

PREVENTION AND EARLY INTERVENTION AND INNOVATION REGULATIONS IMPLEMENTATION PROJECT

Draft Staff Summary, Findings, and Recommendations For Stakeholder Review and Comment

Introduction

In June 2013, Assembly Bill 82 was enacted and mandated the Mental Health Services Oversight and Accountability Commission (OAC or Commission) to adopt regulations for programs and expenditures for two of the five Mental Health Services Act (MHSA) components: Prevention and Early Intervention (PEI) and Innovation. As a result of this change in the law, two separate state entities have a statutory requirement to issue regulations to implement the MHSA. The Department of Health Care Services (DHCS) has the authority to issue regulations for all of the MHSA components except for PEI and Innovation, which are under the authority of the OAC.

From August 2013 through August 2015, the OAC held 15 public meetings, received hundreds of pages of public comment and heard testimony from counties, mental health consumers and family members, representatives from diverse racial and ethnic communities, and members of the public. In response to this extensive public input, the OAC developed regulations to provide a clear framework for counties to implement, evaluate, and report on the PEI and Innovation programs. Those regulations were reviewed and approved by the Office of Administrative Law and went into effect in October 2015. A number of counties sought clarification and guidance on how to implement the following three new regulatory requirements:

- The reporting requirement on the demographics of persons served, including race, ethnicity, sexual orientation, and gender identification;
- The program and measurement requirements for Access and Linkage to Treatment for people with a serious mental illness; and
- The measurement of Duration of Untreated Mental Illness (DUMI) within Access and Linkage to Treatment.

In response to those concerns, the Commission formed a Subcommittee led by Commissioner Larry Poaster and including Commissioners Khatera Aslami-Tamplen and Richard Van Horn, to operationalize the regulations in these three areas. The Subcommittee was assisted by an advisory workgroup that included persons with a range of perspectives and expertise to ensure its guidance appropriately balanced statewide needs and responsibilities with local priorities, and resources. The advisory workgroup also included representatives from county behavioral health departments, DHCS, and subject-matter experts including diverse people with risk of, or experience with mental illness, and their families.

The Subcommittee held four public meetings throughout the State to better understand the challenges faced by counties and providers in the implementation of the regulations with a focus on the three identified areas of concern: (1) the demographic reporting categories; (2) the program and measurement requirements for Access and Linkage to Treatment for people with a serious mental illness; and (3) the measurement of Duration of Untreated Mental Illness (DUMI).

More than 200 people, representing over 40 counties, as well as providers, community based organizations, California Behavioral Health Directors Association (CBHDA), the Department of Health Care Services, and stakeholders, attended the Subcommittee meetings. The first meeting, held in February, was a two day meeting to discuss the program and measurement requirements for Access and Linkage to Treatment for people with a serious mental illness (SMI) and the measurement of Duration of Untreated Mental Illness (DUMI). Regional meetings to discuss the demographic reporting requirements were held in Alameda County, Los Angeles County, and Calaveras County. Participants shared both the challenges faced in their county as well as strategies to address the challenges.

Informed by the knowledge, experience and expertise of the advisory workgroup and meeting participants, MHSOAC staff identified six key challenges regarding operationalizing the three regulatory requirements of focus in this project.

1. Not all counties are currently equipped to collect key, sensitive demographic information.

The PEI and Innovation regulations require counties to collect and report the age, race, ethnicity, sexual orientation, and gender identity of program participants. Collecting such demographic information is essential to reducing disparities in access to mental health services. Information on the race and ethnicity of individuals receiving services in the behavioral health system has been collected for decades. Recent federal and state laws have expanded the collection of demographic information to include information on sexual orientation and gender identification. In 2015 California enacted the Lesbian, Gay, Bisexual, and Transgender Disparities Reduction Act. This Act requires the Department of Health Care Services (DHCS), Department of Public Health, Department of Social Services, and Department of Aging, by no later than 2018, to collect voluntary self-identification information pertaining to sexual orientation and gender identity.

Yet county officials have pointed out that the regulations do not provide guidance on how or when demographic information must be collected. They have also asserted that collecting such information regarding children and youth in school-based PEI and Innovation projects must be done in ways that are consistent with the California Education Code.

A few counties have experience in collecting demographic information including sexual orientation and gender identity. San Francisco and San Mateo Counties have been collecting gender identification and sexual orientation for years and have developed guidelines for data collection, including age thresholds for children and youth. However, in order to meet the information needs of the state and to tell a statewide story, demographic information must be collected in all counties, not just a few.

Recommendation 1

- The MHSOAC and other statewide entities should support counties by facilitating learning collaboratives. Collaboratives would provide an opportunity for counties that have experience in collecting demographic information on sexual orientation and gender identification and other subject matter experts to share lessons learned and best practices for collecting sensitive, culturally and linguistically competent, and age appropriate data.
- In conjunction with learning collaboratives, the MHSOAC should support the development of training and guidance documents for county and provider staff development, including a toolkit that explains why the data is being collected and how it will be used to support quality improvement.
- For programs serving children or youth, the MHSOAC should amend the regulations to clarify that data on children/youth is to be collected and reported to the extent permissible by federal and state law.
- In addition, the MHSOAC should engage with DHCS and other state departments recently mandated to collect sexual orientation and gender identification data, Health and Human Services Agency, and the Legislature, with the goal to have a statewide uniform standard for collecting this data.

2. There is no statewide or integrated IT system that allows counties to submit timely and affordable reports.

Federal and state entities require counties to submit multiple reports which are often different and sometimes require inconsistent information. For example, counties are required to report information on Full Service Partnerships, an element of the CSS component of the MHSA, through the Data Collection Reporting (DCR). This data system is one of several data systems that counties must use to submit reports to the state. In addition, counties have separate Electronic Health Records (EHR) systems that are not interoperable with systems used by their service providers or the state.

PEI regulations require counties to submit specific data, including tracking referrals, which may be duplicative of, or in addition to, the data elements required by federal and/or other state entities. The regulations do not have templates or guidelines on how to collect and submit the required information. The added PEI and Innovation reporting requirements may create additional costs for counties for IT systems, infrastructure, and staffing. However, most contracts between EHR vendors and counties require the vendor to update the system, at little or no cost, to comply with new regulations.

Recommendation 2

- Counties should engage with their EHR vendors to clarify procedures for modifying and updating their data collection systems in light of new reporting mandates.
- Counties should explore use of unspent MHSAs Capital Facilities and Technologic Needs funds to cover the costs of additional data requirements to perform these functions.
- MHSOAC should engage with DHCS and other state departments to explore ways that data collection and reporting requirements may be consolidated and streamlined.

3. Very small counties with a population of 100,000 or less do not have the staff or resources to meet some of the regulatory requirements which are designed for larger counties.

Very small counties range in population from under 2,000 to 99,000 and receive a small amount of MHSAs funds for PEI. For example, in fiscal year 2014-15 the PEI funds distributed to these counties ranged from less than \$300,000 (Alpine County) to approximate \$900,000 (Nevada County). Unlike larger counties, very small counties are typically rural with small populations spread over large geographic areas and are isolated and far from urban centers. In addition, due to the small number of individuals from any one specific demographic group, reporting of program level participants may create violations of state privacy laws.

Recommendation 3

- The MHSOAC should consider amending the regulations to allow very small counties to report data on a county-level instead of program-level.
- The MHSOAC should support very small counties by facilitating learning collaboratives focusing on best practices within very small counties.
- In addition, the MHSOAC may want to consider a broader discussion of whether to amend the regulations to grant very small counties a waiver from some regulatory program and/or reporting requirements.

4. Counties do not currently have the tools needed to collect some of the required Access and Linkage to Treatment data, such as referral tracking and Duration of Untreated Mental Illness.

A driving goal of the Mental Health Services Act (MHSAs) is a significant reduction in the number of Californians who “fall through the cracks” and are unable to access timely and appropriate mental health services. In order to make sure that there is access to MHSAs programs, the PEI regulations require counties to integrate an Access and Linkage to Treatment strategy in all PEI

funded programs. Further, the Office of Administrative Law (OAL) required the regulations to require counties to operate at least one stand-alone Access and Linkage to Treatment program. The OAL was of the opinion that the requirement was necessary to be consistent with the MHSA.

For both Access and Linkage to Treatment strategies and the stand-alone program, the PEI regulations require counties to collect the following data:

1. the number of individuals with serious mental illness referred to treatment and the kind of treatment to which the individual was referred;
2. the number of individuals who followed through on the referral;
3. the average duration of untreated mental illness for individuals without prior treatment for serious mental illness; and
4. the average interval between the referral and participation in the program to which the individual was referred.

There are several technical challenges with collecting the information listed in two, three, and four above. The regulations do not define “referral” nor differentiate the tracking requirements for non-clinical and/or outreach-oriented programs and clinical programs. Thus there is a concern that data may be required to be collected by individuals who do not have expertise to determine if a person has serious mental illness and needs a referral. There is also a lack of clarity as to whether referrals to programs outside of the county mental health system must be tracked. An additional challenge is the lack of an IT system to track referrals. One county working on this challenge is Lake County. The OAC recently approved Lake County’s Innovation project that will test an on-line web portal that supports referral tracking and interagency coordination to facilitate communication between the referring agencies and the agencies receiving the referrals.

In addition, the regulations do not prescribe the metrics for measuring the Duration of Untreated Mental Illness (DUMI) across diagnostic mental disorders. Counties are given flexibility to choose which metrics to use. There are assessment tools for measuring the duration of untreated psychosis in some early intervention psychosis programs, however, there are no such tools for other disorders (e.g. non-psychotic affective disorders, personality disorders, post traumatic stress disorder). Without standardized assessment for DUMI, counties do not currently have the tools for measuring DUMI.

Recommendation 4

- The MHSOAC with other statewide entities should facilitate learning collaboratives and develop training and guidance documents, including standardized metrics for measuring DUMI.
- The MHSOAC should provide clarification on the meaning of “referral,” and specify when such referrals are to be documented.
- The MHSOAC should provide clarification that a county is only responsible for reporting referrals made to other county programs (either county or provider operated).

5. Some counties integrate their referrals into their assessment and treatment systems of Community Services and Support (CSS) and face difficulties separating data from Access and Linkage to Treatment funded by PEI from that funded by CSS.

The components of the MHSAs were rolled out sequentially: Community Services and Support (CSS) in 2005 and PEI in 2007. Thus, some counties provide services similar to Access and Linkage to Treatment as part of their CSS program. For those counties, there are some limitations differentiating or identifying PEI funded referrals from existing CSS funded referrals.

Another area where there is an overlap with PEI and CSS funded programs is the PEI program requirement of Outreach for Increasing Recognition of Early Signs of Mental Illness. The regulations addressed this overlap by allowing the county to fund the Outreach program through another MHSAs component.

Recommendation 5

- The Commission should consider amending PEI regulations Section 3726 to add a subdivision allowing a county to pay for Access and Linkage to Treatment Program through another Mental Health Services Act funding stream such as Community Services and Supports (CSS) as long as the requirements in the PEI regulations are met.

6. The Commission's process for developing and implementing new data collection requirements does not provide sufficient time to establish needed data collection systems.

Establishing data collection systems to timely comply with the regulations is challenging. Under the regulations, effective November 2015, counties are required to submit two reports to the State: Annual Report and Three-Year Evaluation Report. Both reports require counties to submit demographic information on persons served. Although some counties may be able to meet the deadlines for the first reports, many counties will not.

Under the regulations, the first Annual Report, due December 30, 2017 requires data from July 1, 2016 through June 30, 2017. The regulations will have only been in effect for eight months before counties must start collecting data for this report. Counties are required to submit an Annual Report every year thereafter except when a Three-Year Evaluation Report is due. Thus, the second Annual Report is due December 30, 2019.

The first Three-Year Evaluation Report, due December 30, 2018, requires data from three fiscal years: Fiscal year 2015-16 (July 1, 2015 - June 30, 2016); Fiscal year 2016-17 (July 1, 2016 - June 30, 2017); and Fiscal year 2017-18 (July 1, 2017 - June 30, 2018). The regulations were not in effect until several months after the beginning of year one of this report (FY 2015-16) and thus Counties were not required to collect the data for this period. For year two (Fiscal year 2016-17)

the regulations have only been in effect eight months before counties have to start collecting data for this report. Counties would not have sufficient time to design the evaluation, implement data collection protocols, and obtain and analyze the data.

Recommendation 6

- Recognizing the challenges in establishing data collection systems and balancing those challenges with the importance of the required data, the MHSOAC should provide a waiver for those counties that are not able to provide complete data by the 2017 and 2018 due dates. The waiver would specify:
 - For the first Annual Report, due December 30, 2017, a county that is not able to collect all of the required data would only be required to report the data that it was able to collect. The county would include in the report an implementation plan and timeline for complying with future Annual Reports.
 - For the first Three-Year Evaluation Report, due December 30, 2018, a county would not be required to report the data from year one (Fiscal Year 2015-16) or year two (Fiscal Year 2016-17). However, a county would be required to report data from year three (Fiscal Year 2017-18). For years one and two a county would submit available outcomes data on the PEI programs.
 - The second Three-Year Evaluation Report, due December 30, 2021, and each subsequent Three-Year Evaluation Report, must include the required evaluation data from the three fiscal years prior to the due date.