2015

Evaluation of the Privatization of Services from the Community Mental Health Center

Prepared for: Region V Systems

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Table of Contents

Table of Tables and Figures

Glossary

Board - Lancaster County Board of Commissioners
CMHC - Community Mental Health Center
CP - CenterPointe
LFS - Lutheran Family Services of Nebraska
PPC - University of Nebraska Public Policy Center
RFP - Request for Proposals
RVS - Region V Systems

Executive Summary

Over a 3-year period[1] from 2011 - 2014 the Lancaster County Board of Commissioners (Nebraska) initiated a process to discontinue delivering behavioral health services through the Lancaster County Community Mental Health Center. Region V Systems was selected to lead the transition process and services were ultimately moved to CenterPointe and Lutheran Family Services of Nebraska.

Region V Systems, the behavioral health authority whose geographical area includes Lancaster County, contracted with the University of Nebraska Public Policy Center to conduct a process evaluation of the privatization. The purpose of the evaluation was to document the progress of the privatization from the perspectives of clients, staff, and organizational leaders. Information was gathered through surveys, focus groups, interviews, and documentary review.

The complicated privatization of services, although now completed, is still relatively new to clients, staff, and the community. There have been successes. All services planned for privatization through the Request for Proposals process have been transitioned to other agencies. Most clients indicated that the quality of care and their relationships with staff are about the same as that received from the Community Mental Health Center. There have been no increases in clients accessing crisis-type services. Organizational representatives report good collaboration and the benefits of an empowerment approach to services.

There have also been challenges. Although some clients indicated greater satisfaction with care as a result of privatization, there were others who were less satisfied and who cited on-going difficulties and confusion. Most staff, particularly former Community Mental Health Center staff, were dissatisfied with the transition process. Organizational representatives reported challenges in transitioning clients seamlessly and in unanticipated services or delivery processes.

The findings suggest three overall recommendations:

1. The community should continue to **assist consumers** who are struggling with the changes in the delivery system.
2. The community should **monitor** client satisfaction, usage of crisis services, and costs.
3. Future similar efforts will need to **balance** transparency and input with timeliness and disruption, **ensure clarity** about clients served and what would happen to all previously-offered services, and **smooth** the transition with better communications between clients and providers.

[1] The transition period extended from when the Lancaster County Board of Commissioners determined it would no longer deliver behavioral health services (2011) to the date the final services were assumed by the awarded organizations (2014).

Evaluation Approach

Region V Systems[2] (RVS) contracted with the University of Nebraska Public Policy Center (PPC) to conduct an evaluation of the privatization process. The goal of the evaluation was to articulate the successes and challenges of the transition from the perspectives of clients,[3] staff, and organizational and community leaders, and to document lessons learned.

Ideally, an evaluation would have given participants and organizations time to fully implement and adjust to the privatization process.[4] However, the desire for early feedback about the transition outweighed the benefits of allowing clients to acclimate more completely to their new providers.

The following sections present the perspectives of the target groups, based on data gathered through (Table 1):

- Interviews and focus groups
- Surveys
- Documentary review
- Personal feedback (visits/calls from consumers and former staff)

TABLE 1. COMPONENTS OF DATA COLLECTION

Target Group	Data Source	Timeline
Clients	Survey Mailed	May 20, 2014
	Surveys Onsite at CP and LFS	May 27 through June 13, 2014
	Focus Group	May 20, 2014
	Personal Feedback	Periodically from May 21 through June 17, 2014
Staff	Survey Mailed to Former CMHC Staff	May 15, 2014
	Survey Delivered by CP and LFS to Current Staff	May 27, 2014
	Personal Feedback	Periodically from May 20 through June 2, 2014
Provider Organizations and Community Leaders	Telephone Interviews	April 22 through May 25, 2014
	Face-to-Face Interviews	November 3 through 14, 2014
	Documentary Review	Throughout evaluation period

[2] Region V Systems, a political subdivision of the State of Nebraska, has the statutory responsibility for organizing and supervising comprehensive mental health and substance abuse services in RVS' geographical area, which includes Butler, Fillmore, Gage, Jefferson, Johnson, Lancaster, Nemaha, Otoe, Pawnee, Polk, Richardson, Saline, Saunders, Seward, Thayer, and York counties in southeast Nebraska.

[3] People who receive behavioral health services often refer to themselves as consumers of those services. Mental health professionals who provide behavioral health services often refer to those who receive these services as clients or patients. Consumers, clients, and patients are all used in this report, depending on the point of view of the speaker.

[4] For example, consumers were asked to respond to surveys after having had only several months' experience with the privatized psychiatric medication management services, which was still in the transition process.

At times the information within and between the target groups was divergent and conflicting. Throughout the process, researchers confirmed facts wherever possible. When presenting the lived experiences of participants, however, this report documents their perspectives as described by them.

Background

Established in 1976 as a public agency, the Lancaster County Community Mental Health Center (CMHC) provided treatment for persons with severe and persistent mental illness. In 2011, the Lancaster County Board of Commissioners (Board) determined that the County would cease providing behavioral health services. The Board worked with RVS to transition many of the services provided by CMHC to private sector organizations. The only program that would continue to be operated directly by the County would be Crisis Center services.[5]

Initiation of Privatization

From 2011 – 2013, the Board initiated a public process to plan the privatization (Table 2). The Board established two bodies to advise it during the planning process: the CMHC Planning Committee and the CMHC Intent to Negotiate Committee. Acting upon the recommendation of both committees, the Board selected RVS to oversee an Intent to Negotiate process.

TABLE 2. PRIVATIZATION TIMELINE

Date	Activity
June 2011	Board decides to privatize CMHC services; CMHC Planning Committee established
October – November 2011	Focus groups held for consumers and their families, CMHC staff, advocacy groups, and service providers; town hall meeting convened (facilitated by Community Health Endowment of Lincoln and Leadership Lincoln)
January 2012	Health Management Associates issues a report[6] commissioned by the Community Health Endowment of Lincoln that includes a recommendation to privatize CMHC services
February 2012	CMHC Planning Committee issues *Report and Recommendations* that includes recommendations about process to privatize CMHC services
April 2012	CMHC Intent to Negotiate Committee established
October 2012	RVS selected by Intent to Negotiate Committee to administer Request for Qualifications and Request for Proposals process
October – November 2012	Second round of focus groups held for consumers and their families, CMHC staff, advocacy groups, and service providers.
February 2013	Request for Qualifications released by RVS
March 2013	Request for Proposals released by RVS
April 2013	Deadline for responses to Request for Proposals
June 2013	Three agencies selected to assume services delivery: CenterPointe; Lutheran Family Services; and OMNI Behavioral Health
October 2013 – April 2014	Services transition from CMHC to other provider organizations
January 31, 2014	CMHC closes

[5] In Nebraska, counties are statutorily mandated to pay the cost of providing emergency protective custody for residents. The Crisis Center became a new entity, distinct and separate from CMHC, upon CMHC's closure.

[6] Health Management Associates. (2012). *A comprehensive plan to address appropriate, effective and sustainable health care services for the uninsured and Medicaid populations in Lincoln, Nebraska*. Chicago, IL: Author.

On February 1, 2013, a Request for Qualifications was released to identify qualified providers. On March 28, 2013, qualified providers were invited to submit responses to a Request for Proposals (RFP). The Intent to Negotiate Committee approved seven services to be included in the Intent to Negotiate RFP: 24 Hour Crisis Line, community support, day rehabilitation, day treatment/partial hospitalization,[7] psychiatric medication management, outpatient therapy, and psychiatric residential rehabilitation (Table 3). The RFP provided estimates of the number of clients receiving treatment through each of the services (subsequent to the publication of the RFP, it was discovered that many of those estimates were likely inaccurate[8]).

TABLE 3. PRIVATIZED SERVICES

Services	Description
24 Hour Crisis Line	Crisis assessment, intervention, and information available 24 hours per day by phone
Community Support	Case management and services; residential support services
Day Rehabilitation	Clinical rehabilitation program
Day Treatment / Partial Hospitalization	Short term, intensive treatment through group formats. Sometimes described as a service that is a bridge between full hospitalization and outpatient therapy: consumers can be seen daily for therapy while returning home at night.
Psychiatric Medication Management	Medication education and management
Outpatient Therapy	Individual and group therapy sessions
Psychiatric Residential Rehabilitation	Structured residential facility; residential transition from Lincoln Regional Center to community

As the Intent to Negotiate Committee developed the RFP, it was decided that a number of services and supports previously provided by CMHC and not under contract with RVS would not be included in the transition process.[9] Some of these services were supports within services and others were stand-alone services.[10] In many cases, services not included in the RFP may have continued, but ongoing provision of other services has been uncertain. The most visible example is the Sexual Trauma/Offense Prevention (STOP) program, an outpatient treatment

[7] A reference to either day treatment or partial hospitalization indicates the same service.
[8] For example, it was later discovered that estimates included clients who had not recently received services. After the RFP and in anticipation of the transition, RVS administratively closed over 2,000 client records.
[9] RVS and provider organizations made additional decisions about service continuation after further assessment of clients served and their needs.
[10] A description of some of these programs appears as Exhibit A of Lancaster County Board of Commissioners Staff Meeting Minutes dated September 19, 2013.

program. The program's funding was to end June 30, 2014, but in late June 2014 the County Board approved $40,000 to continue the program through September 30, 2014. In October 2014, the Nebraska Department of Health and Human Services authorized temporary state funding through June 30, 2015 to support the program.

The RFP stated (Region V Systems, 2013, p. 2):

> It is the strategic intent of this RFP to ensure that current CMHC consumers continue to receive uninterrupted services while remaining fully informed throughout the transition and ultimately achieve a seamless, successful transition to the new community provider(s). It is also an expectation that the current RVS and Medicaid capacity provided by CMHC be maintained at existing levels to ensure access to services remains consistent for current CMHC and future consumers in need of affordable, high quality services regardless of payer source.

The privatization of services did not change the requirements of all RVS network providers that services be offered on a sliding fee scale to all clinically and financially eligible consumers.

Selection of Provider Organizations

Contracts to assume CMHC services were originally awarded to three organizations: CenterPointe (CP) - 24 Hour Crisis Line, day rehabilitation; Lutheran Family Services (LFS) - community support, psychiatric medication management, outpatient therapy, and day treatment/partial hospitalization; and OMNI Behavioral Health - psychiatric residential rehabilitation. However, OMNI Behavioral Health later withdrew and those psychiatric residential rehabilitation services were subsequently awarded to CP. The transition of services was staggered over six months, with the first services transitioning from CMHC in October 2013 and the last April 2014 (Table 4). CMHC officially ended operations on January 31, 2014.

TABLE 4. SERVICES DESCRIPTIONS

Transitioned Services	Start Date of Transition from CMHC	Description of Privatization Process
24 Hour Crisis Line	October 1, 2013	The new CP Crisis Line number and the former CMHC Crisis Line number operated concurrently for four months (October, 2013 through January, 2014). The CMHC Crisis Line used the same phone number as the agency's main number, so CMHC's Crisis Line could not be discontinued while CMHC was in operation.
Community Support	January 13, 2014	Community support was the first service transferred to LFS from CMHC during the transition. LFS offers community support services from the former CMHC location.

Transitioned Services	Start Date of Transition from CMHC	Description of Privatization Process
Day Rehabilitation	October 1, 2013	CP merged its existing day rehabilitation program with the CMHC's day rehabilitation program. Consumers of the merged programs asked to change the program's name to MidPointe to reflect the merger. Consumers meet for day rehabilitation at the location of CMHC's original day rehabilitation program.
Day Treatment/Partial Hospitalization	Service no longer offered under privatization contract	LFS was awarded the contract, but due to low utilization, LFS and RVS jointly made the decision to discontinue the program. Day treatment/partial hospitalization services are currently offered by Bryan Medical Center West and Blue Valley Behavioral Health.
Psychiatric Medication Management	March 1, 2014	CMHC provided psychiatric medication management until its closure (January 31, 2014), and continued to operate a portion of its psychiatric medication management program until mid-March of that year. That portion of the CMHC psychiatric medication management program remained at the former CMHC location during February 2014 while the County transitioned its medication supply left after CMHC closed. There were two periods of a few days each during the transition when medications were not available for pick up by consumers. This occurred in early February 2014 while medications that had been managed by CMHC were sorted and labeled and again in early March 2014 when County representatives moved those psychiatric medications to the Lincoln-Lancaster County Health Department. The medications were organized there for consumers to pick up by June 30, 2014 (any medication remaining at the Health Department after June 30, 2014 was destroyed). Attempts were made to contact consumers in advance (in person or by telephone) of these downtimes. However, incorrect contact information for many hindered notification of clients. Consequently, some consumers came to LFS to pick up medications that had been moved to LLCHD. County staff, LLCHD, and LFS worked together to resolve these situations. LFS offers psychiatric medication management services from the former CMHC location.

Outpatient Therapy	February 1, 2014	LFS operates outpatient therapy services from the former CMHC location.
Psychiatric Residential Rehabilitation	April 1, 2014	OMNI Behavioral Health was originally selected to assume services, but by September 2013 had withdrawn its offer. In late October 2013, CP was selected to provide psychiatric residential rehabilitation in addition to the two services it was originally awarded. CP assumed those services on April 1, 2014 using the County license. The County has a license for 15 beds at the psychiatric residential rehabilitation location, and CP will obtain their own 15 bed license for the location upon State approval.

Clients Served and Staff from the Community Mental Health Center

Both CP and LFS provided aggregated information about clients served in the newly-privatized programs and staffing profiles through June 30, 2014. Comparisons to clients served through CMHC are impossible due to variation in determining who is an active client and who provides services to clients.[11]

CenterPointe

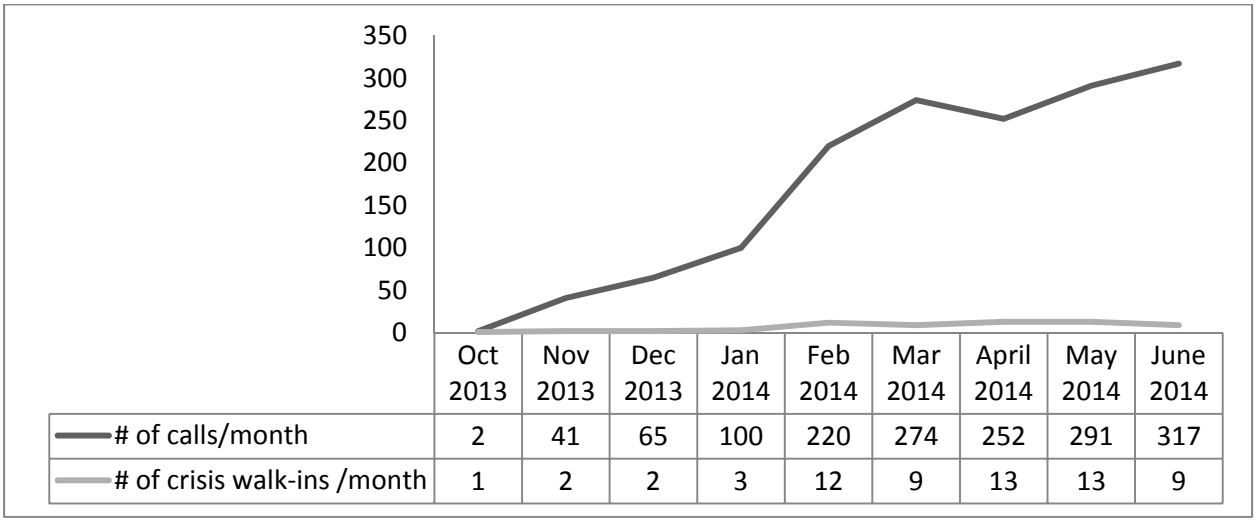
CP was selected to operate the 24 Hour Crisis Line, day rehabilitation, and psychiatric residential rehabilitation services.

Persons Served

The gradual transition of the **24 Hour Crisis Line** from CMHC to CP began on October 1, 2013 and continued through January 31, 2014. Under CMHC the 24 Hour Crisis Line rang at the CMHC main desk number, so that number could not be terminated until the end of January when CMHC officially closed. Because the CMHC 24 Hour Crisis Line number was published many places, both lines (the CMHC main desk/Crisis Line and the CP 24 Hour Crisis Line) remained in operation and both lines answered crisis calls until January 31, 2014. The number of calls to the 24 Hour Crisis Line operated by CP has steadily increased from CP's assumption of those services (with CP becoming the sole provider of 24 Hours Crisis Line service as of February 1, 2014). According to RVS, CMHC's annual reports indicated Crisis Line call volumes between 3,500 and 4,700. Because the Crisis Line was also the main line for the agency, it is difficult to assess the precision of that estimate or to determine whether crisis call volume changed during the transition of services. Annualizing the most recent month for which data was made available for this report (June 2014 with 317 calls), CP would reach over 3,800 calls in a twelve-month period, which falls within the estimated annual call volume when the Crisis Line was operated by CMHC.

[11] CMHC classified many clients as "active" even though they were not currently receiving services. CMHC had a mix of permanent, temporary, on-call, and contracted staff for many programs.

FIGURE 1. 24 HOUR CRISIS LINE USE



	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	April 2014	May 2014	June 2014
# of calls/month	2	41	65	100	220	274	252	291	317
# of crisis walk-ins /month	1	2	2	3	12	9	13	13	9

During the first year of providing **day rehabilitation** services, CP served 121 persons (Table 5). Preliminary estimates of the client population were that 165 persons might be served through this program; however, upon evaluating clients' level of care needs, CP identified a number of clients who were more appropriately served through other services (primarily lower intensity), thus reducing the number of clients receiving day rehabilitation. Having served 121 persons during Fiscal year 2013-14, CP may have established a new, more appropriate estimate for this program. During its first three months of providing **psychiatric residential rehabilitation** services, CP has served 11 persons (Table 5).

TABLE 5. CENTERPOINTE UNDUPLICATED PERSONS SERVED

Service Category	One-year Estimate of Unduplicated Persons that Could be Served (funded through Region V and Medicaid)[12]	# of Unduplicated Persons Served (Fiscal Year 2013-14)[13]
Day Rehabilitation	165	121 **Provided service entire FY** (CP services, July 1, 2013 – September 30, 2013; combined[14] services October 1, 2013 – June 30, 2014
Psychiatric Residential Rehabilitation	*CP did not originally plan to deliver this service, but initial estimates of client population was 20-28 persons*	11 **Provided service 3 months of FY** (services began on April 1, 2014 with a 15 bed capacity)

[12] CP one-year estimate from page 80 of their response to the RFP. The RFP included estimates of the number of clients receiving treatment in each service category; however, the veracity of those numbers has subsequently been questioned.

[13] The fiscal year runs from July 1 through June 30. CP did not provide all services listed in Table 5 for the entire fiscal year.

[14] CP operated its existing day rehabilitation program from July 1, 2013 through September 30, 2013 and then combined the existing program with the CMHC day rehabilitation program on October 1, 2013.

Staffing

CP reports having hired seven former CMHC staff, all of whom continue to work at the agency (Table 6).

TABLE 6. FORMER CMHC STAFF WITH EMPLOYMENT AT CENTERPOINTE

Service Category	Former CMHC Staff Interviewed	Former CMHC Staff Hired	Former CMHC Staff Still at CP as of June 30, 2014
24 Hour Crisis Line	1	1	1
Day Rehabilitation	4	3	3
Psychiatric Residential Rehabilitation	7	3	3

Lutheran Family Services

LFS was selected to provide community support, day treatment/partial hospitalization, psychiatric medication management, and outpatient therapy.

Persons Served

LFS operated **community support**, **psychiatric medication management**, and **outpatient therapy** for approximately one-half of the 2013-14 Fiscal Year. LFS had originally intended to offer **day treatment/partial hospitalization** services, but after reviewing client records, LFS found low rates of authorization for and utilization of these services, making it difficult to sustainably offer the services within the new environment. LFS and RVS agreed that consumers who might benefit from these services will be referred to other providers in the community.[15]

LFS served 284 persons during the first five months of delivering **community support** services, 776 through **psychiatric medication management** services, [16] and 269 through **outpatient services** (Table 7).

[15] Bryan Medical Center West and Blue Valley Behavioral Health offer partial hospitalization.

[16] From January – March 2014, there was some overlap in consumers receiving psychiatric medication management services from CMHC and those consumers receiving psychiatric medication management services from LFS. Both agencies were doing their own psychiatric medication management billing during this period.

TABLE 7. LUTHERAN FAMILY SERVICES UNDUPLICATED PERSONS SERVED

Service Category	One-year Estimate of Unduplicated Persons that Could be Served (funded through Region V and Medicaid)[17]	# of Unduplicated Persons Served (Fiscal Year 2013-14)[18]
Community Support	900	284 **Provided service 5 months of FY** (services began on February 3, 2014)
Day Treatment/Partial Hospitalization	200	Services not offered
Psychiatric medication management	1,800	776 **Provided service 5 months of FY** (services began on February 3, 2014)
Outpatient Therapy	700	269 **Provided service 5 months of FY** (services began on February 3, 2014)

Staffing

LFS hired 10 former CMHC staff, 8 of whom continue at the agency (Table 8).

TABLE 8. FORMER CMHC STAFF WITH EMPLOYMENT AT LUTHERAN FAMILY SERVICES

Service Category	Former CMHC Staff Interviewed	Former CMHC Staff Hired	Former CMHC Staff Still at CP as of June 30, 2014
Community Support	11	10	8
Day Treatment/Partial Hospitalization		Services not offered	
Psychiatric medication management	3	0[19]	0
Outpatient Therapy	3	0[20]	0

[17] LFS one-year estimates from pages 36, 78, 123, and 165 of their response to the RFP. The RFP included estimates of the number of clients receiving treatment in each service category; however, the veracity of those numbers has subsequently been questioned.

[18] The fiscal year runs from July 1 through June 30. LFS did not provide any service listed in Table 7 for the entire FY.

[19] Three former CMHC staff were offered positions but declined.

Crisis Services Utilization

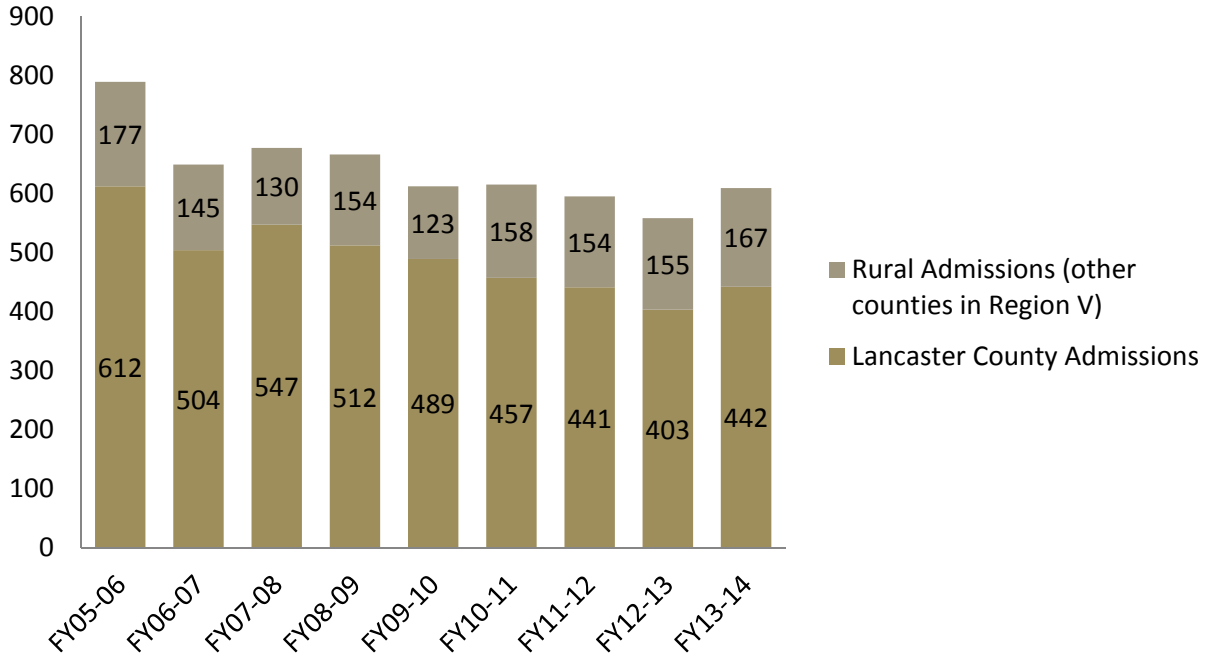
One measure of the impact of the privatization may be the use of crisis services in the community. Most behavioral health services did not transition until at least the second half of Fiscal Year 2013-14,[21] therefore any impact on emergency services due to the transition is likely to be small in that year. Trends in future years may better indicate any influence of the transition on emergency services. RVS reports that it will continue to monitor crisis services utilization, but has seen no increases, even for data into Fiscal Year 2014-15. Crisis services utilization trends available from RVS that may provide important insight into the functioning of the behavioral health system are:

- Admissions to the Crisis Center
- Crisis Center admissions type
- Mental Health Board warrants
- Post commitment days

<u>Admissions to the Crisis Center</u>

Most admissions to the Crisis Center are from Lancaster County (Figure 2). All admissions have been on a general downward trend since 2005-06.[22]

FIGURE 2. CRISIS CENTER ADMISSIONS FROM LANCASTER COUNTY

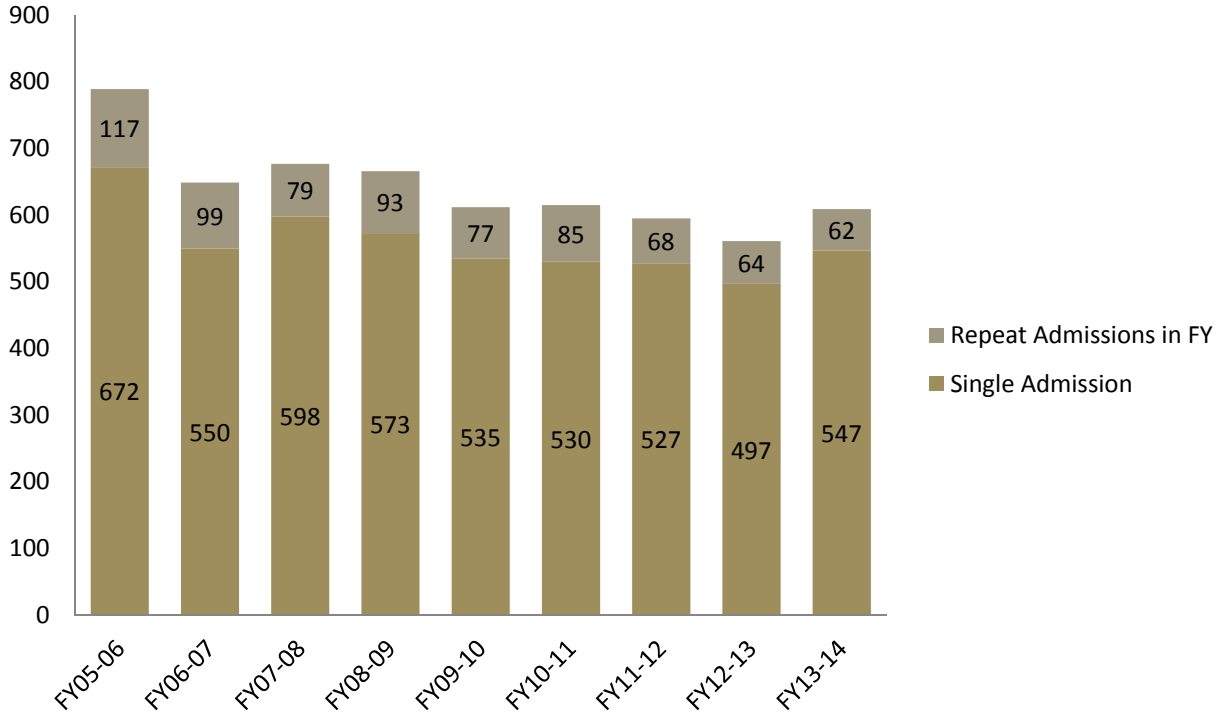


[20] Two former CMHC staff were offered positions but declined.
[21] The fiscal year runs from July 1 through June 30.
[22] The fiscal year runs from July 1 through June 30.

Crisis Center admission type

Repeat admissions and single admissions to the Crisis Center have generally been on a downward trend (Figure 3).

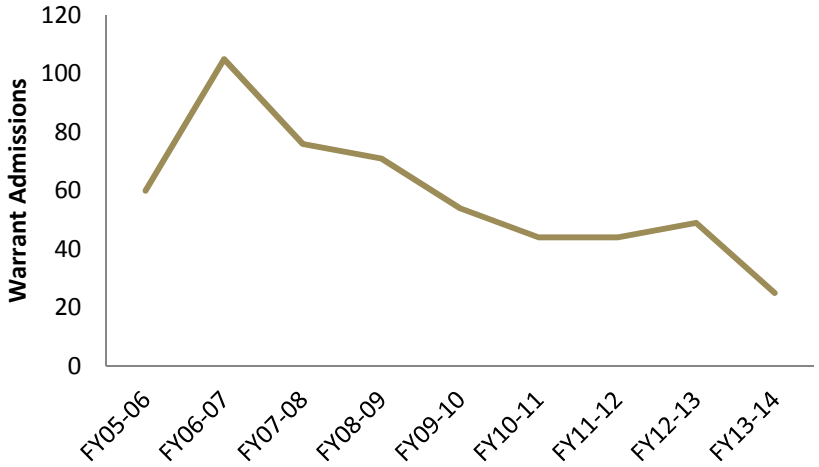
FIGURE 3. CRISIS CENTER ADMISSIONS



Mental Health Board warrants

Persons believed to be dangerous due to a mental illness are admitted to the Crisis Center for evaluation. In Region V, admissions to the Crisis Center as the result of a warrant have been on a downward trend (Figure 4).

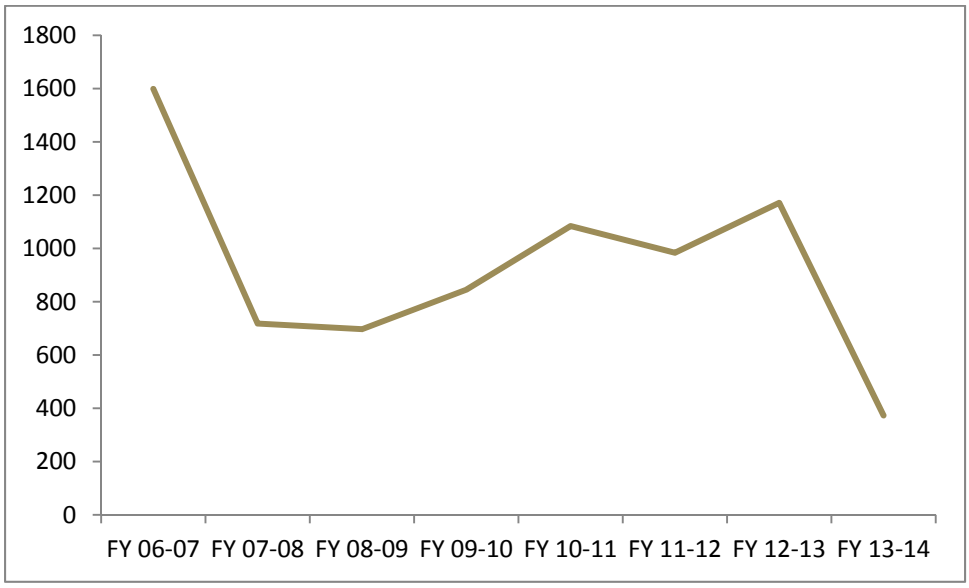
FIGURE 4. MENTAL HEALTH BOARD WARRANTS



Post commitment days

Post commitment days are the number of days individuals wait at the Crisis Center for commitment to the Lincoln Regional Center for treatment. In Region V, post commitment days have been on a downward trend (Figure 5). The decrease may be partly due to a decrease in the number of post commitment days authorized under managed care.

FIGURE 5. POST COMMITMENT DAYS



Consumer Experience

The consumer experience with the privatization was collected through anonymous surveys, a focus group, and personal feedback. The survey data will be presented first, followed by those from focus groups and personal feedback.

Results indicate that:

- Most respondents were dissatisfied with many aspects of the transition process.
- Most respondents feel their care and relationships with providers are about the same as prior to the privatization. However, there are respondents who are more satisfied and respondents who are less satisfied.
- Most respondents offered a mix of positive and negative comments about the privatization.
- Clients differed in satisfaction based on services received: day rehabilitation clients and psychiatric rehabilitation clients were more satisfied with some aspects of the privatization and psychiatric medication management clients less satisfied.

Consumer Survey Design and Administration

A survey was developed to capture consumers' experiences with the privatization. During the evaluation, feedback was received from behavioral health administrators, consumers, and survey experts. The survey was created to measure three separate concepts of the privatization:

- Client experience of the **transition process** (8 questions with response categories of *Yes*, *No*, *Don't Know*)
- Client **assessment of quality of care** (13 questions, plus 11 questions that each appeared on one-third of the surveys, with response categories of *Worse*, *Same*, *Better*, and *Don't Know*)
- Client assessment of **relationship with provider staff** (11 questions, plus 6 questions that each appeared on one-third of the surveys, with response categories of *Worse*, *Same*, *Better*, and *Don't Know*)

The survey also gave respondents the opportunity to describe their experience in two open-ended questions:

- In your opinion, what has been **positive** about the transition of services from the Community Mental Health Center?
- In your opinion, what has been **negative** about the transition of services from the Community Mental Health Center?

Upon compilation of data from returned surveys, tests of internal consistency and separability of concepts were conducted and were positively confirmative. This means that responses within the concepts were answered in similar patterns, and answers between concepts differentiated. Analyses confirmed that qualitative and quantitative responses followed expected patterns, as well. A copy of the final survey, along with detailed survey administration information is included in Appendix A.

The survey was made available to former CMHC clients through a mailing and surveys handed out at CP and LFS (Table 9). The return rate for the mailed survey was relatively low (12%) and for the small number of onsite surveys relatively high (62%). Given the low response rate, caution should be taken in generalizing results to the entire population.

TABLE 9. CONSUMER SURVEY RESPONSE RATE

Modality		
Mailed		
	Sent	1,703
	Returned as Undeliverable by USPS[23]	577
	Presumed Delivered	1,126
	Surveys Returned	135
	Return Rate of Delivered Surveys	12%
Onsite		
	Handed Out	34
	Surveys Returned	21
	Return Rate of Onsite Surveys	62%
	Total Surveys Received	156

Not all surveys that were received were included in the data analysis (Table 10). Twenty-seven were excluded from further analyses for a variety of reasons, the most common of which were respondent self-identification of not having been a client of CMHC or not currently receiving behavioral health services.[24]

[23] United States Postal Service

[24] Respondents who indicated they were currently receiving services (either by checking at least one service in a list of services currently being received or by mentioning services being received in their open-ended responses) were considered to have answered 'yes' to the question "Do you now receive behavioral health services?" Likewise, respondents indicating they previously received services from CMHC (either by checking at least one service in a list of services previously received from CMHC or in responses to open-ended questions) were considered to have answered 'yes' to the question "Did you receive behavioral health services from the Community Mental Health Center?"

TABLE 10. SURVEYS NOT INCLUDED IN ANALYSES

Reason for Exclusion		*n*
Returned		156
Respondent indicated they had not previously been a client of CMHC		10
Respondent returned blank survey		1
Respondent indicated they are not currently receiving behavioral health services		16
Completed treatment	4	
Not interested	3	
Unsure who to contact	3	
Other		
Uncomfortable with LFS religious affiliation	1	
Services needed are not offered	1	
Transitioned, but after provider illness appointment was not rescheduled	1	
Unsure whether receiving behavioral health services	1	
Still want services (but did not indicate uncertainty about who to contact)	1	
Number of surveys included in analyses of respondents receiving behavioral health services		129

A number of services "awarded" to CP or LFS through the privatization process are also offered by other providers in the community. CMHC clients were not restricted to accessing their services only through CP or LFS. The survey did not ask clients to identify the agencies from which they currently receive services, so tracking movement of individual clients to new providers was not possible. However, 16 respondents voluntarily indicated they were receiving behavioral health services from agencies other than CP or LFS (Table 11). Their answers were included in further analyses.

TABLE 11. OTHER PROVIDERS FORMER CMHC CLIENTS MENTIONED

Provider	*n*
Blue Valley Behavioral Health	9
Plaza West Psychiatrists	3
Other private practice providers	3
Combination of Catholic Social Services and a private practice provider	1

Respondents were fairly evenly divided by gender, with 54% of respondents being men and 46% being women (Table 12). Most respondents (57%) were between the ages of 45 to 64: Younger age groups (under 26 years of age) are not well-represented in the survey responses (4%).

TABLE 12. DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

Demographic Characteristics	%	*n*
Gender		
Male	54%	69
Female	46%	58
Total		127

Demographic Characteristics	%	*n*
Age Group		
19 to 25	4%	5
26 to 44	29%	37
45 to 64	57%	74
Older than 65	10%	13
Total		129

Respondents reported receiving similar clusters of services after the transition as they did before the transition (Table 13). Further, receiving a specific service in the past is highly correlated with currently receiving that same service (all correlations of a specific service with itself before and after the transition are significant at $p < .001$).

TABLE 13. SERVICE CLUSTERS

Prior to Transition		Following the Transition	
Service	*Other Services Correlates*	*Service*	*Other Services Correlates*
Day Rehabilitation	Community Support, Day Treatment, and Psychiatric Rehabilitation	Day Rehabilitation	Day Treatment and Psychiatric Rehabilitation
Community Support	Psychiatric Rehabilitation	Community Support	Psychiatric Rehabilitation
		Day Treatment	Community Support and Psychiatric Rehabilitation
		Outpatient Counseling	Community Support

Consumer Responses to Privatization

Overall, consumers reported that the privatization has not led to great differences in their care.

Client experience of the transition process

Consumers rated their experience as positive for five of the eight transition process questions (Table 14).

TABLE 14. TRANSITION PROCESS ITEMS

Transition Process	Yes % (*n*)	No % (*n*)	Don't Know % (*n*)
I received communications about the transition.	71 (90)	23 (29)	6 (7)
Staff members at my new behavioral health provider helped me feel at ease during the transition.	69 (85)	27 (33)	5 (6)
Staff members gave me support during the transition.	59 (74)	36 (45)	6 (7)
Information about me was given to my new provider.	58 (72)	22 (27)	20 (25)

Transition Process	Yes % (*n*)	No % (*n*)	Don't Know % (*n*)
CMHC staff members helped me feel at ease during the transition.	57 (72)	33 (42)	10 (12)
The CMHC and staff members at my new behavioral health provider worked together to transition my services.	48 (61)	29 (37)	22 (28)
I received information about consumer meetings.	33 (40)	59 (72)	9 (11)
My voice was heard about the transition process.	26 (33)	52 (66)	21 (27)

Note: Responses to the items are significantly different ($F(7,50) = 4.707$, $p < .001$, $N = 57$) (analysis excludes "Don't Know" responses). A further analysis revealed that the bottom two items received a lower percent of 'yes' responses than did the top six items, which do not differ significantly from each other.

Client assessment of quality of care

A second set of questions asked clients to assess how their quality of care has been affected by the transition (Table 15). On average, clients rated their experience as *Same* for all quality of care questions. There were ten questions for which the majority response was *Don't Know*. Most of these items asked about specific services (e.g., employment, legal services, housing) which, presumably, the consumer had not accessed.

TABLE 15. IMPACT ON CARE ITEMS

Impact on Care	Mean (*SD*)	Worse (1) % (*n*)	Same (2) % (*n*)	Better (3) % (*n*)	Don't Know % (*n*)
Items appearing on all surveys					
Feeling physically safe in the service setting	2.3 (0.5)	4 (5)	61 (76)	30 (38)	5 (6)
Receiving services you don't need	2.2 (0.6)	4 (5)	33 (40)	15 (18)	48 (59)
The quality of care you receive	2.2 (0.8)	19 (24)	38 (47)	37 (46)	6 (7)
Meeting treatment goals with services you receive	2.2 (0.7)	12 (15)	46 (57)	27 (33)	15 (18)
Being involved in decisions about your treatment	2.2 (0.6)	11 (14)	50 (63)	26 (33)	12 (15)
Receiving needed services, regardless of your personal ability to pay (such as co-pay and other out of pocket expenses)	2.1 (0.7)	15 (19)	51 (63)	23 (29)	11 (13)
Your overall satisfaction with services	2.1 (0.8)	27 (34)	33 (41)	35 (43)	5 (6)
Availability of appointments when you need them	2.1 (0.7)	22 (28)	46 (58)	28 (35)	3 (4)
Coordination of your care by behavioral health and medical health care providers	2.1 (0.7)	19 (23)	43 (52)	23 (28)	15 (18)
Receiving services you need	2.1 (0.7)	23 (29)	44 (55)	28 (35)	5 (6)
Your access to after hour and crisis services	2.0 (0.7)	11 (14)	29 (36)	12 (15)	47 (58)

Having a sense of community with others who receive behavioral health care	2.0 (0.7)	20 (25)	40 (50)	19 (23)	21.(26)
Receiving needed prescriptions, regardless of your personal ability to pay (such as co-pay and other out of pocket expenses)	2.0 (0.6)	17 (21)	50 (63)	14 (18)	18 (23)
Items appearing on subsets of surveys					
Your access to skill-building/educational services	2.1 (0.6)	6 (2)	25 (9)	11 (4)	58 (21)
Receiving help finding meaningful employment	2.1 (0.7)	9 (4)	32 (14)	14 (6)	46 (20)
Receiving help finding legal services	2.1 (0.7)	6 (2)	19 (7)	8 (3)	67 (24)
Your access to group services	2.1 (0.6)	9 (4)	38 (17)	1 (6)	40 (18)
Receiving help finding housing	2.1 (0.7)	11 (5)	24 (11)	1 (6)	51 (23)
Availability of medicine disbursement at the times you want	2.0 (0.7)	22 (10)	44 (20)	24 (11)	11 (5)
Receiving encouragement to use peer-run services	2.0 (0.8)	17 (7)	2 (9)	17 (7)	45 (19)
Receiving help finding transportation	2.0 (0.8)	17 (7)	26 (11)	17 (7)	41 (17)
Receiving help with meaningful connections to friends/family	2.0 (0.5)	11 (4)	56 (20)	11 (4)	22 (8)
Having the health care you need	2.0 (0.7)	20 (7)	49 (17)	17 (6)	14 (5)
Your access to walk-in services	1.8 (0.9)	26 (11)	14 (6)	17 (7)	43 (18)

Note: Mean calculation excludes "Don't Know."

Note: Responses to the first 13 items about the effect of the transition on care did not differ significantly between items ($F(11,14) = 1.175$, $p = .382$, $N = 25$) (analysis excludes "Don't Know" responses).

Client assessment of relationship with provider staff

A third set of questions asked clients to assess how their relationship with provider staff has been affected by the transition (Table 16). On average, consumers rated their experience as *Same* for all relationship with staff questions.

TABLE 16. RELATIONSHIP WITH STAFF ITEMS

Relationship With Provider Staff	Mean (*SD*)	Worse (1) % (*n*)	Same (2) % (*n*)	Better (3) % (*n*)	Don't Know % (*n*)
Items appearing on all surveys					
Staff members being sensitive to your cultural background (race, religion, language, etc.)	2.2 (0.5)	5 (6)	53 (67)	18 (23)	24 (30)
Staff members explaining things in ways you can understand	2.1 (0.6)	13 (16)	56 (71)	25 (32)	6 (8)
Your overall satisfaction with staff members	2.1 (0.8)	23 (28)	36 (44)	34 (42)	7 (9)
Your agreement with staff members about how to address your problems	2.1 (0.7)	19 (24)	43 (54)	28 (35)	11 (14)
Staff members involving your family in treatment as much as you want	2.1 (0.6)	9 (11)	41 (51)	15 (19)	36 (45)
Staff members telling you about your right to refuse treatment	2.1 (0.6)	8 (10)	44 (57)	14 (18)	33 (41)

Relationship With Provider Staff	Mean (*SD*)	Worse (1) % (*n*)	Same (2) % (*n*)	Better (3) % (*n*)	Don't Know % (*n*)
Your trust in staff members	2.1 (0.8)	27 (33)	35 (43)	33 (41)	6 (7)
Staff members giving information about how to maintain mental health	2.0 (0.7)	17 (21)	42 (52)	20 (25)	22 (27)
Staff members making sure your care is coordinated	2.0 (0.7)	21 (26)	38 (47)	24 (30)	17 (21)
Staff members knowing what they should about your mental health history	2.0 (0.7)	21 (26)	41 (50)	23 (28)	15 (19)
Staff members telling you what to do if you have side effects from medications	2.0 (0.6)	15 (18)	42 (51)	14 (17)	30 (37)
Items appearing on subsets of surveys					
Staff members showing respect for what you have to say	2.3 (0.6)	8 (4)	48 (23)	38 (18)	6 (3)
Staff members telling you about different kinds of treatments available	2.2 (0.6)	10 (5)	45 (22)	22 (11)	22 (11)
Staff members listening carefully to you	2.1 (0.7)	17 (7)	43 (18)	29 (12)	12 (5)
Staff members spending enough time with you	2.0 (0.7)	19 (7)	47 (17)	22 (8)	11 (4)
Your access to the staff members you want to see	1.9 (0.7)	26 (11)	41 (17)	17 (7)	17 (7)
Staff members telling you about benefits and risks of medications	1.9 (0.6)	19 (7)	47 (17)	8 (3)	25 (9)

Note: Mean calculation excludes "Don't Know."

Note: Responses to the first 11 items about the effect of the transition on care did NOT differ significantly between items ($F(10,33) = 1.034$, $p = .438$, $N = 43$)" (analysis excludes "Don't Know" responses).

Differences Between Subgroups of Respondents

Number of Services Received

Some respondents reported receiving fewer services following the transition. Overall, there were no systematic differences in answers between those who received fewer services after the transition and those who did not receive fewer services.[25]

Types of Services Received Prior to the Transition

It is possible that clients who had received specific types of services prior to the transition may have had different transition experiences. We found only two patterns of differences based on services:

[25] There were no differences for the transition process items (all $p > .10$). For the impact on care items, the only difference is that those who received fewer services after the transition rated receiving help finding transportation worse ($M = 1.6$) than those who received the same or more services ($M = 2.3$; $F(1,22) = 5.360$, $p = .030$). For the relationship with staff items, the only difference is for staff members involving family in treatment; those who received fewer services after the transition ($M = 1.8$) rated this item lower than did those who received the same or more services ($M = 2.2$; $F(1,77) = 6.664$, $p = .012$).

- Persons who had received day rehabilitation and psychiatric rehabilitation services tended to be more satisfied with the transition process than those not receiving day rehabilitation services (Table 17).

TABLE 17. COMPARISON OF TRANSITION RESPONSES BY SERVICES RECEIVED

	% Yes			
Subgroupings based on Services Received	**Received Service**	**Did Not Receive Service**	***F***	***p***
Outpatient Counseling				
*I received communications about the transition.	84	63	6.964	.009
Day Rehabilitation				
*Staff members at my new behavioral health provider helped me feel at ease during the transition.	91	68	4.505	.036
*The CMHC and staff members at my new behavioral health provider worked together to transition my services.	88	57	4.429	.038
*CMHC staff members helped me feel at ease during the transition.	88	58	5.711	.019
*Staff members gave me support during the transition.	86	56	7.182	.008
*I received communications about consumer meetings.	57	30	5.687	.019
*My voice was heard about the transition process.	55	27	5.935	.017
Day Treatment (no items with significant differences)				
Psychiatric medication management (no items with significant differences)				
Community Support (no items with significant differences)				
Psychiatric Rehabilitation				
*I received communications about the transition.	90	70	5.170	.025
*Information about me was given to my new provider.	90	65	6.382	.013
*Staff members gave me support during the transition.	77	56	4.407	.038
*The CMHC and staff members at my new behavioral health provider worked together to transition my services.	77	55	4.127	.045

*Significant difference between those who received the service and those who did not receive the service.
Note: Analyses exclude "Don't Know" responses.

- Those who had been receiving day rehabilitation services were more pleased with the impact on some aspects of their care following the transition than were those not receiving day rehabilitation services (Table 18). Those who had been receiving

psychiatric medication management services were less pleased with the impact on their care (Table 18) and on their relationships with staff at provider organizations (Table 19) than those who had not been receiving psychiatric medication management services.

TABLE 18. COMPARISON OF IMPACT ON CARE RESPONSES BY SERVICES RECEIVED

	Mean			
	Received Service	**Did Not Receive Service**	***F***	***p***
Outpatient Counseling (no items with significant differences)				
Day Rehabilitation				
*Receiving help finding legal services	3.0	1.9	6.954	.025
*Being involved in decisions about your treatment	2.5	2.1	4.763	.031
*Receiving help with meaningful connections to friends/family	2.5	1.9	4.439	.045
Day Treatment				
*Receiving help finding housing	2.6	1.9	4.439	.048
Psychiatric medication management				
*The quality of care you receive	2.1	2.4	4.903	.029
*Meeting treatment goals with services you receive	2.1	2.4	6.474	.012
*Your overall satisfaction with services	2.0	2.4	7.410	.007
*Availability of appointments when you need them	2.0	2.3	4.235	.041
*Coordination of your care by behavioral health and medical health care providers	1.9	2.4	7.781	.006
*Receiving services you need	1.9	2.3	7.291	.008
*Receiving help finding housing	1.8	2.5	6.216	.022
*Having the health care you need	1.8	2.3	4.307	.047
Community Support (no items with significant differences)				
Psychiatric Rehabilitation				
*Receiving help finding housing	2.6	1.9	4.439	.048

*Significant difference between those who received the service and those who did not receive the service.

Note: Analyses exclude "Don't Know" responses.

TABLE 19. COMPARISON OF RELATIONSHIP WITH STAFF RESPONSES BY SERVICES RECEIVED

	Mean			
	Received Service	**Did Not Receive Service**	***F***	***p***
Outpatient Counseling (no items with significant differences)				
Day Rehabilitation				
*Staff members making sure your care is coordinated	2.4	2.0	6.492	.012

	Mean			
	Received Service	Did Not Receive Service	*F*	*p*
Day Treatment				
*Staff members making sure your care is coordinated	2.3	2.0	4.271	.041
Psychiatric medication management				
*Staff members showing respect for what you have to say	2.2	2.7	6.096	.018
*Staff members explaining things in ways you can understand	2.0	2.4	8.745	.004
*Your agreement with staff members about how to address your problems	2.0	2.5	12.212	.001
*Your overall satisfaction with staff members	2.0	2.5	11.311	.001
*Staff members telling you about your right to refuse treatment	2.0	2.4	10.841	.001
*Staff members telling you about different kinds of treatments available	2.0	2.5	4.216	.048
*Staff members knowing what they should about your mental health history	1.9	2.4	9.205	.003
*Staff members telling you what to do if you have side effects from medications	1.9	2.4	8.499	.005
*Staff members giving information about how to maintain mental health	1.9	2.4	10.329	.002
*Staff members making sure your care is coordinated	1.9	2.4	11.704	.001
*Your trust in staff members	1.9	2.5	13.550	<.001
*Staff members telling you about benefits and risks of medications	1.7	2.3	5.868	.023
Community Support				
*Your overall satisfaction with staff members	2.4	2.0	4.774	.031
Psychiatric Rehabilitation (no items with significant differences)				

*Significant difference between those who received the service and those who did not receive the service.
Note: Analyses exclude "Don't Know" responses.

Consumer Responses to Open-Ended Questions

Of the 129 consumer surveys included in the analysis, 105 (81%) included written comments. To characterize the overall tenor of the responses, researchers read the comments on each survey and categorized the feedback as *positive, mixed*, *negative, or neutral*. Most respondents had mixed (both positive and negative) comments about the transition (47%) (Table 20).

TABLE 20. CATEGORIZATION OF CONSUMER OPEN-ENDED COMMENTS

	n	%
All Surveys included in analysis	129	--
Surveys with open-ended responses	105	100%

	n	%
Positive	20	19%
Mixed	49	47%
Negative	33	31%
Neutral	3	3%

Note: Percentages based on treating surveys with open-ended responses as 100%.

An analysis of the specific comments identified several general themes. Positive themes were:

- Preference for new therapists and caseworkers
- Feelings of greater safety

Negative themes were:

- Dissatisfaction with psychiatric medication management during the transition
- Feeling that there was a lack of information about the process
- Dissatisfaction with new therapists and caseworkers
- Payment problems
- Less convenient to access array of services

Positive Comments

Preference for new therapists and caseworkers

Some consumers noted that they preferred their new providers or new staff following the privatization process. They felt the privatization has led to better services:

> I receive the same if not better services than before.
>
> My new therapist is excellent...Staff were uneasy about what was happening to them but were very professional as to helping us and kind and reassuring to me. Notices were posted in the waiting room to keep us posted on all the legalities, etc., and we could take the papers home.
>
> I felt before my counseling wasn't enough to actually give me usable tools to combat the illnesses symptoms, it was more talk therapy.
>
> I feel better about my treatment since the transition. My new provider is more organized; I feel more like I'm being listened to and my input is taken more seriously.
>
> I've only had one appointment, but I was very impressed with the doctor who saw me for my meds management. She really listened and had great eye contact.
>
> I have a much better provider now, someone who actually listens.

Feelings of greater safety

Several consumers remarked that they felt physically safer and more secure at the locations of new providers:

> I'm at a different provider, where I feel more safe.
>
> I no longer have to put up with the threatening old CMHC waiting room.

Negative Comments

Dissatisfaction with psychiatric medication management during the transition

The single largest class of complaints consumers have had about the transition was its effect on psychiatric medication management. Many consumers stated that they have experienced a disruption in receiving their prescribed medications as a result of the transition. Some consumers noted that as a result, they went without medication for some time.

> It has been a horrible experience. I was changing meds and was told it would be 2-3 weeks for it to come in on patient assistance. That was 3 months ago. I still have no meds, my application was never submitted and now someone else said I have to wait for an approval letter.
>
> The care I received was poorly coordinated, caused by poor communication among the new staff members and twice left me without my medication for a couple days.
>
> I have experienced significant problems with delays of medication to the point where I have tapered or gone without. These problems seemed to stem from a lack of coordination and communication among staff and definitely a lack of follow through. It appears I have several different files, I've been told I would receive phone calls that I haven't and it's been incumbent upon me to make sure my message was actually received. I was given (and returned) the wrong medication. Not all of my medication has been ordered. This has been a nightmare that continues. When I make a phone call (or 3) I have no faith that my message will impact. I work close to full time and can't afford to sit there for hours to make sure I get what's appropriate. I feel like I'm being put into the position of having to be a pest or nag to get relatively simple services.

Feeling that there was a lack of information about the process

A number of consumers had generally negative opinions about the transition process itself, and believed they had not received sufficient information to prepare for it:

> People [are] unsure in how to direct you. No one person to help you. You don't know who you are going to and get tired of telling needs over and over to new workers. Some days not able to describe - since you don't see just one person and no one gets to know you - they can't help you. Frustrated, sad, constant

> change in meds that don't help. Nothing good about [the] Mental Health Center closing.
>
> I was not told of the closing and what I was supposed to do with my care. I received no letters or calls about the closing. I was in limbo and still am with my services.
>
> The actual transition was very sudden. My last appointment with CMHC people was when I found out that the transition would happen at the end of the week. I think that could have been handled more smoothly.
>
> During this transition, I lost my Medicaid coverage. Nothing else about my medical situation had changed, just the provider. So I blame this on the transition and failure to coordinate my care and relay my records.

Dissatisfaction with new therapists and caseworkers

Several consumers stated their dissatisfaction with new providers, or lack of services they once had. Some noted that they have experienced negative outcomes as a result of having to switch to new providers:

> Only person felt comfortable with and seemed liked they cared - gone.
>
> I was seeing a psychiatrist that I trusted and knew what was going on with me. Now I feel like just another number, an anonymous face.

Payment problems

A few consumers have noted that the transition to new providers has resulted in increased costs for services. This has been problematic for those with limited incomes:

> I can't go to counseling as my insurance isn't accepted.… I no longer get my meds free and I'm struggling financially…The cost of the visits of the new provider are unaffordable.
>
> I can no longer receive free referral services through People's Health Clinic. This has been a real hardship.

Less convenient to access array of services

A few consumers noted that the CMHC had many services at their one location in comparison to now having to travel to several locations to receive services:

> I wish it was still the Mental Health Center, because all my services were in one place.

I can't go see the nurse practitioner and the counselor in the same office on the same day.

Quantitative and Qualitative Responses Are Related

The quantitative responses, as a whole, indicate that the service experience of many clients is approximately the same as prior to the transition process. The open-ended responses convey a story of difficulty during and following the transition. In some ways the results paint two very different pictures of the transition. Were the closed-ended questions either not addressing key concerns of clients or perhaps not understandable? Did only those with complaints use the open-ended response?

An analysis of the relationship between the quantitative and open-ended responses was conducted to compare the quantitative responses of those who offered qualitative comments.[26] Those with positive qualitative comments were more positive about the transition process, the quality of care, and their relationship with provider staff. This indicates that the closed-ended and open-ended items were reliably assessing the experiences of clients.

Focus Group and Personal Feedback

A focus group was convened of consumers who had been receiving services at the CMHC prior to, during, and after the privatization transition. Consumers were asked how the transition to a different services provider had gone for them and whether the quality or availability of their services was affected. Discussion topics also included information and support received during the transition process, positive and/or negative results of the transition, the transition's effect on others in the community, and what might have been done differently during the transition. Several individuals who had received the consumer surveys also called the PPC to discuss their experiences with the transition. Several major themes emerged from the focus group and through personal discussions.

Consumers spoke highly of being **comfortable** with the CMHC providers and staff, the friendly atmosphere of the CMHC waiting room, and the fact that CMHC services were located together.

There was a concern with **lack of accessible information** available to clients about the transition, which caused confusion and inconvenience. Some members of the focus group felt that information provided about the transition had not been accurate or complete. There was a feeling that some of the information provided was not carefully developed for consumers with varying levels of literacy.

[26] Respondents with Neutral qualitative responses could not be included in this analysis due to the small sample size for this group (*n* = 3).

Consumers expressed dissatisfaction that several **programs had been discontinued**. Consumers reported that the Friday social group/alumni meetings had ended. Others mentioned that support groups were no longer available.

Consumers expressed that they **experienced difficulties** as a result of the privatization. Several consumers reported that their calls to the new provider agencies had not been returned or the replies were not helpful. One consumer noted that she went without medication for one week during the transition due to a lack of information and adequate help. Another consumer wanted to follow her old counselor to the counselor's new employer, but in order to do so she will have to pay more than the $1 fee at the CMHC, which is a challenge for her. Another individual who wanted to follow her case manager to a new practice reported she now has to pay more, which is difficult.

Staff Experience

The staff experience with the privatization was primarily collected through surveys.

Results indicate that:

- Most staff were dissatisfied with the privatization, with former CMHC staff being more dissatisfied than current CP and LFS staff.
- No respondents offered only positive comments about the privatization, rather most were a mix or negative only comments.

Staff Survey Design and Administration

Two surveys were designed to capture staff experience with the transition. One survey was created for former CMHC employees and another for staff currently providing services at CP or LFS who are providing the transitioned services. Former CMHC employees now employed by CP or LFS were asked to complete the former CMHC survey, since several additional questions were asked on that survey.

The former CMHC survey had 10 Likert-scaled questions that asked respondents to rate their satisfaction with various aspects of the transition (1=*Very Dissatisfied* to 5=*Very Satisfied*; 6=*Don't Know*). There were three pick list questions: services provided at CMHC, departure timing from CMHC, and employment status.

The survey created for CP/LFS staff currently providing transitioned services had the same 10 Likert-scaled questions that asked them to rate their satisfaction with various components of the transition (1=*Very Dissatisfied* to 5=Very S*atisfied*; 6=*Don't Know*). The questions about services, departure, and employment status were omitted from the survey since they were not applicable to this group.

Both surveys included two qualitative questions about the services transition:

- In your opinion, what has been **positive** about the transition of services from the Community Mental Health Center?
- In your opinion, what has been **negative** about the transition of services from the Community Mental Health Center?

Both versions of the staff survey were tested with staff members from RVS who had knowledge of the transition from CMHC. Staff members were shown the survey transmittal letter and also talked through the survey directions and questions. As a result of comments from those reviewing the survey, the survey directions and scale were made clearer and certain questions were rephrased to clarify their meaning. RVS administrators reviewed and approved the final versions of the staff surveys.

A copy of both surveys is included in Appendix B.

Lancaster County provided the names and addresses of former CMHC employees (employed from April 1, 2012 through January 31, 2014), and the survey was mailed to them on May 15, 2014. The mail date was prior to the distribution of the current staff survey delivered to CP and LFS on May 27, 2014 to allow former CMHC employees subsequently hired by CP or LFS to answer the survey from the perspective of a former CMHC staff member. A postage-paid reply envelope was included, and a return date of May 31, 2014 was requested. Three surveys were returned by the USPS as "not deliverable as addressed." Thirty-one former CMHC staff returned completed surveys. The return rate for deliverable surveys was 44% (Table 21).

Surveys for staff currently providing services were delivered on May 27, 2014 to CP and LFS offices and were distributed to staff through each organization's interoffice mail. Postage-paid return envelopes were included with the surveys. Of the 41 total surveys given to current staff, 19 were returned. The return rate for surveys was 46% (Table 21). Respondents were asked not to answer the survey more than once, as some may have received a mailed survey as a former CMHC employee and a survey at work as a current employee of CP or LFS.[27]

TABLE 21. STAFF SURVEY RESPONSE RATE

Employee Group	
Former CMHC staff	
Sent	73
Returned as Undeliverable by USPS	3
Presumed Delivered	70
Surveys Returned	31
Return Rate of Delivered Surveys	44%
Current CP/LFS staff	
Handed out	41
Surveys Returned	19
Return Rate of Onsite Surveys	46%
Total Surveys Received	50

Staff Responses to Privatization

Each of the ten questions had a mean response rating of less than 3.0, indicating that staff were dissatisfied with the privatization (Table 22). The average rating ranged from 1.7 to 2.7.

[27] Based on self-identification, at least one respondent to the current CP/LFS staff survey was a former CMHC staff member. It is not known whether the respondent also answered the survey sent to former CMHC employees.

TABLE 22. STAFF RESPONSE TO PRIVATIZATION ITEMS

	Mean (SD)	Very dis-satisfied (1) % (*n*)	Dis-satisfied (2) % (*n*)	Neither (3) % (*n*)	Satisfied % (*n*)	Very satisfied % (*n*)	Don't Know % (*n*)
Satisfaction with the quality of care clients are now receiving	2.7 (1.5)	24 (12)	28 (14)	6 (3)	18 (9)	16 (8)	8 (4)
Satisfaction with employment opportunities offered to staff members during the transition process	2.3 (1.4)	44 (22)	14 (7)	12 (6)	20 (10)	6 (3)	4 (2)
Satisfaction with how clients were supported during the transition	2.2 (1.3)	44 (22)	22 (11)	10 (5)	22 (11)	2 (1)	0 (0)
Satisfaction with how information about clients was transferred from CMHC	2.0 (1.1)	42 (21)	32 (16)	8 (4)	16 (8)	0 (0)	2 (1)
Satisfaction clients' needs were met during the transition	2.0 (1.3)	48 (24)	24 (12)	8 (4)	14 (7)	4 (2)	2 (1)
Satisfaction with your opportunity to participate in shaping the transition process	2.0 (1.3)	52 (26)	16 (8)	18 (9)	6 (3)	8 (4)	0 (0)
Satisfaction with the overall transition process	1.9 (1.2)	62 (31)	8 (4)	14 (7)	16 (8)	0 (0)	0 (0)
Satisfaction with communications to you about the transition process	1.9 (1.2)	54 (27)	24 (12)	8 (4)	10 (5)	4 (2)	0 (0)
Satisfaction with how clients were informed about the transition	1.8 (1.0)	48 (24)	34 (17)	6 (3)	8 (4)	2 (1)	2 (1)
Satisfaction with procedures that kept clients from dropping through the cracks during the transition	1.7 (1.0)	56 (28)	26 (13)	4 (2)	12 (6)	0 (0)	2 (1)

Note: Mean calculation excludes "Don't Know."

Differences Between Subgroups of Respondents

Former CMHC staff were more dissatisfied with the transition than CP and LFS staff

Former CMHC staff were significantly more dissatisfied with all aspects of the transition process than CP and LFS staff (Table 23). The mean response from former CMHC staff for all items ranged from 1.17 to 1.78; in other words between *Very dissatisfied* (value=1) and *Dissatisfied* (value=2). In contrast to the dissatisfaction of former CMHC staff, CP and LFS staff varied in their level of satisfaction among items (Table 23). The mean response for items ranged from 2.39 to 4.05, or from *Dissatisfied* (value=2) to *Satisfied* (value=4). For all items, with the exception of one, there was a greater than 1-point mean difference between the responses of former CMHC staff and staff from CP and LFS.

TABLE 23. COMPARISON OF RESPONSES OF FORMER CMHC STAFF TO CURRENT CP AND LFS STAFF

	Former CMHC Staff	CP and LFS Staff	Mean Difference
**Satisfaction with the quality of care clients are now receiving	1.78	4.05	2.27
**Satisfaction with employment opportunities offered to staff members during the transition process	1.58	3.53	1.95
**Satisfaction with opportunity to participate in shaping the transition process	1.29	3.21	1.92
**Satisfaction with how clients were supported during the transition	1.48	3.26	1.78
**Satisfaction with the overall transition process	1.23	2.84	1.62
**Satisfaction clients' needs were met during the transition	1.45	2.94	1.49
**Satisfaction with procedures that kept clients from dropping through the cracks during the transition	1.17	2.58	1.41
**Satisfaction with communications to you about the transition process	1.35	2.68	1.33
**Satisfaction with how information about clients was transferred from CMHC	1.57	2.63	1.06
**Satisfaction with how clients were informed about the transition	1.45	2.39	0.94

** Significance <.01

Note: Analyses exclude "Don't Know" responses.

Former CMHC employees who were subsequently employed by CP or LFS answered similarly to those former CMHC employees not subsequently employed by CP or LFS.

Former CMHC staff members who were subsequently employed by CP or LFS answered questions similarly to former CMHC staff who were not subsequently employed by CP or LFS, except on one item: Former CMHC staff members who were subsequently employed by CP/LFS were less dissatisfied with employment opportunities (Table 24).

TABLE 24. COMPARISON OF RESPONSES OF FORMER CMHC BY SUBSEQUENT EMPLOYMENT AT CP OR LFS

	Former CMHC NOT now at CP or LFS	Former CMHC ARE now at CP or LFS	Mean Difference
**How satisfied are you with employment opportunities offered to staff members during the transition process?	1.36	2.50	1.14
*How satisfied are you clients' needs were met during the transition?	1.28	2.17	0.89
How satisfied are you with the quality of care clients are now receiving?	1.64	2.40	0.76
How satisfied are you with how clients were supported during the transition?	1.40	1.83	0.43
How satisfied are you with the overall transition process?	1.16	1.50	0.34
How satisfied are you with how information about clients was transferred from the Community Mental Health Center?	1.50	1.83	0.33
How satisfied are you with your opportunity to participate in shaping the transition process?	1.32	1.17	-0.15
How satisfied are you with how clients were informed about the transition?	1.44	1.50	0.06
How satisfied are you with procedures that kept clients from dropping through the cracks during the transition?	1.16	1.20	0.04
How satisfied are you with communications to you about the transition process?	1.36	1.33	-0.03

* Significance <.05
** Significance <.01
Note: Analyses exclude "Don't Know" responses.

<u>Former CMHC staff subsequently employed by CP or LFS differed on many items compared to CP/LFS staff not formerly employed at CMHC</u>

Former CMHC staff who were subsequently employed by CP or LFS differed significantly from CP/LFS staff not formerly employed by CMHC on most items (Table 25). There were six items with significant differences.

TABLE 25. COMPARISON OF RESPONSES OF CP OR LFS STAFF BY PREVIOUS EMPLOYMENT

	Former CMHC now at CP or LFS	NOT Former CMHC	Mean Difference
**How satisfied are you with your opportunity to participate in shaping the transition process?	1.17	3.21	2.04
*How satisfied are you with the quality of care clients are now receiving?	2.40	4.05	1.65
*How satisfied are you with how clients were supported during the transition?	1.83	3.26	1.43

	Former CMHC now at CP or LFS	NOT Former CMHC	Mean Difference
*How satisfied are you with procedures that kept clients from dropping through the cracks during the transition?	1.20	2.58	1.38
*How satisfied are you with communications to you about the transition process?	1.33	2.68	1.35
*How satisfied are you with the overall transition process?	1.50	2.84	1.34
How satisfied are you with employment opportunities offered to staff members during the transition process?	2.50	3.53	1.03
How satisfied are you with how clients were informed about the transition?	1.50	2.39	0.89
How satisfied are you with how information about clients was transferred from the Community Mental Health Center?	1.83	2.63	0.80
How satisfied are you clients' needs were met during the transition?	2.17	2.94	0.78

* Significance <.05
** Significance <.01
Note: Analyses exclude "Don't Know" responses.

Former CMHC staff subsequently employed anywhere compared to CMHC staff not employed
The subsequent employment status (i.e., employed anywhere compared to unemployed) did not impact satisfaction with the transition. Employed and unemployed former CMHC staff did not differ significantly in their dissatisfaction for any item.

Former CMHC staff who left prior to June 2013 compared to those who left after June 2013
The timing of when former CMHC staff departed from CMHC did not appear to impact satisfaction. The survey asked respondents to indicate whether they left CMHC prior to July 1, 2013 or after June 30, 2013. This time division was chosen because it was approximately the time when employees learned that contracts were to be awarded to transition services. Regardless of when CMHC staff left employment at CMHC, they were equally dissatisfied with the transition.

Staff Responses to Open-Ended Questions

Written comments were provided by 92% of staff respondents (30 of 31 former CMHC staff; 16 of 18 current CP/LFS staff). Similar to the coding applied to client surveys, all comments on each survey were categorized as *positive*, *mixed*, or *negative*[28] (Table 26). Former CMHC staff had a more negative overall view of the transition than did current staff employed by CP or LFS: 63% answered only negatively, while 37% (11) indicated their assessment of the transition was

[28] Unlike consumer survey responses, no staff responses were categorized as neutral.

mixed (both positive and negative comments).[29] None of the former CMHC staff reported only positive comments. In contrast to former CMHC staff, 19% (3) of the 16 current CP or LFS staff members who answered the qualitative questions answered only negatively and 81% (13) had mixed (both positive and negative) comments about the transition. As with former CMHC staff, none reported only positive comments. In addition to the comments made on returned surveys, several staff members contacted researchers and provided verbal feedback.

TABLE 26. CATEGORIZATION OF STAFF OPEN-ENDED COMMENTS

	n	%
All Surveys included in analysis	50	--
Surveys with open-ended responses	46	--
Totals		
Positive	0	0%
Mixed	24	52%
Negative	22	48%
Former CMHC employees	30	
Positive	0	0%
Mixed	11	37%
Negative	19	63%
Current CP and LFS employees	16	
Positive	0	0%
Mixed	13	81%
Negative	3	19%

Note: Percentages based on treating surveys with open-ended responses as 100%.

An analysis of the comments identified several general themes. Positive themes were:

- Client benefits
- Provider agencies' cooperation
- Staff benefits

Negative themes were:

- Disagreement with the decision to privatize
- Disorganized transition process
- Client negative impacts
- Staff negative impacts

Comments that illustrate the themes are provided in the following section.

Positive Comments

Client benefits

Some staff believed that clients have benefited from the privatization of services:

[29] Unlike consumer survey responses, no staff responses were categorized as only positive.

> [The new provider] has updated the entire program with new technology and refreshed care which is more up to speed with the times.
>
> The opportunity to reorganize programs and focus on empowerment more with clients.
>
> I believe that outpatient therapy will help clients very well in the long-run to stay out of crisis and the hospital, and opening up availability for outpatient therapy is therefore a positive development.

Provider agencies' cooperation

Some staff believed that the new provider organizations have worked effectively with CMHC staff and consumers. Several former CMHC staff noted CMHC's diligence during the transition, as well:

> I think [the new provider] is doing an amazing job of assisting consumers through the transition and trying to provide needed services.
>
> Community Mental Health Center staff worked diligently to maintain quality of services to clients throughout the transition and existing CMHC services were continued until close.

Staff benefits

Some staff believe that they have benefited from the privatization:

> I personally have been given an opportunity for growth and a new career path.

Negative Comments

Disagreement with the decision to privatize

Several staff commented that they saw the decision to privatize as a negative:

> The comprehensive interlock of services of CMHC was chopped up and reassigned without regard for clients served. Any attempt to call attention to damage was systematically disregarded.
>
> The eventual loss of county funding will hurt behavioral health for years to come!

Disorganized transition process

Staff commented that the transition of services was disorganized and poorly communicated:

The transition was poorly planned and implemented.

There was no plan.…most of my clients the last two weeks came into outpatient sessions not knowing it would be their last session with me, as that is all the notice we were given.

The clients were very surprised when they were told that Community Mental Health no longer existed.

Lack of accurate and prompt information to staff and clients throughout the entire transition.

Lack of communication! Every day it seemed that something new came up that undermined what we were told a few days prior or something was now defunct.

Clients negative impacts

Some staff believe that clients have been negatively impacted by the privatization:

Clients of the CMHC suffered as a result, because they lost their long-time support network as well as services.

Clients received delays in obtaining medication refills and appointments.

Having services divided amongst different providers or ceased altogether has created unnecessary obstacles for some of the most vulnerable of our population.

Closing the Community Mental Health Center has left a big hole in the community as far as what is now available in mental health services. The community will have to address this problem very soon as the hospitals, jails, regional center will fill up with these displaced clients.

Staff negative impacts

Staff commented that they have been negatively impacted by the privatization:

Many dedicated, hard-working employees of the CMHC were out of a job.

Salaries decreased significantly.

We are given unrealistic deadlines to complete paperwork and are told we can't leave until it is done… We were given minimal training.

The strain on staff was (and still is) incredibly high, which shows in rates of sick days taken or positions having to be refilled after only a few months.

Organizational Experience

The experience of organizations with the privatization was collected through interviews and documentary review.

Results indicate that:

- Organizational representatives had positive and negative comments about the privatization, mostly involving impacts on clients and staff.
- Organizational representatives acknowledged difficulties during the transition process, including inaccuracies in the RFP and lack of communication to clients about services not included in the privatization process.
- Organizational representatives indicated that Lincoln's loss of a community mental health center may mean that federal funding specifically directed toward those organizations would no longer be accessible, and that some clients must now navigate between multiple providers and locations to receive services.

Telephone and in-person interviews were conducted with leaders of provider (CP and LFS) and community organizations involved in the privatization of CMHC services. Community organization interviewees represented Lancaster County, the CMHC Planning Committee, CMHC Intent to Negotiate Committee, and other community members with experience in the behavioral health care field. Ten telephone interviews took place in May and June 2014. Interview prompts were designed to assess each organization's perspectives on the privatization. In November 2014, representatives from CP and LFS further discussed their transition experiences with the evaluators.

Provider Organizations

The two provider organizations cited both positive and negative aspects of the privatization. Positive themes were:

- Client benefits
- Organizational collaboration
- Evaluation of former CMHC staff

Negative themes were:

- Inaccurate or incomplete RFP and lack of communication to clients about services not included in the privatization process
- Negative client impact
- Poor transition process
- Poor facilities
- Negative staff impact
- Loss of CMHC as an organizational structure

Positive Comments

Client benefits

Delivering strong services to consumers was cited as a positive outcome of the privatization, particularly the **quality of services** they offer, their focus on recovery, and their commitment to improvement. In one example, clients of the day rehabilitation service requested a program name change that would symbolize the merging of the former CMHC program with an existing CP program.

In many cases, provider organizations felt **communications with consumers** helped minimize the confusion surrounding the transition. There was consistent communication from RVS, Lancaster County, and the agencies to which services were being transitioned. When it was possible, provider organizations believed that the opportunity to meet with consumers before taking over services was integral to a positive transition. CP acknowledged the importance of having funding for marketing efforts for the new crisis line. LFS conducted some community forums and had informational materials on their website and available in brochures.

Finally, providers noted that maintaining some of the **services in the same location** as those that were provided by CMHC has provided some continuity for clients. For example, LFS operates the services from the former CMHC location and will do so for up to two years to ease the transition for consumers. The County is responsive to LFS maintenance requests. CP has reported that improvements it has made to the facilities it took over from CMHC have resulted in a more comfortable and safe environment (for example, new paint and furniture, functioning emergency lighting and smoke alarms).

Organizational collaboration

Both agencies spoke well of the **cooperation** with the County, RVS, or both. Many unexpected issues arose after service contracts were awarded, and all of the participating organizations' willingness to play an active role and work together to solve those issues was a positive experience.

Evaluation of former CMHC staff

Provider organizations believed that the opportunity to extend **employment consideration** to former CMHC staff went well. CMHC supervisors allowed employees to attend explanatory meetings with new providers so CMHC staff could make informed decisions regarding applying to CP or LFS. Both providers interviewed CMHC employees who were interested in employment. Not all were offered positions and some declined employment offers.

Negative Comments

Inaccurate or incomplete communications about services included and excluded from privatization process

The Intent to Negotiate Committee made strategic decisions about which services would be privatized through the RFP process and which would be excluded. However, provider organizations felt that there were **insufficient communications to clients** about these decisions.

Clients incorrectly believed that the new provider organizations were unilaterally deciding that certain services would not be continued, rather than understanding those decisions were outside the providers' decision-making authority. Consumers believed that all services previously offered by CMHC were being transitioned, rather than just a subset. This caused great confusion and anxiety.

Data on **number of clients served** cited in the RFP proved to be inaccurate (overstated) for many services. In some cases, the inaccuracies were not discovered until the provider organizations had already staffed and made other arrangements to accommodate larger numbers of clients. For example, when CP took over psychiatric residential rehabilitation services, they learned that eight of the fifteen clients had been recently discharged. CP's financial plan for the program was based on the facility being at full capacity, but the number of clients was half what they had expected.

The RFP **did not delineate all services** provider organizations were expected to assume or did become responsible for providing. It was only subsequent to assuming services that provider organizations learned of additional services. For example, LFS was assumed to have become responsible for "not responsible by reason of insanity" clients who had been directed to CMHC. LFS devoted months of staff time and financial resources to verify that it was unable to take custody of these clients. In another example, LFS learned following the award that it would become responsible for operating the Patient Assistance Program[30] which required additional personnel to provide oversight to the 600 clients who had been receiving free medication. LFS later determined that many of these individuals were qualified for Medicaid and devoted staff to enrolling them for those benefits. LFS believes that they have assisted clients find less formalized support systems to replace those that had been offered by CMHC. Providers felt there could have been more communication to the public to clarify that not all services were being continued.

There were several licensing and credentialing challenges. It had been the expectation that one of the organizations awarded service contracts as a result of the RFP process would be licensed as a privately-operated **community mental health center**.[31] Subsequent to the award, it was learned that because of the division of types of services, LFS was ineligible to serve as a community mental health center.[32] Further, LFS learned it could not be licensed until the County's license expired. The uncertainties in licensing delayed staff credentialing and ultimately resulted in LFS being unable to bill for six weeks of services it provided to clients. Federal, state, and local agencies were involved in resolving this complicated process.

[30] The Patient Assistance Program is a national program through which pharmaceutical companies provide meds at no cost to those who qualify.

[31] The statutory definition of a CMHC includes: outpatient services; 24 hour-a-day emergency care services; day treatment, or other partial hospitalization services, or psychosocial rehabilitation services; and screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission (Centers for Medicare and Medicaid Services, 2014)

[32] Community mental health centers must have 24-hour beds.

CP also faced licensing challenges. It was discovered that the psychiatric residential rehabilitation **program had not been licensed correctly** prior to the transition, which necessitated operation of the program under a provisional license. Resolving the licensing issue took a significant amount of staff time.

Overall, provider agencies pointed to decisions about what services were included in the transition process and how services were described in the RFP as a source of **significant subsequent financial obligations** including staff time, legal fees, facilities costs, technology investments (computer hardware, software and networking), and unreimbursed client services.

Negative client impact

It was noted that some clients now need to see **multiple provider organizations at multiple locations** to receive services that had previously been provided by CMHC at a single location. This may be a barrier for clients to receive services.

The provider organizations were hampered in obtaining access to client information. Because of this, their staff first encountered clients having very little, if any information about their past treatment. There would have been two steps to having seamlessly transferred the information. First, the clients would have had to have authorized release of their records. Second, the records would have had to have contained current information. In most instances, clients were **not offered the opportunity to provide authorization** prior to the transition of the services. Due to record-keeping practices, communications could not be sent to all clients in advance because CMHC was unable to provide a list of active clients and their contact information. For a short period of time, provider organizations deployed staff to overlap with CMHC staff at the front desk preceding the transition; however, the practice was discontinued at CMHC's request. When releases were signed, the records were difficult to obtain. CMHC did not have electronic client records and the County would not pay County staff to go through records to find assessments and treatment plans. Provider organizations found that many **clients had not been recently assessed**. Providers were in the position of needing to assess all clients and determine their eligibility for services.

Provider organizations reported having a **fairly short time to engage clients** and coordinate with CMHC. For example, CP had only eight weeks to prepare for assuming the psychiatric residential rehabilitation services. That prevented them from accomplishing the advance consumer engagement and planning that they were able to achieve prior to the transition of the day rehabilitation services.

Poor transition process

One of the providers interviewed spoke of the **long, flawed process**. The individual felt CMHC did not provide a professional or accurate plan to communicate with their staff or clients about the transition. Other interviewees also wondered whether some **expertise was missing** from the process, such as licensing and certification and organizational merger/acquisition expertise.

Poor facilities

Although delivering services from the same locations as did CMHC is felt to be a positive in providing continuity to clients, there have been some drawbacks. LFS has reported that the building is structurally sound, but is **technologically outdated**: the phone system is old and no longer supported, there are dead zones for cellphones, and conference calling is not available from many offices. CP reported that the two former CMHC facilities it uses needed upgrades, including: eliminating bed bugs, purchasing basic supplies, and restoring safety devices (e.g., fire/smoke alarms) to working order.

Negative staff impact

Organizational representatives felt that both the **length and public nature of the privatization** process were difficult for former CMHC staff. Staff were in flux and anxious about job security during the two years leading up to the transition, which may have transferred to clients. CP and LFS both mentioned that their organizations **could not match the salaries and benefits** the County paid CMHC employees. This was the source of some dissatisfaction among CMHC employees.

Loss of CMHC as an organizational structure

Provider organizations noted that community mental health centers have exclusive access to certain types of government funding and grants. Now that the community no longer has such an organization, there is **no mechanism to request these funds** to support services to this population. A provider organization interviewee pointed out that the CMHC had a mix of programs, and those that generated more revenue than costs could subsidize those with costs greater than revenues. If an organization providing the programs after the transition did not have a good financial mix of programs, it could prove difficult for that organization. A community organization representative suggested additional transition funding from RVS, perhaps for the first year, would have helped providers.

Community Organizations

Representatives of community organizations cited both positive and negative aspects of the privatization. Positive themes were:

- New system of providing services
- Privatization process
- Client benefits

Negative themes were:

- Poor planning process
- Negative client impact
- Negative impact on former CMHC staff

Positive Comments

New system of providing services

Some representatives reiterated that the decision to privatize remained valid and that the new system, as a service delivery model, makes sense. One representative mentioned that the new system may **spur additional initiatives**, such as new ways to provide integrated care of behavioral health and physical health services. Another individual predicted that the new system will result in **new, innovative services**. Finally, one individual predicted that the new system will have a positive **overall financial outcome** for citizens and taxpayers.

Privatization process

According to almost all community organization leaders, **successful components** of the transition process included outreach to the community, efforts to seek input from various groups, the mix of community members serving on committees, and public input gained from focus groups and other forums. Some community members thought that the RFP process had clear guidelines and timelines and was a **good process model**. There were additional comments that the services included in the privatization process were the appropriate ones. Finally, some individuals believed that the selection criteria and scoring were implemented well.

Client benefits

One representative suggested that there has been a **decrease in calls** from consumers and their families to report problems.

Negative Comments

Poor planning process

One community organization leader questioned whether the CMHC Advisory Committee included members with **expertise in the complex process** of transitioning a publicly funded service to the nonprofit sector. Many CMHC administrative costs, such as accounting and personnel services, that were covered by the County were hard to break out and estimate, causing cost projections to go through many iterations. These undetermined costs would need to be covered by the nonprofit taking over the services, which made bidding difficult as providers did not have a clear picture of the total cost of service provision. This leader thought the agencies awarded the service contracts should not be blamed for not providing the entire range of services under the CMHC umbrella, as the contracts awarded were not large enough to cover all CMHC services.

Regulatory issues, which one community organization interviewee felt could not have been anticipated, were a major stumbling block to a timely transition of services. CMHC had been operating for over 25 years and was grandfathered in under many licensing criteria that changed over time. Facilities must have the right qualifications and criteria to be classified and licensed as a facility that can treat specific behavioral health issues. Lack of a license affects reimbursement by Medicaid and RVS for services provided.

A number of community members believed that they were **excluded from meaningful participation** in the decision-making process. One community organization leader felt the process did not go far enough if the goal was to gain input to guide the transition. In that case, the forums for consumers and peer agencies should have been **continued throughout the transition process** and a point person to answer questions should have been available. They felt this would have resulted in less misinformation and rumors.

Several community members noted that some **services were not included** in the privatization process and that they have either been terminated or that their continuing status is uncertain. One community organization leader felt that omitting vital programs such as sex offender treatment (STOP program) and Not Guilty by Reason of Insanity/Not Responsible by Reason of Insanity was a major oversight. Several additional individuals mentioned the omission of the STOP program. Another interviewee reported that his/her agency is trying to provide alternatives to services that have been terminated.

Negative client impact

Many former CMHC clients receive psychiatric medication management services and the transition of these services was particularly challenging. Many consumers obtained their medications through CMHC.[33] Changes in the County's recordkeeping and dispensing protocol during the transition process, along with the need for a licensed pharmacist, resulted in moving CMHC psychiatric medicine supplies from the former CMHC site to the Lincoln/Lancaster County Health Department in February 2014. The County remained responsible for the former CMHC medicine supplies and the psychiatric medications that consumers obtained at the Health Department from March 2014 through June 2014. Medications remaining after June 30, 2014 were destroyed. These shifts in **psychiatric medication delivery protocols and location** were difficult and confusing for many clients.

Financial accessibility of services for some consumers has become more difficult. For example, consumers participated in the day treatment/partial hospitalization program at CMHC regardless of their Medicaid eligibility or insurance coverage. Now, consumers needing these services consumers must be Medicaid eligible and/or have private insurance. One community member noted that it is more complicated to make referrals now than it was when all services were located at CMHC.

Provider organizations were typically unable to access client records. Community representatives reported that many consumers believed CMHC could transfer their records to the new provider organizations. Consumers were confused when approached about **releasing their records** to the new provider organizations.

[33] For example, financially eligible consumers who had been discharged from the Lincoln Regional Center were able to obtain their medications from the Regional Center at the CMHC. Clients participating in the national Patient Assistance Program could also obtain their medications at CMHC.

As a result of the transition, new communication processes needed to be developed so that care for consumers needing **multiple services could be coordinated**. One representative noted that during the transition of services some consumers sought admission to **crisis programming** due to emergencies they were experiencing. The interviewee thought the clients were not familiar with alternatives to crisis programming and were disconnected from the helping process formerly available at CMHC. The individual did report, however, this issue improved as the transition process has concluded. Another individual mentioned that clients faced a **long period of uncertainty** about the privatization and there was a period of time when many consumers were anxious about their services. One interviewee felt more should have been done to proactively **communicate with consumers**, before they felt lost or fell through the cracks. A better job could have been done **communicating with peer agencies**, who could have helped clients prepare for the transition.

<u>Negative impact on former CMHC staff</u>

There were timelines regarding outreach to and interviews with CMHC employees, but the procedures were delayed by the regulatory hurdles. Many CMHC employees experienced **uncertainty** prior to and during the long transition and left for other employment. Several community organization leaders commented that new providing agencies also lost **valuable input** of CMHC employees who had left.

Recommendations

Many governmental entities view privatization of services as an opportunity to improve delivery of services at a lower cost. The evaluation of the privatization was conducted to document the experiences of clients, staff, and organizational representatives during the privatization of behavioral health services. The privatization of services from the CMHC remains a substantial and recent change to the system of care for persons with behavioral health needs.

The privatization has been successful on several fronts. Services included in the transition process have now been established elsewhere. Most consumers who have moved to new providers from CMHC report feeling that their care is approximately the same quality as it was through CMHC. There have been no marked increases in access to crisis-type services, such as admissions to the Crisis Center, Mental Health Board warrants, and length of post-commitment days.

The privatization has also been challenging for some stakeholders. The public process took several years to accomplish and most of the newly-privatized services have only been in operation for approximately one year or less. Some consumers reported difficulties in accessing care throughout the transition, organizational representatives identified a number of challenges, and staff (particularly former CMHC staff) report great dissatisfaction.

As the community moves forward in the newly privatized service delivery approach, the results of the study suggest three recommendations:

1. Most clients report that their care and relationships with provider staff are about the same as that received through the CMHC. It is positive that some clients report much greater satisfaction. However, there remains a subset of clients who report on-going difficulties and confusion. The community should continue efforts to assist clients in:
    a. Streamlining and coordinating services between multiple providers at multiple locations.
    b. Obtaining medications at convenient locations.
    c. Navigating confusion about payment.
    d. Learning about alternatives to services that were provided by CMHC but are not being delivered by CP or LFS.

2. The impact of the privatization should continue to be monitored through a number of approaches:
    a. Providers and RVS regularly survey clients about their satisfaction with publicly-funded behavioral health services. The results of these surveys should be

reviewed to identify areas of success and areas where improvements may be needed.

b. The community should continue to monitor usage of crisis services as a possible indicator of the health of the delivery system. Increases in crisis services utilization may indicate that clients are not receiving the care they need.

c. An analysis of costs should be made to compare the delivery costs prior to and following the privatization. The analysis should recognize that Lancaster County now lacks a community mental health center as a delivery entity, which may mean that some federal funds would no longer be available to support behavioral health services.

3. The transition of services was a complex process. If done in the future, there are three areas where improvements could be made:

   a. If possible, shorten and streamline the process. The privatization planning was a lengthy, public process. This engendered much anxiety among clients and CMHC staff. There may be other models for privatization that could balance the need for transparency and input against the desire for a shorter, less anxiety-producing process. Numerous individuals suggested that obtaining outside expertise in privatization of services and in licensing and payment would have been valuable.

   b. Recognize that it is probably not possible to over-communicate information about decisions and process. CMHC offered a wide range of services. Many individuals felt that the process lacked clarity in documenting the array of services that CMHC provided along with how decisions were being made about their continuation. Consumers voiced anger that services they once received have ceased. Provider organizations felt they were unfairly blamed for not providing services that had not been included in the transition process and in some instances provided unplanned services at financial cost to their organizations. In other cases, some services have been assumed by other organizations. The status of some services is still uncertain.

   c. Ensure that estimates of clients served are as accurate as possible and that access to client records is streamlined as much as possible. There were difficulties in transitioning clients due to discrepancies in the numbers of clients that needed services and in barriers to accessing client records. CMHC's estimates of the numbers of clients receiving many services included clients that had not been actively accessing services for a year or longer. This resulted in provider agencies staffing for larger client populations than materialized. Another barrier to planning the services and creating a more seamless transition was that most clients were not given the information and opportunity to meet their new providers, authorize records access, and schedule new appointments

in advance of the transition. These gaps led to challenges to clients and provider organizations.

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Appendices

Appendix A

Consumer Survey Design

A survey was developed to capture consumers' experience with the transition. Items for the survey were drafted, many of which were modeled from similar survey questions for behavioral health clients used in Nebraska and elsewhere in the United States. The survey went through several versions with input from a focus group of consumers, experts in survey design for persons with mental disabilities, RVS administrators, and organizational representatives.

The final version of the survey represented compromises in three areas:

1. The desire to obtain answers to many important questions balanced with the desire for survey length that would not be overwhelming to respondents, possibly resulting in a lower response rate. Result: Many items were cut and a set of items were rotated in three versions (meaning that only approximately one-third of respondents answered this subset of questions).

2. The desire to learn about experiences in a complicated system and transition balanced with the need to make the items understandable. Result: Items were written to try to be appropriately descriptive, yet simple and concise.

3. The desire for multiple levels of response for strength of agreement/disagreement balanced with more simplicity in response. Result: The consumer survey used a small number of response categories for its quantitative responses.

Consumer Survey Items

There were three versions of the consumer survey, each including five or six of 17 rotating questions. Each rotating question, although of interest, was not included on all surveys to keep the surveys a more manageable length for respondents. Each survey version was distributed both by mail and onsite at a CP or LFS location. Survey responses were anonymous.

The consumer survey began with two demographic questions (**gender, age**). Consumers were then asked if they had received behavioral health services from CMHC and to **indicate all services they had received at CMHC** (pick list included: *outpatient counseling; day rehabilitation; day treatment; psychiatric medication management; community support; psychiatric rehabilitation; other*). Consumers were also asked if they were currently receiving behavioral health services and to **indicate all services they were currently receivin**g (pick list included: *outpatient counseling; day rehabilitation; day treatment; psychiatric medication management; community support; psychiatric rehabilitation; other*).

Consumers evaluated the following eight statements about their **experience during the services transition process** using three response categories: *Yes*, *No*, *Don't Know*.

- I received communications about the transition.
- I received information about consumer meetings.
- My voice was heard about the transition process.
- Information about me was given to my new provider.
- Staff members gave me support during the transition.
- Community Mental Health Center staff members helped me feel at ease during the transition.
- Staff members at my new behavioral health provider helped me feel at ease during the transition.
- The Community Mental Health Center and staff members at my new behavioral health provider worked together to transition my services.

Consumers were asked to think about their care at CMHC and at their new provider and then assess the effect of the change in service provider on **quality of care.** They responded to 13 questions that appeared on all survey versions plus three or four rotating questions, depending on survey version. All questions in this section had response categories of *Worse*, *Same*, *Better*, and *Don't Know*.

Quality of care questions included on all survey versions:

- Your overall satisfaction with services
- The quality of care you receive
- Meeting treatment goals with services you receive
- Being involved in decisions about your treatment
- Receiving needed services, regardless of your personal ability to pay (such as co-pay and other out of pocket expenses)
- Receiving needed prescriptions, regardless of your personal ability to pay (such as co-pay and other out of pocket expenses)
- Coordination of your care by behavioral health and medical health care providers
- Receiving services you need
- Receiving services you don't need
- Feeling physically safe in the service setting
- Having a sense of community with others who receive behavioral health care
- Availability of appointments when you need them
- Your access to after hour and crisis services

Quality of care rotating questions (4 on two survey versions, 3 on third survey version):

- Availability of medicine disbursement at the times you want
- Receiving help finding meaningful employment
- Receiving help finding housing
- Your access to group services
- Receiving encouragement to use peer-run services or access to group services

- Receiving help finding transportation
- Your access to walk-in services
- Having the health care you need
- Receiving help with meaningful connections to friends/family
- Receiving help finding legal services
- Your access to skill-building/educational services

Next, consumers were asked to think about their relationship with staff at CMHC and at their new provider and assess the effect of the change in service provider on their **relationship with provider staff.** Eleven questions appeared on all survey versions, plus two of the six rotating questions appeared on each of the survey versions. All questions in this section had response categories of *Worse*, *Same*, *Better*, and *Don't Know*.

Relationship questions included on all survey versions:

- Your overall satisfaction with staff members
- Staff members knowing what they should about your mental health history
- Staff members telling you what to do if you have side effects from medications
- Staff members giving information about how to maintain mental health
- Staff members making sure your care is coordinated
- Staff members explaining things in ways you can understand
- Your agreement with staff members about how to address your problems
- Your trust in staff members
- Staff members involving your family in treatment as much as you want
- Staff members telling you about your right to refuse treatment
- Staff members being sensitive to your cultural background (race, religion, language, etc.)

Provider staff rotating questions (two on each survey version):

- Staff members telling you about different kinds of treatments available
- Staff members showing respect for what you have to say
- Staff members listening carefully to you
- Your access to the staff members you want to see
- Staff members telling you about benefits and risks of medications
- Staff members spending enough time with you

All three survey versions concluded with two open-ended questions about the **transition experience:**

- In your opinion, what has been positive about the transition of services from the Community Mental Health Center?
- In your opinion, what has been negative about the transition of services from the Community Mental Health Center?

Consumer Survey Administration

The survey was mailed to former clients of CMHC and also provided onsite to clients at CP and LFS. Whenever possible, the timing of data collection was scheduled so that participants would have had at least several months' experience past the transition when they were asked to react to it. Ideally, an evaluation would have given participants a longer time period to assess the transition. However, the desire for more immediate information about the transition outweighed the benefits of allowing clients to acclimate more fully to their new providers.

Mailed Survey

RVS mailed the survey to all adult CMHC clients receiving applicable services at any time from August 2013 through January 2014.[34] RVS sent the surveys out on May 20, 2014. A postage-paid return envelope was included and a return date of June 3, 2014 was requested (although responses were accepted through August 25, 2014).

Onsite Survey

The survey was offered onsite at three locations: two programs provided by CP (MidPointe and Community Transitions) and at LFS.[35] At two locations (MidPointe and LFS), onsite survey respondents were given the option to return the survey through the mail (postage-paid return envelope provided) or onsite in locked survey return boxes. Due to the small number (nine) of consumers in the Community Transitions program at the time of the survey, Community Transitions consumers were directed to return completed surveys by mail.

A survey return box was delivered to MidPointe on May 27, 2014, along with surveys to be offered to clients. Seventeen surveys were handed out and ten surveys were returned onsite before the survey return box was removed on June 2, 2014. In addition, two surveys were given to clients who had been absent from MidPointe the week the survey return box was onsite. If these clients chose to complete the survey they would return it using the postage-paid envelope provided.

The front desk staff at LFS agreed to offer the survey to consumers checking in for transitional services. Client surveys and a survey return box were dropped off at LFS on May 27, 2014. The front desk staff agreed to offer the survey to LFS clients as they checked in for services and to keep a survey distribution tally sheet. Front desk staff members were given a suggested script to follow when offering the survey to clients. Of the 23 surveys offered at LFS, six clients accepted the survey and one of those returned a completed survey in the onsite return box. The survey tally sheet showed that five of the clients offered the survey at LFS had not received

[34] The initial mailing list was provided by the State of Nebraska Division of Behavioral Health to RVS. RVS staff identified all individuals who met the criteria. Applicable services include: outpatient counseling; day rehabilitation; day treatment; psychiatric medication management; community support; and psychiatric rehabilitation.

[35] In the letter accompanying the survey, consumers were asked to respond to the survey only one time, as some may have been offered the survey both through the mail and onsite, or onsite at more than one program.

services at CMHC, six had already been offered the survey, and six declined the survey. The survey return box was picked up from LFS on June 17, 2014.

Surveys were delivered to the Community Transitions location on May 29, 2014 for distribution to clients by staff. Clients were asked to return the surveys via mail by June 6, 2014.

Consumer Survey Response

The survey was mailed to 1,703 consumers, 577 surveys were returned to RVS by the United States Postal Service (USPS) as "not deliverable as addressed," and 1,126 were delivered to the addresses provided in the mailing list from the State of Nebraska Division of Behavioral Health. 135 mail surveys were returned (12% response rate of delivered surveys). One of the mail surveys was returned with no responses along with a note stating the recipient was too sick to answer the questions. According to records kept by program staff, 34 surveys were handed out at onsite locations and 21 returned (62% response rate of distributed surveys).

Surveys Included in Analyses

Of the 156 surveys returned, 129 were included in the analyses. Twenty-seven were excluded from further analyses for a variety of reasons, the most common of which were respondent self-identification of not having been a client of CMHC or not currently receiving behavioral health services.[36]

Consistency and Separability of Concepts Represented by Items

Internal consistency of the items used to represent each concept is excellent. For the transition process items, $\alpha = 0.91$ using all 8 items; for quality of care, $\alpha = 0.97$ using the 13 items given to all respondents; and for relationship with staff, $\alpha = 0.97$ using the 11 items given to all respondents.

Ideally, responses to the quality of care items and the relationship with staff items would create two distinct patterns of responses. Transition process items are fundamentally a different type of question (asking whether a process item happened or not, yes or no) and could not be tested with the ratings of the other two concepts. Alternatively, responses could show patterns of a unitary concept, or even of multiple (more than two) concepts. A factor analysis[37] confirmed two strong factors, with no effect on each other. One factor consists only of the quality of care items, with these 13 items all having excellent (over .70) loadings on the factor, and the relationship with staff items all having poor (under .40) loadings. Conversely, the other factor

[36] Respondents who indicated they were currently receiving services (either by checking at least one service in a list of services currently being received or by mentioning services being received in their open-ended responses) were considered to have answered 'yes' to the question "Do you now receive behavioral health services?" Likewise, respondents indicating they previously received services from CMHC (either by checking at least one service in a list of services previously received from CMHC or in responses to open-ended questions) were considered to have answered 'yes' to the question "Did you receive behavioral health services from the Community Mental Health Center?"

[37] This analysis excluded rotating items.

consists only of the relationship with staff items, with these 11 items all having excellent loadings on the factor, and the quality of care items all having poor loadings on the factor. This means that effect on care and effect on relationship with staff were seen as separate concepts by respondents.

Appendix B

Staff Survey Design

Two surveys were designed to capture staff experience with the transition. One survey was created for former CMHC employees; another for staff currently providing services at CP/LFS who are providing the transitioned services. Former CMHC employees now employed by CP/LFS were asked to complete the former CMHC survey, since several additional questions were asked on that survey.

Both versions of the staff survey were tested with staff members from another behavioral health organization who had knowledge of the transition from CMHC. The staff members were shown the survey transmittal letter and also talked through the survey directions and questions. As a result of their comments the survey directions and scale were made clearer, and certain questions were rephrased to clarify their meaning. RVS administrators reviewed and approved the final versions of the staff surveys.

Staff Survey Items

CMHC Staff

Staff members who worked at CMHC prior to its January 31, 2014 close were asked to evaluate the transition of behavioral health services from CMHC. Response options for the following 10 survey questions were *Very Dissatisfied, Dissatisfied, Neither, Satisfied, Very Satisfied, Don't Know*.

- How satisfied are you with how clients were informed about the transition?
- How satisfied are you with how clients were supported during the transition?
- How satisfied are you with how information about clients was transferred from the Community Mental Health Center?
- How satisfied are you with procedures that kept clients from dropping through the cracks during the transition?
- How satisfied are you clients' needs were met during the transition?
- How satisfied are you with the quality of care clients are now receiving?
- How satisfied are you with your opportunity to participate in shaping the transition process?
- How satisfied are you with communications to you about the transition process?
- How satisfied are you with the employment opportunities offered to staff members during the transition process?
- How satisfied are you with the overall transition process?

Former CMHC staff members were also asked to indicate **all services they provided** at CMHC prior to the transition. The pick list included: *outpatient counseling; day rehabilitation, day treatment; psychiatric medication management; community support; psychiatric rehabilitation; other*.

Next, CMHC former staff asked **when they left employment** at CMHC-- prior to July 1, 2013 or after June 30, 2013. Staff who had worked at CMHC were also asked about their **current employment**. Response options were: *CenterPointe or Lutheran Family Services, other behavioral health services provider, not employed, other*.

The survey concluded with two open-ended questions about the **transition experience**:

- In your opinion, what has been positive about the transition of services from the Community Mental Health Center?
- In your opinion, what has been negative about the transition of services from the Community Mental Health Center?

CenterPointe and Lutheran Family Services Staff

Current employees of CP and LFS were asked to **evaluate the transition of behavioral health services** from CMHC. Respondents were asked the same 10 initial questions as former CMHC employees. Response options were *Very Dissatisfied, Dissatisfied, Neither, Satisfied, Very Satisfied, Don't Know*.

- How satisfied are you with how clients were informed about the transition?
- How satisfied are you with how clients were supported during the transition?
- How satisfied are you with how information about clients was transferred from the Community Mental Health Center?
- How satisfied are you with procedures that kept clients from dropping through the cracks during the transition?
- How satisfied are you clients' needs were met during the transition?
- How satisfied are you with the quality of care clients are now receiving?
- How satisfied are you with your opportunity to participate in shaping the transition process?
- How satisfied are you with communications to you about the transition process?
- How satisfied are you with the employment opportunities offered to staff members during the transition process?
- How satisfied are you with the overall transition process?

As with the former CMHC staff survey, the current employee survey concluded with two open-ended questions about the **transition experience**:

- In your opinion, what has been positive about the transition of services from the Community Mental Health Center?
- In your opinion, what has been negative about the transition of services from the Community Mental Health Center?

Staff Survey Administration

Lancaster County provided the names and addresses of 73 former CMHC employees (those employed from April 1, 2012 through the close of the CMHC), and the survey was mailed on May 15, 2014. A postage-paid reply envelope was included, and a return date of May 31, 2014 was requested.

Surveys for staff currently providing services were delivered to CP and LFS offices on May 27, 2014 and were distributed to staff through each organization's interoffice mail. LFS distributed 29 surveys and CP distributed 12 surveys. Postage-paid return envelopes were included with the surveys, and a return date of June 12, 2014 was requested.

Staff Survey Response

Thirty-one former CMHC staff returned completed surveys. Three surveys were returned by the USPS as "not deliverable as addressed." Of the 41 total surveys given to current staff, 19 were returned. Respondents were asked not to answer the survey more than once, as some may have received a survey as a former CMHC employee and as a current employee of CP or LFS.