

PREVENTION AND EARLY INTERVENTION AND INNOVATION REGULATIONS IMPLEMENTATION PROJECT

Revised Draft Summary, Findings, and Recommendations For Subcommittee Consideration

Introduction

In 2004, California voters passed the Mental Health Services Act (MHSA) and called for fundamental, transformational change to California’s mental health system. The Act prioritizes a focus on wellness, recovery, community consultation in decision-making, and a high-level of public accountability. To achieve transformational change, the Act has three primary components: Community Services and Supports, which encompasses most direct mental health services, including an approach known as “whatever it takes” to support recovery, Prevention and Early Intervention, which emphasis early response to emerging needs before they become severe and disabling, and Innovation, which calls for new ways of operating.

California’s mental health system is administered and overseen by the State through the work of the California Department of Health Care Services (DHCS) and the Mental Health Services Oversight and Accountability Commission (OAC). Additional state-level functions are administered by the California Department of Public Health, such as workforce development, the California Department of Education, including some school-based mental health programs, the California Department of State Hospitals, which provide hospital care to the most gravely disabled, and other state agencies.

While the State has an administrative and oversight role over California’s mental health system, service delivery is handled by California’s counties. Many counties provide direct services to their residents, while others contract out services, working with private, primarily non-profit, providers.

The MHSA includes a range of requirements that the counties and their providers must meet. In 2013, the Legislature directed the Mental Health Services Oversight and Accountability Commission (OAC) to adopt regulations for programs and expenditures for Prevention and Early Intervention (PEI) and Innovation programs (AB 82 Committee on Budget, Chapter 23, Statutes of 2013). This change in the law charged both the Commission, and the California Department of Health Care Services with issuing 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. To ensure consistency among these regulations, Assembly Bill 82 requires the regulations adopted by DHCS be consistent with the regulations adopted by the Commission (Welfare and Institutions Code section 5846(c)).

Regulations help to clarify standards or expectations in the law. They cannot modify or change the law, but instead provide clear language for implementing or responding to the law. For example, the law may specify that counties must submit to the state information on persons served by the mental health system as a strategy for documenting needs that are being met. Regulations would specify what information – in what form, and how often – should be gathered and transmitted to the state. In California, the Office of Administrative Law is charged with ensuring that regulations are consistent with the law, are clear and necessary and adequately address the legal requirements outlined in the law.

In order to adopt regulations for California’s Prevention and Early Intervention (PEI), and Innovation programs, the Commission undertook a public process from August 2013 through August 2015. That process included 15 public meetings and the receipt of hundreds of pages of public comment. The Commission 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 they fund and operate. The Commission’s regulations were reviewed and approved by the Office of Administrative Law and went into effect October 2015.

Throughout the Commission’s process of drafting regulations, representatives of California’s county behavioral health agencies raised a number of concerns with how the regulations would be implemented, including issues that were largely outside of the regulations themselves, but which were necessitated by the new regulatory requirements. Following the adoption of the regulations, the County Behavioral Health Directors Association raised three concerns for which they sought guidance from the Commission on how the counties should respond. Those issues include:

- **New reporting requirements on the demographics of persons served, including race, ethnicity, sexual orientation, and gender identification.** Among other challenges, the counties pointed out that the existing data system for transmitting mental health data from the counties to the California Department of Health Care Services is not equipped to receive the more detailed demographic reporting data required under the regulations.
- **New program and measurement requirements, under the statutorily required Access and Linkage to Treatment for people with a serious mental illness.** New regulatory requirements for how programs are organized and funded may be inconsistent with how the state initially directed counties to establish their MHSA funded programs.
- **Requirements to measure the “Duration of Untreated Mental Illness” (DUMI).** The regulations require the counties to measure and report how long a person with untreated serious mental illness went without services when that person is referred to care through a Prevention or Early Intervention Program. Yet there is no agreed upon standard for measuring that timeframe.

In response to these concerns, the Commission formed a Subcommittee of Commissioners to further explore those issues and chart a course for addressing them. The Commission's subcommittee was led by Commissioner Larry Poaster and included Commissioners Khatera Aslami-Tamplen and Richard Van Horn.

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, the Department of Health Care Services, 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 in the three areas outlined above.

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, 2016, was a two-day meeting in Sacramento to discuss 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). Regional meetings to discuss the demographic reporting requirements were held in Alameda County, Los Angeles County, and Calaveras County. In each meeting, participants explored the rationale behind the new regulatory requirements, the challenges associated with those requirements, and strategies the state and the counties could pursue to address those challenges.

Informed by the knowledge, experience and expertise of the advisory workgroup and meeting participants, five key issues were raised regarding how counties and providers should respond to the three areas of concern.

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

The Mental Health Services Act includes a clearly articulated goal to improving access to care and the quality of that care for persons who are unserved and underserved. The Prevention and Early Intervention component of the Act, in particular, is intended to reduce the long-term, adverse impacts of untreated mental illness by reducing barriers to care, prior to first-onset or before a mental illness becomes severe and disabling.

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

- Consistent with the law, the OAC should ensure that the Department of Health Care Services adopts regulations that are consistent with the demographic reporting requirements put in place by the OAC.
- The OAC should support counties by facilitating learning collaboratives and peer-to-peer learning on best practices for collecting sensitive, culturally and linguistically competent, and age appropriate data. Collaboratives would provide an opportunity for:
 - Counties that have experience in collecting demographic information to share lessons learned and best practices.
 - Other subject matter experts, including those representing unserved and underserved communities, to share best practices for individual communities.
- In conjunction with the learning collaboratives, the OAC should develop training and guidance materials for counties and providers. This training would include:
 - Guidance on data collection in clinical and non-clinical types of programs.
 - Toolkits and training on using the toolkits to explain why the data is being collected and how it will be used to support quality improvement.
- For programs serving children or youth, the OAC should amend the regulations to clarify that data on youth is to be collected and reported to the extent permissible by federal and state law, including the California Education Code. The Commission should also consider specifying an age threshold for the data collection.

- In addition, the MHSOAC should engage with the Department of Health Care Services and the three other departments (Department of Public Health, Department of Social Services, and Department of Aging) recently mandated by the Lesbian, Gay, Bisexual, and Transgender Disparities Reduction Act (Assembly Bill 959 Chiu, Chapter 565, Statutes of 2015) 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.
- As the state puts in place a statewide integrated data collection system, the OAC should amend the regulations to require individual-level and non-aggregated data to better monitor who is served by California's mental health system, as well as whether some Californians continue to face barriers to care.

IN ORDER TO IMPLEMENT THE REPORTING REQUIREMENTS, THE DEPARTMENT OF HEALTH CARE SERVICES MUST DEVELOP AN INTEGRATED DATA COLLECTION SYSTEM THAT ALLOWS COUNTIES TO SUBMIT DATA IN A TIMELY, RELIABLE, AND EFFICIENT MANNER.

2. Very small counties with a population of 100,000 or less face unique and significant challenges in meeting regulatory requirements.

Very small counties range in population from under 2,000 to 99,000 and have limited resources. 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). These counties also have limited staffing capacity. For example, the County of Alpine has a staff of 13 including 2.5 staff working exclusively under the MHSOAC programs and 3 clinicians and Modoc County has 13 full time employees providing behavioral health services for all its residents.

In addition, the small size of the county population creates challenges with the reporting requirements. Individual programs in very small counties tend to serve few consumers and thus there is a high risk that the reporting requirements cannot be completed without providing individually identifiable health information in violation of federal and state laws such as the Health Information Portability and Accountability Act (HIPAA), the Confidentiality of Medical Information Act or other state laws that protect against the disclosure of health information.

In looking at the unique needs of very small counties there is a mismatch between the general requirements that apply to other counties and very small counties. This mismatch is true for the reporting requirements and may be true for other MHSOAC requirements.

Recommendation 2

- The OAC should amend the regulations to allow very small counties to report data on a county-level instead of at the program-level.

- The OAC should support very small counties by facilitating learning collaboratives and peer-to-peer learning on best practices within very small counties, including the collection of sensitive, culturally and linguistically competent and age appropriate data. Collaboratives would provide an opportunity for:
 - Counties that have expertise in collecting demographic information to share lessons learned and best practices.
 - Other subject matter experts, including those representing unserved and underserved communities, to share best practices for individual communities.
- In conjunction with the learning collaboratives, the OAC should develop training and guidance materials for counties and providers. This training would include:
 - Guidance on data collection in clinical and non-clinical types of programs.
 - Toolkits and training on using the toolkits to explain why the data is being collected and how it will be used to support quality improvement.
- Recognizing the unique needs of very small counties, the OAC may want to consider a broader discussion to explore how very small counties can pursue the goals of the MHSA in more effective ways to achieve the transformational change envisioned by the Act.

3. Counties do not currently have the tools to collect the required Access and Linkage to Treatment data.

A driving goal of the Mental Health Services Act (MHSA) 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 MHSA 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:

- Number of individuals with serious mental illness referred to treatment and the kind of treatment to which the individual was referred;
- Number of individuals who followed through on the referral;
- Average duration of untreated mental illness for individuals without prior treatment for serious mental illness; and
- 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 3

- The OAC with other statewide entities should facilitate learning collaboratives and develop training and guidance materials, including standardized metrics for measuring Duration of Untreated Mental Illness.
 - As part of the learning collaboratives and guidance, the OAC should partner with counties to identify the efficacy of county strategies for measuring Access and Linkage to Treatment and the Duration of Untreated Mental Illness. This could include focused studies and/or pilot projects and would be part of a continuous quality improvement process for measuring DUMI.
- The OAC should provide clarification on the meaning of "referral," and specify when such referrals are to be documented for non-clinical and/or outreach-oriented programs and clinical programs.
- The OAC should provide clarification that a county is only responsible for reporting referrals made to other county programs (either county or provider operated).

4. Counties that integrate their referrals into assessment and treatment systems for Community Services and Support (CSS) face difficulties identifying Access and Linkage to Treatment data funded by PEI.

The components of the MHSA 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 identifying PEI funded referrals separate 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 MHSA component.

Recommendation 4

- The OAC should amend the PEI regulations to allow a county to pay for Access and Linkage to Treatment Programs through another Mental Health Services Act funding stream such as Community Services and Supports as long as the other requirements in the PEI regulations are met.

5. The regulatory reporting deadlines should be aligned with the county's annual budgeting process and allow for an implementation period.

The MHSA requires every county to prepare Three-year Program and Expenditure Plans (Three-year Plans) setting forth an integrated plan for all of the MHSA components (i.e. programs for PEI, Innovation, Community Services and Support, Workforce and Education, and Technological and Capital Facilities) every three years, and to update those plans annually (Annual Updates). By law, the Three-year Plans and the Annual Updates must be approved by the County Board of Supervisors and submitted to the OAC within thirty days of Board approval.

The PEI regulations adopted by the OAC require counties to submit annually either an Annual Program Report (Annual Report) or a Three-year Program and Evaluation Report (Three-year Evaluation Report). These reports are required to be included as part of each county's respective Three-year Plan or Annual Update and are due within 6 months after the close of the fiscal year (December 30th of each year).

The December 30th regulatory due date for the reports is not aligned with the county's timing for the Three-year Plans and Annual Updates, which are prepared and submitted to the County Board of Supervisors in the context of the county's annual budgeting process. The MHSA requires extensive community planning process and stakeholder involvement prior to Board of Supervisor approval and can take anywhere from 6 to 9 months. The Three-year Plans and Annual Updates are submitted to the Board of Supervisors before the end of the current fiscal year (June 30) for program expenditure authority for the following fiscal year that starts July 1.

This timetable, and the intention that the Three-year Plan or Annual Update shape the local decision-making process on mental health programs budget and priorities, suggests that the reports should be delivered to the County Board before the end of the fiscal year in time for Supervisors to use the report in their annual budgetary deliberations on the priorities for the next fiscal year.

An additional concern is that due to the process to develop and implement the regulations, there is insufficient time to fully comply with the deadline for the initial reports.

Under the regulations, the first PEI Annual Program and Evaluation Report is due December 30, 2017 and is to provide program data for the period 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.

Each Three-Year Evaluation Report requires data from the three preceding fiscal years. The first such report is due no later than December 30, 2018 and would cover fiscal years 2015-16, 2016-17 and 2017-18. As the regulations were not in effect until several months after the beginning of year one (FY 2015-16), counties are not required to collect the data for this period. The regulations will have only been in effect for eight months before counties must start collecting data for year two (FY 2016-17) and establishing data collection systems in time to report this data is challenging. Although some counties may be able to meet the deadlines for the first reports, other counties may not have had sufficient time to design the evaluation, implement data collection protocols, and obtain and analyze the required data.

Recognizing the challenges in establishing data collection systems and balancing those challenges with the importance of the required data, the OAC may wish to revisit and revise due dates for PEI Program and Evaluation Reports. Further, because the regulations did not become effective until several months into FY 2015-16, the OAC may wish to revise the due dates and data reporting periods required to be included in the initial reports.

Recommendation 5

- The OAC should provide a waiver for the initial Annual Report due no later than December 30, 2017. A county would report data only to the extent it was available and would need to explain the obstacles to collecting the required data and provide an implementation and timeline for complying fully with future Annual Reports.
- For subsequent Annual Reports and the initial and subsequent Three-Year Evaluation Reports, the OAC should amend the regulations to modify the due dates to align them with the county process. The reports would be due within 30 days of Board of Supervisor approval but no later than June 30.

Initial Three-Year Evaluation Report

- **Due:** June 30, 2019
- Data from FY 2017-18; Prior FYs only to the extent available

Second Three-Year Evaluation Report

- **Due:** June 30, 2022
- Data from the three prior fiscal years