Attachment E: SAMHSA's Response to the Comments

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Commenter	Comment	Paraphrased	Response
New York State Office of Mental Health	In the introduction, I think it would be helpful to mention the role of the Technical Assistance (TA) providers who administer the annual report. It is confusing to the providers who the various players are who may be contacting them or the State Path Contact (SPC). Page three, fourth paragraph: The word 'must' is not consistent with later sections of the document, which suggests a phase in is more likely. There needs to be an overview of the Homeless Management Information System (HMIS) . Reference that they are local systems administered by Continuum of Care (CoC) programs. Who are the 'designated PATH data collection contacts?' Explain ... that "PATH providers do not have HMIS....' Should Shelter Plus Care (SPC) program work with CoC programs. Last sentence in this paragraph is confusing. Page four: - Not sure if this reflects an accurate description of HUD. HUD CoC ? What about S+C? Should there be a description of phase in? Reference to the 2011 Proposed HMIS Standards - Are they not approved? The 2011 reference is confusing. Page five - #5: Second sentence is confusing. Process section - 'The details of the process are general but may vary ...' and 'brief high-level	Several comments related to the revised PATH Annual Report Provider Guide are offered. Suggestions include: 1. Include information about the Continuums of Care (CoC) that administer local implementations of HMIS, and clarify the role of the 'designated PATH data collection contacts' and the TA providers who administer the annual report. 2. The introduction to the guide states that PATH Providers "must" extract PATH data from local HMIS, yet other sections of the guide state this process will be phased in and is not yet required. 3. In the HMIS and PATH section on page four, it may be helpful to include information on the phase in. The reference to the 2011 Proposed HMIS Standards and Requirements is	Where possible, SAMHSA will incorporate these recommendations for clarification in the PATH Annual Report and the accompanying PATH Annual Report Provider Guide. 1. The 'HMIS and PATH' section of the Provider Guide provides an overview of HMIS. The release of the new HUD HMIS data standard has been delayed; the draft data and technical standards are now expected out later in 2012. The Provider Guide has been updated to include additional information about the TA providers and CoCs. 2. Information has been added to better describe the process of phasing in HMIS for PATH data reporting. 3. Information about the phase in process has been added to the Provider Guide. With the implementation of the regulations issued pursuant to the HEARTH Act, the Shelter Plus Care (SPC) program has been integrated into the Continuum of Care (CoC) program, and does not exist as a separate program. 4. Information has been added to provide additional clarification for this item. 5. Information has been added to this section to help clarify the process. 6. SAMHSA will provide additional clarification for the process of correcting data errors. 7. These recommendations were incorporated into the Provider Guide. 8. Budget Information Section (BIS) #2 is asking for the same information as Item A3 in the current PATH report. BIS #3 is asking for the same information as Item A1 in the current PATH report. SAMHSA will develop additional guidance on these items. 9. Comments related to the burden estimate can be sent to the SAMHSA Reports Clearance Officer at the address listed in the Provider Guide.

	process description' - not clear what this means. Page Eight: Understanding data errors - First paragraph is confusing. - Errors should be investigated, corrected, re-extracted, re-transmitted. – Should it all be in one sentence? Phase in begins to be mentioned here, yet page one says, 'must'. Reference to contacting SPC is not consistent with page nine, last bullet. The last sentence should be "re-validate...." Page Nine - #1: - The discussion regarding the reporting period should be in the beginning of the document. #2 - Should this be 'adult' family members only? BIS #2 and #3 are confusing. #2 - Is this the total 'PATH program'? Explain matching funds, plus PATH funds, equal total PATH program budget. (This may of may not be equal to #3.) Page 16 - Reporting Burden: How were total hours 19, 19, 34 derived? I'm not sure if this is accurate.	confusing. Should the Shelter Plus Care (SPC) program be referenced in addition to the CoC program? 4. Notes on Changes from Previous Report Section: Provide additional clarification for #5, Additional Data Items. 5. In the section on the Process for Obtaining and Submitting Data, it may be helpful to clarify how the details of the process 'may vary depending on the particular HMIS implementation used by the provider.' 6. Clarification requested on the process of correcting data errors. 7. General Definitions and Clarifications, Persons Included in Unduplicated Counts: Information about the reporting period should be moved to the introduction; specify that only adult family members should be	

		counted. 8. BIS #2 and #3 are confusing. 9. Information on how the reporting burden was calculated should be included. It is unclear if these numbers are accurate.	
Loudoun County Virginia	The short answer is: The use of HMIS is duplicating our process for electronic data collection. Some consumers are adverse to providing their information for entry into a database, and most agencies supporting the homeless in our jurisdiction don't use HMIS. In our area, the HMIS database provides a perspective of when, what, and how the consumer access resources. PATH staff enter consumers into the HMIS data base on a monthly basis. The data provided includes the consumer's name, date of birth, race, and ethnicity, location at time of contact, social security number, and gender, veteran status, disabling conditions, marital status, and family size. The opening date, which indicates first point of contact with a PATH provider is entered. To ensure privacy, the PATH team is not identified as PATH but coded as Homeless Program 1. This prevents consumers from being identified by other providers as having a serious mental illness and/or co-occurring disorder.	1. Respondent reports that most homeless services providers in their jurisdiction do not use HMIS, so the use of HMIS creates a duplication of effort in their data collection process, requiring them to enter client data into two separate databases. 2. Respondent provided a description of how HMIS works in their community, and how the PATH program is disguised to avoid identifying consumers as having a serious mental illness. 3. Consumers may be more hesitant to provide identifying information, if it will be stored in a national database. 4. Respondent discussed plan to build an interface between HMIS and their existing data collection system (which is maintained to fulfill other reporting requirements, plus supports discharge planning	1. Entering data into HMIS may result in some PATH programs entering their data into two systems, but the expectation is that for many PATH programs, these changes could reduce duplicate reporting. Some PATH providers have already begun entering data only into HMIS. 2. No response. 3. HMIS is not a national database. The data resides in the Continuum's database, and may only be shared subject to the consent of the consumer. Data may be integrated at the state level, but client-level data is never requested by or furnished to HUD, and would not be requested by or furnished to SAMHSA. PATH providers should request that the HMIS Lead Agency affirm the HMIS's security policies and procedures, so consumers who are concerned about sharing their information can be assured their information will be stored in a secure database and will be properly protected. HUD requires all HMIS systems to maintain certain standards in order to ensure data is kept private and confidential and that consumers' personal information is protected. Revised technical standards, including expanded protections related to privacy and confidentiality will be issued by HUD later this year. 4. The revised data standard includes requirements that HMIS implementations develop a standardized XML format for importing and exporting data that will facilitate integration of different data platforms. Local CoCs may use their HUD funding to assist PATH programs with HMIS implementation. 5. SAMHSA understands that full HMIS implementation will take time and many programs will not be able to have full implementation until 2014 or later.

	All consumer data is stored with the Loudoun Department of Information Technology. There, all information is readily accessible. The Department of Family Services maintains the HMIS/Harmony Database, and it is active and available. The consumer case information is collected in the Loudoun County's electronic health care record database (Anasazi) and the initial contact with the consumer is entered into the HMIS/Harmony database. The use of the Anasazi system is beneficial to discharge planning and case transfers within the CSB. It is recommended that all data be entered into the agency database and migrated to the HMIS/Harmony system. The challenges the PATH program will face is the duplication of data entry in the two systems to fulfill the local and federal requirements. Outpatient CSB clinical staff do not utilize the HMIS/Harmony system, which makes case coordination with the agency difficult. Also, the consumers are apprehensive about providing any vital information to the clinician, if the information is entered into a national wide database. They want to ensure confidentiality, and if the consumer refuses consent, ,the use of HMIS/Harmony would be limited. The tracking and reporting data elements can be accessed from the	and case referral. Implementing HMIS for PATH will require additional work and funding for the development and testing of this interface. 5. Implementing HMIS will require many months of testing, set-up, and training before it can be implemented.	

	HMIS/Harmony database to support the SAMHSA goal. A program interface must be obtained in order to exchange the data from one system to the other, as long as there is a "1:1 relationship" in the data set-up. Harmony will be solicited by the Loudoun DFS HMIS Administrators for the interface program. The HMIS administrator and the Anasazi Data Manager will collaborate on the platform. It is recommended by the Anasazi Data Manager a universal platform be built by Anasazi directly for the active Anasazi users in Virginia who have a PATH program. There is funding in place for statewide initiatives such as this. Additional grant funds need to be awarded to for this requirement. The estimated cost of the Harmony interface is $10,000.00 and a three to six month set-up and testing period is required before the system is active. After the system is designed and active, all staff will require approximately eight hours of training to ensure accurate delivery of the mandated reporting.		
Thresholds, Chicago Illinois	PATH, in order to avoid causing undue burden on agencies, should consider limiting the required use of HMIS to the same standards of use and data entry as required by the HUD McKinney-Vento Supportive Housing Program. Otherwise, increased funding to agencies for	1. PATH should only require the same standards of use and data entry as required by HUD McKinney-Vento Supportive Housing Programs, or increase funding to agencies to support this new data collection process.	1. SAMHSA is working with HUD and other federal partners to make the data standards consistent across programs, minimize conflicting requirements, and facilitate data collection for use in reports related to all federal agencies' requirements. PATH serves a different population and requires different outcomes than McKinney-Vento Supportive Housing Programs, and therefore, some additional data elements must be included.

	data entry staff will be necessary. Most agencies use their own data/records applications and mandating use of HMIS requires double entry of notes – taking time away from the clients we are supposed to be serving. One option is to make integration with other software applications easier. -- Allow those agencies to upload the required data from their own systems to HMIS. In addition, some Continuums of Care (CoC) programs will be charging agencies for the use of the HMIS system, if the program is outside of the HUD McKinney-Vento Supportive Housing Program. Please consider these comments in determining the next steps of mandating use of the HMIS system for PATH providers.	2. Requiring use of HMIS will require providers to enter data twice, as most agencies use their own data collection applications. 3. One suggestion is to make it possible for agencies to upload information from their own data collection systems into HMIS. 4. If the PATH provider is outside of the HUD McKinney-Vento Supportive Housing Program (SHP), some Continuums of Care (CoC) programs will charge the PATH provider to use the HMIS system.	2. SAMHSA understands that this change may result in some PATH providers entering their data into two systems; the expectation is that this change can reduce duplicate reporting for many providers. 3. SAMHSA cannot design a program to upload information from agency data collection systems into HMIS, because each Continuum of Care (CoC) program uses their own system. Using a HMIS would allow PATH providers to utilize a system that is already standardized and will align with the PATH Annual Report. 4. SAMHSA is aware there is often a licensing fee to use HMIS and many HUD programs are also required to pay this fee for HMIS access.
Colorado Coalition for the Homeless	I am writing to comment on the Federal Register Notice regarding the use of HMIS to complete the revised PATH report. Specifically, I have two questions/concerns regarding the revisions of the PATH report: 1) "The PATH report now tracks demographic data for persons contacted, as well as those enrolled." How is this to be accomplished? Not all contacts occur in sufficient depth to obtain all the demographic data we currently collect for enrolled clients. Also, on a related note, will HMIS have a field for psychiatric diagnosis and if so, how will the client's right to	1. Collecting demographic data for persons contacted but not enrolled would be difficult as not all contacts result in collection of demographic information. 2. Will there be a field for psychiatric diagnosis? If so, how will confidentiality be protected in HMIS? 3. Is the total count of the number of times a service was provided or referral made in aggregate across clients or total for each individual served?	1. The collection of demographic data for persons contacted but not enrolled is a common concern, and it is understood that providers may need to leave these fields blank. Providers should work with their local HMIS to ensure missing fields are allowed. 2. No, there will not be a field for psychiatric diagnosis in the new report. PATH providers should request that the HMIS Lead Agency affirm the HMIS's security policies and procedures, so consumers who are concerned about sharing their information can be assured that their information will be stored in a secure database and will be properly protected. HUD requires all HMIS systems to maintain certain standards in order to ensure data is kept private and confidential plus consumers' personal information is protected. 3. The total count for the number of times a service was provided or referral made is an aggregate number across clients. Client level records are in the HMIS; the HMIS can generate aggregate reports for all clients, as well as total service events per client.

	confidentiality be safeguarded in HMIS? 2) "... there is a total count of the number of times that particular service was provided or referral made." Is the total count in aggregate or total per individual client (e.g., total number of habilitation and rehabilitation services across all individuals served or total number of such services for each individual served)? Also, I'm assuming once HMIS is configured to produce the new report, PATH service providers will have sufficient notice to reconfigure their data collection practices to comply with the requirements of the new report. A third point on the voluntary outcome measures becoming mandatory- bravo!	4. It is important to ensure that service providers have enough notice in order to make their data collection processes comply with the new report. 5. We agree with the proposed change to make the voluntary outcome measures mandatory.	4. SAMHSA understands that during the first two years of the new PATH data collection and reporting system using HMIS, some providers will be unable to report on some fields. Having aligned the new PATH report with HMIS, SAMHSA expects providers to begin using a local HMIS system. This will not require providers to reconfigure their data. Entering the requested information in HMIS will automatically generate the exact information needed for the PATH Annual Report. 5. No response.
NH DHHS Bureau of Homeless & Housing Services	In response to the June 12, 2012 Federal Register, page 34960; notice addressing proposed changes in data reporting requirements for Projects Assisting in Transition from Homelessness (PATH), I respectfully submit the following comments: **Proposed change:** For services and referrals, in addition to gathering the number of enrolled persons receiving the service or referral, there is a total count of the number of times that particular service was provided or referral made. **Comment:** Maintaining counts of	1. It should not be required for PATH programs to track the number of contacts or the number of times a service was provided or referral made, as this data does not relate to GPRA measures and would increase the data entry workload of PATH staff. This additional burden would occur regardless of the type of data collection system, including HMIS. We recommend adding a short narrative section in the APR that would allow a	1. While this data does not directly relate to GPRA measures, congress is moving towards performance-based funding, and it is important that the PATH program is able to provide as much evidence as possible to show its effectiveness (HR 2142 p. 24 http://www.whitehouse.gov/sites/default/files/omb/performance/title-5.pdf). This proposed change would capture services provided by PATH providers, many of which have not been reflected in previous PATH Annual Reports. SAMHSA recognizes that there are many elements of the PATH program that cannot be described in numbers; it would, however, be difficult to summarize a narrative section into a succinct report given the size of the PATH program. 2. SAMHSA will take these recommendations into consideration when finalizing the referral section of the Annual Performance Report (APR).

	both contacts and referrals for enrolled persons should not be required. There are no outcomes in the GPRA measures directing or impling that services, supports, or referrals must be provided within a set number of contacts. There are not outcomes that identify a PATH program as better or worse depending on the number of its overall contacts with people served, or with the number of referrals involved with linking a person to essential supports. SAMHSA currently recognizes that due to the extreme challenges involved in serving people who are homeless, living with serious mental illness, and disconnected from vital supports, intensive ongoing contacts and referrals are expected. Also, documenting specific counts of both contacts and referrals, for each service provided, for each enrolled individual will significantly increase data entry workload of PATH Outreach staff, resulting in a decrease of time available for direct service. This increased workload will occur regardless of the type of reporting mechanism, including the Homeless Management Information System (HMIS). **Recommendation:** Rather than requiring counts of contacts and referrals as proposed, the inclusion of a short narrative section in the APR would allow a local program to describe the context of the numerical outcomes they are reporting. For	program to describe the context of the data being reported, instead of requiring counts of contacts and referrals. 2. Regarding the proposed change to make the voluntary outcome measures mandatory: ensure that connection to mental health services, substance use disorder treatment services, and Veterans Administration services are included in this section.	

	example, a program could report that in this APR reporting period, a small number of individuals required extensive PATH case management to achieve meaningful linkage to local treatment resources. **Proposed change:** Current Voluntary Outcome Measures will become mandatory and moved to the Referral section of the APR. **Recommendation:** Ensure inclusion of connection to mental health services, substance use disorder treatment services, and Veteran Administration services.		
Greater Nashua Mental Health Center	Thank you for the opportunity to continue to serve our community through the PATH funding. I believe this funding is critical to address those who are not engaging into needed services. Some thoughts to suggest for future data elements: I hope you consider adding the element of engagement...period. I have a few outreach clients that are paranoid and unable to refer to any program...building the rapport in order to do so takes much time and seemingly, is not captured in the report. Demographics- I wish you could have a separate section to reflect when someone is 'couch surfing' vs. in an apartment, -as it appears they have housing, yet they are really just staying with someone who is allowing them to stay temporarily on a couch.	1. We recommend adding a report item that captures information about engagement with individuals. 2. We recommend distinguishing between staying in an apartment vs. "couch surfing." Stating that an individual is staying in an apartment makes it appear as though he/she has housing.	1. The new report includes an item to report the number of individuals outreached who did not necessarily become in enrolled in the PATH program. The proposed change of "Additional Data Items" will ask providers to now track demographic data for persons contacted, which will provide additional context to the significant engagement work PATH workers are doing. 2. The existing HMIS data standards currently include options for "Living with family" and "Living with friends," and capture the tenure of these living arrangements, but do not further categorize the stability of the living situation. The new housing status field will categorize the stability of the living situation.

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Riverbend Community Mental Health	Our agency, Riverbend Community Mental Health, is currently not using the HMIS system for PATH data. After reviewing the proposed PATH APR data elements, it appears that collecting counts of the numbers of contacts, services, and referrals for each individual category mentioned is going to be additional administrative time for the PATH worker, taking away time from performing outreach. We are interested in finding out if additional grant funds will be added to the PATH grant for increased administrative overhead.	1. Collecting information about the number of contacts, services, and referrals will require additional administrative time for PATH workers and will decrease the amount of time available for outreach. 2. Will additional grant funds be provided to account for the increased administrative overhead?	1. It is important to provide as much information as possible about PATH outcomes. As congress is moving federal programs toward a performance measurement system for reporting effectiveness, it is likely that PATH effectiveness data will be more complex in nature, reflecting actual effort. 2. No additional funds will be provided for administrative purposes at this time. The expectation is that while there is an initial burden related to these proposed changes, they will ultimately lead to a more streamlined data collection process, which will decrease administrative workload related to data reporting.
Federation of Organizations	Federation of Organizations appreciates this opportunity to provide comments in response to the changes that are announced in the Federal Register for the revised PATH Annual Report. One of the biggest challenges we have in completing the PATH Report is it changes from year to year. Some years the changes are more significant than others. We don't usually know what the changes will be until we receive the PATH Annual Report. By that time, the reporting period has ended. This makes it difficult to report accurately. It is important we be made aware of what data elements will be requested before the reporting period starts.	1. It is difficult to ensure that we collect the correct data every year, as there have been changes in data elements from year to year. It is important that providers are informed of changes in data elements before the reporting period starts in order to ensure the correct information is collected. 2. The PATH report should allow for estimated counts of persons contacted and of services provided/received, as it is not possible to collect exact numbers due to the design of certain PATH programs, and the fact that	1. The only change to data elements in recent years was the addition of the Voluntary Outcome Measures, which are not currently required. Unfortunately, due to issues with timing, new data elements in the proposed revision of the PATH Annual Report will come out mid-year. It is understood that some providers will not be able to report on all elements for the first few years. Aligning the data elements of the PATH Annual Report with HMIS data elements will ensure that PATH data collected will meet all the requirements of the PATH report. 2. If a provider is unable to obtain information for certain data elements, they should leave their answers blank until they are able to collect this information. Providers should work with their local HMIS to ensure missing fields are allowed. 3. The collection of demographic data for persons contacted but not enrolled is a common concern, and it is understood that providers may need to leave these fields blank. Providers should work with their local HMIS to ensure missing fields are allowed. 4. This comment reflects why this addition was made.

	This will allow us to set up data tracking systems, so we can report as accurately as possible. The new PATH report will not facilitate entry of estimated counts. Specifically, this relates to question (D1): the number of people who received any service and are PATH eligible and (D2): the number of people that are contacted. Based on our program design, the PATH report needs to allow estimations for these two questions. Federation's P.O.W.E.R. (Peer Outreach With Evening Recreation) Program is a program designed to provide outreach and referral services to individuals who have serious mental illnesses and are homeless or in danger of becoming homeless. The program has several components: a meal program, a food pantry, counseling services, and street outreach. Most of the people we come in contact with during street outreach do not provide their last name. Additionally, people we meet on outreach may attend one of the other components of the program, and therefore, we need to factor in a certain percentage of duplication of individuals contacted. Question DS.9 asks for the housing state of persons served at the time of the first contact. The housing status is not always received during the first contact. During street outreach the outreach team comprised of staff and	participants attending outreach activities or contacted on the street may not fully identify themselves. 3. It may not be possible to collect demographic information or information about housing status during the early stages of client contact. Initial engagement with clients is focused on building trust, and clients often do not want to immediately share personal information. Therefore, it may be necessary to use educated estimates until all information is obtained. 4. We support the addition of the total number of contacts made and total number of referrals given, as this addresses work that was not captured in the previous report.	

	volunteers, some of whom are in recovery themselves and were formerly homeless, are attempting to engage the people with whom they come in contact.. Many of the people we see have experienced stigma, are fearful of the mental health system, have mental illness, are using substances, are homeless, may be undocumented, and are residing in non-traditional settings, such as shelters, and are extremely reluctant to share personal information. In order to be effective, the P.O.W.E.R. Program needs to demonstrate a non-threatening approach. We don't always ask one's housing status during our first contact. At the first contact we are attempting to build trust and engage the person on their terms in order to ultimately assist them. Question DS 12 asks for the demographics of contact clients, as well as enrolled clients. In some cases it is difficult to obtain the demographic information you are requesting. We come in contact with hundreds of people through outreach. As afore mentioned, many people are unwilling to provide their last name and other demographic information. Sometimes it takes several contacts to obtain this information due to our population being cautious of answering questions about themselves.		

	For the reasons mentioned above, we need to use educated estimations with regards to some of the people we come in contact with through street outreach. However, we can obtain this information for individuals we formally enroll in the program. Question D6: which requests the total number of contacts made this reporting period is a helpful addition to the report, as well as question DS8: total number of referrals given during the reporting period. These questions address work we do that was not being captured in the previous report. We appreciate your taking time to review our comments. We are hopeful this feedback will be taken into consideration as you further revise the Annual PATH Report.		