenses (National Institute of Mental Health, 2019). Close to 50 million Americans have a mental health disorder, but only 42.6% receive or seek care (Center for Behavioral Health Statistics and Quality, 2015). The discrepancies in access to care, quality care, and rising healthcare expenditures assert an urgency for behavioral healthcare form (Schwartz et al., 2016).

Value-Based Versus Fee-Based Care

For many decades, the United States has operated under an FFS healthcare model, meaning each service renders amounts to a fixed expense and fixed reimbursement rate regardless of quality or effectiveness of care. A physician or psychiatrist is paid a flat rate

each time a patient is seen, regardless if the patient is getting better or is satisfied with the services received. Without improving the management of healthcare, costs will continue to rise based on supply and demand economic principles (Zelman et al., 2014). Thus, a new system of managing care was needed to address the rising costs with little in quality gains. Managed care is the ability for an entity or organization to manage a person's healthcare delivery, outcomes, and efficiency to seek a cost-effective way of obtaining efficient care (Lown et al., 2016).

Managed care is seen in various forms around the country and the world. Owen et al. (2016) noted that 28 states had transitioned to MMC by 2016. States have been given autonomy in whether to transition to an MMC environment through the expansion of Medicaid through the Affordable Care Act (Furrow et al., 2018). Models of managed care include bundled payments for specialty care, accountable care organizations, managed care organizations, and care coordination or integrated healthcare (Zelman et al., 2014). Each of these models assesses and evaluates costs, quality, effectiveness, and satisfaction in an attempt to meet the triple aim goals of health care (Lown et al., 2016).

Additionally, each of these models may use a VBP system, in which care is not only managed or assessed closely but effective quality care is incentivized through rate reimbursement increases or stipends to healthcare providers and sometimes even patients themselves (Wagner, 2014; Zelman et al., 2014). For example, a psychiatrist who sees 50 patients in a month and for whom none of the patients need emergency mental healthcare for a duration of 3 months may receive a 3% increase in their reimbursement rates from a

managed care organization, the third-party payor (Zelman et al., 2014). Value-based care in the behavioral health field poses to be more challenging in some respects, as the progress of treatment cannot necessarily be tested with blood tests or imaging assessments. Progress is typically reported through subjective measures. However, as reviewed in Bright et al. (2018) most mental health providers do maintain a benchmark of psychiatric evaluation visits to emergency rooms and psychiatric inpatient hospitalization stays.

MMC Efficacy

The terms *managed care* or *health maintenance organization* tend to have negative connotations, as managed care was attempted in the 1990s unsuccessfully in the United States (Burson et al., 2013). However, managed care in the '90s was largely managing costs without coordinating an integrated approach to healthcare (Burson et al., 2013). Managed care was put in place to meet the triple aim healthcare goals of increased client satisfaction, improved health outcomes, and decreased healthcare expenditures (Lown et al., 2016; Wagner, 2014). Thus, the literature review on the efficacy of managed care is discussed within these three categories. It is important to note that there was a paucity of research findings regarding managed care efficacy in relations to children with behavioral health diagnoses.

Client satisfaction. Owen et al. (2016) conducted a quantitative study to compare satisfaction of healthcare between two groups: adult healthcare recipients with traditional Medicaid and adult healthcare recipients with MMC in the 21st century. The researchers

found that people with MMC had significantly less unmet needs than the FFS group (Owen et al., 2016). People with mental health disabilities and lack of transportation reported significantly higher unmet needs than comparison groups (Owen et al., 2016).

Hall, Landry, Lemak, Boyle, and Duncan (2014) studied parent satisfaction with managed care and FFS care for children populations in Florida. Satisfaction was studied over the course of several years with thousands of participants (Hall et al., 2014). Parents of youth with chronic conditions were less satisfied with managed care arrangements than parents of youth without chronic conditions (Hall et al., 2014). These findings may speak to the complex needs of youth with chronic conditions and the difficulty in ensuring all needs are met. Hall et al. (2014) posited that parents more favorably rated managed care arrangements specifically designed with pediatric concerns in mind, instead of general health maintenance organizations.

Heyworth et al. (2014) studied patient reported outcomes, including satisfaction, with regards to Patient Centered Medical Homes (PCMH) in the adult population in Massachusetts. Comparison between a traditional medical home model with a transformed PCMH model with an increase of integration of care and transition from FFS to value-based incentives yielded results of increased satisfaction in the newly revised PCMH model in terms of communication with providers (Heyworth et al., 2014). It is important to note that some client dissatisfaction was noted during the transition (Heyworth et al., 2014).

Schwartz et al. (2016) studied adult clients receiving mental healthcare in a traditional FFS environment and through an integrated managed care environment. Differences in client satisfaction between groups were not statistically significant. Thus, mixed findings on client satisfaction demonstrate a need for additional research.

In general, current client satisfaction regarding MMC is lacking in research. The paucity of research indicates a significant gap in recent studies of client satisfaction. Additionally, even less research is available regarding family or youth satisfaction for the child/youth population, foster care population, and children's behavioral health population (Huffman et al., 2010).

Access and quality. Sparer (2012) completed a synthesis analysis of MMC implementation with regards to access to care within MMC across the United States. It was found that access did improve with MMC, but the degree of improvement if any was state-specific and not standard across the United States. Each state has been given the ability to design MMC how they see fit to meet the needs of its population. However, this has resulted in staggered transitions to managed care across the United States, and significant discrepancies between state offered services under MMC. For example, Sparer (2012) noted that carved-in behavioral healthcare for MMC and has a large provider network may show better access to mental healthcare than a state with MMC that did not include behavioral healthcare in its initial MMC implementation. Findings will vary based on when states carved-in specific services and the type of MMC plans established (Sparer, 2012).

Bright et al. (2018) studied the trends of healthcare use of the FFS versus MMC population of youth in foster care through a quasi-experimental design with youth in Texas as the MC transitioned group and Florida as the FFS group from 2006 to 2010. Youth in foster care have complex medical and mental health needs, coupled with the lack of continuity of care due to multiple placement changes and family dynamics (Bright et al., 2018). The more placements or moves within the foster care system, a youth experiences, the higher their usage of emergency services is reported. "Approximately 30% to 90% of foster youth have at least one physical, mental, or developmental condition" (Bright et al., 2018, p. 397). The researchers in the study mentioned above also found a 6% to 13% increase in access to primary care and 10% to 13% preventive visits for the MMC group compared to the FFS group. Thus, foster youth may benefit from the MMC healthcare model.

Huffman et al. (2010) conducted a literature review of outcome categories to measure the impact of managed care, including children's populations. Within 13 studies of managed care in the United States, a positive effect of access to care was found in MMC populations. The researchers found mixed results with regards to the utilization of care in comparison to FFS Medicaid, with some states indicating a decrease in emergency room visits. In contrast, other states showed no significant difference. Huffman et al.'s (2010) study was used in this literature review due to the broad scope of assessing MMC transitions across the United States and a lack of available research for more recent transitions for children with special needs.

Song et al. (2011) found an improvement in the quality of care within the adult with chronic conditions and the pediatric population within 1 year of managed care and quality initiatives, such as pay-for-performance, implementation in Massachusetts. Heyworth et al. (2014) studied patient-reported access to care among the adult population in Massachusetts. Two groups were compared, traditional primary care and a PCMH model with an emphasis on integrated care and value-based care. The researchers did not find a statistical difference in access to care between the two groups. However, a statistical significance was found in the speed of accessing care with the PCHM patients indicating quicker access to care.

Schwartz et al. (2016) conducted a quasi-experiment to study the impact of medication compliance and psychological treatment outcomes in comparison groups of adults receiving behavioral healthcare. The control group received traditional care, while the treatment group received integrated managed care. Schwartz et al. (2016) found that medication compliance did not deteriorate in the treatment group, as opposed to a decline in compliance for the control group. However, researchers did not find a significant difference in psychological outcomes over time between the control or treatment groups.

Overall, the literature suggests a trend of improved access to care in a managed care environment. However, initial results continue to be mixed, especially during the transition to an MMC phase when continuity of care can become disrupted (Schwartz et al., 2016; Sparer, 2012). Additional research is needed to evaluate the effectiveness of MMC.

Costs. Sparer (2012) found, through a synthesis of statistics and research of states that had begun to implement MMC, MMC implementation resulted in slight, if any, cost savings in general. However, due to state variations of implementation, some states have found more success in cost savings with MMC than other states. It appeared cost savings were found depending on the healthcare needs of each state and which services were carved-in or carved-out, such as mental healthcare. States with historically high FFS expenditures tended to show an increase in cost savings in MMC compared to states with historically low FFS expenditures. Sparer (2012) also commented on the paucity of results regarding cost-savings, which, in part, may be due to how states capture data and expenditures within a new framework of services. States must also review their infrastructure needed to implement MMC, such as staff, to manage the MCO contracts, which could dramatically increase costs for organizations and the states (Sparer, 2012).

While Song et al. (2011) showed an improvement in the quality of care, the same researchers published a study in 2012, which reported a savings of 2.8% in healthcare expenditures for populations that moved into managed care within 18 months of managed care implementation in Massachusetts. An increase in savings was expected to be apparent further into the MMC transition (Song et al., 2012).

Palmer et al. (2017) studied the efficacy of the managed care transition for the foster care population. Kentucky completed a staggered transition of youth in care into MMC, moving one region to MMC before others. This allowed researchers to compare real-time data of youth in care receiving MMC or FFS. Utilizing Medicaid data,

researchers found a decrease of 4% in the probability of monthly outpatient usage among youth in care, when compared to the FFS youth in care population. Additionally, researchers estimated a reduction in outpatient healthcare expenditures for youth in care who transitioned to MMC versus FFS.

As noted above, some research shows a cost-savings for managed care. However, not all research finds this hypothesis to be accurate. Huffman et al. (2010) did not find significant cost savings between MMC and FFS programs in a literature review of 13 studies across the United States pertaining to children with special needs. Schwartz et al. (2016) compared clients receiving mental health services in two group types of treatment, traditional and integrated managed care. The integrated care treatment group received more healthcare services and thus, an increase in healthcare expenditures. Schwartz et al. (2016) did not find statistically significant differences in costs related to traditional care versus integrated managed care. However, it is important to note the increased access to general and specialized services in the treatment group may have contributed to the increase in expenditures.

Healthcare expenditures will undoubtedly be a key factor in assessing the effectiveness of managed care (Burns et al., 2020; Furrow et al., 2018). However, current research appears to show mixed findings on this topic. As managed care becomes more established in the United States, expenditures without transition-related factors may be more accurately studied.

MMC Organizational Transition

The supporting literature shows behavioral health, healthcare, private, public, and nonprofit organizations across the United States are experiencing the impact of healthcare reform (Bao et al., 2013). Stanhope et al. (2017) documented the gap in research regarding behavioral healthcare reform from an organizational perspective. Thus, much of the literature found on organizational transitions to MMC focused on traditional healthcare. Owen et al. (2016) reported a gap in studying the impact of FFS to MMC transition in people with long-term health needs and mental health. Huffman et al. (2010) completed a review of research studies focused on the impact of managed care on children with special healthcare needs. Researchers discussed the importance of health policy decision-makers to understand the impact of managed care for children within several quality care categories. In general, the researchers found noted improvements but also challenges from the effects of the managed care transition. Healthcare reform across the country is underway, and it is imperative health policymakers learn from the experiences of states that have already implemented managed care and the impact on children with special needs.

Semansky, Hodgkin, and Willging (2012) discussed the implications of transitioning to managed care from an organizational perspective by surveying senior leaders across the state during a statewide transition of adult behavioral health services to one managed care organization in 2005. Although the state held reimbursement rates stagnant, leaders reported challenges with meeting the requirements of managed care

without start-up funding to make these changes, both fiscally and programmatically. While implementing the statewide change, BHOs indicated a challenge while trying to maintain quality mental healthcare, as an increase in paperwork, change in billing requirements, use of EHRs, and electronic billing.

Hall et al. (2015) explored the transition to managed care from the perspective of service recipients in Kansas through a qualitative research study. The results of the study pointed out different themes of challenges participants reported with the KanCare transition and current services. The main themes from participants indicated a need for improved planning for transitions to a new healthcare system, especially planning as it relates to participants with long-term chronic needs. As states continue to transition from FFS to managed care plans, this study provides important learning experiences that can be used to improve the transition process (Hall et al., 2015).

Holtrop et al. (2016) explored the care management program implementation through the lens of the normalization process theory (NPT) analysis. The researchers found that care managers with more expertise, clinical skills, and a strong work ethic experienced normalization, or acclimation and effective work practices, responded to organizational change faster than other care managers. The researchers' findings are useful in understanding how a healthcare delivery system change can be implemented and well-adopted from a systems and NPT perspective. The transition to MMC focuses on the importance of care management for integrated healthcare in meeting the triple aim healthcare goals. This study assists in understanding the factors that may assist in

successfully implementing a significant change in a healthcare setting from a systems approach. It is critical providers and staff not only understand and buy into the changes but also have the skill set to make the changes necessary (Holtrop et al.).

Williamson et al. (2017) explored the transition from Medicaid to managed care through the experiences of state representatives, service providers, and caregivers involved with adults with long-term intellectual or developmental disabilities. The challenges of one state's transition can inform the practices and progression of another state's transition. Themes from the interviews indicated a need for more preparation before the transition occurred to avoid confusion and gaps in services, a need for greater stakeholder engagement, average access to services, and a need for improved communication (Williamson et al., 2017).

Stanhope et al. (2017) studied how BHOs prepared for healthcare reform with regards to training. Researchers studied one state's preparation and training for implementation of MMC for the behavioral health population. Researchers found that larger organizations (serving more than 800 clients) and clinics were significantly more involved in MMC preparation training than smaller organizations (serving under 800 clients). Stanhope et al. (2017) discussed the possibility that larger BHOs are able to devote the time, staffing, funding, and resources to training and preparation may be able to adapt to behavioral healthcare reform easier than smaller organizations. Researchers posited that larger organizations may have more leadership staff and the ability to strategize significant organizational change more so than small organizations. Stanhope

et al., (2017) reviewed the importance of further exploring organizational factors that play a role in the ability to adapt to a changing environment.

Although studies regarding statewide transitions were located, there is a paucity of research focusing on two specific areas of the MMC transition: nonprofit provider organizations and children with special needs, specifically behavioral health needs (Bright et al., 2018; Huffman et al., 2010). This may be due to behavioral healthcare reform lagging behind traditional healthcare reform or a lack of focus on the identified population (Bao et al., 2013). Another factor in the gap in research may be due to the significantly complex needs of children with special needs in which the few studies in existence show mixed results (Owen et al., 2016). Many states have carved-out these specific populations due to the complex needs and a desire to achieve the triple aim healthcare goals in traditional health first. Regardless of the reason for delaying this population to MMC, the unmet healthcare needs of children with complex health conditions continue to be of concern (Owen et al., 2016).

Leadership and the MMC Transition

Aarons et al. (2011) studied the impact of a statewide behavioral health transition in SNIs and found transformational leadership was related to lower turnover rates and improved organizational transition success. The BHOPS is considered an SNI needing to meet state regulations to continue operations. The conceptual framework, results, and recommendations for addressing organizational change within behavioral health reform is a critical piece of information needed to assist with this practice problem. The researchers

point out the often lack of anticipating the organizational impact of health reform, as health reform is mainly focused on billing and patient outcomes (Aarons et al., 2011). However, the researchers connect the importance of a healthy organizational climate to be successful with a systemwide behavioral health transition.

Steaban (2016) encouraged transformational leadership as a way to provide motivation and creativity during times of healthcare reform when significant change is occurring at the organizational level. Steaban (2016) posited that transactional leadership is needed to complete daily work activities, while transformational leadership empowers the workforce. The researchers also found that transformational leadership assists the workforce in understanding healthcare environment changes.

Herd, Adams-Pope, Bowers, and Sims (2016) conducted a qualitative study of leadership competencies among senior leaders experiencing healthcare reform. The reviewed learning organizations are adaptable to the changing healthcare environment. Thus, leadership also tends to model characteristics expected from a learning organization. Herd et al. (2016) posited that change leadership, self-development, talent development, and team leadership were characteristics highly endorsed by senior leaders when leading healthcare reform in an organization. Change leadership is preparing and supporting an organization and its workforce in being adaptable to a changing healthcare landscape. Self-development is a characteristic that describes a leader's need to continue learning and obtaining new skills. Talent development is ensuring an organization has a workforce with the skill set needed to implement change successfully. This may include

training current staff or bringing on staff skilled in a specific area to assist in healthcare reform. A CFO may receive training on how to bill multiple insurance companies or bring on a staff person experienced in billing multiple insurance companies. Team leadership is ensuring the organization has leaders at every level of operations and administration. Developing leadership skills across an agency can provide an increase in the sense of responsibility, collaboration, and buy-in from a workforce in the midst of a significant systems change (Herd et al., 2016). The researchers discussed the importance of these aforementioned leadership skills in sustaining an agency's operations and finances during times of change.

Anderson et al. (2015) explored 45 organizations across the United States with success in meeting at least one of the triple aim goals of healthcare in a managed care environment. The researchers discussed the importance of leadership throughout an organization, not just at the top level of executives when serving populations with complex healthcare needs in managed care settings. Anderson et al. (2015) posited an organization should empower its workforce and various departments to learn new systems and seek out training to become leaders in their roles of serving high-needs populations. This focus on leadership with effective program models work synergistically for optimum performance of an organization, per qualitative report (Anderson et al., 2015).

Summary of Literature

The literature review summarized the key findings of MMC and MMC transition-related studies. The findings revealed the need for healthcare reform and behavioral healthcare reform within the United States due to poor outcomes and high expenses. While MMC has shown some promising small preliminary results in decreasing healthcare expenditures, increasing access to care, and decreasing the use of emergency services, more studies and evidence are needed regarding the quality of services in MMC, especially for specialty populations, such as youth with serious mental illness and youth in foster care. The paucity of research on the impact of MMC could, in part, be due to the revision of MMC implementation within individual states for the past 2 decades. Because each state is given the ability to create an individualized MMC strategy, results across states can be conflicting, as MMC in one state may differ significantly than another.

Additionally, senior leaders' perspectives indicated MMC transitions imposed on healthcare organizations posed significant challenges for healthcare and behavioral healthcare providers. Significant challenges included changing timelines for MMC implementation, reimbursement rate changes, stakeholder changes, workforce challenges, and ultimately financial losses and instability. Organizations that exhibited leadership skills through a learning organization environment, coupled with effective leadership strategies, appeared to withstand the changes of the transition.

Sources of Evidence

Qualitative research requires multiple sources of evidence for credible and trustworthy studies (Ravitch & Carl, 2016). I sought and used several sources of evidence for the purposes of this case study to improve the rigor of this study. I conducted semistructured qualitative interviews of senior leaders as the primary source of data. I conducted interviews at the BHOPS. In qualitative case studies, naturalistic engagement or exploring a phenomenon in the environment in which it occurs is a crucial component (Rubin & Rubin, 2012). Interviews included questions focused on the senior leaders' experiences with the MMC transition and organizational change within the key factors of the Baldrige excellence framework: leadership, vision, strategy, clients, workforce, operations, results, and knowledge management (NIST, 2017). The following senior leaders were interviewed: CEO, CFO, CHRO, CCO, and two EVPs. Interviewing all senior leaders at the BHOPS allowed for various perspectives as well as obtainment of saturation of data and themes (see Mason, 2010; Saldaña, 2016). A full list of semistructured interview questions can be found in Appendix A.

I also used secondary data sources for evidence. Internal secondary data sources included internal agency manuals, policies and procedures, formal correspondence, formal memos, internal correspondence, manager's and leadership meeting minutes, the agency website, newsletters, financial statements, and internal shared network drives containing internal organizational charts, the Employee Handbook, the Administrative Manual, program directories, and the Corporate Compliance manual. These materials

were provided voluntarily by the BHOPS's CEO for data collection purposes. External secondary data sources included state manuals and presentations about the MMC transition and pretransition services, public census and demographic websites, public nonprofit annual tax filings (990s), news articles, and public press releases.

Triangulation, or the use of multiple sources of data to study a phenomenon, assists in improving quality of the case study. Primary and secondary data sources allowed experiences to be sought from multiple perspectives and multiple modalities of research (see Ravitch & Carl, 2016). Thus, the use of semistructured interviews and various forms of secondary data sources improved the credibility of the research methods and results.

Thorough data collection and analysis are imperative to understanding the BHOPS's performance in relation to the Baldrige excellence framework key factors and senior leaders' experiences. In the next subsection, I focus on the assessment of the BHOPS's leadership and strategy through the conceptual framework of the Baldrige Performance Excellence Program (NIST, 2017).

Leadership Strategy and Assessment

Leadership strategy is a key factor in understanding how the BHOPs maintains a competitive advantage in an ever-changing reform environment through the conceptual lens of the Baldrige excellence framework (NIST, 2017). BHOPS's senior leaders create an environment for success through their commitment to the vision, mission, effective communication, and ethical behavior, as evidenced below. The vision, mission, and

values of the BHOPS were established approximately fifteen years ago after the CEO's first few years at the agency. The CEO strongly believed the organization would benefit from having a clear vision and mission to share with the community to advance the interests of the individuals served. Prior to the CEO joining the BHOPS, most of the individual programs were delivered in a rural area, in a sense hiding individuals with disabilities from the public's eye, which used to be a common practice across the United States (see Semansky et al., 2012). The CEO viewed the vision and mission statements as a management tool to assist in strategic decision-making for the agency, per senior leader report. Along with the creation of the vision and mission statement, the CEO, with support from the BOD, moved the agency's headquarters to a nearby small city. This move was to increase the comfortability of the community with individuals with disabilities; to decrease stigma. Most importantly, individuals served were mainstreamed into the community. This goal was accomplished by partaking in community events, volunteering within the city, and visiting the local businesses. This information was gathered from two senior leaders' reports, as the history of the vision and mission is not in written format at the agency. It may benefit the workforce and the community to know more about the origination of the vision and mission and its impact throughout the organization.

The BHOPS's vision, mission, and core values are displayed throughout the agency and regional offices. Visibility and accessibility of the vision to employees, clients, community stakeholders, and partners is key to ensuring an agency is working

towards its vision (Bryson, 2018). The vision, mission, and values are integrated into practice not only through its visibility, but its role as fundraising, management, and strategy tools.

Senior Leader Communication

Effective communication is crucial for sustainable operations and effective leadership in an organization (Lussier & Achua, 2016). The senior leaders at this BHOPS, communicate with their workforce in various ways, informally and formally. They also meet with one another in a biweekly executive administration meeting called the *admin meeting*. All senior executives attend this meeting, which typically lasts from 1 hour to 3 hours depending on the topics discussed, per senior leader reports.

Senior leaders meet quarterly with all directors and managers to communicate how the agency's vision and mission are being met through updates and strategy plans on operations. These managers' meetings contain communication on new policies and procedures, reminders of agency practices, and key updates from various departments, such as the Quality Assurance and Finance Departments. Directors are given an opportunity to update the agency and senior leaders on their operations. Managers and supervisors are also given an opportunity to discuss any updates. The Executive Administrative Assistant sends out an email reminder of the meeting 2 weeks in advance and gives the opportunity to all supervisors through senior leaders to be added on to the agenda for a discussion time. All members of management are expected to attend the

managers' meetings in-person. This information was gathered from managers' meeting minutes and agendas.

Information disseminated in the managers' meetings is then passed along to frontline supervisors and the workforce through meetings and emails from the directors and managers who attended the managers' meeting, per review of this communication through internal emails, memos, and staff meeting minutes. Communication with supervisory staff and the workforce is maintained through internal emails, memos, and a weekly agency happenings email. The weekly agency email contains information on various topics, such as the process to nominate an employee of the quarter, new policies, and updates on agency events.

Senior leaders are known to keep their doors open to promote communication and comfortability among the workforce, per senior leader report. Senior leaders often interact with clients at the agency headquarters. Senior leaders of operations often visit regional offices and the agency's residential homes regularly to build relationships with staff and clients and monitor operations, per internal emails.

Senior leaders also convey information in the agency's semiannual newsletter. The newsletter is sent to all regional offices, community partners, board members, and service recipients. Staff or supervisors from each department of operations are encouraged to write newsletter articles highlighting the agency's efforts in meeting the BHOPS's mission and vision. This information was gathered from a review of the agency's newsletters.

General information about policies and procedures, agency updates, and agency events are delivered through agency internal email to all staff. All staff employed at the agency maintain an agency email account. All staff can access their email remotely through the BHOPS's payroll website. The payroll website also hosts many employee resources, such as the Employee Handbook, benefits information, agency updates, employee of the quarter winner information, and various forms used throughout employment.

Senior Leader Communication of the MMC Transition

Senior leaders have been reviewing the purpose, status, and preparedness activities since 2012, per managers' meeting minutes. However, a significant portion of the MMC transition did not go into effect until 2019 for most of the children's behavioral health services. Thus, the senior leaders have been challenged to maintain communication regarding upcoming MMC transition changes to leaders and the workforce. With several years of delays, the communication regarding changes remained consistent, but it is unclear how much information was retained by the organization's leaders and workforce due to the various changes and delays. Senior leaders tasked the director, managers, and supervisors of the Children's Services Department with keeping the workforce up to date regarding the MMC transition from an operations perspective.

Senior Leaders Commitment to Legal and Ethical Behavior

Senior leaders demonstrate their commitment to legal and ethical behavior, as evidenced by their support of the Quality Assurance (QA) department's activities to

monitor, assess, and investigate programs, incidents, and providers as a neutral and separate entity in the organization. The QA Department provides the checks and balances for the nonprofit agency's operations, Medicaid, and third-party billing. External auditors from state government entities are welcomed and garner the full cooperation of the agency as reviewed in the Administrative Manual and Corporate Compliance Manual.

External financial auditors complete a review of the agency's financial transactions on an annual basis. The agency's financial team's structure and functions were established with legal and ethical behavior in mind. Separate individuals operate the agency's payroll, accounts receivable, accounts payable, Medicaid/MCO billing, and contract billing. A financial director oversees the operations of the finance team and is physically located within their workspace, per the BHOPS's headquarters map, and the Administrative Manual.

Regardless of individual departments or systems within the agency, legal and ethical behavior need full commitment by each senior leader to sustain efficient and effective organizational performance (see Burns et al., 2020; Lussier & Achua, 2016). Senior leaders review agency happenings, incidents, policies, and strategic plans in a biweekly administrative senior leadership meeting, the admin meeting. The transparency within the senior leadership team is a key factor in ethical leadership (see Lussier & Achua, 2016).

As noted in internal audit finding emails, senior leaders show their support of the QA team by being courtesy copied into each program's individual quarterly Medicaid

audit or investigation, per review of internal emails regarding audits. Including senior leaders in this method of communication, allows senior leaders to maintain awareness of strengths and areas for improvement within each program in relation to compliance. Ensuring the audit results are distributed to the managers by the QA team with the senior leaders also copied into these emails displays to the manager these findings and audits are important to senior leaders and the agency.

Significant processes are in place to report the misconduct of staff, supervisors, or concerns with senior-level officials. These procedures are outlined in the Employee Handbook, as well as the Administrative Manual for supervisors. If a complaint was to arise about a senior-level official, the complainant would discuss this concern directly with the CEO. If a complainant wanted to express a grievance with the CEO, they would provide this information to the BOD through the CCO, who maintains a separate reporting line to the BOD. Having sound ethical policies in place for these situations is the first step in creating an ethical work environment. Furthermore, the evaluation of senior leaders within the agency and governance system is important to review in determining the agency's effectiveness through the lens of the Baldrige excellence framework (NIST, 2017).

Evaluation of Senior Leaders and the Board of Directors

The BHOPS evaluates senior leader performance on an annual basis. Senior leaders, apart from the CEO, participate in an annual performance evaluation with the CEO, conducted annually from the leader's hire date, thereby staggering evaluations

throughout the year, according to senior leader report. Performance evaluations focus on several key factors: job performance, quality of work, professionalism, and how the employee exemplifies the mission, vision, and values of the agency. These items are scored in a 14-statement, Likert-type scale with indicators of excellent, good, fair, and poor, per review of this document.

The second page of the evaluation allows for a narrative from the evaluator, goals for the next year, employee comments, and signature reviews, per performance evaluation documents. Before a performance evaluation is completed, a preperformance evaluation document is sent to the employee, providing an opportunity for the employee to highlight their accomplishments, areas for continued improvement, and their perspective on how they have exemplified the mission, vision, and values. The same performance evaluation is used for all employees, including senior leaders. This information was gathered from the Administrative Manual and confirmed with two senior leaders.

According to a senior leader, The BOD's executive committee reviews and delivers the CEO's performance evaluation on an annual basis. The first 3 months of every year, the CEO prepares goals for the agency, and ultimately goals for the CEO, for the upcoming year. Goals can vary in focus, from financial, to expansion of services, to satisfaction, or outcomes. The performance evaluation is reviewed with the CEO and the executive committee, which includes select members of the BOD. Goals are discussed and changed as needed during the review process. During the year, the CEO prepares

update reports regarding the specific goals to the executive committee and BOD. The following year, the CEO will be evaluated on the outcomes of the established goals. This information was gathered from, per senior leader report.

The BOD does not participate and is not subjected to evaluation, per senior leader reports. The BOD does not participate in any self-evaluation activities on an annual or recurring basis, according to senior leaders. The BHOPS does not have BOD term limits established, as term limits are absent from by-laws. Several board members have governed the BHOPS for more than 2 decades, per review of the BOD roster.

Anticipating MMC Transition Impact on Governance Structure

The MMC transition has required the BOD to be updated on a monthly basis regarding transition activities. Because the organization restructured the Children's Services Department in 2017 to meet the regulatory, structure, and governance needs of the transition, the BHOPS did not need to make additional changes to program level or leadership level structure. The BHOPS's leadership and workforce updated directories, phone lists, internal organizational charts, financial cost centers, website programs, and agency stationary at the time of transition. The collaboration and shared decision-making across programmatic and administrative lines were credited for this readiness activity, per internal memos and meeting minutes.

The BOD and leadership collaboration must ensure the organization is ready to continue with transition activities. Strategic foresight into an ever-changing regulatory and financial landscape requires the BOD and senior leadership team to focus on MMC

transition activities, which will meet the needs of the community and clients, per senior leader report. The BOD and leadership team must also learn to adapt to a VBP and outcome-based system, a newer concept for the BHOPS, but one that characterizes the current movement of healthcare reform in America (see Lown et al., 2016). The next subsection provides an overview of MMC regulatory changes, which could impact leadership and strategy throughout the BHOPS.

MMC Regulatory Changes

According to state regulations, state program manuals, and the state MMC transition website, the MMC consolidation of 1915c programs and expansion of services moved primary state oversight to the Health Department, while various state entities maintain secondary oversight, such as the state Mental Health Department and state Child and Family Services Department. At any given time, the BHOPS is following the service delivery requirements of up to seven state oversight entities. This may pose a challenge for program staff, leadership, compliance, finance, and administrative departments.

The MMC transition prompted additional contracting beyond traditional approvals to operate Medicaid programs. The BHOPS recently entered into formal contracts with seven out of eight MCOs in its service region, per review of these contracts. Each MCO requires compliance with its policies and procedures regarding service delivery notification, concurrent service authorizations, denials of services, billing standards, and utilization management, per state manuals (Markus & West, 2014).

The ever-changing regulations from multiple state agencies, rate variation, and compliance changes, may create challenges to the agency's ability to adapt and respond in a manner that sustains programming and financial health. Williamson et al. (2017) reviewed the importance of significant planning for MMC transition changes. When regulations are revised multiple times per month, it is difficult to adjust practices and make programming changes to the agency's EHR within required time frames, per senior leader report and internal emails. The organizational capacity for change status lies within the responsibility of the BHOPS's senior leaders to guide and support the agency through the changes, per senior leader report. Strategic planning is key to ensuring the MMC transition is sustainable for the BHOPS, as any major reform requires significant planning and strategy for effectiveness (see Bryson, 2018). The next subsections will review the BHOPS's agency-wide strategy assessment and how it may pertain to the MMC transition.

Senior Leadership Strategy Assessment

Strategic planning for a large nonprofit agency that serves over 2,000 individuals annually and employs over 700 staff is important for maintaining effective operations (see Bryson, 2018). Strategic planning is defined as an organization's informal or formal process for meeting the vision and mission through preparation and implementation (Bryson, 2018). Currently, the BHOPS does not have a formal strategic plan for the agency. Senior leaders from the BHOPS indicated formal agency-wide strategic planning is difficult and almost futile during state-mandated healthcare reform. Howrigon (2013)

discussed the difficulty healthcare providers face when trying to prepare for short-term goals of 1 year due to healthcare reform changes. However, Howrigon (2013) strongly posited the importance of strategic planning to address the ever-changing environment to achieve and maintain financial stability as a provider. Strategic planning allows for the specific allocation of resources and responsibility of tasks to accomplish goals and objectives to ultimately meet the organization's vision and mission. If strategic planning is completed, informally, clarity regarding tasks and responsibilities warrants further clarification.

Strategic planning for specific programs or departments is completed by the leaders within the specific department in collaboration with senior leaders through discussions, emails, and meetings. Strategic planning for specific programs or departments does not necessarily follow the hierarchical structure for decision-making. Decisions can be shared within a program or department or established by supervisors, managers, or the directors. The director and managers decide when a decision will be made by staff and leadership, or just within the program or department leadership. This information was gathered from senior leader reports, Manager's meeting minutes, and reviewed in internal emails.

Strategic plans are not effective if they will not be adequately reviewed and maintained as a working and active document and process (Bryson, 2018). The BHOPS decided to forgo formal strategic planning but maintains an informal fluid strategic planning process. In addition to the informal planning within and across programs and

departments, informal strategic planning within the senior leadership group takes place every other week during admin meetings attended by all senior leaders. At these meetings, discussion regarding internal and external factors that may impact the agency occurs, such as planning and implementing behavioral healthcare reform. Decisions are made through group discussion and group consensus, with the CEO having final say with regards to decision-making. Decisions made at admin meetings regarding operations can be implemented immediately. The Board of Directors is then updated on a monthly basis during the formal BOD meeting or through executive committee involvement. If a member of the BOD has questions or concerns regarding decisions made or preparation and implementation, they are discussed at the BOD meeting and resolved as a group. This information was gathered through senior leader interviews.

The BHOPS collects and analyzes data and information in various ways to be used in strategic planning. The BHOPS maintains financial reports for each program, department, and agency on a monthly basis, per review of these financial reports. These reports are provided to senior leadership, directors, and managers of each program. The leaders and supervisory staff review the financial information and make strategic decisions based on the financial status of each program, as reviewed in managers' meeting minutes and internal emails. The financial status of each program gives leaders and decision-makers an idea of how to allocate resources, identify how to close deficits, how to strategically use excess over revenue, and how to sustain programming, according to senior leader reports and managers' meeting minutes. Additionally, financial data is

used to make strategic decisions for innovation of services, technology, staffing, and training, as described in internal emails. For example, a new program may use an excess of revenue over a period of time to invest in increasing staffing or training for the program.

In addition to financial data, the BHOPS uses information, such as individual program outcome measurements and census reports, gathered from specific programs to make strategic decisions, as reviewed in staff meeting minutes. All of the supervisory staff and leadership have a responsibility to benchmark their services with other services in the community, region, and state, per leadership meeting minutes. This information is gathered by staff through attendance at provider meetings, phone calls with providers or state officials, and through training webinars and conferences. Information gathered regarding non-financial data is used in conjunction with financial data to create informal strategic plans with regards to service expansion or changes, according to internal memos, emails, managers' meeting minutes, and per senior leader reports. Information that is deemed pertinent is shared with all of the senior leaders during biweekly admin meetings, per senior leader reports.

According to senior leaders, the BHOPS values providing direct service provision to the community. The BHOPS limits the number of processes accomplished by external suppliers, as noted in internal emails and the Administrative Manual. When choosing the agency's EHR, it was important that the EHR s for the agency to develop most forms and reports without the assistance of the EHR company, per senior leader report. If the

BHOPS can provide a service or manage a process without costing more than the revenue obtained, the agency manages the process. In some situations, the agency contracts out for services beyond the scope of practice of the agency, such as translators or major construction at a residential group home, in which the process to do so is documented in the Administrative Manual. Maintaining most processes within the agency allows for fluid communication and collaboration without barriers of contracts and external communication, per senior leader report. The agency does not contract with any agency or consultant for strategic planning activities, according to senior leaders.

The BHOPS's key strategic goal is to sustain the agency through several managed care and regulatory transitions for the various populations it serves, per managers' meeting minutes. This is a broad goal, with discussed objectives of understanding managed care, VBPs, utilization management, and gaining proficiency in billing MCOs. Programs that are not involved in managed care focus on quality service provision, sustaining, and expanding programming. These goals and objectives have been ongoing for several years and align with the agency's vision and mission. Goals and objectives are balanced throughout the agency by tasking a majority of preparation and implementation of action plans to each department director and managers with confidence, according to senior leader reports. Directors and managers then create specific action plans for supervisors and staff to carry out. These action plans are delivered during staff meetings, documented in staff meeting minutes, and also documented in written plans depending on the scope of the goal or objective, per review of these documents. Delegating these

activities assists the agency in balancing several goals and objectives at the same time. The vision and mission are to ensure the agency is meeting the desired services in the community. Using the vision and mission statements as management and strategic planning tools assists in keeping the agency grounded to achieve its true purpose for operating, according to several senior leaders and managers' meeting minutes.

Four major key performance indicators measure success of action plans and operational strategic plans:

- Financial status and projections.
- Community and client satisfaction.
- Program quality outcomes.
- Compliance.

The financial outcome of the strategic action or initiative is important in assessing the sustainability of the initiative. Client satisfaction outcomes are a key source of feedback to existing and new programs (Linfield & Posavac, 2019). Likewise, feedback from stakeholders in the community provides a perspective of how the initiative was received from the community served. Individualized program quality measures are vital in understanding if the initiative is meeting its purpose, aligned with the vision and mission of the agency (see Bryson, 2018; Linfield & Posavac, 2019). Lastly, compliance with agency, local, state, and federal regulations are a key component in determining the effectiveness and efficiency of the program. This information was gathered from senior

leader reports, internal and external program audit reports, and managers' meeting minutes.

As reported in minutes from various levels of staff and leadership meetings, internal memos, and internal emails, the BHOPS demonstrates flexibility in adapting action plans to internal and external changes. Changes in action plans are communicated throughout the agency through internal emails, internal discussions, and throughout the staff, leadership, senior leadership, BOD, and managers' meetings. Changes are communicated as soon as information becomes available and has been reviewed by senior leaders and upper management. Transparency and communication continue to be essential factors during times of change. Communication does not follow a linear line from top to bottom of the hierarchy. Communication lines within the agency can best be described through a matrix model, where communication is delivered through various directions, paths, and is interconnected throughout the agency, per review of internal communication via emails, memos, and meeting minutes.

Strategic Planning for MMC

As documented in several studies, statewide MMC transitions have been challenging for private and public organizations (Hall et al., 2015; Stanhope et al., 2017; Williamson et al., 2017). Strategic planning for the MMC transition was reviewed on a regular basis in leadership meetings, admin meetings, BOD Meetings, managers' meetings, and staff meetings for approximately five years. Tasks to complete readiness activities were shared among the employees and leaders based on the details and

decision-making requirements of each task. For example, to decide which managed care organizations the BHOPS would contract with, recommendations of MCOs currently working with care coordination came from direct care staff, supervisors, managers, and directors to inform the decision-making process. Managed care contracts were then established by the children's services director, with assistance from senior leaders and the Finance Department.

A formal, yet brief, strategic plan of approximately five pages was created in the Children's Services Department as a requirement for an MMC readiness grant from the state. The grant monies were used to establish service with a billing company familiar with managed care. Strategic planning items mainly focused on organizational readiness for billing and utilization management. The strategic plan was in place for 6 months to assist in readiness. This plan was reviewed by the EVP of Operations for accuracy before being sent to the state for approval. The EVP of Operations reviewed the progress of the strategic plan with leadership in the Children's Services Department.

The BHOPS's leadership and strategy assessment included several forms of collaboration and communication internally throughout the agency. Next, a thorough assessment of the BHOPS's engagement, continuity of care strategies, and disengagement will be discussed through the conceptual framework of the Baldrige excellence framework (NIST, 2017). The review of clients and populations served concludes this section's review of the Baldrige excellence framework's key factors.

Additional key factors are discussed in Section 3, such as knowledge management, workforce, operations, and results.

Clients/Population Served

Satisfied clients and engaged stakeholders play a significant role in organizational effectiveness and strategic planning (Bryson, 2018). Thus, in preparation for the MMC transition, it is imperative the BHOPS understands the needs of clients throughout services in the agency. This section provides an in-depth view of how the BHOPS serves clients throughout various programs, with a focus on clients served by the Children's Services Department.

Client Engagement

The BHOPS enters into service delivery relationships with clients through various entry points to care. Additionally, relationships are built with community partners and service providers to develop additional access points to care for community members. Referrals for voluntary children's services are completed by service providers, care coordinators, community members, families, and self-referrals. Referral documents for each of the program's in the Children's Services Department are found on the BHOPS's website. Each program has its own webpage discussing the services provided, geographic locations served, purpose of the services, eligibility criteria, referral documents, and contact information for each program. Supervisory staff in the Children's Service Department are established members of multidisciplinary children's mental health

services committees in each of the 12 counties served to assist youth and families accessing services, per internal memos and meeting minutes.

County meetings vary on the frequency, duration, and scope of the meetings, depending on community needs. Larger counties are known to meet on a weekly basis, while other counties meet once or twice monthly. While attending these committee meetings is not required to receive services, families with high-needs, especially residential care needs (outside of foster care), must utilize this committee to access intensive residential services. Through this collaboration, supervisory staff provides training and assistance in referral processes to community partners as well as youth and families in efforts to impact social change in the service region, according to staff meeting minutes. BHOPS's supervisors participate on the committee regardless if a family is seeking services from the BHOPS or another human service agency. The BHOPS's supervisors provide feedback, insight, and support within these committees. This information was gathered from managers' meeting minutes, leadership meeting minutes, and staff meeting minutes.

In addition to the website and county committee meetings, the BHOPS maintains easy to read print publication brochures and flyers used to educate and engage youth, families, and referral sources., per review of these documents. Supervisory staff conduct presentations for community partners, service providers, and youth and families around the service region on a regular basis, as noted in leadership meeting minutes and review of print materials. From these various sources, supervisory staff within the department

gain an understanding of the need and demand for services. The information gathered assists in informing strategies to meet the needs of the community, which could result in increased staffing or focus on a specific geographical area, as discussed in leadership meeting minutes.

As reported in internal emails and TFC policies and procedures, the TFC program receives referrals directly from county social services departments in which the BHOPS contracts. The BHOPS is not able to board any individual without a formalized contract with the county. County social services workers complete referral forms or call with referral information directly to the TFC program. If an emergency placement is needed after hours, a 24/7 on-call system is in place to match youth to homes and to support foster parents, biological parents, and youth during times of crisis. The TFC program then reviews the referral information, and if the staff believes the youth would be an appropriate fit in a community-based placement, it matches the youth to a therapeutic foster home. This process can be completed as a planned admission or an emergency placement. Due to the emergency needs of the foster care population, all staff in the TFC program are trained in vetting referrals and matching youth to homes. Supervisory staff and the EVP of Operations are always involved in the decision-making process for TFC placement, as evidenced in internal emails and policies and procedures for the TFC program.

Determining Client Satisfaction and Ongoing Engagement

The BHOPS maintains a commitment to providing individualized and person-centered care, encompassed in the vision, mission, and values. In order to provide individualized care, it is vital the agency staff and leadership know how to listen to the needs and wants of their clients and have an action plan to meet said needs and wants (see Burns et al., 2020). Clients are centrally involved in the treatment planning process in all programs, when possible. Many programs complete treatment plans with clients present to ensure the workforce is capturing the needs and wants of the youth, family, or individual. Treatment planning is person-centered and strengths-based. Clients and their guardians, if applicable, sign each treatment plan as evidence of their participation, per review of these documents. This information was gathered from treatment planning policies and procedures.

In general, clients provide information regarding service delivery needs and desires when meeting with staff on a regular basis, per review of internal emails and staff meeting minutes. Each program provides clients with a client's rights policy and a grievance process policy, according to policies and procedures. Many programs also provide clients with a family service agreement form, laying out the communication and collaboration expectations staff and youth or families will maintain throughout the client is with the agency, whether the placement is a community-based or residential program, per admission form reviews.

In the TFC program, youth must complete a survey every 6 months with several questions addressing their sense of safety and wellbeing in the foster home. While safety and comfort are assessed per discussion on a weekly basis with youth with case coordinators, the 6 month survey is typically completed with the youth by a neutral staff person. This information was gathered from the TFC program's policies and procedures. Youth in foster care have significant histories of neglect, abuse, trauma, and complex trauma (Bright et al., 2018). Safety for this population is more than just meeting basic needs; it is ensuring the youth feels as safe and comfortable as possible in their given situation to limit the long-lasting effects of trauma and improve resiliency (see Bright et al., 2018). Foster parents are also surveyed, as well as biological families, and county foster care caseworkers. The information from these surveys is reviewed during TFC staff, and policy or procedure changes, or action plans are created with collaboration from the TFC team.

Other programs in the Children's Services Department also partake in 6 month client satisfaction surveys, in which youth and families are asked questions regarding satisfaction with providers and service delivery. The surveys also include a section for feedback on how to improve programming, per review of survey documents. Survey results for all programs, including client feedback gathered from individual meetings and services, are reviewed by supervisory and leadership staff. Feedback is reviewed with staff, and policy changes are made accordingly and swiftly, whenever possible, according to policies and procedures.

Determining how to engage clients and sustain relationships with clients and stakeholders is key for effective organizational performance (Brown, 2011). Furthermore, how an organization disengages or ends therapeutic relationships with clients can also be a factor when assessing organizational performance (NIST, 2017). Client disengagement and managing concerns from clients served by the BHOPS are reviewed in the next subsection.

Client Disengagement

According to programs' grievance processes and procedures, any concerns from clients regarding services or providers is to be reported to their supervisor. Supervisors then tend to the information provided by the client, which may be shared with a manager or director to review any need for change in policies, procedures, or staffing for the family, as reviewed in the grievance processes. Youth and families also use this same communication system to express gratitude to providers for quality services.

In a more formal format, many agency programs survey client satisfaction on a semiannual basis, per review of program policies and procedures in the Children's Services Department. Surveys often use Likert-type scales to gauge the satisfaction of youth and families as well as open-ended questions on the same document. Youth and families can remain anonymous or identify themselves if they would like further follow-up. Typically, the manager of the program or a compliance coordinator analyzes the survey data and creates a report on strengths and areas for improvement. This report is

reviewed with staff, supervisors, managers, and directors. State operations auditors regularly review the results of these surveys as part of the program's audit results.

Discharge criteria are discussed when a client is enrolled in a program of behavioral health, residential, or intellectual disability at the BHOPS, as reviewed in program discharge policies and procedures. The agency's behavioral health services are not meant to stay in place as a long-term solution. Short-term services anywhere from 3 to 9 months, is the goal for duration. Due to individuality in services, duration of services or lengths of stay varies based on the individuals' needs and desires, according to program manuals and the agency's website. When goals are reasonably attained, youth and families are successfully discharged.

Other times, families or youth may request services be transferred to another agency if they are dissatisfied with services at the BHOPS after attempts at resolution have been made, as reviewed in policies and procedures for grievances and transfers. Transfers from and to the BHOPS due to these reasons are rare but do occur on occasion, per program census reviews that document if a youth was transferred. The BHOPS's mission is to empower individuals, which also means respecting a family's right to choose a service provider. Whenever a client is discharged, regardless of the degree of success, programs provide a summary of active services for the family for continuity of care to occur, as reviewed in program policies and procedures. Additionally, the grievance process is reviewed with families during admission. Complaints concerning corporate compliance can be anonymously called into a compliance hotline, which is a

separate phone line only accessed by the CCO with a private passcode. The matter is then investigated by the CCO while maintaining anonymity and confidentiality of the individual with a concern. This information is found on the organization's website, visible to all clients.

Linfield and Posavac (2019) posited the importance of maintaining an openness of feedback from clients. Upon in-depth assessment of the BHOPS's engagement, provision of services, and disengagement with clients, it is important to explore how the BHOPS will continue to effectively collaborate with clients amidst significant changes. The next subsection reviews how the BHOPS may determine the needs of existing and new clients in the context of the MMC transition.

Determining Needs of Existing and New Clients for MMC Transition

The MMC transition exists to meet the triple aim health goals of improved health outcomes, increased client satisfaction, and decreased costs (see Davis et al., 2014; Lown et al., 2016; Wagner, 2014). In order to move towards value-based care, client outcomes and satisfaction need to be at the forefront of strategic planning for implementation of the MMC transition. The MMC transition includes an expansion of behavioral health services to all children receiving Medicaid, who meet eligibility criteria as established by the state. The goal of the federal Early Periodic Screening and Diagnostic Treatment policy, which is tied to this state's MMC transition, is to prevent the worsening or onset of behavioral health symptoms (Rosenbaum, 2017). The Children's Services Department is most experienced in serving children with serious

emotional disturbances, per the agency website. Expanding the eligibility criteria for services exposes a new client population the agency must engage.

Approximately 4 months prior to the primary activities of the MMC transition, the Children's Services Department conducted a 2 day action planning or mini-strategic planning meeting to discuss how to engage the newly eligible population of youth and families. The following information was gathered from the strategic planning meeting minutes. All staff in the department, approximately 130, were invited to attend. Each hour and a half of the meeting was dedicated to one county or region out of the 12 counties served. Actions stemming from this meeting included a list of over 200 community locations in which staff could inform the community of the new services through direct promotion and promotion to referral sources. Each county's SWOT analysis and community locations for marketing were transcribed into a written plan shared on the network drive, accessible by all staff. Employees were encouraged to update the plan with places or providers they had outreached, per review of meeting minutes and SWOT analyses.

Community providers, pediatrician offices, food pantries, schools, mental health clinics, county social services departments, and churches received information based on their preferences. For example, three pediatrician offices requested information regarding new services through email. Several schools invited supervisory staff to present at their staff meetings. Flyers and brochures were placed in community locations for visibility

from families. In four regional offices, presentations were made available to the public. This information was gathered from staff meeting minutes and internal emails.

Leadership, Strategy, and Clients Summary

The in-depth review of the BHOPS's approach to leadership, strategy, and client services, provides a foundation of information needed to inform the results and recommendations of this study. As aforementioned, the BHOPS values preparation and communication as tools to sustain effective programming and maintain services. Specific policies and procedures to protect legal and ethical standards, as well as embrace client feedback, appear to be important to the agency. A review of additional Baldrige excellence framework's key factors will be discussed in Section 3. Together, all key factors must work together to maintain and sustain an effective organization, similar to a systems approach (Brown, 2011; NIST, 2017). The next part of Section 2 will review the analytical strategy of the study to include the research process, participants, methods, reliability and validity.

Analytical Strategy

Overview

The research design for this study was a qualitative case study. Qualitative case studies allow researchers the ability to explore an event or phenomenon from a naturalistic perspective (Ravitch & Carl, 2016). Qualitative research is an iterative and recursive process, in which information continually informs the research process to enhance and enrich the research study (Merriam & Tisdell, 2016). A constructivist

context often underlies the iterative process of case studies, in which the participant's perspective and researcher's interpretation create the results (Denzin & Lincoln, 2013). In this section, I review in detail the research design, method, participants, data collection, procedures, and efforts I employed to ensure the study is credible and trustworthy.

Information gathered through primary and secondary sources of operational and archival data was used to assess the BHOPS in regard to each key factor of the Baldrige excellence framework. Information was analyzed through thematic coding and analysis, which allowed for the identification of themes and patterns across varying sources of data (see Ravitch & Carl, 2016). Themes and patterns from interviews were cross-referenced to themes and patterns from secondary sources. Finding similarities across multiple sources of data increases the credibility and trustworthiness of the study through a process called triangulation (Ravitch & Carl, 2016). Themes and patterns in the data assisted in identifying strengths and recommendations regarding the BHOPS's practice problem.

Role of the Researcher

Researchers in qualitative research have a unique role in the research process due to the iterative nature of the study and their relationship to and within the study. For this study, I assumed the researcher or scholar-consultant role; both terms are used synonymously in this subsection. The Behavioral Health Leadership program focuses on organizational consulting skills for the behavioral health field (Walden University, 2019). Thus, in this capstone project, I focused on a consulting perspective to identify a practice

problem within an organization through various assessment tools, gathering in-depth information regarding the practice problem, presenting findings, and offering recommendations to organizational leaders to increase the effectiveness of organizational performance (see Block, 2011; Brown, 2011). The scholar-consultant is also a qualitative researcher and must acknowledge and plan carefully around how his or her presence can impact research, known as reflexivity (Ravitch & Carl, 2016). The researcher is a part of the study and acknowledges subjectivity is possible due to human nature.

The unique role of the qualitative scholar-consultant researcher impacts each stage of the qualitative inquiry or study through *positionality* and *social location*, determining the effects of the researcher's relationship to the study through various contexts, including power, authority, gender, position, and bias. Transparency with the readers regarding these concepts in a qualitative study adds validity and trustworthiness to the research (Ravitch & Carl, 2016). Transparency allows the study's audience to gain insight into the context of the study from the researchers' perspective (Denzin & Lincoln, 2013).

The researcher is responsible for following qualitative research best practices in creation of the study design, methods, and how results will be identified and analyzed. It is essential for the researcher to conduct the study in an ethical manner, considering ethical safeguards throughout the iterative qualitative process. In the next subsection, I review the concept of researcher bias in relation to this study.

Researcher Bias

Potential researcher biases should be revealed in the study as a commitment to transparency and ethical research as well as to acknowledge the researcher's social location and positionality (Ravitch & Carl, 2016). I am an employee of the BHOPS in the role of a director. A director is not part of the senior leadership team, which consists solely of senior executives as reviewed in the organizational profile. I do not have a role in senior level decision-making, nor do I take part in admin meetings. The main focus of this study was the experiences of senior leaders, and I did not focus on the experiences of directors, supervisory staff, or the workforce. Minimal secondary data self-authored prior to the study topic being chosen were reviewed for information for the organizational assessment, such as program policies and procedures established before 2018. However, secondary data sources solely self-authored after the topic of the MMC transition was chosen for the doctoral study project were not used as evidence in this study. Secondary data sources authored by staff, supervisors, managers, administrators, secretaries, community providers, and stakeholders were used sufficiently. In order to avoid conflict or any appearance of coercion, due to the power and authority of my position, no employees in the department or supervisors or managers supervised directly by me participated in the interview portion of the study.

Due to my proximity to the MMC transition at the agency, consistent awareness of potential biases and assumptions was required. The knowledge of the MMC transition's preparation from a program operations standpoint served as an advantage in

gathering the study's background information, as pertinent documents were easy to locate. However, the experience of senior leaders was not known prior to the data collection process. The use of a personal research journal to document notes, thoughts, feelings, and observations about data collected was used to monitor biases and assumptions. A journal entry was not created every day but was used on days of data collection and used to document my experiences with the data on an ongoing basis. Self-reflection plays a significant role in limiting potential researcher bias impacts on the study (see Ravitch & Carl, 2016). I consistently asked myself the following questions when collecting any data:

1. What role did I play, if any, in the creation of this document?
2. What would be an alternative explanation for one point of view?
3. How do I know the evidence is accurate? How will I support the findings?

These questions assisted in self-reflection activities and the necessity to view data from the standpoint of a scholar-consultant and qualitative researcher.

Archival Data

As aforementioned, archival data, considered secondary data sources, provided a substantial amount of information for this study. Archival data included the following:

- Administrative Manual versions 2014 through 2019. All supervisory and senior leaders have access to this manual on the agency's shared network drive, containing policies and procedures for the departments of administration, finance,

human resources, information technology, transportation, training, and quality assurance.

- Employee Handbook versions 2014 through 2019 as made available to all employees at orientation and maintained on the agency's virtual payroll website.
- Corporate Compliance Manual maintained up to date by the QA Department and contains information regarding HIPAA, security, quality standards, and compliance requirements of the agency, state government entities, and federal government.
- Internal emails pertaining to the MMC transition or organization performance from 2014 through 2019.
- Internal memos from 2014 through 2019 pertaining to the MMC transition or organization performance.
- Managers' meeting minutes from 2014 through 2019. Recorded by the executive administrative assistant. All supervisory staff and senior leaders meet quarterly to review agency updates and strategic vision.
- Leadership meeting minutes from 2015 to 2019 documenting the preparation of the Children's Services Department for MMC.
- Staff meeting minutes from 2014 through 2019 from various programs, including TFC, care coordination, 1915c Waiver programs, and the expanded service programs through the MMC transition. These meeting minutes contained

information on program operations, strategic vision, trainings, and program updates as recorded by a department secretary.

- BHOPS's financial statements from 2016 through 2019 as maintained by the BHOPS's Finance Department.
- Children's Services Department's financial statements from 2016 through 2019 as maintained by the Finance Department for informational and strategic planning for the operations of programs within the department.
- Program census reports from 2014 through 2019, recorded by secretaries and supervisors to maintain accurate records of youth served.
- BOD meeting minutes from 2016 through 2019, recorded by the BOD's Secretary as required by the BHOPS's by-laws and governance.
- Job descriptions from 2014 through 2019, as maintained by the Human Resources Department required by state and federal law.
- Program specific policies and procedures from 2016 through 2019, as maintained by managers and supervisors, required by state regulations.
- Client satisfaction surveys from 2014 through 2019, as collected semiannually.
- Staff exit interviews from 2017 through 2019 for staff exiting the Children's Services Department, as maintained by the Human Resources Department.
- Quarterly and annual staff turnover reports from 2016 through 2019; composed by the Human Resources Department and sent to all managers and senior leaders at the BHOPS.

- Agency website, as maintained by the CPRO.
- State audit reports from 2014 through 2019 for the Children's Services Department, as required by state government entities.
- Federal audit reports from 2009 through 2019 for the agency.
- Internal Medicaid and quality documentation audits from 2014 through 2019, as completed by QA team, required by most state entities to maintain regular internal audits.
- Children's Services Department strategic planning meeting minutes from September 2018, as recorded by a department secretary.
- Training records and rosters, as maintained by individual programs and the Training Department.

Participants

The BHOPS's senior leadership team was individually asked to voluntarily participate in semistructured interviews for the purpose of exploring their experiences in relation to their role in the MMC transition. In total, seven senior leaders were asked to complete interviews. The following leaders were invited to be interviewed: CEO, CFO, CPRO, CHRO, CCO, and two EVPs. These senior leaders were chosen due to their proximity and involvement in organizational change, especially the agency's transition to MMC.

Purposeful Sampling

Qualitative researchers have the responsibility of choosing a sample of participants based on the nature, contextual framework, and phenomenon of the study. With dozens of purposeful sampling strategies to choose from, the participants requested to participate in this study stemmed from several sampling strategies. The purpose of this case study was to explore senior leaders' experiences with the MMC transition. Complete target population and key informant sampling strategies were used. Complete target population strategy includes all participants from a certain group, in this case all senior leaders involved in senior level decision-making were invited to take part in the study (see Ravitch & Carl, 2016). Additionally, all invited senior leaders played a significant role in the agency's strategy and decision-making, according to secondary data sources gathered in the beginning of the study; thus, these key informants were invited to share their experiences regarding the MMC transition. This sampling strategy was chosen to gain a comprehensive understanding of experiences at the senior leader level while also obtaining saturation, as discussed in the next paragraph.

The number of interview participants, known as a sample size, in qualitative case studies varies greatly depending on the setting of the research and the specificity of the phenomenon being studied (Mason, 2010; Rubin & Rubin, 2012). Best practices in qualitative research recommend a sample size large enough to reach saturation, in which topics have been fully explored and no substantial new information would be expected with more interviews (Ravitch & Carl, 2016). In total, seven senior leaders were asked to

participate in semi-structured interviews regarding the phenomenon of the MMC transition. These seven leaders attend biweekly admin meetings and participated in various aspects of the MMC transition, as reviewed in managers' meeting minutes. The seven leaders' roles vary, with three leaders directly connected to operations and four leaders connected to the MMC transition through various administrative departments including finance, public relations, human resources, and compliance. The BHOPS's most senior leader, the CEO, was interviewed regarding all aspects of the transition with a focus on operations.

Data Collection Instruments

Semistructured interview questions were created as the primary data collection instrument for senior leader interviews. The interview questions can be found in Appendix A. Additionally, interview guides were created to assist in the flow and consistency of questions and topics throughout interviews. The interview guide can be found in Appendix B. A new interview guide was used for each interview and hand-written notes were taken on the interview guide to document key information, follow-up questions, and clarifying statements. A personal research journal was maintained to keep notes when reviewing archival data.

Research Process

As previously mentioned, qualitative studies take on an inherent iterative process. Thus, it is critical for a qualitative research method and plan to support a recursive process. How and when various types of information are gathered can impact the

experience of the researcher; thus, it is critical to review the process for data collection for this study to support the rigor of the study as well as inform future studies with a similar case study design.

First, secondary data sources were used to answer the Baldrige excellence framework questions regarding the organizational profile and organizational assessment (NIST, 2017). Each Baldrige excellence framework question was connected to a secondary data source, such as archival Baldrige excellence framework questions regarding leadership structure prompted me to search for a written or visual document that discusses leadership structure, such as an internal organizational chart. A personal research journal was used to document notes regarding specific documents and to keep a running log of documents reviewed. Also included in the personal research journal were questions stemming from review of the documents or gaps in knowledge. Additional questions raised from review of the secondary data sources lead to a search for additional documentation or materials to find answers to gaps in knowledge or to gain a better understanding of the MMC transition and agency's performance. This cyclical process of information gathering is key to the qualitative process (see Ravitch & Carl, 2016).

The review of archival data in relation to the Baldrige excellence framework assisted in developing and finetuning the semistructured questions for senior leader interviews. The use of multiple sources of data in qualitative studies adds to the rigor and trustworthiness of the study (Ravitch & Carl, 2016). Information that conflicts with another source of information was given additional attention. Paying attention to

conflicting information and analyzing the possible meaning of conflicting information is a natural part of the iterative research process (Rubin & Rubin, 2012). It is vital to understand all information and experiences, not just shared experiences and patterns. Finding conflicting information lead to further inquiry and analysis.

Coding

Analysis of the data included coding and theme finding in the interviews through the use of NVivo® qualitative research software (QSR International, n.d.). The creation of codes marked the beginning phase of thematic analysis, as codes were later categorized, and then themes and patterns identified through the codes and categories (Saldaña, 2016). Codes, identified as nodes in the software, are concepts, words, or phrases that had similarities across interviews. In total, 64 codes were identified from senior leader interviews and pertinent secondary data.

Categories and Themes

Categories were created from identifying similarities in codes from the interviews. Codes such as *communication*, *listening*, and *sharing ideas* could be categorized as effective ways to communicate or collaborate. Categories were then analyzed to find common themes and ideas in the data, not just specific words, but concepts, actions, and philosophies (Saldaña, 2016). These themes informed the results section of the study and ,ultimately, my recommendations for the BHOPS. Data obtained through secondary resources pertinent to senior leader experiences were also coded, categorized, and themed through NVivo® qualitative software. The 64 identified codes

were paired down to 11 major categories. The 11 major categories led to the creation of four major themes of senior leader experiences. Additional pertinent findings were also considered results and are comprehensively discussed in Section 4.

Procedures

Semi-structured interview questions were formulated during the Prospectus phase of the doctoral study. The University's Institutional Review Board (IRB) gave approval for senior leader interviews and secondary data collection. Walden University's ethics approval number for this study is 03-07-19-0741056. Approximately 4 months were used to gather secondary data sources in preparation for the senior leader interviews. As secondary data was gathered and reviewed, original questions were modified, and one question added to fill gaps in knowledge related to senior leaders' experiences with the MMC transition in relation to the Baldrige excellence framework. The final interview questions can be found in Appendix A.

Next, an interview guide was created to establish the questions being asked in a naturalistic setting and to serve as a prompt for the researcher. The interview guide is listed in Appendix B. Informed consent, written and formatted by the University's IRB, was emailed to each leader separately with a prompt to respond with "I consent" if the senior leader was agreeable to be interviewed. All seven senior leaders replied with "I consent" to participate in the study. When consent was obtained, an email was sent to each participant requesting a time to interview within the next week in the respective leader's office. Naturalistic engagement is a key factor of credible and trustworthy

qualitative studies (Rubin & Rubin, 2012). Thus, it was important that interviews took place in a setting leaders are comfortable and completed their work on the transition, such as their office. All interviews were scheduled and completed within approximately seven to10 days of one another due to the regularly changing healthcare reform environment. The seven to 10 day-window was used to limit possible effects on the interviewees of changes within and external to the agency.

Interview preparation took several weeks. A digital voice recorder with high review ratings was purchased to ensure clarity of speech and tone were as accurate as possible. Transcription and qualitative analysis software were purchased through NVivo® qualitative software (QSR International, n.d.). I reviewed NVivo® training manuals, tip sheets, and videos to prepare for using the software correctly. I created a test coding file to practice coding, categorizing, and choosing themes.

I verbally practiced interview guides with the digital voice recorder several days before the interviews took place. The night before each interview, interview questions were sent through email to each senior leader to assist in their preparation for the interview, as listed in Appendix A. On the day of each interview, the digital recorder was tested. A backup smartphone application was used in case the recorder did not work.

All interviews took place with the use of the interview guides. A new interview guide was printed for each interview, and notes were taken on the guide. Interviewees, as written in the interview guide in Appendix B, were reminded of the voluntary nature of the interviews, the confidentiality and anonymity of the interview process, and that

recordings would not be shared with anyone in the agency. Follow-up and probing questions were used as needed to explore topics further. Reflection and summarization were used to ensure that information was clear (see Rubin & Rubin, 2012). Interviewees were thanked for their time and contribution.

I conducted all seven interviews. As reviewed in the Researcher Bias subsection, I am an employee at the agency. However, I am not part of the senior leadership team, nor a part of senior leader decision-making. Specific procedures were implemented to decrease researcher bias, such as consistently using interview guides that reminded the participants of my scholar-consultant's researcher's neutral role, along with role-neutral questions. As described below, additional qualitative best practices were utilized, including the use of qualitative coding software and member-checking to decrease researcher bias and increase credibility (see Merriam & Tisdell, 2016; Ravitch & Carl, 2016).

Recordings were uploaded to NVivo® transcription software on the same day as the interview. Transcription software chosen indicated a 90% accuracy rate, according to the NVivo® website (QSR International, n.d.). I reviewed all transcriptions to ensure written words correctly matched the audio recording. In total, I spent approximately 15 to 20 hours, ensuring transcriptions were accurate. Interviewees were asked to review their transcription for content corrections or to clarify statements through what is formally known as member-checking in the qualitative research field (see Merriam & Tisdell, 2016; Ravitch & Carl, 2016). As interviews are the primary data source, it was vital

discussions or statements accurately reflect the interviewees' experiences. All senior leaders were emailed their interview transcripts requesting the leaders review the transcript for accuracy of content and statements. There were no corrections requested from the interviewees.

Secondary data was obtained by gaining permission to review internal documentation for the purposes of this study through consent from the BHOPS's CEO, as documented in formal emails, the Organization Participation Agreement, and the Service Order Agreement, the latter two required documentation from Walden University. Once permission was granted, and IRB approval was obtained, secondary data was reviewed and analyzed after work hours. Notes were taken, and copies of information were highlighted with pertinent information. Public information was consumed through keyword internet searches of the agency's name. Documents pertaining to senior leader experiences or key MMC transition information was uploaded to the NVivo® qualitative software for coding and triangulation purposes.

Data Storage

I ensured the confidential recordings and documents were stored privately. The digital voice recorder's audio files were uploaded to a password protected personal MacBook, in which only I have access. The NVivo® site provides security through its website and a password protected account is used to protect information (QSR International, n.d.). When not in use, the digital recorder and interview guides with notes were stored in a safe at my residence. Secondary data sources, if containing business-

sensitive material, were also stored in the safe, if allowed to be taken off premises of the BHOPS. Secondary data containing any client information was not removed from the agency but reviewed within the parameters of the agency's privacy viewing policies. The recordings, documents, and transcripts will be securely stored according to Walden University's policies of approximately 5 years poststudy completion.

Ethical Research

I was responsible for the study to be carried out in an ethical manner to protect the credibility of qualitative research and to protect the participants and the organization. The research design, method, processes, and analysis were planned with qualitative ethical best practices as a primary framework. The BHOPS was presented with documents describing the qualitative case study process and the scholar-consultant model to be used. I also verbally discussed the study and process with the CEO on multiple occasions. Additionally, a Partner Organization Agreement and Service Order Agreement were reviewed and signed by the CEO and myself. These forms were submitted to the IRB, along with the study's application to collect data. The study and proposed design and data collection method received IRB approval before any data was collected. The IRB provided an Informed Consent letter which was required to be sent through email to each interview participant with instructions to reply to the email with "I consent." Interviews did not occur until informed consent was obtained in writing through email.

Special attention was given to ensure participants and their names, titles, and positions would be masked and kept confidential. Additionally, the BHOPS is de-

identified throughout the study, and the state, were masked. Job titles and the specific wording of the mission, vision, and values were altered to protect the identity of the participants and organization. These efforts were made to protect the confidentiality of the organization and the participants. Creating an environment of trust in a research setting is vital for gaining sensitive and comprehensive information.

Validity

Validity in qualitative studies is gained through the researcher's use of various qualitative best practices and ethical procedures. Several of these methods have been mentioned but will be reviewed in this subsection. Validity in qualitative research is also characterized as trustworthiness and rigor (Ravitch & Carl, 2016). Multiple data sources were used in this study, including internal and public archival data and interviews. The use of multiple data sources supported the validity method of triangulation, which aimed to find themes and patterns in multiple sources of data to add to the credibility of the study (see Ravitch & Carl, 2016). Member-checking was used to ensure that interview statements in transcripts were correct (see Merriam & Tisdell, 2016). The process for member-checking involved providing the interview participant with a copy of the full transcript for review of clarity and content. The interview participants were able to respond to ensure their statements were correct. I used structured reflexivity processes to review my possible impact on the study by using personal journal entries and self-reflection questions (see Ravitch & Carl, 2016). Thick description is another validity strategy used in this study, characterized by establishing thorough and comprehensive

descriptions of evidence to support findings, which is found in the organizational profile, in-depth organizational assessment, and is reviewed in the results sections. These strategies were woven throughout the research process to increase the validity and trustworthiness of this study.

Reliability

Reliability speaks to the ability to repeat the research methods and procedures and finding similar results. However, qualitative research is an iterative process that studies a phenomenon at a specific point in time with a specific sample population. Thus, finding the same results could negatively impact the credibility of the study, as human nature and situations change over time (Merriam & Tisdell, 2016). In this study, reliability is viewed from dependability of the findings through examining the methods and procedures for rigor and trustworthiness. Dependability was increased through the use of structured interview questions and protocols, the use of triangulation strategies, and through the thorough description of the research design methods, procedures, and analytic strategies, including coding and thematic analysis (see Ravitch & Carl, 2016; Saldaña, 2016).

Summary and Transition

The literature regarding this practice problem indicates that MMC transitions often pose significant challenges for BHOs. The goal of MMC is to decrease healthcare expenditures, improve client satisfaction, and improve quality outcomes. Current research is mixed on the degree to which MMC meets the triple aim goals of healthcare. However, the BHOs tasked with achieving the triple aim goals of healthcare face significant

challenges in transitioning from an FFS environment to an MMC environment. The literature suggests that organizations are more effective and prepared for these transitions when there is fundamental regard for leadership at all levels throughout a learning organization.

The information in this section provided a detailed overview of the foundation of the organization's vision, mission, leadership, strategy, and clients. The next section of this study provides a comprehensive review of how the organization supports its workforce, manages knowledge and outcomes, and sustains operations. In summation, these categories provide a full assessment of the organization's performance according to the Baldrige excellence framework (NIST, 2017). These key factors benefit from working in tandem through a systems approach to organizational management (Brown, 2011).

The review of the study's methods and analytical strategy section detailed the qualitative research process. Primary and secondary data were used to inform the findings from within the Baldrige excellence framework. Senior leaders' experiences regarding the practice problem were explored. Archival data were used to build a comprehensive assessment of the organization, as well as provide triangulation of data captured in senior leader interviews. Special attention was paid to researcher bias, reliability, and validity. The primary and secondary data discussed in this section informed the BHOPS's practice problem with information pertaining to the Baldrige excellence framework's key factors for organizational excellence, specifically leadership, operations, strategy, and workforce.

Section 3: Workforce, Operations, Measurement, Analysis, and Knowledge

Introduction

The BHOPS faced significant challenges as it prepared and implemented the MMC transition, as was consistently found in organizations around the country experiencing healthcare reform (see Hall et al., 2015; Stanhope et al., 2017; Williamson et al., 2017). The purpose of this study was to explore senior leaders' experiences with the MMC transition to better understand this phenomenon, identify areas of organizational strengths and areas of improvement for continuing healthcare reform implementation, and add to the small but growing research literature.

In Sections 1 and 2, I introduced the reader to the practice problem, the BHO, and the study's analytical strategy. Section 2 included a comprehensive assessment of the agency's leadership, strategy, and client engagement. Section 3 continues the analysis of the BHO through the lens of the Baldrige excellence framework, including a comprehensive analysis of the organization's workforce, operations, knowledge management, and results (NIST, 2017). Evidence for this assessment section was primarily collected from archival documents, public sources, and senior leader interviews. Archival documents included manuals, policies and procedures, the Employee Handbook, the Administrative Handbook, meeting minutes, internal memos, and internal emails. Public sources of data include the agency's website, press releases, and semiannual newsletters. I first review the BHOPS's workforce and operations assessment.

Workforce

Recruitment

The Administrative Manual outlines the responsibilities for recruiting and retaining staff, as discussed in the Recruitment and Retention subsections. Recruiting and retaining staff at the BHOPS is a responsibility of all leaders within the agency. Recruitment of staff is specific to each program in the agency and available positions within each program. Job position openings, either new positions or replacement positions, are approved by the manager, director, and an EVP. Then, the position request is sent to a human resources specialist for input into the available position system, posting on the BHOPS's website, and announcing the position internally to all staff in the agency through email, per the Administrative Manual. The BHOPS lists the job postings on free external sites. If the manager of the program would like to obtain a broader pool of candidates, the manager approves the purchase of a posting on a popular Internet employment site and on social media. Human resources staff and program supervisors and managers attend local job fairs as offered. However, the best method of recruitment is internal postings and external employment sites, according to senior leaders.

All sites are required to maintain a list of recent open positions. If a current employee is interested in an internal position in a different program, they may express internal interest to the Human Resources Department. If the internal employee meets qualifications and expresses interest within 7 days, the employee must be interviewed by the program. Though an interview is required, internal employees are not granted any

additional preference for a position. The most qualified candidate is chosen. Internal promotions within a program are allowed to be granted without posting the position.

Once prospective employees pass the interview process, their references and driver's license status are checked by a human resources specialist. Then, a formal offer is submitted by the manager and signed by a director. If a prospective employee accepts the position, they are established with a date and time to complete new hire paperwork, including setting up additional necessary background clearances, including but not limited to criminal history record checks, child abuse registry, and Medicaid exclusion lists, as listed in the Administrative Manual. Internal and external trainings required prior to service completion are established by the employee's supervisor. Often, the new employee shadows a similar position, reviews policies and procedures, training manuals, and case files, according to policies and procedures.

Retention

The BHOPS has various strategies for recruitment of staff, many of which are discussed in the organizational profile in Section 1 of this study. According to the Administrative Manual, a referral bonus is given to an employee who refers a newly hired employee. The internal employee recruiter receives a $100 bonus upon the recruited employee's hire and an additional $100 when the recruited employee meets their 6 month anniversary milestone with the agency.

Purdon (2018) reflected on the importance of benefits in retaining employees. Benefits, as reviewed in the organizational profile in Section 1, are comprehensive,

including medical, dental, vision, life, short-term, long-term, and supplemental insurance options. Health insurance options include a traditional comprehensive plan and a high-deductible plan to meet requirements of the Affordable Care Act (Furrow et al., 2018). A nationally known financial management company oversees the BHOPS's 401(k) program with several diverse options for employees to choose. The BHOPS matches employee contributions up to a certain percentage, based on years of employment, according to the Administrative Manual. Open enrollment for benefits occurs annually. Additionally, a supplemental insurance specialist provides in-person meetings for all employees in most regional offices to review insurance options, per review of a brochure of the agency's benefits offering.

Despite efforts to retain employees through benefit packages, competitive salaries, training, support, and appreciation events, the BHOPS is not immune to the epidemic of behavioral health and child welfare staff turnover. Exposure to vicarious trauma or direct exposure to trauma presents a risk to staff wellbeing (Lanham et al., 2012). The very nature of the positions in the Children's Service Department require consistent and fast responses to crisis situations, as indicated in program job descriptions. To decrease possible exposure to trauma, vicarious trauma, and burn-out, all staff in the Children's Services Department attend a trauma-informed care training within 6 months of hire, either internally or externally. Staff safety protocols are maintained by all programs in the Children's Services Department and reviewed on a quarterly or semiannually basis during staff meetings, per policies and procedures. Safety check-ins

when staff arrive home from providing services are in place, as noted in staff safety protocols. Safety planning before entering a family's home also takes place. In the TFC program, a safety plan is developed for a youth on the first day of their placement and is given to the foster parent. When an emergency placement is arranged, verbal safety planning takes place, according to TFC policies and procedures.

Staff are also supported through the BHOPS's contracted Employee Assistance Program (EAP). The EAP program is located near the BHOPS's headquarters. Recently, the EAP program has begun to offer telemental health counseling to staff in regional offices, per staff meeting minutes.

Preparing Staff for Change

Because the behavioral health field is experiencing such significant and frequent changes, it is imperative the workforce prepare for change (Stanhope et al., 2017). Training and communication are key components to preparing staff for change. Senior leaders provide support to directors, managers, and supervisors who in-turn implement strategies to prepare staff. According to internal memos and meeting minutes, during biweekly leadership meetings, leaders discuss upcoming changes to the behavioral healthcare landscape. At every staff meeting, staff are prepared through consistent discussion of upcoming changes that may impact their positions. Half-day trainings are also scheduled to prepare staff for changes. Additionally, one-on-one support from supervisors to staff is important in ensuring each individual employee is grasping evolving needs.

Managing Staff

Consistent support from supervisors through feedback, supervision, and training assists in the recruitment and high performance of staff (Brown, 2011). As documented in program policies and procedures, staff at the BHOPS receive regular supervision from their direct supervisor at least once monthly individually and once monthly in a group session. Many programs provide weekly supervision for newer staff and graduate staff to biweekly supervision once the employee and supervisor is comfortable and based on performance. Through supervision, additional one on one training occurs, if needed. Cases, work performance, praise, and areas for improvement are discussed in supervision.

Safety in the Workplace

Information in this subsection was gathered from the BHOPS's policies and procedures, the Administrative Manual, and senior leader reports. The BHOPS maintains secure facilities through staff safety procedures. Policies and procedures for staff safety are followed throughout the agency at all sites. Staff safety training includes blood borne pathogens, back safety, and workplace safety. A majority of all children's behavioral health services occur in the home and community. Additionally, staff in the Children's Services Department review safety measures for working with youth and families in the communities and family homes. Staff safety protocols are reviewed frequently in staff meetings throughout the department, per staff meeting minutes. Any injuries that occur while an employee is working are reported to a human resources specialist. The injured

employee completes an injury form, also called a workers' compensation injury form, regardless if the employee sought medical care. The form is then reviewed with the employee by the supervisor to determine a root cause of the injury and how it can be prevented in the future. These reports are then reviewed by the Human Resources Department and the BHOPS's internal Safety Committee. The Safety Committee meets once monthly to review that all safety-related incidents, such as workplace injuries and vehicle accidents, are handled in a similar manner to workplace injuries, according to the Administrative Manual.

The BHOPS's headquarters is equipped with an AED defibrillator. Many staff are trained in First Aid and CPR, which is a requirement for TFC staff. The agency employs several registered nurses, with at least two based out of the BHOPS's headquarters. The agency's headquarters and several regional offices are handicap accessible. If a building is not handicap accessible, first floor conference rooms or work space in an accessible building are available to use. The agency makes any necessary accommodations for staff to complete their job duties, per senior leader reports.

All staff must carry and show their badge to enter a facility. All visitors at the main headquarters and regional offices must sign-in to a visitor log and carry a visitor pass or guest badge, according to BHOPS's policies and procedures. At the headquarters, badges also serve as secure access to the building. Badge access is limited to mainly business hours, except for employees who may be working in the evening or weekends,

per the BHOPS's IT badge access guidelines. Intruder drills are practiced approximately annually at the headquarters, according to senior leader reports.

Workforce Engagement

Several factors prepare the high performing workforce. Training, matrix style communication, and a systems approach dedicated to the vision and mission are key factors (Brown, 2011). The BHOPS relies on clear and consistent communication within all levels of the agency. The agency does not particularly rely on top-down or bottom-up communication, but a combination of the two and communication vertically as well as horizontally, per review of internal communication consisting of emails, memos, meeting minutes, and senior leader reports.

Assessing Staff Engagement

The BHOPS does not have any formal assessments or activities which assess staff engagement throughout the agency, as indicated by senior leaders. However, supervisors and managers of programs are expected to regularly assess individual staff engagement through supervision, staff meetings, expression of concerns, or feedback related to policies and procedures or changes. There are no formal employee satisfaction surveys. Employees who have left the agency are given the opportunity to complete a written exit interview or have an in-person/phone exit interview, as reviewed in the Administrative Manual. The interview questions ask staff questions that are rated on a Likert-type scale in regards to management, support, ethical behavior, compliance, and general satisfaction with the agency. Open-ended questions are also used to allow staff to write a narrative,

per review of the survey. Exit interviews are reviewed by the CHRO and emailed to the CEO, director, and supervisor, or manager of the program. The CCO is copied into the email if any ethical or compliance concerns were noted. The content of the interview is then discussed through an email chain regarding next steps and how to improve programming if items were not already addressed before the employee left the agency. The exit interview process, written interviews, and email correspondence were used. Linfield and Posavac (2019) indicated that an agency may benefit from collecting employee engagement surveys.

Performance Management System

Performance management system information was gathered from the Administrative manual, review of supervision notes, staff meeting minutes, and senior leader reports. Performance management at the BHOPS includes a system of work performance assessment focused on boosting high performance among the workforce. Workforce performance is discussed and reviewed in one on one supervision, staff meetings, internal and external audits, managers' meetings, and admin meetings. The supervisor or manager of each program is responsible for the workforce performance for their respective program. However, the individual employee performance annual assessment contains the same measures of performance across the agency. Before an annual evaluation, an employee is sent a preperformance evaluation document to gather the employee's opinion on their work performance, concerns, feedback, and short-term and long-term goals. The information from this assessment is used to complete the

employee's performance evaluation by a supervisor. The performance evaluation contains a 14- statement, Likert-type scale of four levels, including *excellent*, *good, fair*, and *poor*. Questions focus on professionalism, job performance, compliance, and connection to the agency's mission, vision, and values. Programs use this assessment as an optional performance management tool at the end of a 90 day orientation period for all staff.

Learning and Development System

The BHOPS does not have a formal learning and development system focusing on one specific approach to learning, as reviewed in the Administrative Manual and monthly training calendars. The BHOPS invests in evidence-based practices for employees and supports the training department's continuous learning, according to policies and procedures. The BHOPS's internal training department maintains a monthly calendar of trainings offered to all staff and several trainings that are program-specific. Training plays a significant role in effective high performing systems and organizational environments (Brown, 2011). Most programs have a specific requisite of trainings needed for each position; however, staff is encouraged to seek out further training for serving a special population, per program manual reviews. For example, a service provider working with a child with autism for the first time can seek out an internal in-person training on autism in children or seek out an external or online training to increase skills. If the current budget does not support external trainings, supervisors ensure their staff has the skills necessary to work with new populations. Training can occur in an informal

manner in supervision and staff meetings or through the training department, as reviewed in the Administrative Manual.

Many of the programs within the agency require significant teamwork to provide effective services. For example, the TFC program's care coordinators participate in an on-call rotation to assist in after-hour emergencies and placements, cited in the program's policies and procedures. The TFC program staff supervise visitation, transport to medical appointments, and provide support to foster parents, as reviewed in job descriptions. Care coordinators must work and collaborate with one another to ensure their youth and families are supported regardless of the care coordinator responding to the emergency. The program manager maintains a general awareness of team dynamics and collaboration. On an annual basis, the program connects with the training department for team building activities, per staff meeting minutes.

Future Leaders in the Workforce

The BHOPS supports the development of its workforce through skill, degree, and leadership training and support. The BHOPS offers tuition reimbursement for staff seeking to further their education in a field that pertains to their job, as described in the workforce engagement subsection. The BHOPS provides a pay raise for employees who obtain their associate's, bachelor's, master's, and doctoral degrees while employed at the agency, according to the Administrative Manual. The BHOPS maintains openings in programs that vary in hours of operation, allowing employees to have the flexibility to further their education while continuing to stay employed at the agency. The BHOPS

provides internship opportunities for current employees in secondary education and local college students. Internships are offered for individuals completing secondary education. Interns must be at least 18 years of age, per the internship application.

The BHOPS has several committees to review safety, incidents, staff appreciation, employee of the quarter/year, quality assurance, human rights, and fundraising committees. Information for this subsection was gathered from the Administrative manual, program policies and procedures, and senior leader reports. Staff from various programs throughout the agency create the multidisciplinary membership on these committees. For example, two care coordinators from the Children's Services Department are members of the Employee of the Quarter Committee. Additionally, leadership is encouraged among the workforce and within teams. If a supervisory position opens in one of the programs, current staff are able to apply and use their leadership skill set to answer interview questions. If a direct care employee is chosen to be a supervisor, the supervisor is connected to external supervisory and leadership training within the first 6 months of hire in addition to the extensive supervisory training which occurs during one on one supervision. The Children's Services Department holds a training specifically on the topics of supervision and leadership on an annual basis.

In the small city of the headquarters, a county-wide leadership collaborative training course is offered through a partnership with the local community college, called the Leadership Academy. According to the Leadership Academy's syllabus, the course is approximately 5 to 9 months long and requires participants to attend classes twice

monthly to build leadership skills with a diverse population of leaders in the community. The class focuses on supervisory, leadership, and management skills. The class completes a final project to impact social change in the community, per the agency newsletter. Graduation from The Leadership Academy is attended by the supervisors of the attendees, as well as executives, including the CEO.

During regular supervision and annual performance evaluations, employees and their direct supervisors review future goals and plans, per review of these documents. Supervisory staff is generally supportive of the staff's future goals, which may include a lateral move or internal promotion. Depending on the employee's goals, supervisors may also support a position in another field or in a separate organization that is not related to the organization's service offerings, such as a desire to work in a correctional facility or hospital-setting. The aforementioned information provides a comprehensive overview of workforce development, learning, training, and assessment. The BHOPS's established protocols of engaging, retaining, and building the skills of the workforce provide a solid foundation to prepare the workforce for the ever-changing healthcare landscape. The following subsections review the workforce changes required by the MMC transition.

Workforce Changes Due to MMC

Williamson et al. (2017) posited that preparing for workforce changes due to an MMC statewide transition is imperative for continuity of care and sustainability of organizations. According to leadership and managers' meeting minutes, as well as senior leader reports, the BHOPS planned for workforce changes related to the MMC transition

for 5 years. There are several components of the MMC transition staffing changes that are currently implemented, and it is expected that additional changes will be made as the BHOPS moves closer to VBPs. The MMC transition impacted the organization's staffing pattern and organizational structure. In 2017, the organization created the Children's Services Department to prepare for the anticipated MMC, which entailed the merger of several children's programs while also expanding services to new populations simultaneously. Through this restructuring and merger, all positions were maintained and expanded, as noted in the internal memos, job descriptions, and staff meeting minutes from 2016 through 2019.

The MMC transition has required additional education and experience of service providers and supervisors, per state manuals. Despite raising experience requirements, rates for overall services decreased, as evidenced by state MMC transition manuals. These new requirements changed several core positions, including increasing caseload sizes, as discussed further in the Results section of this study.

Operations

Determining Service Needs

Determining programs and services an organization will establish plays a significant role in the organization's financial sustainability, performance, and reputation in the community (Linfield & Posavac, 2019; Zelman et al., 2014). The BHOPS determines key programs and services by assessing community needs with the value and mission statements at the forefront of decision-making, per senior leader reports. The

agency was established over 40 years ago and operated one program specific to adults with developmental disabilities. As the small program built a positive reputation in the community, additional programs or services were added to the agency's scope of practice and articles of incorporation based on stakeholder and community feedback. At times, state or county officials approached the BHOPS about potential contracting services, according to senior leaders. Most of the BHOPS's programs were initiated through a state application to provide specific services in a focused region of the state. The agency uses several factors to make decisions regarding adding services, including assessing community needs, relatedness to the vision and mission, fiscal sustainability, resources available to provide the service. Questions the BHOPS asks internal and external stakeholders or partners include the following:

1. Is there a community need for the service? What is the evidence of the community's need? Are there other agencies already providing the service?
2. Does the service fit within our vision and mission statements and agency purpose?
3. Is the reimbursement rate for services enough to sustain quality operations, including sustaining personnel and operating costs?
4. Are there qualified individuals in the community who can provide the service through the agency?

The BHOPS continually assesses future needs of programs and services through consistent communication with external stakeholders and partners, per internal emails,

managers' meeting minutes, and senior leader reports. Communication occurs through external committee meetings, informal and formal meetings with stakeholders. As the state's healthcare system evolves, key programs and services will also need to evolve, either based out of necessity for sustainability or through state mandates (see Anderson et al., 2015). The BHOPS prepares for program and service changes through extensive training and discussion of logistics of change throughout all levels in the agency, as evidenced in the meeting minutes of staff, leadership, and managers' meetings.

Program Design

Program design is the next step in strategizing new programs and services, which are often required for review in a request for proposal or program application (Linfield & Posavac, 2019). Program design procedures at the BHOPS are not documented in policies and procedures; thus the following information was gathered from senior leader reports and corresponding internal emails. The final decision to pursue the creation of a program lays with the CEO. When the BHOPS has decided to pursue a program application with the state or a local county, the BHOPS creates an informal program development team which is typically led by the director who will oversee the program in their department. The director is responsible for the application process and communicating application needs with other departments, such as the Finance Department. Once the application pieces are complete, the EVP and CEO review the application. Once internally approved, the application is sent to the local government unit or state. The BHOPS maintains many programs that are licensed, certified, or approved by state departments. Applying to

provide one of these programs requires significant planning before state governmental entity approval.

Applications typically require a full program description, policies and procedures, overview of the agency's history and background, staffing pattern, a summary of how resources will be allocated, and how the organization will comply with local, state, and federal regulations, per review of program applications through local and state sources. When applying to provide new services, the BHOPS is often required to send recent financial audits for the state to review the financial health of the organization, which aligns with federal guidelines from the CMS (Burns et al., 2020). Ensuring the program design includes work processes to meet standards of care requirements for each county, state, or federal entity is crucial for program approval and sustainability (Linfield & Posavac, 2019).

As recorded in job descriptions and from senior leader reports, the creation of policies and procedures and their implementation is the responsibility of the prospective manager of the new program. These policies and procedures should comply with legal regulations, as well as describe how the BHOPS will implement the requirements based on the agency's structure, resources, and governance. Once programming begins, policies and procedures are added based on needs and requirements. Policies and procedures are reviewed on an annual basis by each program's supervisory staff. Annual changes to policies and procedures are also presented to the QA Department for review, per the Administrative Manual.

Work Processes

The BHOPS ensures key processes of work requirements are met through various layers of management and leadership, as described in supervisory job descriptions. Each program has its own case record, and service provision requirements, reviewed in the programs' policies and procedures and corresponding state regulations. Ultimately, a program manager is responsible for the compliance of their program, per manager job descriptions. Supervisors and managers monitor work quality and processes on a continuous basis through case record reviews, supervision, staff meetings, and observations. In the Children's Services Department, regular supervision with staff is an important tool in ensuring work processes are followed. Supervision provides an opportunity for staff to review cases, challenges, positive experiences, and ask questions. Supervision provides an opportunity for supervisors and managers to provide feedback, praise, ask questions, and check-in with adherence to quality standards, per review of supervision notes.

According to various programs' staff meeting minutes, staff meetings provide information and reminders regarding work processes, changes in processes, and feedback regarding case record reviews. Most programs hold staff meetings every other week. Service providers attend staff meetings once a month due to the mobile nature of the job and difficulty in gathering all of the providers at one time. The TFC program holds staff meetings weekly to discuss cases, as this program maintains a 24/7 on-call system to

support youth, biological families, and foster parents, as reviewed in staff meeting minutes and policies and procedures.

Case record review frequency also varies based on each program, per program policies and procedures. Generally, case documentation is reviewed throughout the month and before end-of-the-month billing. TFC documentation is reviewed on a weekly basis, and formal case record reviews occur monthly. EHRs for care coordination and service provision increase the accessibility to monitor case records; thus supervisors often review case notes and billable notes through a review of electronic records. The QA Department assists with quarterly Medicaid audits as a neutral review of the agency's billable services. This information was gathered from Children's Services Department programs' policies and procedures.

Utilization management is measured and monitored by all three of these processes to monitor work efficiency. Supervisors and managers maintain the responsibility of ensuring all monthly face-to-face, and collateral contacts are met for each youth or family, per supervisory job descriptions. Electronic record systems allow for quick tracking of these requirements, per review of the EHRs. However, reviewing the quality of the interaction and progress of each youth and family takes a more in-depth review approach by supervisors, as indicated in supervision notes.

Improving Work Processes

Effective organizations have processes in place to gather feedback and implement improvements to work processes over time (Linfield & Posavac, 2019). Semiannual

client satisfaction surveys are completed in many programs throughout the agency, per review of these documents. Surveys request feedback regarding service provision, processes, relationships with providers, and overall comfortability with the agency, per review of client satisfaction surveys. Youth also participate in a client satisfaction survey of similar categories. In the Children's Services Department, staff meeting minutes and Youth Council meeting minutes indicate the TFC program holds a monthly Youth Council meeting, in which adolescents in foster care can advocate for internal policy changes. For example, one year, the Youth Council revised the Youth Rights policy to include youth-friendly language and added items important to the group, such as access to healthy meals to meet the cultural and religious needs of the youth, not just food and nourishment. These youth also participate in external advocacy groups.

Implementing client, parent, youth, and stakeholder feedback and suggestions when warranted and reasonable is crucial to operate effective programming (Linfield & Posavac, 2019). Such suggestions are typically reviewed in a staff meeting to gain feedback from staff. Suggestions are then discussed by the manager to the director for official procedure or policy changes, as reviewed in internal emails and leadership meeting minutes. In addition to client surveys, grievance processes are given to all families in the Children's Services Department. A formal process for expressing concerns and seeking resolution is important to sustaining relationships with clients and stakeholders, according to policies and procedures.

A majority of work process improvements stem from staff feedback. Staff feedback is gathered during staff meetings, regular supervision, committee meetings, and informal emails, per review of documentation of these meetings and emails. Whenever possible, improvements to work processes are made immediately and communicated to staff through email. If a significant process is going to change, the leader of the specific group will often discuss the change in a staff meeting and follow-up with an email. Changes suggested by supervisory staff are often discussed during biweekly leadership meetings in the Children's Services Department. This information was gathered from leadership meeting minutes and internal emails.

Several changes are simple to implement at the BHOPS, according to staff meeting minutes, leadership meeting minutes, and internal emails. There are times when suggestions for work process improvements require a significant effort and an innovative approach to a problem or new process. The next subsection will review the BHOPS's general approach to innovation in an ever-changing healthcare environment.

Innovation

Brown (2011) posited organizations are increasingly innovating to create growth or out of necessity to sustain services. The BHOPS changes and adapts as necessary, with mixed innovation efforts, per review of managers' meeting minutes, agency newsletters, and senior leader reports. Innovation can be difficult to assess without benchmarking to similar organizations (Brown, 2011; Linfield & Posavac, 2019). The BHOPS supports innovation by addressing needs in the community. Staying attuned to local and regional

needs, concerns, or gaps in services is key and evidenced in managers' meeting minutes. According to senior leaders, the BHOPS implemented an EHR over 5 years ago to meet the requirements of the HITECH Act (see Burns et al., 2020). The HITECH Act promotes integrated care through collaboration between electronic documentation databases (Burns et al., 2020). The BHOPS received funds through HITECH initiatives to move into an EHR, which was completed in 2014, per senior leader report. The BHOPS is an active participant in the implementation and ongoing revisions needed to the EHR, as reviewed in internal emails. Innovations at the agency can be evidenced through the use of new or improving technology, adapting to new service needs, and changes in the workforce.

Innovation and Operations for MMC

MMC will require the BHOPS to meet new requirements, regulations, and service needs while shifting to new state oversight agencies, stakeholders, and working with insurance companies instead of state-run Medicaid, as reviewed in state MMC transition guidance. As the agency moves from FFS to value-based care, the QA Department has prepared to shift its focus from documentation compliance to documentation and service quality, per senior leader report. The QA team has begun to use their evolving knowledge of quality in regular audits as well as assist in training new staff. Quickly adapting policies and processes as the MMC transition changes is a crucial activity for the BHOPS. The next subsection will review the BHOPS's process in ensuring the continuous effectiveness of operations.

Operational Effectiveness

Managing Costs

The BHOPS self-identifies as a fiscally conservative agency, per senior leader reports. Controlling costs is essential in sustaining effective services (Ott & Dicke, 2016). The information in this subsection regarding the agency's budget cycle was gathered from the Administrative manual, internal emails, internal memos, program budgets, and senior leader reports. To ensure the BHOPS's revenue is covering expenses, the director of each department creates a break-even budget annually in the Fall. The budgets are approved by the EVP. The director and EVP present each program budget to the CEO and CFO during an annual budget review meeting, per senior leader report. Once the budgets are approved, they are reviewed by the BOD's Finance Committee and overall by the BOD. The BHOPS is a nonprofit organization; however, it must ensure programs are not operating in a deficit. Some program contracts require break-even budgets and cost reporting, which entails unspent contract dollars or financial surpluses being returned to the local or state agency. Programs without a necessity for break-even budgets are budgeted with a small surplus over expenses to account for unforeseeable expenses throughout the year.

Cost management is everyone's responsibility at the agency, per senior leader reports and the Administrative Manual. Fiscally sound decisions are made regarding assets, personnel costs, and no personnel costs throughout the year by managers, directors, and senior leaders. Managers are responsible for their program budgets, per job

descriptions. Managers track service utilization to ensure enough services were provided to cover the expenses of the program, including personnel expenses.

Managing Suppliers

According to the Administrative Manual, all third party vendors are managed through contracts and business associate agreements that include HIPAA protections. Business Associate Agreements (BAAs) are created with other health-related agencies before HIPAA related information is passed between the two entities. These agreements discuss how data will be transmitted and protected from both entities. Additionally, releases of information must be consented to be a client or guardian to discuss health-related information with any other entity. All BAAs are reviewed by the CCO, as noted in agency policy.

Each program that works with a third-party vendor is responsible for managing the work provided by a vendor or supplier. If the supplier services the entire agency, the contract is typically overseen by the department the contract most relates to, according to internal emails. For example, the janitorial supplier is managed by the Department of Building Management.

Analysis of the Organization

Operating Environment Safety

Staff and client safety is paramount at the BHOPS, as evidenced by senior leader reports, the Administrative Manual, and internal training offerings. The BHOPS maintains safety standards that are required by regional, state, and federal laws, according

to program policies and procedures. The BHOPS carries all required insurances, such as liability, disability, workers compensation, auto, and residential insurance policies, per review of these documents. The requirements of some insurance policies also assist in dictating what safe operating environments must look like. For example, staff is not allowed to take youth to a trampoline park, as trampoline injuries are not covered under the BHOPS's insurance due to the high incidences of injuries with trampolines (see Kasmire, Rogers, & Sturm, 2016).

Office environments are kept free from clutter, garbage, and storage to maintain fire safety standards through several cleaning contracts for headquarters and regional offices. All hallways, rooms, and offices at the agency's headquarters are handicap accessible and ADA compliant. The BHOPS's residential facilities must follow all pertinent safety standards as well. All regional offices and residential sites are visited annually for a safety inspection by the CCO and the director of building management. Front and back doors are always locked in regional offices. Staff is provided with keys to enter buildings. Visitors must sign in and wear a badge. All staff is trained in the staff safety protocol for office safety. The BHOPS's headquarters are locked at all times, with security cameras focused on each entryway. This information was gathered from the Administrative Manual, visitor policies and procedures, and fire safety compliance emails.

All visitors must push a button at the front door to be let in. Visitors sign in and receive a visitor's badge. Visitors are not allowed to roam any offices to protect

confidential and business-sensitive information. Visitors must be accompanied by staff at all times. Staff who are terminated, whether they resigned or employment was ended, are required to turn in all agency materials, badges, keys, technology, and any information containing confidential materials, as outlined in the visitor policy and procedure. All staff completes a back safety, bloodborne pathogen, and OSHA training upon new hire, as noted in new hire paperwork requirements. There is an AED machine at agency headquarters, per senior leader report. Staff participate in workplace harassment training upon hire and on an annual basis, per an internal memo. Vehicle Safety and Use training is completed in a staff's orientation period. This training focuses on how to safely use the agency vehicles when transporting clients. A review of vehicle safety is completed annually by the Transportation Department. This information was gathered from the Administrative Manual and internal memos.

Emergency Preparation

In recent years, workforce security measures have increased due to the increase in workplace violence in the United States (Davis, Landon, & Brothers, 2015). The BHOPS's headquarters hold an intruder drill approximately once a year, per internal memo. Supervisors within the headquarters region have received formal workplace violence training from a professional. However, supervisors in regional offices may or may not have attended the trainings, per review of training attendance sheets.

The BHOPS maintains a phone list of emergency contacts in its shared network directory, per review of this document. All directors and several senior leaders are

available after business hours through agency cell phones. The agency maintains protocols for when directors and senior leaders need to be informed of an incident, whether regarding a client or an employee, also outlined on the emergency contact document. In the event of a weather-related emergency, the BHOPS prepares staff for weather-related driving through a winter safety tips sheet and staff safety protocols; both reviewed for this study. Throughout the BHOPS many employees are trained in First Aid/CPR due to their program requirements, indicated by job description and job titles. All programs must maintain a first aid kit, as well as all agency vehicles, per internal memos.

The TFC program maintains strict safety requirements to prepare for emergencies and natural disasters. The TFC program's preparedness for emergencies was reviewed through the TFC emergency preparedness, self-preservation, and youth safety policies and procedures. Each foster home is equipped with a natural disaster preparedness written plan. Upon admission, youth in care take a verbal and physical self-preservation test. Results are written on an assessment form and reviewed by the foster care coordinator. The self-preservation test assesses the youth's knowledge of fire safety. A fire drill is then completed on the initial placement day. Fire drills are completed monthly by foster parents with foster youth. These drills are typically unannounced, and the location of the imagined fire is different each time to ensure the youth is accustomed to using all exits available. The fire drill is timed to ensure the youth is able to get out of the home in a timely manner. A thorough safety inspection of the foster home is completed

by staff before the home can be a licensed foster home. Foster care coordinators complete a safety inspection each month, which includes: checking all smoke detectors, carbon monoxide detectors, and fire extinguishers. All medications, cleaning solutions, and tools must be locked or out of the reach of youth in care. Any items that are deficient must be immediately addressed by the foster parent, as reviewed in the policies and procedures.

Security of Information Systems

Protecting confidential and health-related information is a crucial component of operating an effective and compliant agency (Burns et al., 2020). Information regarding the security of information systems was gathered from the Administrative Manual, internal memos, and Information Technology (IT) Department staff. The BHOPS maintains security and cybersecurity of sensitive data and information through various techniques and modalities. According to IT Department staff, the best tool in keeping information safe is training staff on how to keep information secure. Upon hire, employees attend HIPAA and information security training at new hire orientation. Ongoing training, either in-person or via email, is provided by the IT Department as new threats are posed to the agency, as reviewed through internal emails.

Additionally, secure data servers, firewalls, password-protected computers and data systems, EHRs, and virtual privacy networks (VPNs) are used to protect the agency's sensitive information. Encryption of client sensitive information is used by agency staff when sending emails externally. The IT Department monitors the general safety of systems and email accounts on a continuous basis. Generally, most staff do not

have access to the agency's headquarters after business hours except for staff or supervisory employees with access badges. Decreasing the number of people allowed in the building assists in protecting sensitive information. Server and VPN rooms are always locked.

Measurement

A key factor in the Baldrige excellence framework is assessing how the organization manages knowledge and data through analysis and measurement techniques (NIST, 2017). If a healthcare organization manages knowledge and data effectively and uses this information to improve service delivery and program operations, it is believed the organization, as a system of interrelated processes, is performing in an effective manner (Burns et al., 2020). The next subsections will review performance measurement, analysis of data, and knowledge management. A closer look into the BHOPS's performance measurement systems regarding client outcomes, satisfaction, and healthcare costs will be addressed. From an overarching agency perspective, performance measurement of the agency in terms of satisfaction and nonprofit cost management will also be reviewed. Additional discussion will provide insight into how information and data are used to promote agency operations and how information and knowledge are built and maintained in the agency.

Performance Measurement

Program Performance Management

The BHOPS manages the performance of each program through ongoing leadership review and regular supervision among the governance structure, as reviewed in job descriptions and internal emails. Information for this subsection was gathered from the Administrative Manual, internal emails, internal memos, and senior leader reports. Ultimately, the performance measurement of programs is measured through three domains: client performance outcomes, program audit findings, and program financial status. As mentioned above, internal and external program audits provide the agency with knowledge of how the program is performing within specific regional, state, or federal standards. Areas for improvement noted by internal and external auditors are addressed through a plan of corrective action (POCA). A POCA is a document that contains key information regarding the area for improvement or deficiency. The manager of the program provides an explanation of the antecedents and causes of the finding. Also, the POCA addresses how a particular area will be improved to meet regulations and compliance in the future. If billing is adjusted due to the findings, the manager of the program attaches the billing adjustment form signed by the Finance Department to the POCA for transparency to the QA Department to evidence follow through.

Client Performance Measurement

The BHOPS does not have a single performance measurement tool used across the agency's wide-ranging programs, other than financial measurement, per review of

agency documentation and senior leader reports. Instead, each program follows program-specific performance measurement requirements, including regional, state, or federal requirements, per program policies and procedures and audit findings. Linfield and Posavac (2019) posited the importance of measuring client outcome performance when evaluating the effectiveness of the program or service.

Programs measure client performance in a variety of ways depending on the specific program, reviewed in policies and procedures of Children's Services Department programs. A common measurement of healthcare program is annual visits to the emergency room, hospital admissions, and re-admissions (Burns et al., 2020). However, in the Children's Services Department, state auditing entities do not focus heavily on this statistic during program site reviews, according to annual state auditing reports.

The BHOPS has several ways to measure client satisfaction, as discussed in various previous sections, on an ongoing basis. Client satisfaction surveys are provided to youth and families semiannually. Results of which are reviewed in staff meetings. Recommendations or areas of improvement are reviewed with staff and leadership to be incorporated into improved policy and procedures for each respective program. Clients are encouraged to provide feedback as often as possible through communication with their treatment team. Additionally, teenagers in the TFC program are the members of the agency's Youth Council, a youth in care-led group encouraged to voice opinions and solutions regarding policies and procedures. This information was gathered from program policies and procedures, leadership meeting minutes, and staff meeting minutes.

Financial Performance Management

Zelman et al. (2014) posited that healthcare organizations must achieve and maintain fiscal sustainability in an ever-changing healthcare environment. In order for a BHO to create fiscal viability, it must first ensure the delivery of services will cover associated costs, otherwise known as cost-benefit analysis (see Zelman et al., 2014). A cost-benefit analysis is used by the BHOPS when considering new program development, reassessing new program financial performance, and used as financial projections when rate trends are known in advance, per senior leader report and review of internal emails.

Each program creates an annual budget, prepared in September, presented in October, and implemented in January, the beginning of the BHOPS's fiscal year. The annual program and overall agency budgets are presented to the BOD in November, per senior leader report. Each month of operation, the manager, director, and senior operations leaders receive financial statements pertaining to programs they oversee. The financial statements provide monthly revenue and expenses compared to the monthly budgeted items, as well as a year to date revenue and expenses, per review of these documents. These reports assist leadership in understanding the financial health of their programs, as noted in managers' meeting minutes and internal emails. A common misconception of nonprofits is that they are not allowed or supposed to make any profit (Ott & Dicke, 2016). However, most nonprofit organizations must incur a surplus or break-even with costs and revenue numbers to remain financially solvent.

According to senior leader reports, managers' meeting minutes, financial statements, and internal emails, the BHOPS aims to have excess revenue over expenses, to some degree, to provide financial stability as the agency prepares for rises in costs of the workforce, resources, and infrastructure. When a program is not sustaining itself, managers and leadership review financial detail statements, program expenses, program census, and service utilization to gain insight into why the program is not able to break-even. Often, the agency is faced with this scenario when reimbursement rates for services are decreased.

MMC Changes to Performance Management

Pre-MMC transition, the Children's Services Department maintained a positive reputation at the regional and state level for quality services and compliance to regulations, per audit report review and emails. Within the past 5 years, two of the programs in the department had three state program audits with no areas of improvement noted, a rarity in the state, according to internal emails and state audit reports. Thus, the BHOPS maintains high expectations for performance from its programming.

Transitioning into a new environment with different regulations, billing procedures, billing stakeholders, and expectations pose a significant challenge for the BHOPS, as is the same for many healthcare agencies facing healthcare reform (see Burns et al., 2020; Lown et al., 2016). The challenges may be compounded by the delays in implementation dates set by the state and federal government. Stanhope et al. (2017) posited the importance of training agency staff on the various components of an MMC

transition. The BHOPS provided significant training regarding new regulations, performance expectations, and documentation changes to the workforce. However, delays in implementation coupled with last-minute changes to regulations posed a serious challenge for the agency, per senior leader report, review of correspondence from the state, and internal emails. State service and billing manuals were still in draft form as the beginning stages of the transition took place, per review of these manuals. Additionally, the drafts were revised multiple times throughout the first few months of implementation. These revisions caused ripple effects in EHR documentation design, billing algorithms, and rules and changes in typical service provision, according to internal emails, senior leader reports, staff and leadership meeting minutes.

In summary, the BHOPS measures performance through several various factors, including client, program, and financial outcomes. The MMC transition may pose significant changes to performance management expectations and challenges to meeting those expectations. The next subsection will focus on how the BHOPS manages its knowledge and information.

Knowledge and Information Management

Building Organizational Knowledge

The BHOPS creates organizational knowledge as each program is created, as programs evolve, and revised through program reviews and in response to events or incidents. Information for this subsection was found in the Administrative Manual, staff meeting minutes, and senior leader reports. Each program creates the foundation of

knowledge needed to operate a program based on local, state, and federal requirements, as reviewed in program policies and procedures. However, external regulations must be broad enough to be implemented in varying types and sizes of agencies. Thus, it is important to create procedures that are specific to the BHOPS's processes. When a new program is created, preliminary procedures are created and often revised within the first few weeks or months of the program's operations, per review of draft policies and procedures. Revisions are needed to address information gathered from putting the program in practice. Policies and procedures are reviewed on an annual basis by managers. Policy and procedure updates are communicated to staff during staff meetings. Policies and procedures are kept on the agency's shared network for staff to view on a continuous basis. Newly hired staff are required to read policies and procedures before providing services.

According to the Administrative Manual and review of internal training curriculums, and training schedules, the BHOPS builds staff's organizational knowledge through new hire training, training specific to the staff's program, and continuing education training. Mandated reporter training is offered for free by the state as web-based training. Staff is required to acquire knowledge regarding their role as a mandated reporter before providing services to children. To maintain a trauma-informed and person-centered approach to working with children and families, Therapeutic Crisis Intervention (TCI) is a training offered in the Children's Services Department, per review of the training curriculum. Staff in the TFC program must learn TCI within the first 6

months of hire, per policies and procedures. TCI training is an evidence-based approach to de-escalating crisis situations (Cornell University, n.d.). TFC staff recertify in TCI techniques every 6 months. This information was gathered from TFC's policies and procedures.

Use of Information and Knowledge

The BHOPS ensures the quality of organizational data and information through policies and procedures, secure infrastructure, and a trained workforce, reported by senior leaders. Linfield and Posavac (2019) posited the significance of maintaining quality data and information in effective organizations. Each program or service must follow the documentation requirements informed by local, state, or federal regulations.

The BHOPS uses performance measurement tools and reports, as mentioned above, to monitor the progress of clients and programs, as reviewed in program policies and procedures. This information is used internally to improve program processes, as reviewed in staff meeting minutes. If an area of improvement was noted during review of client information, the area for improvement is discussed with managers, supervisors, and staff through one on one supervision and staff meetings, per review of meeting minutes and supervision notes.

Access to Information and Knowledge

The BHOPS maintains a shared internal network that houses essential agency, department, and program information. Information for this subsection was gathered from the Administrative Manual, senior leader reports, IT Department staff reports, and review

of the shared network. Access to the shared network is granted to the workforce upon hire and as needed to be approved by a supervisor. Workforce granted access to the shared network are able to access agency forms, graphics, stationary, the Administrative Manual, and policies and procedures for each program. Each program in the Children's Services Department maintains several shared folders for each program. It is typical to have folders that vary in access by position type, according to a review of the shared drive. For example:

- The TFC shared folder allows full access for TFC staff and TFC leadership. It contains youth files and editable forms. Staff is responsible for maintaining the information for the youth on their caseload.
- The TFC Forms shared folder allows read-only access for TFC staff and full editing access to TFC leadership and secretaries working within TFC. Information on this drive includes foster parent contact information, billing forms, youth census lists, referral logs, policies and procedures, and program-specific forms not to be edited. Leadership and secretaries are responsible for maintaining the information in this folder. Staff may email a supervisor or secretary if a form needs to be updated.
- The TFC management shared folder allows full access to TFC leadership. TFC Staff and TFC secretaries are not able to view this folder. This folder contains information specific to management, such as staff training trackers

and program financial information. Leadership is responsible for maintaining this folder.

The shared network folders are in use alongside the many EHR systems used by the agency. The agency maintains its own EHR, which has been in place for over 5 years. The EHR primarily houses client information. Billable and non-billable progress notes, assessments, treatment plans, medical, educational, and service provider information are captured for children's behavioral health programs. Residential programs use the EHR for documentation and tracking purposes, such as medication administration. The EHR has customizable reports staff, supervisors, and clerical and quality assurance staff may create on a regular basis to track due dates, signatures, quantity of service provision, and billable documentation, per review of EHR functionalities.

The care coordination program utilizes two EHRs as required by the medical health home the agency subcontracts with, as reviewed in state regulations. The TFC program utilizes the state's required child welfare EHR, which allows the TFC program and the local departments of social services to read each other's notes and happenings, per review of this record system.

Before the MMC transition, care coordinators and service providers worked within the same EHR or in the same youth shared folders, as reviewed in staff meeting minutes. However, the MMC transition further siloed these two entities, and there is no longer viewable access from the other silo, also reviewed in staff meeting minutes. This

may pose a significant challenge for the programs impacted by the MMC transition, as the access and knowledge to a specific client and family is now limited.

Building Organizational Knowledge for the MMC Transition

The MMC transition, when completed, is expected to change the entirety of services in the Children's Services Department, per senior leader report. The agency is preparing to build a knowledge base of new regulations and requirements by carefully reviewing all transition materials, draft manuals, proposed regulations, and emails from the state, per review of internal emails, planning documents, senior leader reports, and leadership meeting minutes. At the time of the initial MMC transition, state program and billing manuals were still in draft form, as noted during this study's data collection period. Additionally, manuals and regulations were interpreted as vague, according to internal emails. The lack of concrete information has created an obstacle for staff and leadership, attempting to build knowledge and information to effectively implement the MMC transition, per senior leader report, staff meeting minutes, and internal emails.

Continual changes in regulations can impact service provision long after the MMC transition was implemented, as the staff needed to take time to learn new documentation requirements, new regulations, and a new EHR or system requirements, documented in leadership meeting minutes. Ultimately, care coordinators and service providers could spend less time in the field providing services because they need to learn and relearn continual changes, as reviewed in internal emails.

Protection of Electronic Data

Information in this subsection regarding the protection of electronic data was gathered from the Administrative Manual, IT Department staff, internal emails, and memos. The BHOPS maintains a high-powered firewall system. Server systems are updated consistently to ward off cyber threats, according to IT Department staff. The BHOPS maintains a back-up server system and generators to protect information. In the case of a power outage, the agency is able to protect all data which was saved prior to the power outage. Power outages are rare for the agency. All computers and laptops outside of the agency, in regional offices or operating in a mobile setting, all website links are disabled. The user must copy the hyperlink and paste it into an internet search engine, per review of this feature. This additional step reminds users to slow down and review the credibility of the site. Some websites may be disabled on agency computers, such as streaming services. Agency computers and laptops prohibit the use of flash drives. Inserting a flash drive will lock the computer and prompt notification to the IT Department. If information needs to be transferred to an external source, such as state auditors, an encrypted flash drive is created by the IT Department and sent securely to the external source. Verification of the information was received is required.

In the case of a cybersecurity threat, the IT Department is continually monitoring for possible threats, which typically present themselves in a phishing scam through email, as noted in internal emails. The IT Department conducts significant training on cybersecurity and the risk of involvement in phishing scams. The consequences of which

could provide a hacker with full access to the agency's shared network and HER, if passwords were gained. The IT Department reports that the best protection from cybersecurity comes from trained and vigilant staff. Staff is trained in orientation the importance and regulation of locking their computer or laptop when leaving their desk. IT Department and QA Department staff often spot check areas for compliance with this policy. Supervisory staff is tasked with ensuring this policy is followed consistently, as reviewed in leadership meeting minutes.

When an employee is terminated or leaves the agency, supervisors inform the IT and HR departments to discuss termination of shared drive and building access. All agency cell phones, laptops or tablets, and keys or badges must be returned at the time to termination, per the employee termination form and policy and procedures. This policy, in part, assists in keeping the agency's data safe. For staff who have access to EHRs outside of the agency, supervisors are required to end access to those systems upon the employee's departure. Guest policies in place in the Children's Services Department prohibit any guest from accessing, viewing, or having the opportunity to access client and business-sensitive information, per review of this policy and procedure. Guests are required to sign in to the agency and wear a guest badge. Staff accompanying guests ensure guests do not have access to confidential information, as indicated in the guest policy and procedure.

Protection of Material Information

The BHOPS has various methodologies in place to protect material information. The agency has three types of material information to be protected: client sensitive information, business-sensitive information, and intellectual property, as indicated in the Administrative Manual and internal correspondence from the IT and QA Department. Client sensitive material information is defined as any physical material, such as paper, with identifying information or treatment-related information. Identity theft is a common threat that could impact healthcare agencies (Burns et al., 2020). When people typically hear the term identity theft, they think of electronic data. However, physical data can be in danger, as well. Agency staff must be extremely cautious in protecting the information of clients for reasons of identity theft, fraud, HIPAA compliance, and to generally protect the client's privacy, as indicated in the Administrative Manual and Corporate Compliance Manual.

The building and regional offices remain locked 24/7. The BHOPS's headquarters maintain security cameras to the three access points of the building. Guests entering any building of the BHOPS are required to sign in, wear a guest badge, and remain with agency staff for the duration of their visit. For example, if an interview occurred on the second floor of the agency's headquarters, the interviewer is expected to bring the interviewee back to the front desk to ensure the guest has left the building. This information was gathered from the Administrative Manual, internal memos, and staff meeting minutes.

Client files. Client files are stored in various forms of locked cabinets, as indicated in staff meeting minutes. When a client is maintained in an EHR, a paper client file is also made to hold original signatures on documentation, per review of these files. In the TFC program, per staff meeting minutes, client files hold court hearing documentation, medication administration forms from foster parents and signed safety plans. Staff responsible for those specific cases maintain access for their files. Shared client files are stored in a shared locked cabinet. If a staff person leaves their desk to take a short break, they must lock their files in their cabinets, per internal memos and new hire security training. Staff who work in a mobile environment maintain little to no physical paperwork, with a majority of information access through the EHRs and shared network.

Files of former clients, referred to as "closed files" are stored in locked facilities or rooms. Closed files are stored as long as required by each specific program's regulations, many of which must comply with Medicaid. Files pertaining to youth in foster care programs must be maintained for 30 years, per state regulations. Once a closed file reaches its end date, the file is purged and shredded, per internal emails. Typically, files are purged and shredded with a HIPAA compliant shredding company twice a year. The CCO maintains a list of all closed files and their shred dates. This information was gathered from internal emails, senior leader reports, program policies and procedures, and staff meeting minutes

Business-sensitive materials. Materials that are business-sensitive include information with agency-specific data, as noted in internal memos. These materials

include financial statements and reports, census reports, agency reports, and internal memos. Most of the business-sensitive information is maintained with managers, directors, the Finance Department, and senior leadership. Business sensitive information is stored in locked cabinets within locked offices, as reviewed in internal emails and memos.

Intellectual property. The BHOPS maintains a trove of policies and procedures and forms were created within the agency, evidenced by a review of this documentation. In general, policies and procedures and forms stay within the agency. Agency created forms cannot be shared with other agencies without permission from the CEO. The BHOPS's policies and procedures and forms align with the agency's vision, mission, and values. These documents are considered unique to the BHO. This information was gathered from internal correspondence and senior leader reports.

Summary and Transition

The BHOPS's workforce, clients, operations, performance, and knowledge management were comprehensively reviewed in Section 3 in relation to the MMC transition. The BHOPS maintains policies and work processes to maintain organizational effectiveness, per review of this archival data and from senior leader reports. The BHOPS relies heavily on training and policies and procedures implemented by the workforce to maintain effective operations. Safety at the BHOPS is implemented through safety measures for clients, staff, infrastructure, and equipment. Performance measurement is unique to each program in the agency, while financial sustainability is a universal

performance outcome for the agency. The BHOPS maintains an internal EHR and interfaces with several state EHRs to maintain knowledge and information. The BHOPS has processes in place to protect electronic and material data.

Despite the BHOPS's robust policies and processes to maintain effective and efficient programming, the ever-changing MMC transition implementation at the BHOPS faces current and future challenges common in healthcare reform (see Stanhope et al., 2017; Williamson et al., 2017). Understanding these processes will assist the organization in transitioning services to MMC and inform Section 4 and 5 of this study. Section 4 will review the results of the qualitative case study, which include themes and patterns in senior leaders' experiences with the MMC transition regarding the MMC impact on the delivery of services, clients, workforce, leadership, mission, results, strategy, and knowledge and performance management.

Section 4: Results - Analysis, Implications, and Preparations of Findings

Introduction

Previous sections of this study laid the foundational knowledge of the BHOPS and the qualitative methods used to conduct this case study. The results of these experiences are conceptualized with the Baldrige excellence framework key factors, including leadership, vision, workforce, clients, results, strategy, and knowledge management. In this section, I review the analysis, results, and implications of the BHOPS's senior leaders' experiences with the MMC transition. Findings and themes absent from or aligned with scholarly literature are discussed throughout this section. The strengths and limitations of the study are also discussed in this section.

Analysis, Themes, and Results

I discuss the analysis, themes, and results of this study in this subsection. Healthcare reform can impose significant implementation challenges for health serving organizations. The BHOPS's senior leaders were interviewed in the midst of the MMC transition, which provided the scholar-consultant with the unique opportunity to understand this organizational change while it was occurring. Senior leader interviews (*N* = 7) provided the primary source of evidence. Other sources of data included archival resources, public data, and scholarly research literature. All seven senior leaders employed at the BHOPS participated in interviews for this study. All senior leaders, except one, had worked at the agency between 16 and 31 years at the time of the interviews, with one senior leader newly joining the executive team 2 years prior to this

study. NVivo® qualitative software was used to analyze the data and create themes from the senior leaders' interviews as well as secondary data sources. In total, seven senior leaders participated in this study. Each participant's identity and position was masked for ethical research purposes. Moreover, anonymity and confidentiality were ensured to build trust in the qualitative interview environment, which is vital in capturing experiences of people (see Rubin & Rubin, 2012). Participants were alphabetically labeled as Participant A through Participant G. The alphabetical identifiers were randomly selected and did not correspond with any leader's title or name.

Findings and major themes from the data and findings are discussed through the Baldrige excellence framework categories. Findings may relate to one specific area in the organization or a few senior leaders' experiences and could be considered as subthemes. Themes were viewed as overarching topics, which were discussed by a majority of senior leaders (over 50%), found in secondary data sources, and had far-reaching implications for the Children's Services Department and the entire agency (see Ravitch & Carl, 2016). Together, findings and themes assist in identifying recommendations for the senior leaders at the BHOPS to be discussed in Section 5: Recommendations and Conclusions.

Healthcare Delivery and Process Results

The MMC transition resulted in significant changes to health services delivery provided by the BHOPS. The expansion of state plan services, merging 1915c waiver programs, and moving care coordination to a distinct service were the major transitions during the time of this study. The BHOPS followed all state-mandated transition

guidelines, transitioning clients, and programs during their prescribed implementation period. Service expansion at the BHOPS was effective on the first date of implementation, with core staff members in place. This finding aligned with the agency's values of compliance, creativity, and quality, as evidenced in the BHOPS's vision, mission, and values. Participant E described the agency's commitment to quality of service provision: "If it's an FFS program or if it's a managed care program, the vision still remains the same … getting the best quality service that we can absolutely provide."

Senior leader participants were asked to identify the internal and external challenges the agency faced in implementing the service delivery changes required by the MMC transition. All senior leader participants discussed external challenges that, in their perspective, caused or exacerbated internal challenges. Participant E stated, "It was hard for us to basically show them [the workforce] what the end road is going to look like when the end road keeps changing." Additionally, senior leaders discussed internal challenges within the agency they believed impacted preparedness for service delivery. Many of the internal and external challenges identified connect to key factors of the Baldrige excellence framework (see NIST, 2017) described in later sections. The findings were clear across all senior leaders: These external and internal challenges impacted service delivery; thus, these challenges are discussed in the healthcare delivery results.

External challenges and impacted internal challenges are reviewed in Table 3. These challenges are reviewed in-depth in each associated subsection. It is important to note that my findings are consistent with findings in the literature. Organizations

experiencing MMC transitions indicated challenges implementing widespread changes to healthcare delivery (Bao et al., 2013; Semansky et al., 2012; Williamson et al., 2017). The most significant external challenges noted corresponded to state delays, regulation changes, and uncertainty of effects. Participant E stated, “One of the challenges we have is basically trying to keep up with all regulations and rules that seem to be changing every day.”

Table 3

Senior Leaders' Identified Internal Challenges Impacted by External Challenges

External challenges	Senior leaders identifying challenge	Internal challenges
State delays in MMC implementation.	100%	• Difficult preparing for moving target dates. • Resistance to change. • Uncertainty of when to hire staff. • Inability to fulfill marketing plans. • Internal preparation mainly in operations departments.
Uncertainty of finalized state regulations and requirements.	100%	• Difficult to create policies and procedures. • Difficulty in preparing staff and clients. • Innovation with uncertainty. • Delayed marketing plans.
Moving from FFS to MMC rate environment; reimbursement rate cuts.	71%	• Fiscal sustainability challenges. • Budget challenges. • Preparing for infrastructure needs. • Implementing services in rural communities with extensive staff travel required.
Human service field workforce shortage.	71%	• Shortage of qualified staff for service expansion. • Difficulty retaining staff.
MCOs inexperience with children's behavioral health.	57%	• Reimbursement delays. • BHOPS' efforts to educate MCOs.

Note. $N = 7$. Information gathered from seven senior leader interviews coded with NVivo® qualitative software.

State Transition Context

Communication from state governmental entities to senior leaders across the state were reviewed, and findings are reported in this subsection for context to the MMC transition discussion. State officials had planned the MMC transition for children's behavioral health services for many years through an MMC transition state workgroup, which met at least monthly and communicated frequently to stakeholders. The state's adult behavioral health population moved into MMC before the children's population; thus, the state was aware of challenges experienced with the adult behavioral health population. Delays and changes in regulations or processes resulted were often attributed to changes in the applications requested by the federal government, federal government administration changes, state electronic system unreadiness, MCO systems and infrastructure unreadiness, and delays in readiness with organizations across the state. The state contracted with MMC consultants who assisted with MMC transitions in other states to increase preparedness, according to training webinars and technical assistance from the consultants. The state maintained a public transition website page that contained years worth of webinars, written guidance, memos, manuals, and technical assistance to assist BHOs in preparing for and implementing the MMC transition, in which this information was gathered.

Theme 1: Preparation

A major theme found throughout data sources of interviews and archival data was the BHOPS senior leaders' commitment to widespread and far-reaching preparation for

the MMC transition. The BHOPS spent years planning for the MMC transition, which aligned with its vision and mission for the agency to be responsive to the community's needs, as viewed on the agency's website. A significant amount of agency preparation to combat internal and external challenges of the MMC transition was a theme from all seven senior leader interviews. The senior leaders described the BHOPS as proactive, prepared, and engaged in trainings to prepare behavioral healthcare delivery changes. Participant C indicated, "The organization, in general, has planned very well in getting out ahead of the game and anticipating some of the things that were going to be happening."

The agency's proactive nature was also evidenced in a multitude of secondary data sources, including meeting minutes ranging from staff meetings to board meetings, internal memos, and internal training materials. This finding aligns with the literature review, as Stanhope et al. (2017) posited the importance of training and preparation for agency-wide MMC transitions. Holtrop et al. (2016) also discussed the importance of workforce competency training for the effective implementation of care management services. While all senior leaders believed the agency was prepared to implement the delivery of services, two senior leaders indicated a desire to have additional training specific to how their department would be impacted by the MMC transition. Participant F noted, "I think the internal challenge that I did discover the most was there wasn't enough communication to all the departments that may or could be affected by managed care." These internal and external factors are further discussed in the next subsections.

Service Delivery Changes

Service delivery was impacted as the MMC transition changed, merged, and expanded various services as reviewed in this study's organizational profile. Face-to-face visit requirements with youth decreased in frequency and duration for care coordination services as reviewed in Table 4. Additionally, service providers experienced a significant limitation on the duration of each service (see Table 4). While a majority of youth did not receive 4 consecutive hours of skill-building services, high-risk youth who required substantial service provision were no longer able to receive the same duration of service. There is no clear data to indicate the decrease in service provision negatively impacted youth served. However, staff supervision notes and staff meeting minutes indicated significant concerns from families and providers. Staff and service providers across the state indicated concern that an increase in youth psychiatric hospitalizations could be possible in the near future, according to BHO comments in state webinars and BHOPS's staff meeting and leadership meeting minutes. At the time of this study's data collection period, data was not conclusive regarding any significant increases in hospitalization rates among pretransition youth because this data point was not collected. Table 4 describes the changes to youth contact requirements for three of the most utilized services.

Table 4

MMC Transition Changes to Service Frequency or Duration

Service	Pre-transition service/contact requirement	Post-transition service/contact requirement
Care coordination	Two 15 to 45 minute face-to-face youth visits per month, including several collateral contacts.	One face-to-face youth visit per month, one collateral contact. No duration requirement.
Skill building	Up to 4 hours of service provision in 1 day.	No more than 2 hours of service provision in 1 day.
Crisis avoidance in-home services	Up to 4 hours of service provision in 1 day.	No more than 90 minutes of service provision in 1 day.

Note. Information gathered from the states' pretransition and posttransition program and billing manuals.

Several aspects of the children's behavioral health redesign were viewed as positive additions to the children's service array. Expanded eligibility, the ability for families to self-refer, and in-home counseling were popular with stakeholders, clients, and service providers, according to the program and management meeting minutes, review of active referral sources, and internal correspondence. However, these positive aspects were overshadowed in archival data and senior leader interviews by the challenges the agency was experiencing and the possible impact on clients, as reviewed in the next subsection.

Client Results

Senior leader interviews did not lead to an abundance of information regarding clients, as most senior leaders are not directly involved in client engagement. Four senior leaders could not comment directly regarding client matters, which is outside of their direct job responsibilities. However, almost all senior leaders reported the agency's commitment to preparedness was provided to the workforce tasked with preparing clients and the community. Although two senior leaders indicated the MMC transition for clients should have been seamless, the MMC transition resulted in several changes to service delivery for current and active clients. Because the MMC transition split several programs into siloed services, instead of one integrated treatment plan, clients now had to participate in anywhere from one to seven separate treatment planning processes, according to staff meeting minutes. The MMC transition regulations changed the BHOPS's crisis services available to families, moving from behavioral health crisis de-escalation to coordination of crisis situations. Behavioral health crisis support was absorbed by each county's crisis intervention supports, per state officials. Families informed the agency this was a significant loss for them, as reviewed in client satisfaction surveys anticipating MMC changes. It is important to note at the time of this study's data collection period client satisfaction surveys did not capture posttransition client feedback.

The BHOPS's workforce ensured families had access to crisis support outside of the BHOPS, per review of safety plans. Additionally, service delivery to high-risk youth decreased due to the significant reduction of the duration of services that could be

provided to a youth in 1 day, per state billing manuals, and described in Table 4. For example, if a youth received 3 hours of Skill Building per session, the MMC transition reduced the maximum daily allowance to 2 hours of services. While the transition was meant to be seamless for clients, multiple data sources indicate it was not seamless. Senior leaders indicated a concern with MCOs lacking experience with children with serious emotional disturbances, developmental disabilities, medical fragility, and youth in foster care. Previously, the healthcare of this population was overseen by state Medicaid in an FFS environment. Senior leaders indicated concern of possible gaps in services and denial of services if any of the seven MCOs the BHOPS contracts with do not fully understand the client's needs. This information was found to be aligned with the current literature, as Hall et al. (2014) and Huffman et al. (2010) described the impacts of MMC transitions on children with special needs, including unintentional service gaps and service delivery changes.

Marketing and communication were the most significant strategies senior leaders attributed to clients being prepared for the transition. Senior leaders were confident staff prepared clients and their families for the transition, although state transition delays and regulation changes increased the number of times families had to be updated on transition activities, according to senior leaders and internal memos. State marketing materials were customized for the agency and printed within 48 hours of the state releasing finalized expansion of services brochures, per senior leader report. Additionally, the BHOPS made proactive changes necessary to the agency website to detail the newly expanded and

reformed services. Referral documents were uploaded to each program's web page. The website changes were effective on the day of each service change or expansion. The BHOPS invested in search engine support to assist possible clients or referral sources in finding the agency's redesigned children's services, per senior leader report.

The BHOPS supervisors, managers, and director travelled to various agencies, service providers, and community resources throughout the service region to promote the expansion of services pretransition and posttransition, per senior leader report and internal emails. Promotional meetings of the new state plan services included discussion of in-home counseling, intensive treatment and support services, and skill-building services, as well as how providers and families can access services.

Senior leaders attributed the agency’s proactive marketing and promotional activities as a key factor in the expansion of services to the community. Because the BHOPS was one of the only designated agencies ready to accept referrals for the new state plan services on the first day of the expansion, combined with the numerous promotional meetings, the agency experienced a higher referral rate than previously expected, per review of the referral tracker compared to previous estimates of services. Over 250 referrals were made in the first 6 months of service expansion, approximately 150 more referrals than originally expected per senior leader reports and the state plan service referral tracker. Despite accepting referrals, the BHOPS was not able to serve all referred youth due to not having enough service providers in the first 6 months of the transition, as further discussed in the Workforce Results section.

Workforce Results

As reviewed in the organizational assessment, the BHOPS employs approximately 700 individuals, according to senior leaders. Staff is engaged through orientation training, appreciation events, and various methods of communication. As evidenced in policies and procedures, senior leader reports, and review of documents listed below. Communication from senior leaders to directors and managers to employees occurs through methods including

- One-to-one supervision
- Group supervision
- 24/7 phone or in-person support
- Virtual meetings
- Staff meetings
- Emails
- Weekly newsletters
- Internal memos
- Payroll portal agency updates
- BHOPS website

Staffing plans are individualized for each program at the BHOPS, as reviewed in program policies and procedures. In the Children's Services Department, there are two main categories of staff functions: service providers and care coordinators, as reviewed in Table 2. Job descriptions for these two positions clarify that service providers deliver

rehabilitative and habilitative services to youth and families. Care coordinators manage the holistic wellbeing of the youth, ensuring the youth is connected to medical and mental health care as well as addressing the social needs of youth and families. A team of supervisors and managers oversee operations of the four main posttransition programs: care coordination, state plan amendment services, 1915c children's waiver array, and TFC. To understand senior leaders' experiences in changes to the agency's workforce, it is crucial to understand how the MMC transition changed workforce roles, responsibilities, and staffing structures, as discussed below.

Workforce Changes Due to MMC Transition

Care coordinator and service provider qualifications changed posttransition, as described in Table 5. It is important to note, skill-building, the most utilized pretransition service, went from being able to be provided by an entry-level employee to an employee with a high school diploma plus 3 years of experience working with children with special needs. Finding staff with 3 years of experience of working with children with special needs proved to be challenging for the BHOPS, according to staff meeting minutes and senior leader reports. This change impacted continuity of care for children and decreased the talent pool from which the BHOPS could hire employees, per senior leader report and staff meeting minutes. The MMC transition also had an impact on the workforce's background clearance process due to state oversight changes, according to state transition memorandums. Almost 100 staff required duplicative child abuse clearances and criminal history record checks, according to internal documents. This resulted in approximately

$10,000 of additional cost for the agency, not factoring in the worktime used to set up all clearances and employees' time at fingerprint appointments.

Table 5

Staff Qualification Changes Pre- and Post- MMC Transition

Position	Pre-MMC transition minimum requirements	Post-MMC transition minimum requirements
Care coordinator	Bachelor's degree with 4 years of coordination experience.	Bachelor's degree with 2 years of experience with children with special needs.
Service provider-state plan amendment services	High school diploma to Bachelor's degree with 2 years of experience.	High school diploma plus 3 years of experience to Bachelor's degree with 2 years of experience with children with special needs.
Licensed Counselor- state plan amendment services	Not applicable. Position did not exist pretransition.	Licensed mental health professional.
Service provider- 1915c children's waiver services	High school diploma to Bachelor's plus 2 years of experience	Same.

Note. Information gathered from pre and post transition BHOPS's job descriptions.

The MMC transition impacted caseload sizes for care coordinators and service providers. Care coordinators moved from caseload sizes of six youth to 10 youth increased to 12 to 18 youth, per new state care coordination staff to youth ratio requirements. Fulltime service provider caseloads increased from approximately 12 youth to 18 youth to accommodate MMC limitations on the amount of services a child can receive in 1 day. These changes required the department to work collaboratively with senior leaders to restructure workloads and support staff, per internal emails and senior

leader reports. For example, an MMC transition committee was established for service providers to meet and discuss the challenges of the new service limitations. The product of these meetings assisted in creating new utilization requirements and secured additional technology for the service provider workforce to become fully mobile, according to internal emails and meeting minutes.

Three supervisors were no longer approved to manage posttransition services previously under their purview due to a lack of professional licensure, even though the services were not considered clinical in nature, as the services were not required to be delivered by licensed professionals, per state requirements. The BHOPS hired clinical supervisors to oversee these three specific services, two of which were preexisting (non-clinical) and one new service, in-home counseling, which was considered clinical work. Ultimately, new positions were added to meet the required regulations, as well as the communities' need for expanded services.

Theme 2: Senior Leader Experiences With Workforce Changes

During interviews, senior leaders frequently discussed the necessity for staff buy-in for the MMC transition through training, support, transparency, and preparation. The operations workforce was kept informed of the purpose of the transition, implementation delays, and service delivery regulation changes through operations supervisors, managers, directors, and senior leaders. Holtrop et al. (2016) posited the importance of care coordinators obtaining training on core competencies needed to effectively

implement care coordination. Senior leaders attributed these efforts and transparency as a key factor in preparing the workforce for the MMC transition. Participant D stated,

> We brought in the staff who were directly affected by the change and made them part of the process and gave them ownership of it. When it [MMC transition] rolled out, staff already understood it. They bought into it, and you do that by giving them ownership.

Prior to the transition, the BHOPS did not have an internal clinical team; thus the agency hired licensed clinical supervisors and licensed counselors. Because the MMC transition had been delayed several times with short notice, the agency waited until 3 months prior to the MMC transition to post the clinical team employment opportunities, as it was uncertain if the MMC transition would be implemented on the date indicated, per review of internal emails and senior leader reports. On day one of the transition, the BHOPS was ready to provide services, but 75% of the clinical team had not started employment yet. In the meantime, internal staff with mental health professional licensure provided necessary supervision to the workforce and necessary clinical assessments to referred clients, according to senior leaders and internal emails. Participant D indicated,

> I would have liked us to bring the [clinical] staff on sooner. I know there were fears of 'Is it [MMC transition] really going to happen?' We could have hired the clinical staff to be ready on day one, not ready to go 3 weeks after the transition.

All senior leaders reported difficulty in recruiting and retaining qualified staff for posttransition service implementation. Senior leaders attributed this difficulty to a human service workforce shortage in the state, as well as the increased restrictive qualifications for staff, claims also supported through internal correspondence. Senior leaders indicated staffing shortages negatively impacted the BHOPS's MMC implementation efforts, as the agency was unable to meet the high demand for services within the community, despite initially increasing the workforce. Participant C stated "It doesn't matter what else you have, but you can't run programs without the right staff." Senior leaders discussed the difficulty in hiring a clinical team in a rural area. Participant G indicated,

> It is always difficult to find good qualified people in a community that is saturated already as far as employment goes. I think that one of our other struggles is trying to keep staff positions filled while also finding a qualified staff person to fill a very specific role that the program needs.

To address a high demand for services, matched with a decrease in reimbursement rates, the BHOPS looked to alternative staffing structures as a possible solution. The agency studied whether full-time or per diem positions would best suit the needs of the MMC transition and the BHOPS's need for sustaining financially. While benefit costs can be saved with a per diem workforce, senior leaders indicated instability in the per diem workforce. Per diem staff often did not rely on a position at the BHOPS as their sole source of financial income or occupational responsibility, with a majority of per diem staff in secondary education or holding a full-time job outside of the agency, per review

of per diem staff resumes. Thus, the BHOPS implemented a staffing structure with approximately 25% full-time positions and 75% per diem positions. The limitations of daily service caps posed significant challenges for full-time staff, who now had to work 6 days a week to maintain their utilization productivity requirements. This information was gathered from senior leader interviews and internal emails. Participant D stated,

> Another challenge that we didn't foresee is that maybe per diem [staff] is the way we have to go to survive. Unfortunately, maintaining per diem staff is even harder than full-time staff. It's hard to get a per diem employee to work 5 hours a week because they have another job. Some per diem staff have three other jobs. Their schedule doesn't always fit the hours that we need, which becomes a real problem.

Hiring, paying for background clearances, and training per diem staff takes significant time and money. Also, there is a risk of a per diem employee finding other employment before the BHOPS's position starts. The high rate of turnover of per diem staff decreases the BHOPS's return on investment in employing per diem staff, according to senior leaders.

Another workforce finding was the absence of workforce satisfaction surveys. The agency does not partake in staff satisfaction surveys, per reporting from senior leaders. Linfield and Posavac (2019) posited the importance of workforce feedback in improving services and retaining employees. Thus, it is unclear, except anecdotally, how staff view the agency, its support, leadership, and policies. In the first few months of the transition, the BHOPS experienced a significant turnover of staffing, which is common

with widespread organizational change, as one change in a system can impact additional change (see Brown, 2011). Staff members leaving the agency are provided the opportunity for an in-person or written exit survey, though the response rate is minimal. Several staff indicated the changing service delivery environment as reasons for leaving the agency. Many staff members impacted by the MMC transition left the agency and began employment in a different field, such as education or child care, or in agencies that provide more flexible working schedules. While exit interviews provide some perspective to supervisors, overall comprehensive data regarding the level of workforce satisfaction are not captured at the BHOPS.

Leadership Results

The senior leaders at the BHOPS understood the transformational and supportive leadership which was needed for the transition to succeed, as is consistent with findings in the literature regarding organizational change (see Aarons et al., 2011; Yasir et al., 2016). All senior leaders reported taking ownership and responsibility for the implementation of the MMC transition in relation to each of their specific roles to the transition. Senior leaders noted the gravity and depth of state-mandated changes that needed to take place with the MMC transition. Senior leaders identified experiencing a myriad of emotions over the course of the transition from frustration to distress to hope and anticipation. The following subsections review how senior leaders made decisions and communicated with the workforce and stakeholders through the preparation and implementation of MMC.

Theme 3: Communication From Leadership

Senior leaders communicate with clients, stakeholders, staff, management, and BOD members through various means of communication. Communication is viewed as a key factor to the BHOPS meeting its mission and vision, as indicated by senior leaders. Communication from senior leaders to the workforce and clients is often handed down by the programs and service supervisory teams. Communication from senior leaders to clients occurs through the agency website, newsletters, and correspondence. Communication from senior leaders to the workforce is delivered through the agency website, newsletters, a weekly electronic newsletter, an online payroll portal, and events. Communication throughout the agency does not necessarily flow in a top-down or bottom-up manner. Communication is multidirectional and could be viewed as a matrix format, per review of internal correspondence and senior leader report. Participant G indicated, "I believe the communication efforts from senior leadership to director level and director level to senior leadership has been instrumental in making sure the agency is prepared for the MMC transition."

Communication to the workforce about the MMC transition was handled in the same manner as stated above. Additionally, senior leaders supported years of additional trainings to prepare the workforce and management teams for the MMC transition, per internal emails and senior leader reports. Senior leaders supported training and a culture of transparency necessary for workforce buy-in, also evidenced as an important leadership trait during behavioral healthcare reform (see Aarons et al., 2011). An internal

MMC transition presentation, focusing on the purpose of MMC and service delivery changes, was provided to all regional offices over the course of 18 months, per review of the training and attendance forms.

Senior Leader Meetings

The BHOPS's senior leaders convene biweekly for *admin meetings.* Admin meetings can last anywhere from 1 hour to 3 hours. All senior leaders meet to discuss the status of departments, programs, strategies, and make key decisions. These meetings are vital to the agency's decision-making, per unanimous senior leader report. The CEO runs the meeting, and all senior leaders listen, provide feedback, and take personal notes. Participant A described admin meetings as "It [admin meetings] serves as a big think tank. Everybody [senior leaders] says what's going on in their individual world, but then discussions take place."

A significant finding was that there are no formal meeting minutes for admin meetings. Verbal decisions made in admin meetings are not required to be assigned in written format. When senior leaders were asked if they believed it would be beneficial to have meeting minutes, mixed results were evidenced. Two senior leaders pointed out that taking notes could be beneficial, but could also decrease the candidness and creativity in the group. Two senior leaders desired more specific information about how the MMC transition would impact their specific department. However, all senior leaders indicated the agency was well prepared for the MMC transition, in part due to the number of years of preparation, which were increased due to implementation delays.

When reviewing the scholarly literature, it is important to note the paucity of information regarding MMC transitions from an organizational perspective (Stanhope et al., 2017). Literature regarding organizations having difficulty with implementation and confusion among state and organization workforce were visible (Semansky et al., 2012; Williamson et al., 2017). Thus, the findings from the BHOPS's senior leaders align with current literature.

Governance Results

As reviewed in the organizational assessment, the BOD meets approximately nine times per year. The BOD is comprised of six men and six women, according to the BHOPS's website. There are no term limits, training requirements, or self-assessments for the BOD. Several members have participated on the BOD for decades, according to senior leaders. Experience and expertise from long-standing board members can provide stability for an organization during times of change (LeRoux & Langer, 2016). However, when the BOD maintains the same members over decades, stagnation and resistance to organizational change may pose a governance challenge for the BHOPS (LeRoux & Langer, 2016).

BOD members participate on several committees within the organization, such as the Compliance Committee. BOD meetings include review of programs, finances, and strategic decisions, innovations, and initiatives. Senior leaders reviewed all facets of the MMC transition to the BOD throughout the years of preparation. The BOD was

supportive of agency decisions and preparation activities, according to the senior leaders interviewed for this study.

Regulatory and Ethical Findings

The BHOPS is not an accredited organization. The BHOPS follows regulations as set forth by each program and service. Additionally, the BHOPS follows local, state, and federal laws regarding nonprofit healthcare operations, as reviewed in the agency's Corporate Compliance Manual and the Administrative Manual. The BHOPS is committed to ensuring healthcare delivery and agency conduct is within ethical and legal parameters and best practices, which is aligned with the agency's vision and mission. Senior leaders' roles in ethical behavior are further described by Participant F:

> Senior leaders have two specific roles: dedication to the vision and mission and always define or clarify ethics for our staff … I also believe it will keep us grounded with the reason we're really here, which is to provide services.

The QA Department, along with all employees and leaders, is charged with ensuring compliance practices are followed. An anonymous compliance hotline is monitored by the CCO and available to all employees, stakeholders, and clients to report any concerns of ethical or compliance concerns, per the agency's website and corporate compliance manual.

Strategy Results

The BHOPS develops and implements strategies that assist the organization in meeting its' vision and mission. The BHOPS does not have a formal agency strategic

plan. Additionally, the agency did not create a written strategic plan for the MMC transition. Bryson (2018) and Brown (2011) discussed the importance of having a written plan for significant organizational change to be implemented effectively across organizational systems. A majority of strategic decisions are made during biweekly admin meetings, informed by ideas and input from managers, directors, and the workforce. Admin meetings are not recorded in written format; thus decisions and strategic activities were discussed verbally and in internal emails. In order to understand the senior leaders' experiences of developing strategies for the MMC transition, it is important to review MMC transition changes to the competitive environment and healthcare delivery.

Competitive Environment Changes

When the MMC transition's expansion of services began, the BHOPS was one of the only providers in the service region accepting referrals for services for youth not already served by the agency, per several regional emails and meetings attended by leadership**.** Many other agencies were in hiatus, had waitlists, or had been de-designated, per BHO comments on state webinars and emails from regional BHO providers.

The reduction of competitors in the service region, resulted in a reduction in collaboration with other providers regarding the MMC transition, per leadership meeting minutes. The BHOPS's significant presence in the field for these new services had benefits and unintended consequences. Benefits included increased revenue, visibility in the community, and expanded services to newly eligible youth and families. Unintended

consequences included a decrease in the quantity of services, as staffing or supply were not able to meet the high demand and an increase in costs, per senior leader report, internal emails, and review of financial reports. Similar challenges can be seen during times of organizational change (Brown, 2011) and with MMC transitions (Semansky et al., 2012).

Theme 4: Strategies and Innovation

Senior leaders reported strategies they believed were successful in implementing the MMC transition. These strategies are identified in Figure 1. All senior leaders indicated their involvement or observation of preparation for the MMC transition was evident throughout the agency. From the workforce through all agency departments. Innovations tied to required changes are discussed at admin meetings and implemented immediately at the BHOPS. The BHOPS values quality, compliance, and integrity. Thus, the agency prepared for the significant change in its operations through extensive training over the course of several years. Aarons et al. (2011) and Stanhope et al. (2017) and posited the importance of training when implementing MMC at an organizational level. The state provided almost weekly webinars and phone conferences regarding various parts of the MMC transition. The BHOPS supported any staff, supervisors, managers, directors, and senior leaders' attendance at these trainings. The importance of understanding the changes so that effective implementation could occur was evidenced by the support of the intensive training the operations side received. Staff buy-in was achieved through transparency, training, and support.

Promotional meetings and marketing initiatives were successful in preparing clients, referral sources, and community stakeholders. These initiatives assisted the agency in its responsiveness to providing new and expanded services on day one of the MMC transition. Additionally, innovation was a common theme in interviews, as senior leaders reported the need to revamp processes throughout the agency to prepare for a new way of business. The Revenue Cycle Management Committee (RCMC) was created to bring all necessary departments, including operations, information technology, finance, and compliance together to address new billing requirements, as the agency moved from traditional Medicaid FFS to contracting with seven managed care organizations.

Figure 1. The BHOPS's identified strategies that were successful in implementing the MMC transition. Information gathered from senior leader interviews.

Financial and Market Results

Senior leader interviews and review of secondary data sources were reviewed to understand senior leaders' experiences of the MMC transition's impact on the BHOPS's financial status. A significant finding was senior leaders' concerns regarding state-mandated reimbursement rate cuts as part of the MMC transition. These rate cuts would be effective immediately upon the roll-out of services. It is important to note that the state provided transition funding slated to assist BHOs' care coordination programs for approximately twenty-one months after the transition, with assistance decreasing every 6 months until the completion of 21 months, per review of state guidance. Transition funds were not provided for services other than care coordination.

Additionally, senior leaders indicated concern with the increased workload on the agency's infrastructure resources. Moving from one state contract to seven managed care contracts was a concern for senior leaders. The need to learn and adapt to billing rules of seven payers instead of one payer along with lower reimbursement rates left senior leaders wondering how the agency would be able to sustain all of the services it provided pretransition and an expansion of services. Stanhope et al. (2017) commented on the need for significant organizational infrastructure to meet the demand of MMC.

Senior leaders were interviewed approximately six months after the first implementation and noted the reimbursement rate cuts were already negatively financially impacting the agency. Financial statements for the first 6 months were also reviewed and evidenced the same finding. The overall rates were decreased compared to

pretransition rates. Additional rate cuts were slated for after the first 6 months of services and again after the first year of services. Then, the rates for services are supposed to stabilize for approximately one year. After the1 year of guaranteed rates, the BHOPS will need to negotiate service rates with each MCO. The expansion state plan services had resulted in deficits for several months at the BHOPS. However, care coordination revenue was able to meet its expenses with transition funds. TFC rates did not change during this time. Senior leaders expressed feeling uncertain about the future of programming. However, it is important to note all senior leaders expressed a strong desire to continue to provide services because of the agency's commitment to meet the needs of the community, as expressed in the agency's vision and mission. Participant E stated, “You formulate the budget upon the staffing you need, which is basically dictated to us by the regulatory environment. The state gives you a certain rate to start [the MMC transition], then cuts it by 25% [after the first 6 months].” Senior leaders indicated frustration with reimbursement rates being cut too early and the impact on the nonprofit organization. Participant E added “The services are so valuable…we can't stop the programs because it would impact hundreds of children.”

To address the financial challenges presented by the MMC transition, the BHOPS senior leaders assessed possible solutions. The BHOPs employs both full-time and per diem service providers, per program staffing plans. Senior leaders assessed whether or not hiring per diem staff would suit the agency better financially due to the absence of fringe benefit costs and limited nonbillable paid hours. However, one senior leader

reported it is difficult to rely on per diem staffing for regular and consistent billable hours, as most per diem staff service providers hold additional employment outside of the agency.

One senior leader mentioned the successful strategy of implementing an RCMC at the BHOPS to address all aspects of the managed care revenue cycle. As previously mentioned in the Strategy Results subsection, the RCMC is an interdisciplinary group of BHOPS employees representing various departments involved with the managed care revenue cycle. RCMC members include employees from the Finance Department, IT Department, QA Department, and operations. The amount of infrastructure needs for billing systems and the agency's EHR to work with state regulatory changes was more than initially expected. The lack of readiness from state systems to MCOs created unnecessary denials of claims, time to investigate the denials, and waiting for external systems issues to be resolved. Aarons et al. (2011) also evidenced this finding, which resulted in increased workloads, documentation, and delays in payment. The goal of the RCMC is to increase utilization oversight from the beginning to end of the revenue, as depicted in Figure 2. The RCMC meets on a monthly basis.

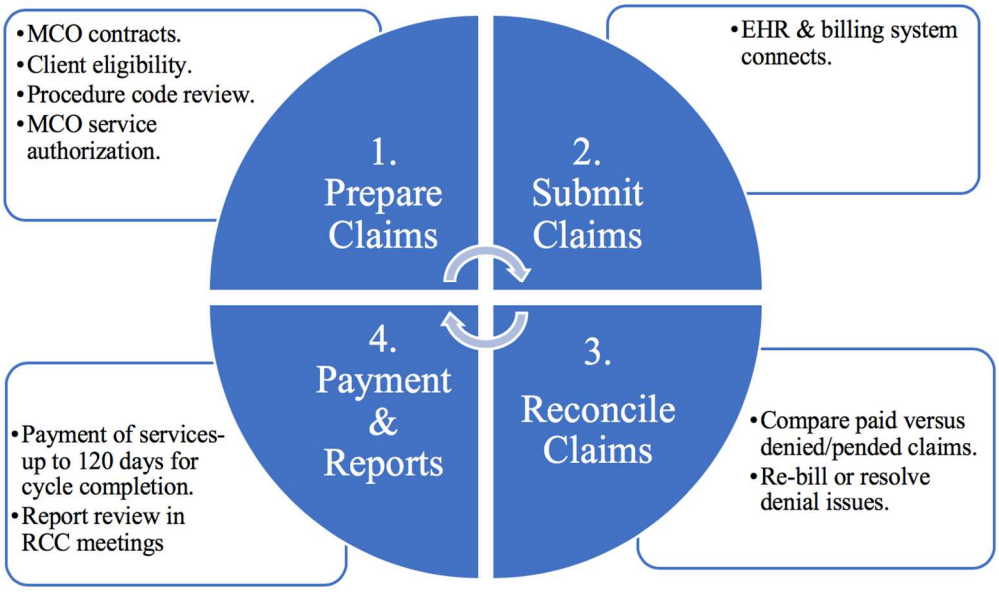

Figure 2. The BHOPS's revenue cycle.

MMC Transition Assets

The agency utilized infrastructure transition grant funds of approximately $25,000 to enter into a professional agreement with an electronic behavioral health billing service compatible with the agency's EHR. The behavioral health billing service is well versed in billing MCOs, which assisted in the transition, as the BHO did not have prior experience with extensive managed care billing, as reported by senior leaders. Despite the use of the billing service, significant internal workforce time and resources are used to complete the MMC revenue cycle, as reviewed in RCMC meeting minutes.

The expansion of services increased the need for overall physical assets, including office space, vehicle needs, and technology needs. During times of organizational change, effective communication among leaders, supervisors, and the workforce

regarding necessary resources is a key factor in fiscal sustainability (Burns et al., 2020; Zelman et al., 2014). Balancing the needs stemming from the transition with the ever-changing regulations and rates is an ongoing discussion documented in memos and internal emails.

Knowledge, Learning, and Outcome Results

Key factors of operations were reviewed in the previous subsection. This next subsection focuses on how the BHOPS uses information gathered within the context of the Baldrige excellence framework's key factors to maintaining organizational knowledge. Knowledge management, learning, and outcome measurements are crucial areas organizations must consider to increase the potential effectiveness of the agency (NIST, 2017).

Leader and Development Learning System

The training department is open to creating training opportunities throughout the agency, per managers' meeting minutes and internal memos. The agency's specific programs and departments are responsible for ensuring its staff are well equipped to perform their jobs and work effectively with youth and families. Allowing supervisory staff to evaluate their program's learning and development needs results in unique and focused training opportunities, per the Administrative Manual.

Supervisors understand, generally, working in the mental health and child welfare fields carry a high burnout risk (Lanham et al., 2012). Significant supervisory support can mitigate some factors of burnout (Aarons et al., 2011). However, supervisors aim to

remain supportive of their staff's future personal and professional goals through the creation of annual goals as documented in the performance evaluation. For example, a care coordinator may indicate that they are interested in building their leadership skills. Through discussion with their supervisor, the employee would discuss leadership opportunities or leadership trainings to initiate activities of their goal.

Outcomes

Senior leaders were asked, "How will the organization measure effectiveness of MMC?" Senior leaders' responses varied, with most responses fitting the categories of the triple aim healthcare goals, as viewed in Table 6 Additional responses included: maintaining financial sustainability, agency's responsiveness, and provision of services on the first day of expansion. Holtrop et al. (2016) found a lack of client outcome data in the scholarly literature for care coordination. Lack of outcome data analysis will make it difficult to discern whether or not MMC transition services will be effective.

Table 6

Senior Leaders' Desired Outcomes of MMC in Comparison to Triple Aim Healthcare Goals

Goal 1: Improve client outcomes	Goal 2: Increase client satisfaction	Goal 3: Reduce healthcare costs
Successful discharges.	Successful discharges.	Revenue cycle completion.
CANS-NY assessment of client functioning.	Client satisfaction surveys.	Utilization management.
Benchmarking results across the state.		VBPs

Note. Senior leader responses to the question "How will the organization measure the effectiveness of MMC?" Triple aim healthcare goals are defined by Lown et al. (2016).

Senior Leader Recommendations

The last question of senior leader interviews asked senior leaders to think retrospectively about what they would do differently if they could change anything in their process of preparation or implementation of the MMC transition. The results of senior leaders' responses are displayed in Figure 3. Despite all senior leaders noting the significant amount of energy the BHOPS invested into preparation, three senior leaders indicated they would seek out written and verbal information specific to how the MMC transition would impact their administrative departments. When Participant A was asked what they would change, if anything, about the MMC preparation and implementation, they responded, "Definitely have more support staff involved." Participant F responded to the same question with the following statement:

> I think there needs to be more organized discussion amongst all departments, not just the Admin [team], because the Admin team is going back to their respective departments, and if it didn't involve them at that time, there was no information being shared.

Two senior leaders discussed the desire to have influence over the state's timeline of implementation based on the BHOPS readiness. One senior leader indicated that formalized written plans would benefit the senior leaders. One senior leader would hire clinical staff several months before the transition occurred to optimize agency readiness. Senior leader recommendations and further recommendations are discussed in Section 5.

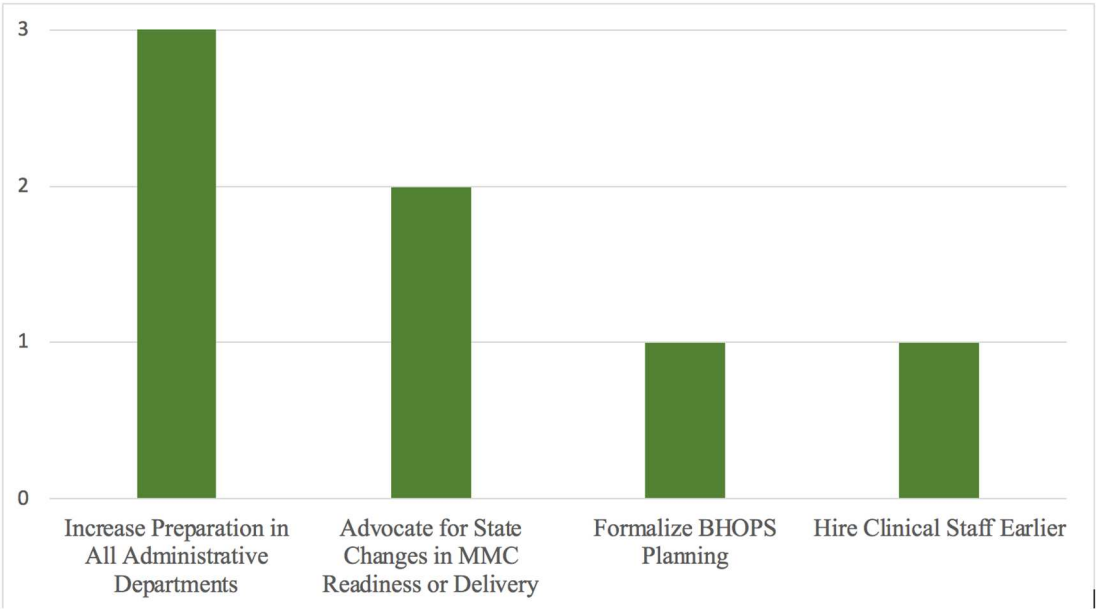

Figure 3. Senior leader retrospective suggestions for the MMC transition. Categorized with all seven leader participant responses.

Implications for Senior Leaders in Behavioral Health Organizations

The findings and themes from senior leaders' experiences at the BHOPS could have implications for BHOs implementing healthcare reform, specifically a transition to MMC. The BHOPS' organizational profile, organizational assessment, and results evidence an agency effectively serving its community and accomplished the transition to MMC. These findings complement current scholarly literature regarding the importance and significance of preparation across organizational systems and leadership support (see Brown, 2011; Yasir et al., 2016). Organizational preparation for change is a major endeavor, as leaders prepare all organization employees, BOD members, clients, and community stakeholders for behavioral healthcare reform and organizational change. Preparation includes communication, training, discussions, problem-solving, and

innovation from leaders. However, it is important to note, even with substantial preparation, confusion, questions, gaps in services, and implementation challenges are likely to occur (Hall et al., 2015; Huffman et al., 2010; Williamson et al., 2017). The findings suggest that preparation should include workforce buy-in, which increases when transparency and trust of organizational leadership is present (Aarons et al., 2011; Yasir et al., 2016).

The findings of this study and scholarly literature indicate BHOs experience internal and external challenges when implementing significant healthcare reform. Changes to programs, services, documentation, reimbursement, and shifts from volume-based to value-based care take significant organizational labor of time, money, and resources. Resources spent on preparation may not correlate with positive returns on financial investments in the MMC environment, as noted by senior leaders. Ultimately, one goal of MMC is to lower healthcare expenditures, meaning lower revenue for service provision (Zelman et al., 2014). Decreasing funding while implementing widespread organizational change are two activities that do not necessarily positively impact one another when it comes to the financial sustainability of nonprofit BHOs. BHOs must be prepared to invest in needed infrastructure to successfully move from working with one payer (Medicaid) to multiple payers (MCOs). The significant investment in a transition to MMC must be viewed in the context of the organization's vision and mission. Is the agency prepared to undergo years of preparation, changes, delays, and financial uncertainty to continue to serve its community?

Addressing workforce challenges within a behavioral healthcare environment implementing reform is another finding with implications for current practice. Senior leaders reported the significance of staff buy-in and transparency. Care coordinators and service providers, as direct care staff, are the employees interfacing and representing the MMC transition to clients. If direct care staff struggle to understand the MMC transition, clients may struggle, too.

Planning, preparation, patience, communication, innovating, and adapting are skills necessary for senior leaders to implement MMC in a behavioral healthcare setting. A majority of the MMC transition research is not focused on the behavioral health population or children (Hall et al., 2015; Williamson et al., 2017). Thus, it is challenging to pull insight from past transitions if they are absent from the literature. Future research is needed to continue to fill the gaps in the literature regarding MMC transition in behavioral healthcare settings as well as with the children's behavioral health population. Additionally, it could be beneficial to invest in a longitudinal study that would evaluate the impacts of MMC on BHOs' fiscal sustainability and client outcomes. Longitudinal studies provide researchers with ongoing data and the ability to assess a phenomenon or outcomes over a significant period of time (Ravitch & Carl, 2016). It could be beneficial to further study the BHOPS' status in the MMC environment one year, 5 years, and 10 years after the implementation. Quantitative research can also be useful in assessing the outcomes of the triple aim goals of healthcare. It would be beneficial to capture client satisfaction pre- and posttransition. In conclusion, this study may fill a small gap in the

research, but the behavioral healthcare field would benefit from further research on the implications for professional practice. The next subsection will review the study's possible implications for social change.

Implications for Social Change

Citing dedication to the mission and vision, all senior leaders interviewed reported the importance of ensuring the agency was ready to provide behavioral health services to children on the first date of service expansion. While the MMC transition implementation posed challenges for the agency, the agency persevered to ensure the community's needs would be met. There was significant buy-in from senior leaders that the expansion of eligibility of behavioral health services to children across the region was important for the community's wellbeing and the triple aim goals of healthcare, per senior leader report. Effectively implementing MMC is hoped to result in improved client outcomes, increased client satisfaction, and decreased healthcare expenditures (Hoverstadt et al., 2013; Lown et al., 2016). If the triple aim healthcare goals are met, the long term impact potential could be an increase in healthy lives.

Beyond the scope of the BHOPS's social change endeavors, implementing MMC effectively across the state or the country is hoped to have positive effects on the lives and mental health of children. Also, treating children and adolescent mental health disorders before adulthood could decrease the need for mental health treatment as an adult (Asselmann et al., 2018). Furrow et al. (2018) as well as Davis et al. (2014) discussed the complexity of the United States healthcare system and the difficulty of

navigating within it from a healthcare provider or patient standpoint. The findings from this qualitative study, albeit not evidencing correlations or causation, was meant to provide descriptive experiences of the MMC phenomenon to shed light on the challenging journey senior leaders face when implementing widespread behavioral healthcare reform in the United States.

It is hoped this study will fill a gap in research regarding experiences of senior leaders pioneering the way through children's behavioral healthcare reform. Much of the scholarly literature of MMC transitions focuses on the adult population (Hall et al., 2015; Williamson et al., 2017). Aarons et al. (2011) discussed the lack of research regarding behavioral healthcare reform. This study provides a unique perspective of studying a phenomenon in real-time, as the period of data collection included preparation and the first 6 months of the MMC transition. Many scholarly articles reviewed the phenomenon in hindsight (Hall et al., 2015; Huffman et al., 2010). It is hoped this study will provide useful descriptive information for organizations, senior leaders, managers, direct care staff, and stakeholders impacted by MMC. Future research could focus on the outcomes of the triple aim goals of healthcare after several years of MMC implementation to study the effectiveness of MMC. Next, the strengths and limitations of the study will be discussed.

Strengths and Limitations of the Study

Strengths

The strengths of this qualitative case study include qualitative best practices utilized. Triangulation was used by implementing primary and secondary data sources. A variety of secondary data sources, including public, internal, and state materials, were utilized. All senior leaders reviewed their interview transcripts, in a process called member-checking, to ensure the accuracy of their interview experiences. NVivo® qualitative software was used to code, categorize, and find themes within the data. Second cycle coding was implemented to ensure saturation was achieved. This study captures experiences of a phenomenon happening in real-time, not in hindsight, as data was collected during the preparation stage and throughout the first 6 months of the MMC transition.

Limitations

There are several limitations of this case study. These limitations impact the ability for the findings to be generalized (Ravitch & Carl, 2016). First, the case study sample size was small, with only seven participants. The qualitative nature of this study assists in exploring the experiences of senior leaders from one organization and cannot be generalized to senior leaders in other organizations. MMC transitions across the country are implemented differently, thus the state in which this study was based cannot necessarily be generalized to other states' transitions. This study does not portend correlation or causation, but offers descriptive experiences. Another limitation of the

study is possible researcher bias, as I am employed at the BHOPS. Qualitative best practices such as triangulation, member-checking, thickness of data, interview guides, personal reflexive research journal, and saturation were used to combat researcher bias. There were no unanticipated limitations in this study.

Summary and Transition

Results of the BHOPS seven senior leaders were reviewed in this section with the identification of findings and themes. The BHOPS's senior leaders experienced significant external and internal challenges when preparing for and implementing the MMC transition. To combat these challenges, the agency used various strategies, including verbal strategic planning, preparation, training, communication, and innovation. This study is able to inform other BHOs implementing MMC transitions. It is hoped other agencies will be able to learn from the experiences of the senior leaders at the BHOPS.

Additionally, social change implications can be drawn from the BHOPS dedication to implementing the MMC transition effectively in hopes of meeting the triple aim goals of healthcare including, improving health outcomes, increasing client satisfaction, and decreasing healthcare expenditures. If these goals are met, it is believed the community would see a positive impact on healthy lives and the mental health of children in one's community. The next section will discuss recommendations for the BHOPS, as well as the final conclusions of the study.

Section 5: Recommendations and Conclusions

Introduction

Senior leaders' experiences of preparing for and implementing significant behavioral healthcare reform from an FFS environment to an MMC environment were explored in this study. Senior leader interviews were the primary source of information for this study. Archival data were also used as secondary sources of information, including the Administrative Manual, Employee Handbooks, program policies and procedures, the agency website, and agency and public financial statements. Findings and themes from the data were concluded based on the triangulation of both types of data collected, member-checking, and using qualitative research software to code, categorize, and analyze themes in the data. The study's results were discussed and analyzed through the lens of the Baldrige excellence framework (see NIST, 2017). The Baldrige excellence framework's key factors are used to facilitate discussion of the recommendations for the BHOPS. Key factors include leadership, strategy, clients, workforce, operations, results, and knowledge management. When these factors are working synchronously, organizational optimization is possible. Recommendations for the BHOPS's senior leaders, BHOs, and future research are reviewed in this section. I conclude with final reflections on the capstone project and its possible implications for social change.

Behavioral Healthcare Operations Recommendations

The BHOPS's senior leaders and workforce demonstrated expertise with the MMC transition, as evidenced by several years of documented preparation and training,

which was also acknowledged by the state as reviewed in emails and internal correspondence. The agency's goal of providing the full array of children's behavioral health services on the first day of expansion came to fruition. This was a major accomplishment for the organization, as many organizations across the state were not ready to provide services at the start of the expansion, as reviewed in state correspondence and state webinars. The communication, collaboration, and cooperation within and between the agency, BHOPS's stakeholders, community partners, and clients was not only evident in multiple data sources; collaboration was effective. and the agency met its' initial goals.

Many of the challenges experienced in delivering the MMC children's behavioral healthcare services were attributed to state-mandated external changes, according to senior leaders. It is recommended the BHOPS continue to inform pertinent state leaders of the challenges the agency is experiencing. The BHOPS senior leaders occasionally provided information regarding challenges to the state and often raised these issues to a state advocacy coalition group. As the organization built relationships with MCOs, MCOs were also informed of the challenges experienced that were impacting the capacity to serve the community. The agency's leaders maintained an active voice in discussing challenges and successes of the MMC implementation. Advocating on behalf for the BHOPS, clients, and workforce is recommended to continue.

The BHOPS's senior leaders are also encouraged to continue the support of streamlining administrative processes and decreasing nonbillable activities for direct care

staff. The BHOPS has implemented several strategies to lower nonbillable activities and increase productivity, including

- Regionalized staff within 30 minutes of clients whenever possible.
- Tracked staff productivity.
- Tracked use of service hours.
- Created productivity guidelines for staff.
- Provided technology to create a mobile workforce.

Because the BHOPS provides services in rural areas, staff travel time can exceed the service provision time, which increases service costs and decreases service revenue to cover administrative expenses. Regionalizing service providers to serve clients within 30 minutes of the service provider's home has assisted in decreasing excess cost. However, there may be a decrease in staff in rural areas, creating a service gap. Utilization and productivity trackers allow staff, supervisors, and administrators to monitor whether or not a service provider is covering the costs of their position and meeting the needs of client service provision. The data from these trackers are reviewed with staff and supervisors in supervision and staff meetings, per review of documentation from these meetings.

Once state manuals were finalized, productivity guidelines were officially revised to provide staff with clear expectations of documentation and time management. These guidelines were developed into a policy and reviewed at staff meeting, per review of the policy and staff meeting minutes. Within the first several months of the transition, care

coordinators and service providers began to voice their changing technology needs. As both positions were increasing their caseloads, the ability to have flexible working arrangements and complete documentation in the community or with a family was noted, per staff meeting minutes. Senior leaders approved technology plans individualized to each program to increase productivity of staff. After reviewing these changes, the initial impact on productivity and was positive. An increase in service provision was seen, with a decrease in overall expenses, as reviewed in financial statements. The BHOPS's senior leaders are encouraged to continue innovating and streamlining processes to mitigate rate reductions.

Leadership Recommendations

The BHOPS has an executive team consisting of seven senior leaders. While the CEO is responsible for final decisions, the senior leadership team participates in active shared decision-making within their executive group. The executive team, consisting of the seven senior leaders, meets on a biweekly basis to discuss the status of operations and projects and to make decisions. As discussed in Section 4, the senior leadership group works as a team to come to solutions that move the agency towards its vision and mission during admin meetings, per the senior leader report. However, a significant finding was the absence of admin meeting minutes. The absence of minutes plays a positive role in the creativity and openness in the group culture, as indicated by several senior leaders. However, it appears that from interview and archival data, the absence of meeting minutes could also play a role in the misperceptions of decisions made and the

misunderstanding of assigned action items to address. Two senior leaders did not feel as confident in the MMC transition as other senior leaders and indicated that the lack of written documentation of decisions may have been a contributing factor.

Bryson (2018) discussed the necessity for meeting minutes and action plans to be well documented. Without documentation, plans or actions are at significant risk of incompletion. Reasons for task incompletion can vary widely due to interpretations of who an action is assigned to, what action to take, and when the action needs to be fulfilled (Bryson, 2018). In addition, any senior leader who missed an admin meeting would need to rely on a verbal account of any decisions made or topics discussed. One senior leader recommended a more formalized process for major planning at the agency, indicating that it could be beneficial for the senior leadership team. Two additional senior leaders indicated that some form of written documentation of senior leader decisions would be helpful.

Recommendations to address this finding need to take into account the differing opinions on this topic among BHOPS' senior leaders and the senior leadership group culture. In order for a recommendation to be successfully implemented, there needs to be buy-in and ownership from a majority of senior leaders (Brown, 2011; Bryson, 2018). Thus, a compromise between an absence of meeting minutes versus formal meeting minutes is discussed further.

Scholar-Consultant Recommendation 1

I recommend the senior leaders discuss and create a process for maintaining a written record of action items and key decisions made at the end of each admin meeting. Brown (2011) and Bryson (2018) indicated the necessity of written planning, especially in the midst of organizational change, for optimal organizational systems effectiveness. I further recommend the senior leaders integrate the creativity of their group culture and openness of the group while maintaining a written record of

- Key decisions.
- Action items for senior leaders or their departments.
- Status updates about program or service changes.
- Strategic planning activities.

Scholar-Consultant Recommendation 2

The second leadership recommendation is for the BHOPS's governance to consider establishing board term limits within the BOD bylaws. The agency's BOD model and bylaws were established decades ago, according to a senior leader. In recent decades, board term limits are increasingly recommended to enhance new ideas, community connectedness, and creativity (Ott & Dicke, 2016; Tschirhart & Bielefeld, 2012). While the current BOD members offer consistency and expertise regarding the agency, implementing staggered board term limits may offer the BHOPS fresh perspectives and a growing community reach. According to a senior leader, establishing BOD term limits would need to be voted on during the BOD meeting and added into the

agency's governance bylaws. Thus, I suggest senior leaders and BOD members review the advantages and disadvantages of developing term limits and how such changes could impact the agency's vision and mission, short-term and long-term.

Strategy Recommendations

The BHOPS's senior leaders' strategies for preparing for and implementing the MMC transition were evidenced throughout senior leader interviews and archival data. Senior leaders indicated several strategies that were successful for the agency and assisted the agency in meeting its MMC implementation goals, see Figure 1. In review, strategies that were successful included significant communication, marketing, creation of the RCMC, transparency with workforce and stakeholders, and significant preparation, planning, and training. Lussier and Achua (2016) and Tschirhart and Bielefeld (2012) reviewed the importance of positive organizational culture when attempting to implement system-wide changes. The agency's leadership staff's commitment to supporting the workforce through the MMC transition was evident in staff meeting minutes and managers' meeting minutes. The commitment to positive organizational change was a strategy the agency used to decrease resistance to change and maintain positive organizational culture (see Brown, 2011; Lussier & Achua, 2016). The top-down, bottom-up, and vertical communication lines at the BHOPS was a significant finding from senior leader interviews and archival data. The high level of communication may have mitigated any negative effects due to the absence of a formal strategic plan related to the MMC transition.

Scholar-Consultant Recommendation 3

I recommend the BHOPS's senior leaders consider developing, implementing, and consistently reviewing, a semiformal strategic action plan when implementing significant change. Bryson (2018) posited the criticality of a strategic plan when implementing significant organizational change. Strategic planning has been shown to play an important role in successful leadership, management theories, and organizational development (Brown, 2011; Bryson, 2018; Lussier & Achua, 2016; Tschirhart & Bielefeld, 2012). Bryson (2018) provides guidance for leaders in organizations deciding if a strategic plan is needed for their agency, based on whether the changes are purely operational or strategic. The BHOPS's transition to MMC resulted in significant changes to funding, regulations, decision-making, financial decisions, infrastructure, and needed preparation. Thus, Bryson (2018) suggests that the issues facing the agency are strategic and not just operational in nature. These agency-wide changes show the need for an action plan to address the agency's strategy, as a whole, instead of the action planning within one specific operational department.

Although strategic planning as an activity and process is important, a formal or semiformal strategic plan is not useful, if the plan is not consistently reviewed or implemented (Bryson, 2018). Two senior leaders indicated a formal strategic plan was created many years ago at the BHOPS, but the plan became outdated due to frequent changes in the external environment. Senior leaders indicated, due to the frequent changes in the healthcare delivery system, investing time and effort into a formal,

multiyear strategic plan would be futile. Thus, a semiformal strategic action plan is recommended, in which the senior leaders identify an overarching goal, objectives, and methods needed to prepare for a significant change 1 to 2 years prior to the implementation of the change. A less formal and condensed version of a strategic plan, a strategic action plan, allows the agency to focus on key deliverables needed to implement significant change without formal elements of planning, such as mission and vision revisions, stakeholder meetings, and identifying strategic issues. The BHOPS's senior leaders reported strategic issues are often state-mandated; leaders are confident in the vision and mission; leaders maintain positive relationships with a wide variety of stakeholders. This semiformal strategic action plan will also assist in all senior leaders understanding their role or their department's roles and responsibilities with upcoming changes and decrease any miscommunication of assignments or tasks for senior leaders or their staff, as desired by three senior leaders as shown in Section 4, Figure 3.

The strategic action plan should be created during an admin meeting or a meeting with all senior leaders and key stakeholders from the department(s) of the purposed changes. The strategic action plan should be typed and saved on the agency's shared network drive. The goals, objectives, and methods should be specific, measurable, attainable, reasonable, and time-sensitive (Bryson, 2018). A template of a suggested semiformal action plan is shown in Appendix D. The strategic action plan should be reviewed in admin meeting, at least once monthly, or in stakeholder meetings, as often as needed. As the agency moves towards value-based payments, while coincidingly

experiencing financial challenges from rate reductions in the MMC transition, senior leaders are encouraged to create a semiformal strategic action plan to prepare all agency departments for ever-changing healthcare reform.

Client Recommendations

Linfield and Posavac (2019) discussed the importance of assessing client satisfaction and engagement to evaluate programs and services. The programs impacted by the MMC transition have implemented client satisfaction surveys, per review of these surveys. These surveys take place semiannually, as reviewed in program policies and procedures.

Scholar-Consultant Recommendation 4

I recommend the results of these surveys be reviewed with senior leaders and the BOD during the transition period or up to 2 years. Because substantial change occurred, impacting services for youth and families, it is imperative the agency's senior leaders understand if and how the change impacted client satisfaction, which may also impact engagement and service utilization. Frontline supervisors ensure the client satisfaction surveys are distributed according to policy. Then, the compliance coordinator assesses and aggregates the quantitative and qualitative data from the surveys. Managers and the compliance coordinator review results. These results are shared with the direct care staff and frontline supervisors, per policies and procedures.

Scholar-Consultant Recommendation 5

While general client satisfaction is shared with senior leaders and BOD members, it is recommended all results from MMC transition programs are shared at the BOD level of governance to provide in-depth feedback about MMC transition successes and challenges. This feedback could have quality and financial implications for the BHOPS's future of VBPs. Senior leaders and BOD members may gain insight from this process to inform future executive decision-making. In addition to survey results, Linfield and Posavac (2019) posited the importance of using available data also to assess client engagement and satisfaction. It is suggested the following data be analyzed from the agency's EHR and shared network: cancellation and no show rates, service utilization, and formal grievances.

Scholar-Consultant Recommendation 6

I recommend the BHOPS's senior leaders further support advocacy with the agency's contracted EHR to integrate MMC treatment plans. As stated in Section 4, due to the MMC transition's separation of services, youth and families may need to participate and sign, one to seven, treatment plans requiring family-led decision-making, collaboration, review, and signatures, per review of the agency's EHR programs. State guidance requests BHOs use an integrated treatment planning approach whenever possible to decrease confusion and increase youth and family engagement, according to state-plan treatment planning guidance. The BHOPS's Children's Services supervisors and managers attempted to implement an integrated treatment plan. However, the EHR

liaison indicated this was not a capability of the EHR, as reviewed in internal emails. Senior leader discussions about EHR solutions to this problem are encouraged.

Workforce Recommendations

The BHOPS employs over 700 people, according to senior leaders and reports from Human Resources. Significant workforce findings included a workforce shortage, a lack of qualified staff in rural areas, and high staff turnover. The ability to recruit and retain staff is a major task for nonprofit human services agencies (Ott & Dicke, 2016).

Dark et al. (2017) found that behavioral healthcare reform and organizational changes negatively impacted staff ratings of organizational culture during the reform period. However, the researchers that organizational culture was resilient and rebounded after the change was complete. The BHOPS primarily recruits staff through the agency website, local job fairs, local college career fairs, employee referrals, social media, and employment websites. The BHOPS utilizes various methods to retain staff through employee recognition events, awards, and small gifts of appreciation. The agency also maintains a comprehensive benefits package. Despite these efforts, the BHOPS has a high staff turnover rate, which ultimately negatively impacts service provision, both of which were significant findings for the BHOPS.

When an employee departs the agency, they are given the opportunity to complete an exit survey, which is voluntary and has a relatively low response rate, per review of Children's Services exit surveys in 2018 and 2019. However, there are no formal measures in place to gauge workforce satisfaction with current employees. Without a

workforce satisfaction survey, it is difficult to gauge the impact of behavioral healthcare reform and organizational change on the workforce. It is also difficult to assess for reasons of high staff turnover specific to the BHOPS, aside from anecdotal information coupled with exit survey responses.

Scholar-Consultant Recommendation 7

I recommend the BHOPS's senior leaders consider implementing a method to assess staff satisfaction, to increase the staff retention rate with knowledge gained from the assessment. In addition, retaining staff may have a positive impact on the high demand for service provision. The Satisfaction of Employees in Health Care (SEHC) survey, a quantitative measure developed by Alpern et al. (2013), used to measure staff satisfaction in Ethiopian healthcare settings, could be implemented at the BHOPS through a web based survey platform for current employees. The main SEHC questions can be viewed in Appendix C. The SEHC is a 20-question Likert-type scale survey, which asks employees to rate their job and work environment, with high reliability and validity established for use in the United States healthcare settings (Chang, Cohen, Koethe, Smith, & Bir, 2017). I recommend that employees voluntarily complete the SEHC annually. I suggest adding one or two demographic questions to identify the employee's department within the agency and how long the employee has worked at the agency. If desired, additional qualitative questions could be added to the surveys to capture descriptive responses. As indicated above, the survey may be best utilized through a web-based platform to analyze data and results quickly. An alternative to an

external web-based application could be the use of interns or staff of the Human Resources Department to complete in-person or phone surveys. However, this option could also pose challenges to time and resources.

The survey should be kept anonymous and individual results kept confidential. The initial SEHC would serve as a baseline of employee satisfaction. The creation, implementation, and review of the SEHC should be completed within the Human Resources Department. Results from the initial SEHC should be reviewed in the Human Resources Department, admin meetings, BOD meetings, and managers' meetings to inform the agency's leaders on the level of satisfaction of employees. I suggest that significant areas for improvement be reviewed throughout all levels of leadership. A formal meeting or committee, including senior leaders, Human Resources Department, directors, and one or two direct care employees is encouraged to problem-solve areas of dissatisfaction and ways to sustain satisfaction. Because of the BHOPS's demonstrated strengths in communicating to all levels of employees, involving frontline supervisors and direct care staff in employee satisfaction improvement efforts is highly encouraged.

Financial Market Recommendations

The BHOPS relies on Medicaid and MMC funds for a significant portion of the agency's revenue, per 990s public financial documents. As the MMC transition continues to decrease reimbursement rates, senior leaders identified sustaining services in the future could be a fiscal and logistical challenge for the agency. Within the first 6 months of the transition, the reimbursement rate cuts resulted in deficits of MMC transition

programming, according to senior leaders and internal monthly financial statements. Semansky et al. (2012) found similar fiscal and programming challenges with MMC transitions.

Scholar-Consultant Recommendation 8

Due to the state's ever-changing healthcare reform impacting reimbursement rate stability, I recommend the agency seek to diversify funding streams. The BHOPS has experience in applying for grants and securing local county contracts to provide similar services of MMC programming, as reviewed in the agency's internal organizational chart, and managers' meeting minutes. Thus, it is suggested the agency determine the level of need for resources to sustain MMC funded programs as well as a level of need within local, county, or regional governmental units.

An exploratory community needs assessment may yield areas in which the agency can be of service to local governmental units. For example, the MMC transition focuses solely on the Medicaid population, excluding youth and families with private insurance, according to state eligibility requirements. All counties in the state receive state funding, funding levels vary by county population and other variables, to serve non-Medicaid youth with behavioral health needs in the manner the county sees fit, according to various county committee meeting minutes. Many counties contract with nonprofit community BHOs, also referred to as safety-net providers, to serve non-Medicaid youth with behavioral health issues. The BHOPS provides these contracted services in the county of the headquarters residence and has recently established additional smaller contracts in

counties in the service region. I recommended the BHOPS's senior leaders seek to establish contracts with other counties in the service region that would support counties' needs as well as support the BHOPS's current staffing, supervisory, and administrative infrastructure. According to a county contract proposal completed by the BHOPS and internal correspondence, many county contracts do not have the same limitations of staff qualifications and service provision limitations as the MMC transition services, Thus, blending caseloads with MMC and contracted services, with appropriate staffing allocations, could provide a way to sustain programming.

Infrastructure costs were not comprehensively built into the state's MMC transition rate methodology, as noted by a state advocacy group. Thus, braiding various types of funding may assist the agency in covering infrastructure costs, as is commonplace in nonprofit organizations (Ott & Dicke, 2016). Funding sources may include federal, state, and county grants and contracts. In addition, it is unclear if MCOs or alternative MMC funded workgroups could provide additional funding opportunities. This is a topic that merits further discussion within the senior leadership group. I further recommend diversifying funding streams be added to the strategic action plan. In addition to diversifying funding streams, increasing current funding rates through positive client outcome data is another method to sustain current programming, as discussed in the next section.

Results and Outcome Measurement Recommendations

As the MMC transition provided financial challenges for the BHOPS, the agency must be prepared to use client outcome data to enhance future agency-specific reimbursement rates. Data analytics to measure specific outcomes of MMC programs is warranted as the future of healthcare reimbursement (Zelman et al., 2014). In the next 2 years, as the state moves from government regulated rates to a value-based reimbursement rate environment, it is imperative the BHOPS has outcome data to negotiate rates or incentives with MCOs (Zelman et al., 2014).

Scholar-Consultant Recommendation 9

I recommend the BHOPS capture and analyze outcome data to include:

- Time to the first service from date of referral.
- Average lengths of stay.
- Emergency room and hospitalization rates.
- Percentage of treatment plan goal and objective attainment.
- Client satisfaction surveys and engagement.
- Youth functioning levels, as determined by the CANS-NY.
- Behavioral healthcare expenditures, as determined by the state behavioral health data portal.

These data points directly correlate with the triple aim goals of healthcare (Lown et al., 2016). Continuing to build relationships with MCOs will be important as VBPs come to fruition (Wagner, 2014). Using common data points and knowledge will assist

each MCO in understanding the capability and value of the agency and its services. Many of these data points can be collected from internal or state accessible EHRs. I recommend the EVP of Operations to request each program within the MMC transition to begin to collect and analyze this data on a quarterly basis. Managers of these programs should share the data with senior leaders quarterly. Furthermore, I recommend quarterly client data outcomes become an objective in the strategic action plan. The results of the data outcomes should not only be shared with senior leaders but members of the RCMC, as this committee's purpose is to enhance and sustain MMC funding and programming through completion of the revenue cycle, per RCMC meeting minutes.

The recommendations for the senior leaders at the BHOPS align with the Baldrige excellence framework's goal of optimizing organizational components to strengthen organizational effectiveness (NIST, 2017). While the recommendations posited are directly applicable to the BHOPS in this study, BHOs around the country may benefit from the findings and recommendations posited here. The next subsection will review general recommendations for BHOs preparing for and implementing MMC.

Recommendations for Behavioral Health Organizations

The BHOPS is not unique in its situation with MMC implementation. The challenges organizations faced with the MMC implementation were also reviewed in the scholarly literature, albeit to a limited extent (Semansky et al., 2012). It is hoped this study can provide insight for BHOs preparing for a similar transition. The

recommendations for BHOs can be gleaned throughout this section but will be summarized in the following paragraphs.

Preparation for a transition to MMC is paramount. Stanhope et al. (2017) found that BHOs larger in size, defined by the number of employees and clients served, were more likely to attend MMC trainings. However, regardless of size, Stanhope et al. (2017) discussed the criticality of preparation and training for an MMC transition. The BHOPS's senior leaders chose to be open and transparent with directors, managers, supervisors, direct care staff, clients, and stakeholders from the beginning of the transition preparation over 5 years ago, per internal emails, staff meeting minutes, BOD meeting minutes, managers' meeting minutes, public agency newsletters, correspondence to clients, and according to all seven senior leaders. Even though the transition was delayed numerous times, regulations changed, reimbursement rates changed, and services changed during those 5 years, the agency ensured all stakeholders were updated on the status to show transparency. Transparency assisted in stakeholder and workforce buy-in, per senior leader report and archival data. Anderson et al. (2015) posited the importance of organizational buy-in and ownership of the triple aim goals of healthcare. The time spent preparing for changes which did not occur, was well worth it, according to senior leaders. Because the transition triggered such substantial change, the more the transition was discussed, the more commonplace and accepted the term *MMC transition* and the idea of MMC became among the workforce.

Preparation, training, and planning are crucial for operations staff, but also for leaders and staff in administrative departments, including finance, human resources, marketing, information technology, compliance, transportation, and building management. Regardless of the organizational structure of the BHO, key leaders and administrative department staff need significant training and time to prepare for how MMC will impact their daily roles and functions (Anderson et al., 2015). A formal or semiformal strategic plan for an MMC transition should include how and when administrative departments are expected to change their processes or policies for the transition.

In summary, the successful strategies in preparing for the MMC transition, according to senior leaders and archival data identified in this study, include transition preparation, communication, technology capabilities, EHR capabilities, infrastructure, transparency, and billing support. Transformational leadership plays a significant role in effective organizational change (Lussier & Achua, 2016). Within transformational leadership resides transparency, flexibility, support, and encouragement (Aarons et al., 2011). Though, these strategies and characteristics presented are limited to one BHO. Additional research is needed to grow the literature regarding effective strategies for BHOs' implementing MMC or general behavioral healthcare reform.

Recommendations for Future Research

As mentioned throughout this study, there is a paucity of information regarding MMC transitions for children with behavioral health needs and nonprofit BHOs (Hall et

al., 2015; Huffman et al., 2010; Williamson et al., 2017). Despite the lack of scholarly information, a majority of non-clinical community-based behavioral health services are provided by safety-net institutions, a majority of which are nonprofit organizations (Aarons et al., 2011; Stanhope et al., 2017). Thus, it is imperative to increase the research in this field of study to increase the available knowledge of MMC transitions to leaders and stakeholders responsible for implementation. This study, exploratory in nature, provides a glimpse into the experiences of senior leaders. However, this study is limited to one organization in one state. Case studies provide insight into a phenomenon, but the insight from this study is limited to a small sample size of senior leaders.

Recommendations for additional research include:

- Qualitative studies of BHO MMC implementation in states around the country.
- Quantitative studies determining MMC effectiveness for children with behavioral health needs, including serious emotional disturbances.
- Qualitative or quantitative studies to address challenges BHOs face from MMC transitions.
- Qualitative studies exploring experiences of direct care staff and frontline supervisors in a BHO implementing MMC behavioral health services.
- Quantitative studies to explore the impact of MMC transitions on the behavioral health workforce.
- Quantitative studies on the fiscal sustainability of agencies pre and post MMC transition.

- Multifactor analyses of MMC transitions in behavioral healthcare around the country.

Topics for future research can be broad or limited, as any additional research would assist in decreasing the gap of information on this topic. It is important to note, while many states have transitioned to MMC, implementation, regulations, rates, and policies have varied from state to state or within states, such as the adult versus children transition (Bao et al., 2013; Furrow et al., 2018; Hall et al., 2015; Williamson et al., 2017). Thus, additional research could support how MMC transitions impact the triple aim goals of healthcare. In the next subsection, the plan for this study's dissemination to the BHOPS's senior leaders is addressed.

Conclusion

This study's purpose was to explore the experiences of senior leaders in a BHO undergoing a state-mandated MMC transition of children's behavioral healthcare services. The intention of the study from the scholar-consultant role was to provide the BHOPS's senior leaders with insight on the agency's transition. Seven senior leaders were interviewed for this study. In addition, a multitude of archival data was used as secondary data sources. Qualitative best practices were used to increase the study's reliability and validity and decrease researcher bias, which included triangulation, member-checking, thickness of research, use of a personal research journal, reflexivity, and informed consent (Ravitch & Carl, 2016). Results, findings, and themes were identified through the assistance of qualitative coding software. Results indicated the

BHOPS spent years preparing the agency and its' workforce for the MMC transition. The BHOPS's communication and strategies for implementation were robust, despite several implementation delays and regulation changes over the course of 5 years. Despite preparation, the agency experienced challenges with decreased reimbursement rates and in meeting the need for services.

It is hoped the information gathered and analyzed in this study could be used to improve organizational processes, further benefiting clients, and hopefully positively impacting client outcomes. The triple aim healthcare goals of increasing client satisfaction, improving client outcomes, and reducing healthcare expenditures have a better chance of being achieved if behavioral healthcare delivery systems effectively implement behavioral healthcare reform, with significant support and guidance from state and federal entities. The social change goals of behavioral healthcare reform are to improve the lives and mental health of individuals served. Ultimately, behavioral healthcare reform in an MMC environment poses challenges for BHO's senior leaders endeavoring to make a difference in the lives of youth and families, while sustaining programming. These challenges have called for senior leaders to maintain positive organizational culture through transparency, to be vision and mission-driven, to extensively strategize, and to expansively prepare for the journey into behavioral healthcare reform.

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Appendix A: Interview Questions

1. What role do senior leaders play in the transition to Medicaid Managed Care (MMC)?
2. What role does the agency's vision and mission play in the transition to Medicaid Managed Care?
3. What are the most significant internal challenges the organization faces in its attempts to implement the MMC transition?
4. What are the most significant external challenges the organization faces in its attempts to implement the MMC transition?
5. What strategies have been successful or unsuccessful in implementing the MMC transition?
6. How has the organization prepared the workforce for the MMC transition?
7. How has the organization prepared clients for the MMC transition?
8. How will the organization measure the effectiveness of MMC?
9. How has the organization planned, either formally or informally to address the MMC transition? If there is a plan, how often is the plan reviewed and with whom?
10. What are the key factors in ensuring organizational change is effective?
11. Reflecting on the MMC transition, what, if anything, would you change in the beginning stages of preparation or implementation of the transition?

Appendix B: Interview Protocol

Interviewer: Hello (senior leader's name), thank you for meeting with me today. Please note that I am not here in my role as a Director, I am meeting with you today in my role as a scholar-consultant, so, pretend I know nothing. Our interview will be kept confidential and if at any time you want me to stop the recording I will do so." Thank you for agreeing to participate in this interview to assist in my capstone project. I received your informed consent via email, but I will verbally go over a few items before we get started, if that is okay?

Leader: Response.

Interviewer: This interview will be audio recorded so that the content can be transcribed into a document and used to help me understand experiences and analyze themes in the data. You will have an opportunity to clarify statements through a process called member-checking, in which you will be able to review parts or all of the transcript for accuracy. The audio recorder and transcription process is about 90% accurate, so it is important that we conduct the interview without background noise, so thank you for allowing us to interview in your office. Participation in this interview is voluntary. Interview recordings and full transcripts will be shared with each interviewee, upon request. Transcripts with identifiers redacted may be shared with my university faculty and my peer advisors. Any reports, presentations, or publications related to this study will share general patterns from the data, without sharing the identities of individual participants or partner organizations. The interview transcripts will be kept for at least 5

years, as required by my university. The identity of each participant, agency, and state is confidential and will not be revealed in the study. No one at this agency will be able to review your interview, audio file, or transcript other than you and me. The purpose of the interview is to explore your experience as a senior leader regarding the agency's transition to managed care. The majority of my project is focusing on the children's transition, but any experiences with the adult transition will also be helpful. My study focuses on key areas of organization performance including workforce, operations, clients, strategy, knowledge management, and leadership/vision. Most of the questions asked are connected to one of these key areas. I expect the interview to take anywhere from 30 to 45 minutes, are you able to meet for this amount of time today?

Leader: Response.

Interviewer: Okay, great. Thank you for your help! Do you have any questions about the interview process before we begin?

Leader: No.

Interviewer: Okay, we will get started with some general questions. Can you please tell me how long you have worked at this agency?

Leader: ___ Years.

Interviewer: When did you become part of the senior leadership team?

Leader: Response.

Interviewer: What was your role at the agency before that time? (internal promotion) or What was your role in your job previous to this agency?

Leader: Response

Interviewer: Ask follow up questions if needed. Okay, we will now move on to questions regarding the agency's transition to Medicaid Managed Care (MMC)?

Leader: Response.

Interviewer: Reflection/summarization. Follow-up or clarify (For all responses).

What role do you play as a senior leader in the MMC transition?

Leader: Response.

The agency maintains a clear vision, mission, philosophy, and values posted on the website and visible in all offices. What role does the agency's vision and mission play in the transition to Managed Care?

Leader: Response.

Interviewer: The next two questions have to do with challenges experienced from the managed care transition, both internally or within the organization and externally or outside/beyond the organization. What are the most significant internal challenges the organization faces in its attempts to implement the managed care transition?

Leader: Response.

Interviewer: Continuing with this set of questions, what are the most significant external challenges the organization faces in its attempts to implement the MMC transition?

Leader: Response.

Interviewer: What strategies have been successful or unsuccessful in implementing the MMC transition in relation to your role and oversight in the agency?

Leader: Response.

Interviewer: The next few questions are worded in a broad manner and can be answered with the whole agency in mind, or as it pertains to your role. These questions go back to the key factors of organization performance I'm studying. How has the agency prepared the workforce for the managed care transition?

Leader: Response.

Interviewer: Alright. A very similar question. How has the organization prepared clients for the MMC transition?

Leader: Response.

Interviewer: How will the organization measure the effectiveness of MMC? In other words, how will the organization know if managed care was successful?

Leader: Response.

Interviewer: The next question may be something you were closely involved in or reviewed during admin meetings. How has the organization planned, either formally or informally to address the MMC transition? If there is/was a plan, how often is/was the plan reviewed and with whom?

Leader: Response.

Interviewer: This next question is on the topic of general organizational change, not necessarily tied to the managed care transition. What are the key factors in ensuring organizational change is effective?

Leader: Response.

Interviewer: I have one last question. Now that the agency has participated in initial transition activities, it is possible to look back on all of the years of preparation. Reflecting on the MMC transition, what, if anything, would you change in the beginning stages of preparation or implementation of the MMC transition?

Leader: Response.

Interviewer: Alright. Thank you. That concludes the questions I have for this interview. Is there anything else you would like to add to any of your responses or share any general information you believe may be beneficial for me to know regarding this topic or the agency in general?

Leader: No.

Interviewer: Okay, great. Thank you again for taking time out of your day to help me with my project. This concludes the interview and I will stop recording now. Have a great day

Appendix C: The Satisfaction of Employees in Health Care Survey

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. The management of this organization is supportive of me.	1□	2□	3□	4□
2. I receive the right amount of support and guidance from my direct supervisor.	1□	2□	3□	4□
3. I am provided with all trainings necessary for me to perform my job.	1□	2□	3□	4□
4. I have learned many new job skills in this position.	1□	2□	3□	4□
5. I feel encouraged by my supervisor to offer suggestions and improvements.	1□	2□	3□	4□
6. The management makes changes based on my suggestions and feedback.	1□	2□	3□	4□
7. I am appropriately recognized when I perform well at my regular work duties.	1□	2□	3□	4□
8. The organization rules make it easy for me to do a good job.	1□	2□	3□	4□
9. I am satisfied with my chances for promotion.	1□	2□	3□	4□
10. I have adequate opportunities to develop my professional skills.	1□	2□	3□	4□
11. I have an accurate written job description.	1□	2□	3□	4□
12. The amount of work I am expected to finish each week is reasonable.	1□	2□	3□	4□
13. My work assignments are always clearly explained to me.	1□	2□	3□	4□
14. My work is evaluated based on a fair system of performance standards.	1□	2□	3□	4□
15. My department provides all the equipment, supplies, and resources necessary for me to perform my duties.	1□	2□	3□	4□
16. The buildings, grounds, and layout of this facility are adequate for me to perform my duties.	1□	2□	3□	4□
17. My coworkers and I work well together.	1□	2□	3□	4□
18. I feel I can easily communicate with members from all levels of this organization.	1□	2□	3□	4□
19. I would recommend this health facility to other workers as a good place to work.	Definitely No 1□	Probably No 2□	Probably Yes 3□	Definitely Yes 4□
20. How would you rate this health facility as a place to work on a scale of 1 (the worst) to 10 (the best)?	□ □ □ □ □ □ □ □ □ □ 1 2 3 4 5 6 7 8 9 10 Worst……Best			

Note. Adpated from "Development of a Brief Instrument for Assessing Healthcare Employee Satisfaction in a Low-Income Setting" by Alpern et al. (2013), PLoS ONE, 8(110), p.3. Copyright by the Creative Commons Attribution License. Material can be reproduced and used with acknowledgement of the authors.

Appendix D: Strategic Action Plan Template

Goal:				
Vision/Mission:				
Objective (Use measurable and time-specific language)	Person Assigned	Target Completion Date	Completion Date	Outcome
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Note. The strategic action plan template, created by the scholar-consultant researcher, was developed specifically for the BHOPS's senior leadership. The plan is intended to assist the senior leaders in preparing for and managing organizational change. Permission is granted to anyone who desires to adapt or use this plan for research or training purposes.