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ASSOCIATION OF COMMUNITY HUMAN SERVICE AGENCIES

July 21, 2016

Larry Poaster, Subcommittee Chair
Richard Van Horn, Subcommittee Chair
Khatera Aslami-Templen, Subcommittee Chair
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Re: Feedback to MHSOAC on 6/22/16 Draft Staff Summary, Findings and Recommendations for PEI and Innovation Regulations Implementation Project

Dear Commissioners:

The Association of Community Human Service Agencies (ACHSA) represents more than 85 community mental health and child welfare agencies throughout Los Angeles County. Our agencies are all nonprofit, community-based organizations dedicated to insuring the provision of the highest quality mental health, foster care, and juvenile justice services to vulnerable persons in need within the County.

It was a pleasure to meet with you at the Mental Health Services Oversight and Accountability Commission (MHSOAC) special subcommittee and advisory workgroup meeting at Aviva Family and Children's Services on April 14th in Los Angeles. Thank you for taking the time hold the meeting here and listening to our concerns regarding the demographic reporting requirements of the new Prevention and Early Intervention (PEI) and Innovation (INN) regulations set to go into effect in October 2016.

We appreciated the opportunity to comment at that meeting and to now provide input on the June 22nd Draft Staff Summary, Findings, and Recommendations of the PEI and Innovation Regulations Implementation Project, which we believe represent a significant improvement in the overall approach to defining and measuring the impact of PEI and Innovation services within the behavioral health service continuum. At the same time, ACHSA would like to reiterate several ongoing serious concerns we have with implementing the regulations current requirements related to measuring the duration of untreated mental illness and the new demographic reporting. We respectfully submit the following recommendations to modify the *Prevention and Early Intervention and Innovation Regulations Implementation Project* draft document.

MHSOAC Recommendation 1:

ACHSA requests that bullet #4 on page 3 be amended to read (new language in red font, italized, and underlined):

> In addition, the MHSOAC should *suspend implementing the demographics section of the regulations and* 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, *to ensure that there is* ~~with the goal to have~~ a statewide uniform standard for collecting this data.

Comment:
In regards to the expanded demographic information, the MHSOAC and some LGBTQ advocates have argued that the primary goal of the expanded racial/ethnic/cultural and sexual/gender minority identity categories is to provide better and more reliable information to stakeholders, counties and the State with respect to differences in access, penetration and outcomes across a number of groups that were not previously captured. While ACHSA supports this goal, counties and providers have stressed that any new data reporting must be attainable, cost effective, clinically appropriate, culturally competent and beneficial to the client in treatment. The current regulations as adopted do not meet this very basic standard for implementation.

Separately, AB 959, the Lesbian, Gay, Bisexual, Transgender Disparities Reduction Act (2015), directs the Department of Health Care Services (DHCS), the Department of Aging, the Department of Public Health and the Department of Social Services to collect information pertaining to sexual orientation and gender identity. By no later than July 1, 2018, the Departments will have to come into compliance. Accordingly, to ensure consistency and prevent unnecessary changes in two years, it only makes sense that the demographics section of the PEI and Innovations regulations be postponed until DHCS directs counties on what to collect and re-configures the Client Services Information (CSI) to meet the new requirements.

MHSOAC Recommendation 2:
ACHSA requests that all of the staff recommendations in this section be addressed before requiring compliance and that bullet #4 be added on page 4 to read (new language in red font, italized, and underlined):

> *MHSOAC should engage with DHCS and counties, who should engage with their providers, to ensure the necessary IT infrastructure is in place to securely record, process, store and transmit large data sets that include aggregated data required to accurately describe demographic profiles across multiple domains before requiring the implementation of the new reporting mandates.*

Comment:
The participants at the April 14th Los Angeles meeting identified a number of IT barriers that make the retention and reporting of data more complex and cumbersome with respect to provider

Electronic Health Records (EHR). The clinical, administrative, fiscal and IT impacts involved in collecting and reporting data must be weighed against the utility of the data that is being required. Technical capacity, storage and transmission standards were identified as raising serious IT feasibility concerns. Not only would there need to be a change to counties general intake protocol, including new forms and new processes, but each contracted provider's EHR would need to be modified.

ACHSA underscores the point in Staff Recommendation Bullet #2 that substantial Capital Facilities and Technologic Needs funding would have to be identified to support these IT changes. The MHSOAC also expressed the desire to have data transmitted in aggregated reporting sets that would make the data reporting meaningful to the Commission. However, the larger data sets required for aggregated reports may make the transmission of these reports technically unfeasible in a mass reporting scenario. This must be further explored to determine whether transmission is in fact feasible or not, and then be addressed, before any implementation goes forward.

As well, the three staff recommendations must be addressed before moving forward with implementation because technological infrastructure is essential to the counties and providers ability to collect, record, and report the new data sets. These are not just small and inexpensive changes made to an existing EHR. The changes must be evaluated for each system being used by the counties and individual provider agencies. They must address technological storage capacity, data loads and interoperability – and the associated costs to make required changes.

MHSOAC Challenge 3:
ACHSA requests that the last sentence of the opening paragraph on page 4 be amended to read (new language in red font, italized, and underlined):

> 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 *and federal* privacy laws *or protected health information laws*.

Comment:
Aggregated reporting raises HIPAA privacy concerns that may be implicated by data that contains Patient Health Information (PHI) which would need to be protected and secured (e.g., recording a client's HIV status within the context of an EHR). This amendment ensures consistency.

MHSOAC Recommendation 4:
ACHSA recommends that the requirement to collect information from individuals served about their "duration of untreated mental illness" (DUMI) be piloted as a MHSOAC-funded research project with selected programs before it is considered to be required statewide.

Comment:
The DUMI must focus on a standardized sample population (e.g., TAY receiving PEI at first break). Without a standardized measurement, the data becomes meaningless and does not tell us

anything about the penetration or effectiveness of receiving early mental health treatment. Additionally, the Staff Report itself highlights that fact that, "the regulations do not prescribe the metrics for measuring the Duration of Untreated Mental Illness (DUMI) across diagnostic mental disorders" and "[w]ithout standardized assessment, counties do not currently have the tools for measuring DUMI."

ACHSA strongly supports the goal of assuring that people access services at the earliest point possible to prevent their symptoms from getting worse. The development of a pilot project will assure that we find a mutually agreeable way to determine if people are seeking mental health services as close to when their symptoms first appear as possible, and whether the MHSA-funded service positively impacts timely access.

MHSOAC Recommendation 6:
As noted at the June 29th meeting which reviewed these staff recommendations, ACHSA supports the CBHDA recommendation for the following amendments to the three bullet points on page 7 (new language in red font, italized, and underlined):

> For the first Annual Report, due *June 30, 2018, which would report on PEI activities for FY 2016-17* ~~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 *June 30, 2019* ~~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.
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> The second Three-Year Evaluation Report, due *June 30, 2022* ~~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.

Comment:
These new proposed due dates align with current practice for reporting.

Conclusion:
Thank you for your consideration of ACHSA's recommendations. ACHSA, along with other stakeholders, has consistently supported an achievable approach to regulations related to PEI and Innovations. In L.A. County, contract providers have been at the forefront of data informed practice. We sincerely believe that the proposed MHSOAC regulations need to be implemented in an achievable way that ultimately strengthens and improves client systems of care. We also want to reiterate the need to defer implementation of the regulations until the barriers identified in the staff report are properly resolved.

Very truly yours,

Bruce Saltzer
Executive Director

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Mental Health Policy Director

cc: Toby Ewing, Mental Health Services Oversight and Accountability Commission
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