Pinellas Integrated Care Alliance

Evaluation Report

Annual Report: Year 3

For the Period 10/1/20 – 3/31/21

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EXECUTIVE SUMMARY

The purpose of this evaluation is to assess the implementation and outcomes of the Pinellas Integrated Care Alliance (PICA) initiative, the primary goal of which is to improve coordination and collaboration among Pinellas County behavioral health providers in order to increase access to behavioral health services, address system gaps and inequities, improve follow-up care and long-term outcomes, and decrease utilization of auxiliary services for mental health needs such as jails and crisis stabilization units (CSUs). Qualitative and quantitative analyses have been conducted by the evaluation team to measure the impact of the initiative at both the client and systems level. This report combines new findings from the second part of Year 3 (10/1/20 – 3/31/21) with a retrospective analysis of findings from the entire evaluation period (6/1/2018 – 3/31/21). The components of the evaluation include analyses of client outcomes; steering committee and PIC Team/MHU meeting observations, interviews, and focus groups; stakeholder surveys; and client interviews.

PICA Model

A **steering committee** for the initiative has been comprised of leaders from agencies who have an integral role within the behavioral health system and who are connected with behavioral health services in Pinellas County: The Central Florida Behavioral Health Network (CFBHN), Pinellas County Human Services (PCHS), the Pinellas County Health Department (PCHD), and the Pinellas County Sheriff's Office (PCSO). The steering committee acts as a decision-making body that drives strategic changes in Pinellas County's behavioral health system of care at the systemic level, and works closely with lead provider agencies to oversee processes at the client level.

A **centralized care coordination team**, the Pinellas Integrated Care Team (PIC Team), is responsible for connecting clients with appropriate behavioral health and related services. Clients are referred through the PCSO Mental Health Unit (MHU), which is comprised of co-responder teams made up of a deputy and a mental health clinician. Individuals within the PCSO's jurisdiction who receive Baker Act exam initiations, make frequent 9-1-1 calls, or who have multiple arrests that are considered to be potentially related to mental health are flagged for consideration for care coordination services by the PIC Team. Members of the PCSO MHU determine whether services are appropriate, and if the individuals meet criteria for enrollment, they are referred to the PIC Team.

Client Outcomes

Enrollment and engagement data, functioning outcomes, arrest and jail data, and involuntary mental health exam initiation (Baker Act) data were used to assess how the PIC Team has impacted clients. Since July 2018, 599 clients were referred to the PIC Team and of those 382 (63.8%) were admitted for care coordination services. Key findings are identified below and elaborated in subsequent sections.

Key Client Outcome Findings

- ➔ **Primary reasons for referral were mental health challenges (72%) and substance misuse (20%)**
- ➔ **The PIC Team makes approximately 4 engagement contacts on average prior to enrollment**
- ➔ **For most clients (72%), the length of service is between 1-6 months**
- ➔ **Client functioning and self-sufficiency scores improved overall for PIC Team clients**
- ➔ **Arrests decreased for PIC Team clients in the short term (by 42%) and long term (by 11%)**
- ➔ **Baker Acts decreased at the same rate (44%) in the short (< 1 year) and long term (> 1 year)**

Enrollment and Engagement

With regard to **client characteristics**, male and female clients are roughly equal (51% and 49%). The majority of clients identify as White or Caucasian (89%), and Black and Other racial minorities make up 11% of admitted clients. About 8% of clients reported their ethnicity as Hispanic. Approximately 18% of clients reported ever being homeless. The top three cities clients come from are St. Petersburg (25%), Clearwater (21%), and Largo (12%). Clients ranged from 18 to 87 years of age with an average age of 42 years. The vast majority of clients (91%) are unpartnered (single, divorced, widowed, or separated). Most were not employed due to retirement (6%), unemployment (48%), disability (27%), or other reasons (6%). About 46% of clients reported having less than a high school education.

Engagement data indicate that the PIC Team made an average of 3.73 contacts and spent 2.58 hours on average engaging admitted clients after they were referred by the PCSO MHU. For referred clients who were not admitted, system coordinators made 5.41 contacts, spending 3.55 hours on average on engagement. Engagement strategies include phone calls, face-to-face contact, “activity on behalf” (arranging appointments for clients), collateral contact (contact with a family member or other support), and telehealth.

The primary **reasons for referral** to the PIC Team were reported as primarily mental health challenges (72%) and substance misuse (21%); medical reasons, developmental disability, and domestic violence make up the other 8%.

The **length of stay in PIC Team services** varied widely, between less than one month and more than twelve months. Care coordination lasted less than one month for about 8% of clients. For the majority of clients (72%), care coordination services were provided for one to six months. The length of service lasted greater than six months for about 22% of clients. (see Figure 1a).

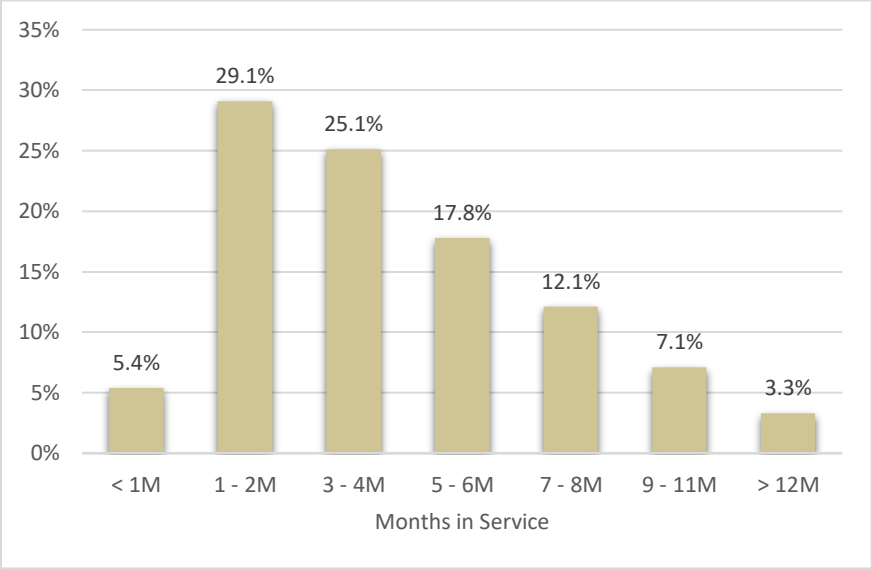

Figure 1a. Length of care coordination service time (n=354)

Client Functioning

There was an **increase in client functioning** for clients admitted to the PIC Team. The Functioning Assessment Ratings Scale (FARS) scores decreased significantly over time for each factor, indicating greater functionality in all areas (see Figure 2a). Overall, the decrease in FARS domain scores indicate greater functionality and is suggestive of effective service provision by the PIC Team. Scores of re-admitted clients continued to show improvement from baseline, indicating that improvements in functioning were sustained after discharge.

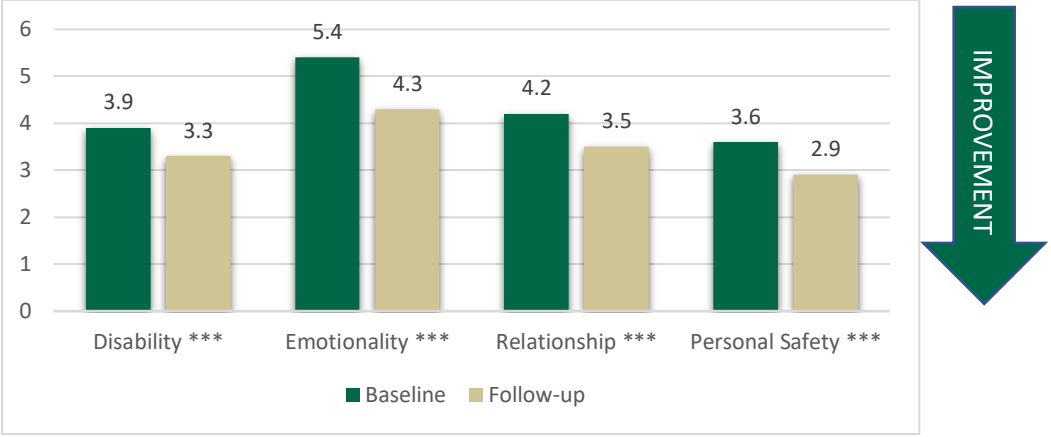

Figure 2a. Average FARS Scores at Baseline and Follow Up (n= 292)

Self-Sufficiency

Clients also showed significant **improvements in self-sufficiency** across all domains of the Self-Sufficiency Matrix (SSM) (see Table 1a). Overall improvements in scores from baseline to follow-up were seen across all 13 domains assessed, with the greatest proportion of clients showing improvement in Access to Services (60%), followed by Life Skills (50%), Substance Use (44%), Safety (44%), and Mental Health (42%). As with FARS scores, SSM scores for re-admitted clients showed that improvements were sustained after discharge.

Table 1a.

Client Improvement in Functioning

SSM Domain	% Improved
Access to Services	59.9%
Life Skills	49.7%
Substance Use	43.7%
Safety	43.6%
Mental Health	41.5%
Support Services	37.8%
Transportation	35.4%
Income	30.6%
Food	26.9%
Housing	26.5%
Family Health Care	20.7%
Family Physical Health	17.9%
Employment	16.5%

Client Arrests and Jail Days

Data on arrests before and after referral to or engagement in care coordination showed that the **number of arrests decreased** for PIC Team clients both in the short-term (within one year of discharge) and long-term (more than one year after discharge). Arrests decreased by 42% in the short term and 11% in the long term (see Figure 3a for long-term arrest rates). However, these patterns were similar to individuals who were referred to services only and not admitted, so the extent to which admission to the PIC team is responsible for this decrease is unclear. The results are encouraging, but more research is warranted to understand why this pattern exists with both groups.

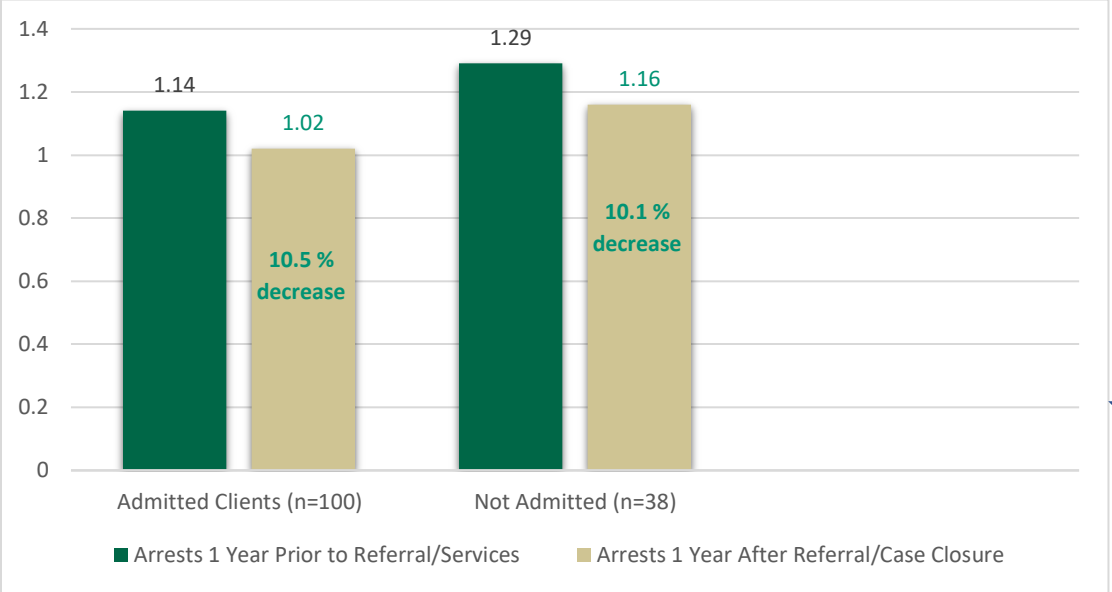

Figure 3a. Average Number of Arrests for Cases Closed at Least 1 Year

For PIC Team clients who were arrested, their **days in jail increased** in both the short and long term, as did the number of jail days in for those referred to PIC Team services but not admitted (see Figure 4a for long-term rates for jail days). For admitted clients, days in jail more than doubled, increasing by 169%. For non-admitted clients, days in jail nearly doubled (95%). There is little other contextual data to understand the reason for these patterns and further investigation would be warranted.

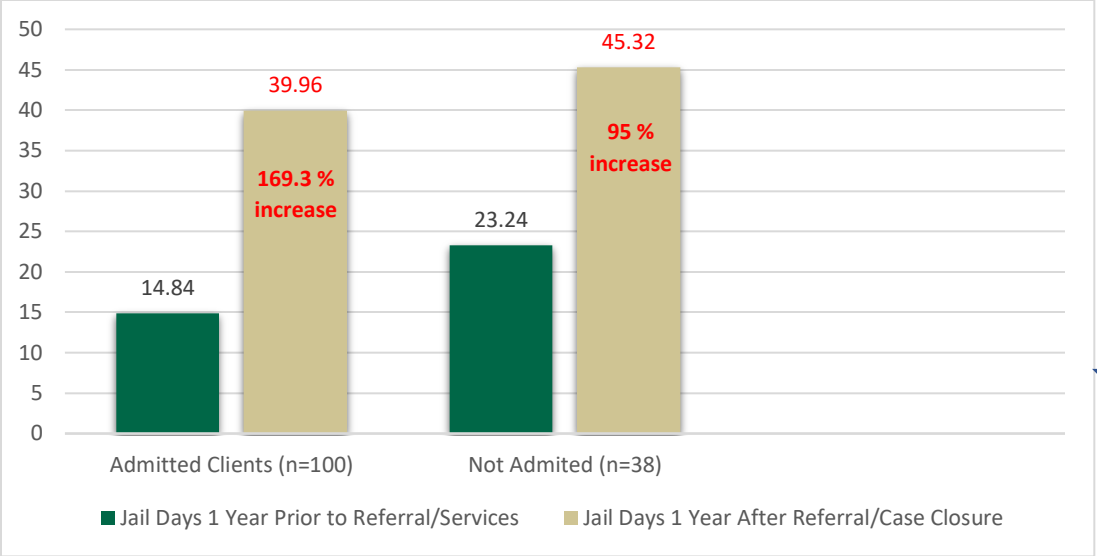

Figure 4a. Average Number of Jail Days for Cases Closed at Least 1 Year

Baker Act Exam Initiations

The average number of **Baker Act exam initiations decreased significantly** for clients who were admitted as well as for individuals who were referred but not admitted after one full year of the referrals or cases being closed (see Figure 5a). It is expected that Baker Act exam initiations would decrease for admitted clients, as system coordinators work with clients to maintain stability and prevent mental health crises. However, it is unclear why individuals who are not admitted to services would also have a significant decrease in Baker Acts. One possibility is that, through their initial engagement, they are prompted to seek services or support, even if it is not through the PIC Team.

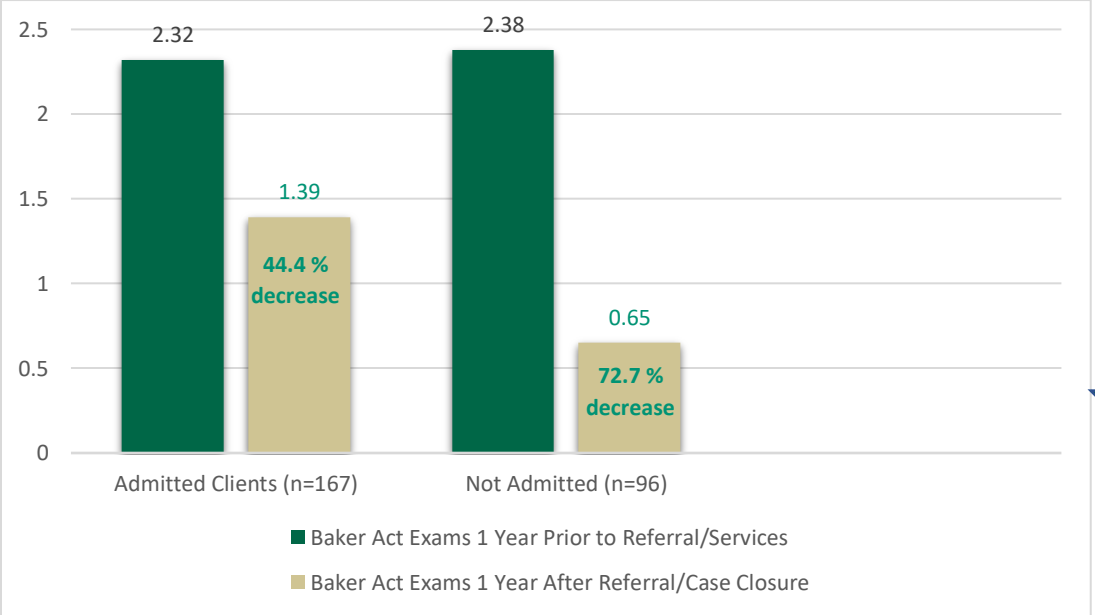

Figure 5a. Average Number of Baker Acts for Cases Closed at Least 1 Year

Most of the client outcome indicators suggest that the PIC Team model meets target goals of increasing functioning and self-sufficiency of clients and decreasing their interactions with auxiliary services (jails, Crisis Stabilization Units). However, because similar patterns are observed with clients who are engaged by the MHU and PIC Team but don't ultimately enroll in services, it is important to conduct further analyses to better understand why these patterns are occurring with both groups.

Implementation Findings

The goal of the implementation analysis is to provide an understanding of factors that support or hinder implementation of PICA initiatives (PIC Team, work group tasks, collaborative efforts) at both the systems level, at which overarching project decisions are made, and the client level, through which project goals are carried out. Key findings are highlighted below.

Key Implementation Findings

- ➔ **There was overall agreement that there was a shared vision for change and that collaborative efforts and interagency components were major strengths of PICA**
- ➔ **Unique benefits of the PIC Team were service flexibility and intensive client engagement**
- ➔ **Barriers included lengthy wait times, difficulties accessing some services, hesitancy engaging with law enforcement, and a need to better engage racially and culturally diverse clients**
- ➔ **Client feedback suggests that system coordinator support was crucial to client improvements**
- ➔ **High levels of collaboration and commitment by PICA were indicated by stakeholder surveys**
- ➔ **Funding and sustainability were key challenges to long-term system improvement**

Steering Committee and Core Staff Perspectives

With regard to **Vision and Goals**, the majority of responses indicated that a shared vision for the PICA initiative was established. Concerted efforts were made to streamline efforts across agencies and within the system and to ensure that future efforts were integrated. There was some lack of clarity of how existing initiatives would lead to population change, and there were some discrepancies about who the target population should be and how potential PIC Team expansion should be carried out.

Regarding the **Service Environment**, responses and observations indicated that there was a basic level of sufficiency to carry out implementation of the PIC Team, and there was support among other providers and system stakeholders for the initiative. There was strong

agreement about the PIC Team's proficiency in identifying community resources and services and ability to effectively engage clients. Barriers to services that were identified include difficulties accessing some services, lengthy wait times for psychiatric appointments, a lack of substance use treatment facilities and treatment, and difficulties with service coordination and data sharing processes. Specifically, there was a need for in-home services and targeted case management, insufficient short-term residential treatment facilities, and difficulty accessing intensive services like the FACT team, assisted living facilities, and housing for individuals with sex offenses. Steering committee members spent a considerable amount of time on efforts to improve system-wide functioning, such as investigating data improvement systems and aligning contracts among providers. Additionally, as a result of recommendations from the *Elevate Behavioral Health Pinellas* report, commissioned by PCHS, PICA steering committee members prioritized the development of an optimal data set (ODS) to better assess systemwide outcomes.

Organizational Capacity and Infrastructure was considered to be sufficient on several levels, including staffing, communication processes, and oversight and monitoring. Other areas, such as data assessment, funding, and sustainability were seen as in need of further development. Particular challenges to implementation capacity included difficulties identifying a strategy or funding support for expansion of the PIC Team.

Overall **Barriers to Implementation** spanned a wide range of issues. Responses highlighted some continuing challenges of a lack integration of behavioral health services, which is especially difficult for clients with complex needs. Challenges with client engagement included some hesitancies interacting with law enforcement as a first point of contact, which may lead to longer pre-enrollment engagement periods or lack of willingness to engage in services. Post-discharge challenges clients independently managing their treatment were also widely noted. Barriers to engaging racial and ethnic minorities were also discussed, due to historic tensions with law enforcement as well as cultural differences in addressing mental health through informal means (e.g., families, faithed-based organizations). Respondents also highlighted some barriers to trust with both law enforcement and behavioral health service providers.

> **…if you get a person that has complex needs, then you're kind of left to piecemeal together services. And that shouldn't be a thing. I would like to see it if we had like a one stop shop for people. Just go in there, you can see the doctor, see the nurse, you know, see your therapist, get your rent paid, the whole thing.**

Collaborative efforts were widely cited by steering committee members and core staff as key **Facilitators of Implementation**. Steering committee respondents saw it as highly beneficial to have representation from key agencies meeting regularly and assessing system functionality and needs. PIC Team staff felt they benefitted from the interagency make-up of their team and from steering committee involvement. With regard to the PIC Team, the level of client engagement they provided was considered not only unique to their role in the system, but also crucial to the team's effectiveness. Much of this had to do with the flexibility of being able to provide services and interactions without restrictions like other case management models. The MHU staff were also described as being effective in their role of providing numerous pathways of diversion from future arrests and Baker Act exams, as well as making efforts to improve community perceptions of law enforcement.

> **…the level of intensity we can provide, there's nothing else out there that can do that. If [a provider] simply gives someone a piece of paper and says, go to this mental health treatment center, there are many obstacles and things that come in the way of that, including just the client's readiness.**

Client Perspectives

Over the three-year evaluation, interviews were conducted with a sample of 30 clients who were admitted to services with the PIC Team. **Experiences during PIC Team services** indicate that many clients had never been or had infrequently been connected to care prior to contact with the PIC Team. Many clients said they lacked of awareness of local resources, had confusion navigating services and resources, lacked sufficient insurance coverage, had barriers to transportation, and felt a negative stigma associated with seeking mental health care. Participants had nearly unanimous praise for their system coordinators and appreciated the support they offered in finding transportation, housing, and employment, but they found regular engagement with system coordinators to be the most helpful. There were few complaints, such as disliking unannounced visits, receiving an overwhelming number of resources, and fewer calls than they desired.

[The PIC Team is] so much better than a lot of your other community resources that are out there. They treat you and they respect you with fairness and kindness, and no judgement.… other agencies, to try and get help with my parents, my dad, they just wanna slam the door right in your face … Whereas the PIC Team, from the jump street they were on top of everything and helping me and guiding me.

Twenty-three clients participated in follow-up interviews. Feedback on **experiences post-discharge** suggests that many clients became more knowledgeable about resources available to them and felt more confident about using coping mechanisms, managing personal relationships, and using budgeting skills. Several participants experienced serious challenges managing their care after discharge, such as difficulties finding employment or care, keeping up with appointments, continuing medication, arranging transportation, and finding financial assistance. When asked about how services could be improved, participants suggested behavioral healthcare should be integrated from a young age, and training should be provided across healthcare systems so professionals can better identify those in need, connect clients from one point of care to another immediately, educate clients about their conditions in language they can understand, and provide more comprehensive follow-up engagement.

Collaborative Activities and Stakeholder Perspectives

Collaboration and systems change assessments were administered to steering committee partners, behavioral health agency administrators, the PIC Team and PCSO MHU, and ancillary providers. **Collaboration and coordination were reported to be strong among stakeholders** who participated in the Interagency Collaborative Activities Scale (IACAS) survey. According to the systems change Stakeholders Survey, respondents indicated there was a shared understanding of the vision, mission, and goals for PICA; substantial support among stakeholders; and a high level of commitment to carrying out goals of the initiative (see Figure 6a). Negligible differences were seen from baseline (Year 1) to follow up.

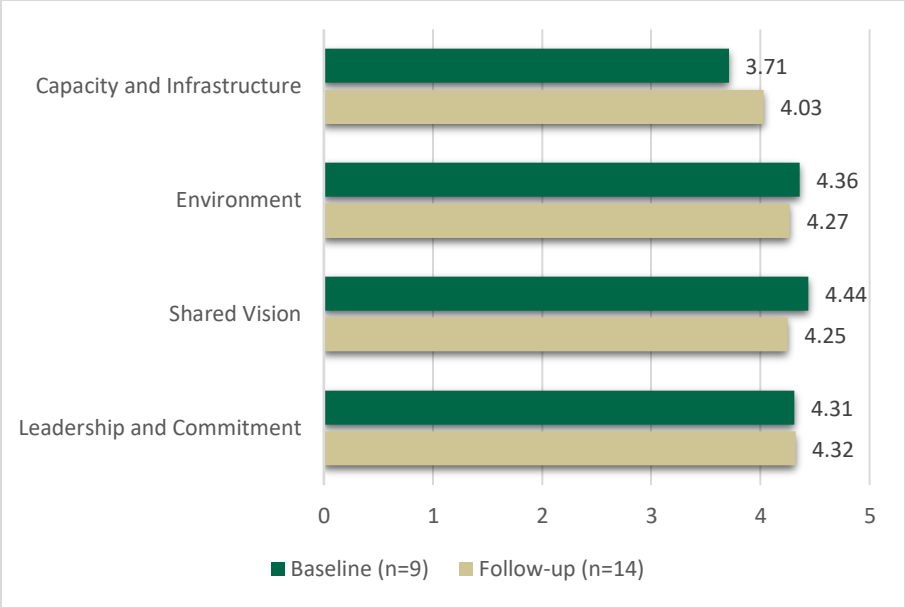

Figure 6a. Average Domain Scores for the Stakeholder Survey

A network analysis was conducted among PICA stakeholders to understand perceptions of commitment and coordination among different levels of stakeholders. Perceptions of coordination were largely in alignment with the intended model in that agencies in higher administrative roles (steering committee and provider agency administrators) were seen as more influential in coordinating services and supports for clients than those who provide more direct service (e.g., the PIC Team); however the PIC Team was seen as central to coordination among all stakeholders. For commitment, strong connections among the majority of stakeholders were shown, indicating perceptions that these **stakeholders were highly committed** with regard to funding, time, and/or human resources invested in PICA.

Some **deficits were identified through open feedback** from the assessments, such as lack of clarity in roles among the PIC Team and MHU, problems with establishing a common framework for the PIC Team, limitations to using CFBHN funding for services, and inconsistency in client care across the system. Concerns related to decision-making, insufficient resources to support interagency collaboration, infrequent or inconsistent communication, previously strained relationships among members, and frequent changes in staff were also reported. However, feedback also pointed to several facilitators to effective collaboration, such as communication, convening regularly scheduled meetings, stakeholders' willingness to commit resources, shared purpose and vision, and having effective leadership.

Indicators of Systems Change

A framework for assessing systems initiatives was used to determine levels of focus for different components of systems change (see page 66 for full assessment). Areas that were determined to have the highest focus were **Components and Connections**. This is appropriate given the purpose and aims of PICA, which are oriented around collaboration and coordination, and establishing the PIC Team as a core component. A Substantial level of focus was seen for the **Infrastructure** domain; many activities have been initiated in this area (such establishing the steering committee, and leveraging funding), though some are still under development, and some have not yet been initiated. The **Context** domain had Some Focus, there is little evidence of explicit efforts or strategies to engage policymakers, the media, and the public, yet this component is critical to sustaining systems changes and would be an appropriate area to focus additional efforts on. Finally, it was determined that there was Some Focus on the **Scale** domain, as there have been some efforts addressed here, such as identifying and providing new services to clients through the PIC Team and some shifts in systems ownership have been identified by stakeholders. Given numerous discussions about expanding the PIC Team, this would also be a beneficial area to address by making determinations about additional constituents that would best be served by system coordination and identifying partner agencies to collaborate with.

Recommendations

The following recommendations have been compiled from data presented in this report, including client outcomes, implementation, and systems change analyses.

- ➔ It is plausible that client success and other client outcomes may depend on the complexity of needs. Although reasons for referral were analyzed in this report, data did not capture co-occurring mental health and substance misuse challenges. Examining outcomes of clients with co-occurring disorders may help in determining how the PIC Team might better serve more complex client needs.

- ➔ Determine how to optimize use of PICA 2 to maintain and track data on clients referred to the PIC Team. The evaluation team is open to continuing discussions toward this purpose.

- ➔ Consider collecting more comprehensive information on discharged clients. Appendix H shows where clients were referred once discharged. However, tracking whether clients engaged with referral agencies will help determine whether PIC Team intervention achieved the goal of care coordination.

- ➔ In order to expand reach to more racial and ethnic minorities in Pinellas County, it is recommended that the steering committee uses a racial/ethnic

equity analysis to assess service impact prior to future efforts to ensure that initiatives are reaching a diverse array of constituents.

- Identify strategies to expand case management and/or system coordination efforts based on consistent feedback across groups that this is a significant gap in services, and based on engagement outcomes associated with the PIC Team.

- Consider ways to increase availability of in-home services without strict criteria, given that many clients with complex behavioral health conditions struggle to travel to appointments outside the home.

- Determine concrete steps and/or a timeframe to make progress towards developing the Health Information Exchange initiative, and ensure that the appropriate stakeholders and decision-makers are involved in the process.

- Consider integrating support positions such as peer support specialists and community health workers more broadly to help with needs around client engagement, particularly in communities with cultural or trust barriers to reaching out for help.

- Based on indicators of systems initiative activities, determine strategies to increase political engagement and focus on media and community outreach efforts to build a stronger context for behavioral health improvements.

- Feedback suggests there are few policies to encourage system collaboration or sustain behavioral health initiatives, therefore it would be warranted to explore policy changes that could support these efforts.

- Determine a process or plan for making determinations about scaling programs or initiatives, such as the PIC Team to expand the reach of these initiatives.

- Explore whether there is a need to strengthen discharge planning or post-discharge follow-up for PIC Team clients (e.g., focusing on educating clients on care management or concrete needs resources, or increasing follow-up engagement).

INTRODUCTION

Background

The Pinellas Integrated Care Alliance (PICA) officially formed in February of 2018 following years of county and statewide initiatives that have resulted in the need for a collaborative leadership body to provide oversight and coordination of mental health service improvements. This initiative was informed, in part, by local assessments of behavioral health services and initiatives, along with statewide policy initiatives that have called for specific coordination and collaboration efforts among behavioral health systems of care. This initiative builds on several existing efforts to improve communication and synchronization of behavioral health services, such as the Pinellas County Sheriff's Office (PSCO) Mental Health Unit, the Crisis Intervention Team (CIT) training for local law enforcement, local medication assisted treatment, an electronic referral system for behavioral health partners (Care Connect), and emerging efforts to address the housing needs of individuals exiting homelessness.

PICA Overview

The overarching goal of PICA is to improve coordination and collaboration among Pinellas County behavioral health providers in order to increase access to behavioral health services, address system gaps and inequities, improve follow-up care and long-term outcomes, and decrease utilization of auxiliary services for mental health needs such as jails, crisis stabilization units (CSUs), and emergency departments (a method for collecting ED data has not yet been identified). In order to achieve this goal, a centralized case management team will be responsible for coordinating client care, rather than case managers at separate provider agencies. Furthermore, a steering committee for the initiative has been comprised of leaders from four agencies who have an integral role within the behavioral health system and who are connected with behavioral health services in Pinellas County: The Central Florida Behavioral Health Network (CFBHN), Pinellas County Human Services (PCHS), the Pinellas County Health Department (PCHD), and the Pinellas County Sheriff's Office (PCSO). The steering committee acts as a decision-making body that drives strategic changes in Pinellas County's behavioral health system of care at the systemic level, including how behavioral health services in Pinellas County will be funded and sustained. Representatives from this group have been meeting monthly since February 2018 to determine the steps necessary for carrying out the vision of improving service coordination, communication, and collaboration in the county. An important, and strategic component of the initiative is that three of the agencies providing leadership are also contributing funding (PCHS and PCSO through their own funds, and CFBHN through a grant with Foundation for a Healthy St. Petersburg); this was seen as one of the most direct means for influencing change and aligning partners around a common goal.

Other key stakeholders that are central to the implementation of PICA goals include the key provider agencies that are receiving funding to contribute personnel to the Pinellas Integrated Care Team (PIC Team). Personal Enrichment through Mental Health Services (PEMHS) serves as a centralized site that provides facilities and administrative oversight for the PIC Team, as well as four system coordinators and a certified recovery peer specialist (CRPS) who are funded through a grant with the Foundation for a Healthy St. Petersburg (FHSP). The Suncoast Center and BayCare Medical Group have been contracted through PCHS to provide system coordinators for the PIC Team. Directions for Living was contracted by the PCSO to provide clinical personnel for the co-responding MHU through September 30, 2020. As of of October 1, 2020, the MHU was comprised of deputies and clinical staff hired internally. In all, the PIC Team consists of a supervisor, nine system coordinators, and one CPRS. Ultimately, leaders from PICA plan to develop policy initiatives to improve the overall collaboration between major funders, policy makers, and providers of behavioral health services within Pinellas County in order to strengthen service provision and access, contracting processes, program development, and funding.

MHU/PIC Team Referral Model

Figure 1 shows a visual representation of the MHU and PIC Team referral process. First, an officer from the PCSO MHU scans daily reports from the PCSO to flag any cases that may be related to mental health, which include Baker Act exam initiations that come in through 911 calls or arrests. Individuals flagged from this report are put on a list that the MHU uses to follow up via a “co-responder” team including a deputy and licensed clinical social worker (LCSW), at which point the team checks in on the client and explains how PIC Team services may benefit them. If clients want to enroll (or even if they’re not sure), they will be put in touch with a system coordinator to discuss or start services. The MHU may provide ongoing engagement or monitoring after initial referral.

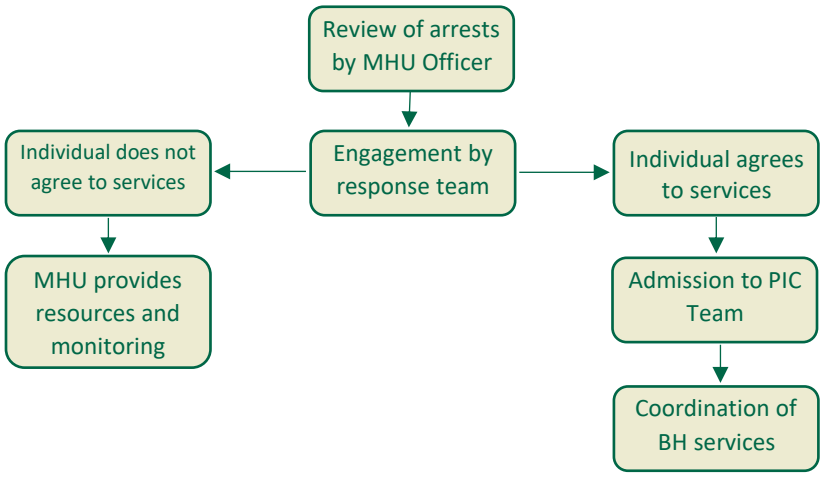

Figure 1. Visual representation of MHU/PIC Team Model

Evaluation Approach and Methods

A team of researchers from the Department of Child and Family Studies (CFS) in the College of Behavioral and Community Sciences (CBCS) at USF has been contracted through CFBHN to conduct an evaluation of the implementation of PICA and of PIC Team outcomes. The evaluation approach is grounded in implementation science and systems change frameworks. Implementation science provides guidance on which components of implementation warrant assessment in order to understand barriers and facilitators to implementation (WPIC, 2009). A systems initiatives framework was used to assess levels of focus on key indicators of change (Coffman, 2007). These frameworks assume that by addressing implementation and systems-level components, improvements will be made to consumer access to and engagement with behavioral healthcare. Qualitative and quantitative analyses address both client and system-level aspects of PICA. At the system level, the analysis focuses on the extent to which partnerships and processes allow for effective collaboration among providers and other stakeholders and the extent to which the goals outlined by partners are being met through implementation. With regard to clients served through the PIC Team, the analysis examines whether target changes are occurring as a result of implementing the PIC Team model by measuring outcomes related to use of mental health crisis services, interactions with law enforcement, changes in adult functioning assessment scores, and utilization of related behavioral health services. The evaluation team has also continuously gathered feedback from clients on their experiences with care coordination services through the PIC Team.

This study was reviewed by USF's Institutional Review Board (IRB) in order to determine whether oversight by the board was necessary, as human subjects are involved. The study was deemed exempt from IRB review because it is a program evaluation of existing activities, and therefore, does not meet the Board's definition of research. The evaluation team has upheld principles of ethics in human subjects research, including protecting the privacy of individuals who are part of the study, keeping records secure and data confidential, and ensuring that participants understand the goals of the research they are taking part in and know that their participation is voluntary.

OUTCOMES ANALYSIS

The outcomes evaluation was designed to assess client-level progress across numerous targeted outcomes. Client-level outcomes measure and assess the extent to which the PICA initiative achieves proposed client outcomes through the PIC Team care coordination component outlined in the evaluation plan. The intended method of data collection for PIC Team client outcomes was to draw from a database developed specifically for PIC Team clients (PICA 2), utilizing CFBHN's and PEMHS' existing electronic health records (EHR) data systems. Referral information and outcomes data on most clients have been populated and continue to be updated. The evaluation team has utilized numerous sources to compile data. Administrative records from the Pinellas County Sheriff's Office on jail days and arrests and data on involuntary Baker Act examinations from USF's Baker Act Reporting Center (BARC) were also assessed to demonstrate how the initiative has impacted PIC Team clients. Appendix A provides further detail on data sources, when data were pulled, and the dates the data components represent.

Some desired data elements have not been fully available. Information on utilization of housing resources and engagement in follow-up services, for example, were intended to be captured in the PICA 2 database[1]. Although the self-sufficiency matrix does ask clients to report on their housing circumstances, neither this data nor data on follow-up services are being captured in a way that allows for measurability. The evaluation team has had frequent communication with the PICA project director, PIC Team supervisor, and data specialists and administrators from PEMHS and CFBHN around these issues, and all parties have taken steps to ensure that appropriate protocols are followed when sharing data. Outcomes included in this report include demographic characteristics, functioning outcomes, arrests, jail stays, Baker Act exam initiations, and case closure and re-admission patterns.

Characteristics

Demographic characteristics of clients were retrieved from the PEMHS EHR database, Avatar. As of December 31, 2020, 599 clients (unduplicated) were referred for services through the PIC Team, and of those 382 were admitted (63.8%). One client was being engaged at the time of this report. Characteristics of referred and admitted clients are detailed in Table 1. Slightly more clients are male (52.4%) than female (47.6%). The majority of clients identify as White or Caucasian (87.2%), and Black and Other racial minorities make up just over 10% of clients referred. Almost 10% of clients reported their ethnicity as Hispanic. A quarter of clients resided in St. Petersburg at the time they were referred and another 19.1% lived in Clearwater. Other referrals were for clients who lived in Largo (12.1%), Palm Harbor (11.6%), Pinellas Park (7.3%), and Seminole (7.1%). Almost 19% of referred clients experienced homelessness.

[1] Referrals at PIC Team discharge are captured in PICA 2, but these provide a limited understanding of the extent of referrals made throughout services, as well as the outcomes of client engagement with these services.

Table 1

Characteristics of Clients Referred to and Admitted to PIC Team

Characteristic	All Referred % (n)	Admitted Clients % (n)
Sex		
Male	52.4% (n=314)	50.8% (n=194)
Female	47.6% (n=285)	49.2% (n=188)
	Total n = 599 [a]	Total n = 382
Race/ Ethnicity		
White	87.2% (n=517)	88.5% (n=338)
Black	8.1% (n=48)	6.3% (n=24)
Other	4.7% (n=28)	5.2% (n=20)
	Total n = 593 [a]	Total n = 382
Hispanic	9.7% (n=51)	7.9% (n=30)
City of Residence		
St. Petersburg	24.7% (n=128)	24.9% (n=95)
Clearwater	19.1% (n=99)	21.0% (n=80)
Largo	12.1% (n=63)	11.5% (n=44)
Palm Harbor	11.6% (n=60)	10.8% (n=41)
Dunedin	7.5% (n=39)	7.3% (n=28)
Pinellas Park	7.3% (n=38)	6.8% (n=26)
Seminole	7.1% (n=37)	7.6% (n=29)
Safety Harbor	3.5% (n=18)	4.2% (n=16)
Oldsmar	3.1% (n=16)	2.1% (n=8)
Other	4.0% (n=21)	3.7% (n=14)
	Total n = 519 [a]	Total n = 381
Ever Homeless	18.5% (n=111)	18.3% (n=70)

[a] Missing data: Data on client race are missing for 6 clients (1%). Ethnicity is missing for 74 clients (12.4%). City of residence data are missing for 80 clients (13.4%). Client characteristics represent valid data only.

Note- Most recent data provided includes clients referred through December 31, 2020

Figure 2 shows the age ranges of current PIC Team clients. Clients ranged from 18 to 87 years of age with an average age of 42 years. The majority of PIC Team

clients were 25 to 34 years of age at the time they were referred for services (24.3%). About 18% of clients were 55 to 56 years of age and another 16.8% were 35 to 44 years old. Nine percent of referred clients were 65 years of age or older.

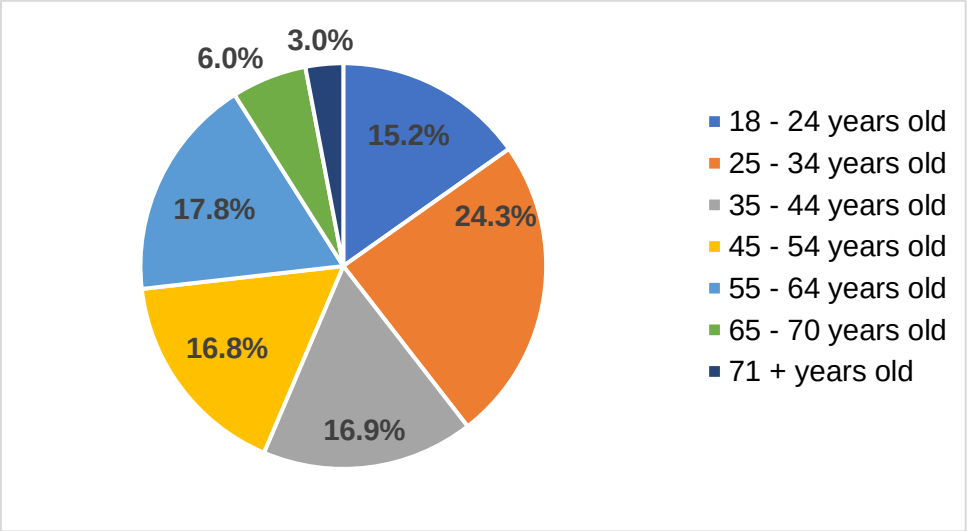

Figure 2. Age range of all clients referred to the PIC Team (n=595).

Demographics were also shared on the marital status, employment status, and educational attainment of clients who were referred. As shown in Table 2, a large majority of clients were single (63.8%) and many others were divorced (17.5%). About 9% of referred clients indicated they were married. Almost half were unemployed (48.3%) and 26.8% were disabled or unable to work. Most clients obtained less than a high school education (45.5%) but over a quarter graduated high school (27.6%). Many others obtained some college-level education.

Table 2

Other Characteristics of All Clients Referred to the PIC Team

	Characteristic	% (n)
Marital Status (n=464)	Single	63.8% (n=296)
	Married	9.1% (n=42)
	Widowed	5.2% (n=24)
	Divorced	17.5% (n=81)
	Separated	4.5% (n=21)
Employment (n=470)	Employed	12.7% (n=60)
	Retired	6.2% (n=29)
	Unemployed	48.3% (n=227)
	Disabled	26.8% (n=126)
	Other	5.8% (n=28)
Education (n=497)	Less than High School	45.5% (n=226)
	High School Graduate	27.6% (n=137)
	Vocational/Special School	4.0% (n=20)
	Some College	12.8% (n=64)
	Associate or Bachelor Degree	8.0% (n=40)
	Graduate Degree	2.0% (n=10)

Reason for Referral

The primary reason for referral varied across clients (see Table 3). Over 70% of those referred to the PIC Team were referred due to mental health challenges. Another 20% were referred due to substance misuse. Although substance misuse and mental health deficits often co-occur, potential clients were assessed for the predominant disorder. Referrals due primarily to developmental disabilities (e.g., autism) and domestic violence were less common. There was not a significant difference in reasons for referral between clients admitted for PIC Team services and those who were not.

Table 3

Reasons for Referral

	All Referred % (n)	Admitted Clients % (n)
Mental Health	71.6% (n=403)	71.5% (n=273)
Substance Misuse	20.2% (114)	20.7% (n=79)
Medical	5.0% (n=28)	4.7% (n=18)
Developmental Disability	2.3% (n=13)	2.9% (n=11)
Domestic Violence	0.7% (n=4)	0.3% (n=1)
	n = 562	n = 382

Engagement and Length of Services

The length of time referred clients were engaged was recorded along with how engagement occurred and the how much time PIC Team staff spent engaging potential clients. For admitted clients, the engagement period took place from the date clients were referred to the date the case was opened. For clients not admitted, for whatever reason, the engagement period took place from the date clients were referred to the date the engagement period was closed. As shown in Figure 3, the engagement period lasted less than one week for 38.1% of clients referred and 1 to 4 weeks for 35% of clients. For about 10% of individuals referred, engagement persisted for 2 months or longer.

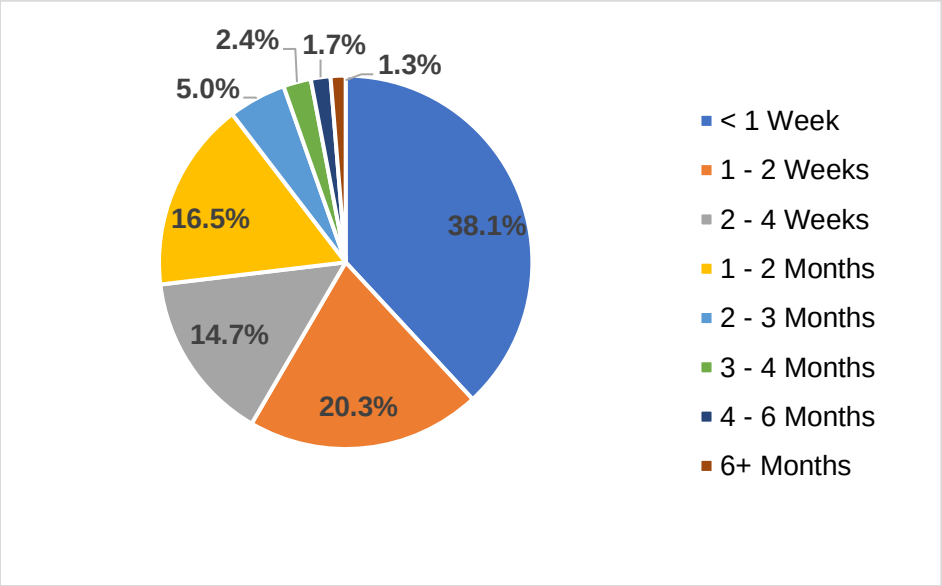

Figure 3. Engagement Period (n=462).

The engagement period was significantly shorter for referred clients who were admitted (15.6 days on average; n=330) compared to referred clients whose case was not opened to receive PIC Team services (49.9 days; n=125). Table 4 compares the average number of engagement contacts and the average amount of time spent engaging potential clients. Significantly fewer contacts occurred for clients whose case was opened for PIC Team services (4.32 contacts on average) compared to those whose case was not opened (5.46 contacts). Further, significantly more time was spent attempting to engage clients whose case was not opened. This likely reflects additional efforts by PIC Team staff to encourage referred clients to accept services.

Table 4

Number of Engagement Contacts and Time Spent Engaging Referred Clients

	Referred Only (n=145)	Admitted (n=175)
Engagement Contacts	5.46 contacts	4.32 contacts
Time Spent Engaging	3.47 hours	2.90 hours

Engagement occurred via telephone, through face to face communication, “activity on behalf,” or “collateral contact.” Within the last year, “telehealth” was added as an engagement strategy due to service changes related to the COVID-19 pandemic. “Activity on behalf” refers to PIC Team Staff arranging appointments for potential clients, collaborating with service providers on behalf of a potential client, setting up appointments, and assisting with medication, for example. “Collateral contact” refers to contact made with a family member or other informal support to discuss care for a potential client. As shown in Table 5, although slight differences are observed, engagement via telephone and “activity on behalf” occurred most frequently for all referred clients.

Table 5

Engagement Strategies

	First Contact	Second Contact
Admitted	n=175	n=129
Phone	37.1% (n=65)	38.8% (n=50)
Face to Face	8.0% (n=14)	10.9% (n=14)
Activity on Behalf	37.2% (n=80)	32.6% (n=42)
Collateral Contact	7.1% (n=11)	11.6% (n=15)
Telehealth	2.3% (n=4)	3.9% (n=5)
No show/ cancelled	0.6% (n=1)	2.3% (n=3)
Referred Only	n=145	n=134
Phone	34.5% (n=50)	35.8% (n=48)
Face to Face	8.3% (n=12)	16.4% (n=22)
Activity on Behalf	44.1% (n=64)	31.3% (n=42)
Collateral Contact	10.3% (n=15)	11.9% (n=16)
Telehealth	2.8% (n=4)	2.2% (n=3)
No show/ cancelled	---	2.2% (n=3)

Referred clients were not admitted for various reasons. As reported previously, the most common reasons were that potential clients could not be located (24.6%), they were not in need of services (21.7%), or they refused services (21.7%). Clients who moved outside of the service area were also not admitted for care coordination (13%).

The length of service across clients is shown in Figure 4. Care coordination with the PIC team lasted less than one month for about 5% of clients. For the majority of clients, care coordination services were offered for six months or less. The length of service lasted greater than six months for less than 20% of clients. On average, clients received PIC Team services for 4.3 months.

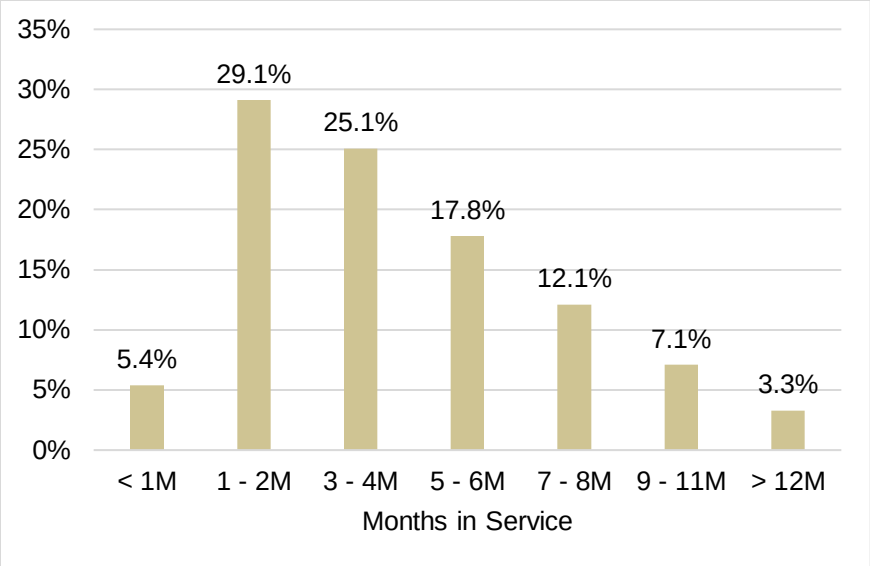

Figure 4. Length of care coordination service time (n=354)

Functioning: FARS Scores

Scores from the Functional Assessment Rating Scale (FARS) were assessed for clients enrolled in PIC Team services. The FARS is composed of a four-factor scale: Disability, Emotionality, Personal Safety, and Relationships (Ward et al, 1999). Disability assesses problem severity ratings of hyper affect, thought process, cognitive performance, medical/physical health, functioning in activities of daily living, and ability to take care of oneself. Emotionality examines depression, anxiety, and traumatic stress. Substance use, danger to self, and security management needs encompass the personal safety factor. Lastly, the Relationships factor incorporates ratings for interpersonal relations, family relations, family environment, work or school functioning, socio-legal, and danger to others. Each functional domain is rated on a scale from 1 (“no problem”) to 9 (“extreme problem”) to describe problem severity within the previous three weeks.

FARS scores were available for 292 discharged clients. Paired t-tests were used to assess change in problem severity from baseline to follow-up. As noted previously, lower scores indicate decreases in problem severity. Change in FARS factor scores from baseline to discharge are shown in Figure 4. Scores decreased significantly over time for each factor. At both assessments, Emotionality was observed to have the greatest problem severity score. However, this is also the factor where the greatest change is observed from baseline to follow-up. High problem severity was also observed for the Relationships domain at baseline, but functionality improved significantly by follow-up assessment. Overall, the decrease in FARS domain scores indicate

greater functionality and is suggestive of effective service provision by the PIC Team.

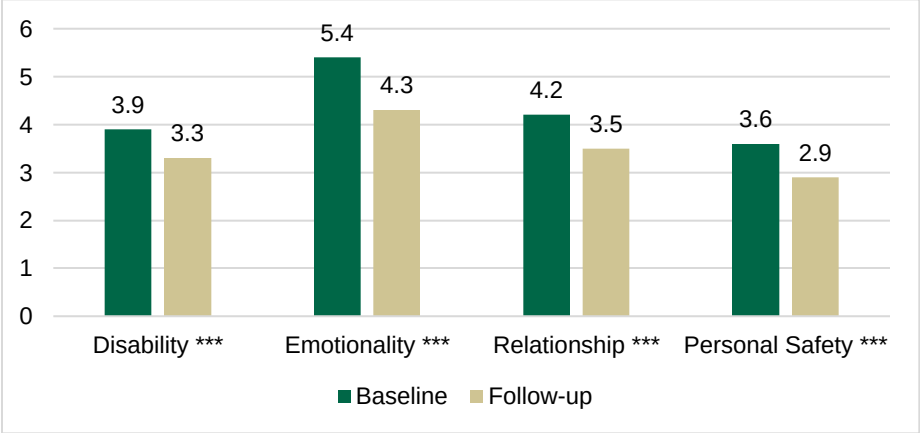

Figure 5. Average FARS Factor Scores at Baseline and Follow Up (n= 292)
Note- Updated FARS assessment data were provided on January 20, 2021

The proportion of clients whose functioning improved according to FARS data was calculated for each domain (see Figure 6). Functioning related to Disability improved for 62.3% of PIC Team clients and for 70.5% of clients specific to Emotionality. Further, functioning related to Relationships improved for 73.3% of clients and for over half of PIC Team clients specific to Personal Safety (61.9%).

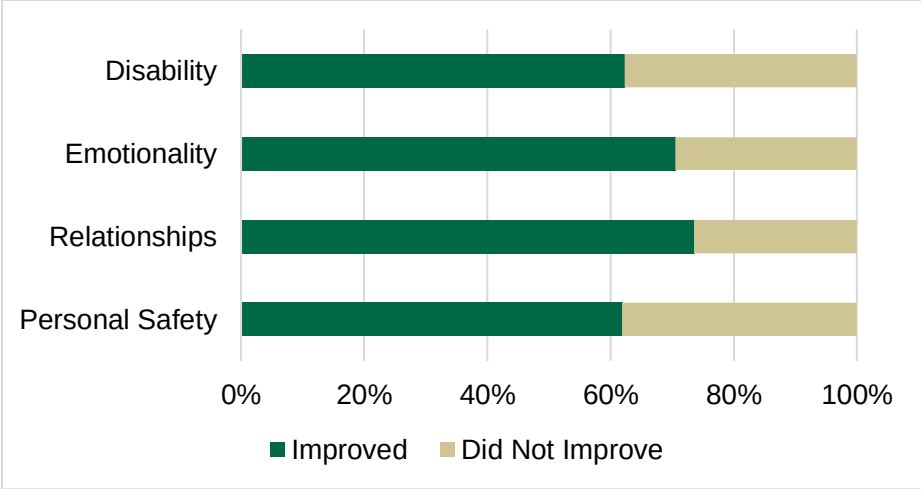

Figure 6. Average FARS Factor Scores at Baseline and Follow Up (n= 292)
Note- Updated FARS assessment data were provided on January 20, 2021

Functioning: Self-Sufficiency

One of the goals of the PIC Team is to support clients in becoming self-sufficient. As such, a Self Sufficiency Matrix (SSM) was administered with clients to

understand individual strengths and areas for improvement and assess progress made towards self-sufficiency over the course of PIC Team involvement. The SSM used with PIC Clients examined self-sufficiency across the following areas: Access to Services, Food, Housing, Income, Employment, Transportation, Support Systems, Mental Health, Substance Use, Life Skills, Safety, Family Health Care Coverage, and Family Physical Health. Each of these domains are scored on a continuum from “1,” meaning “In Crisis,” to “5,” meaning “Thriving.” An initial SSM was completed with clients when they began with the PIC Team and follow-up assessments were competed at 3-month intervals. A closing SSM was also administered.

One way of understanding how PIC Team services impacted client’s self-sufficiency is to examine the proportion of clients who were rated as being “stable” or “thriving” for each domain assessed. As a result of engagement with care coordinators, it is expected that, overall, this would increase over time. Figure 7 illustrates the proportion of clients who were stable or thriving at baseline compared to closing assessment. Initial assessments indicated that many clients were stable or thriving in various self-sufficiency domains at baseline. More than half of PIC clients were stable or thriving in regards to Family Health Care Coverage (58.4%) and Safety (55.9%). However, less than a quarter of clients were stable or thriving regarding Access to Services (19.3%), Life Skills (14.5%), Income (15.4%), Mental Health (8.1%), and Employment (3.9%) at baseline. These were the areas in which clients had the greatest needs. As a result of PIC Team intervention, more than half of PIC Team clients were stable or thriving across nine self-sufficiency domains: Access to Services (60.8%), Housing, (67.3%), Transportation (53.9%), Support System (59.2%), Substance Use (59.7%), Safety (67.9%), Family Health Care Coverage (83.5%), and Family Physical Health (54.1%).

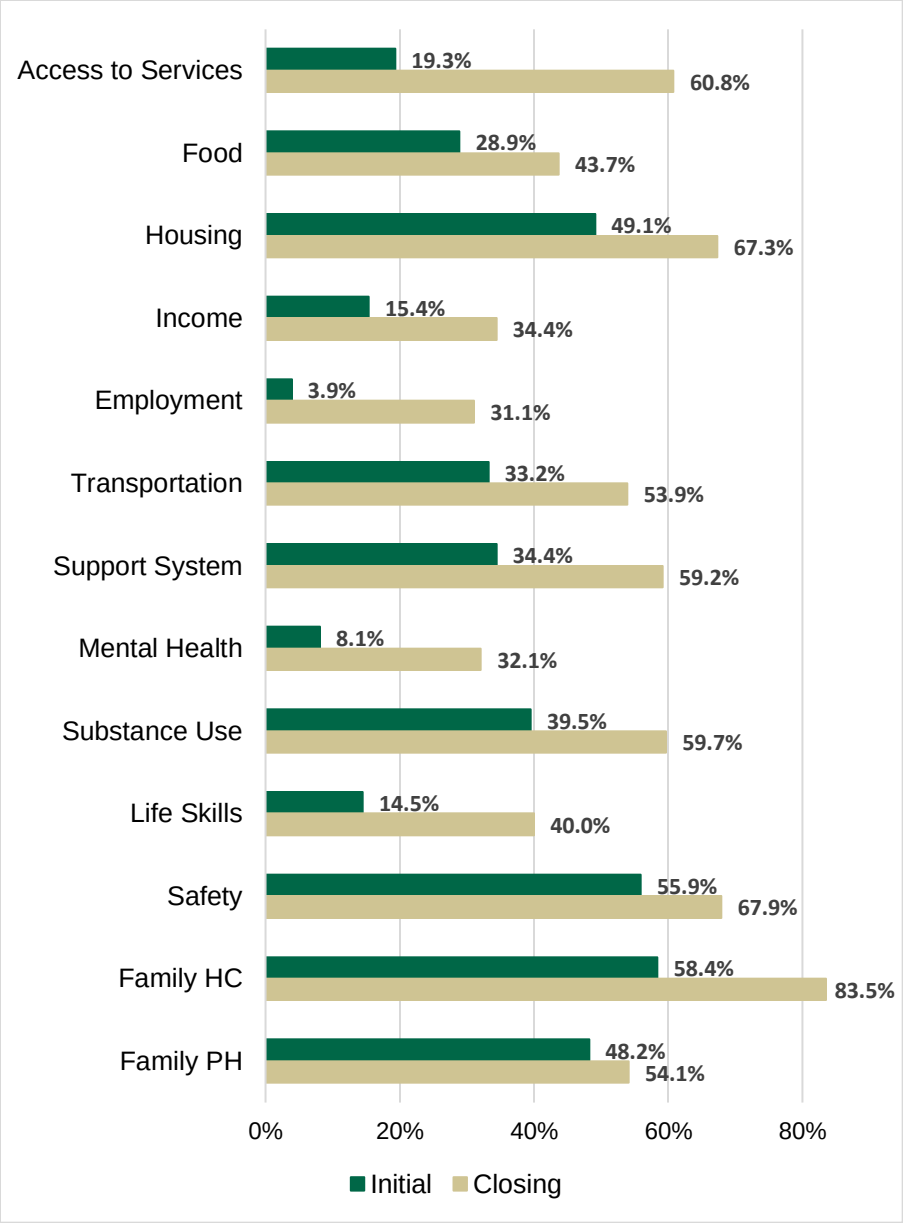

Figure 7. Proportion of Clients Stable or Thriving (n ≈ 275)

Table 6 below details the proportion of clients whose functioning improved following PIC Team intervention for each SSM domain assessed.

Table 6.
Client Improvement in Functioning

SSM Domain	% Improved
Access to Services	59.9%
Life Skills	49.7%
Substance Use	43.7%
Safety	43.6%
Mental Health	41.5%
Support Services	37.8%
Transportation	35.4%
Income	30.6%
Food	26.9%
Housing	26.5%
Family Health Care	20.7%
Family Physical Health	17.9%
Employment	16.5%

Arrests and Days in Jail

Administrative data on arrests of all individuals referred for PIC Team services was obtained from CFBHN. These data detail dates of arrest, arrest charges, and the number of days individuals were incarcerated. The most recent data was shared with the evaluation team on January 23, 2021. Two of the outcomes used to measure the impact of the PIC Team are reduction in the number of arrests for PIC Team clients and a decrease in the number of days in jail for PIC Team clients. Arrest and jail days were recorded for one year prior to clients' engagement with the PIC Team and one year following case closure. For comparison, this data was also obtained for clients who were referred but not engaged (not opened). Clients currently being engaged or served and those who were never arrested were omitted from this analysis. About 39% of all referred clients were ever arrested. Paired t-tests, mean comparison analyses, were used to assess for significant reduction in the number of arrests and days in jail.

Figure 8 shows the average number of arrests across clients the year prior to being referred for PIC Team services and one year following services. According to the data received, for those who were referred but not engaged in services, the number of arrests one year after being referred was recorded. Arrests decreased significantly overtime, generally. **A 41.5% decrease in arrests was observed for PIC clients compared to a 37.3% decrease for clients referred but not admitted.** Arrests for clients who were referred but not admitted decreased from 1.34 arrests to 0.84 arrests. A greater decrease was observed

for the average number of arrests for clients who received care coordination with the PIC Team (1.35 arrests to 0.79 arrests).

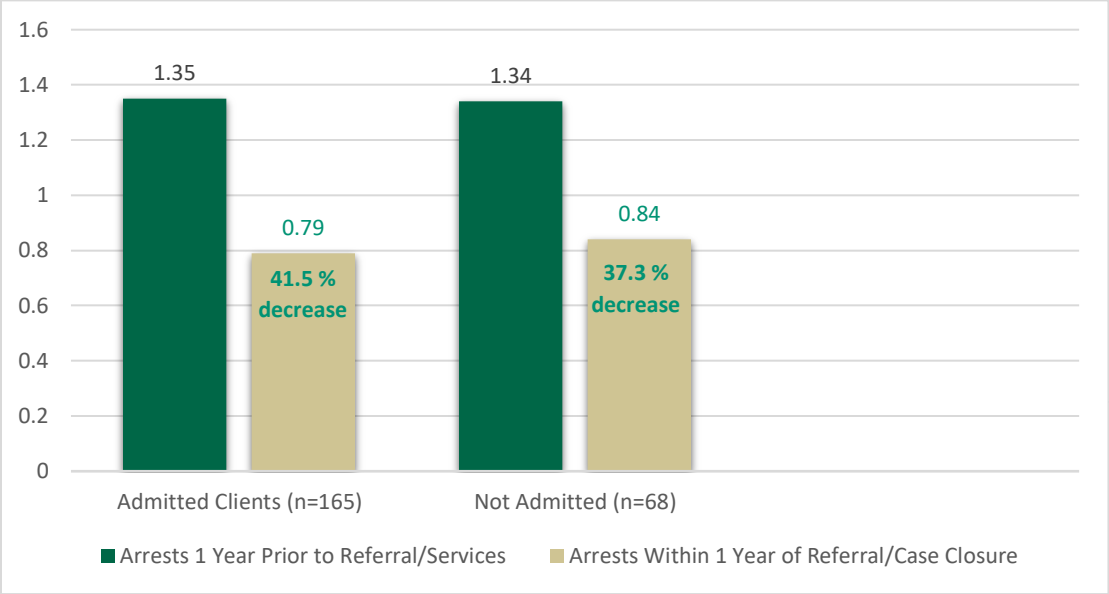

Figure 8. Average Number of Arrests

Overall, jail days increased for both groups (see Figure 9). **A 35.7% increase in jail days was observed for PIC Team clients compared to a 4.3% increase for clients referred but not admitted.** Days in jail increased slightly from 28.71 days to 29.93 days for clients who were referred but not admitted. Clients who received care coordination with the PIC Team also experienced an increase in days in jail on average (22.35 days to 30.33 days).

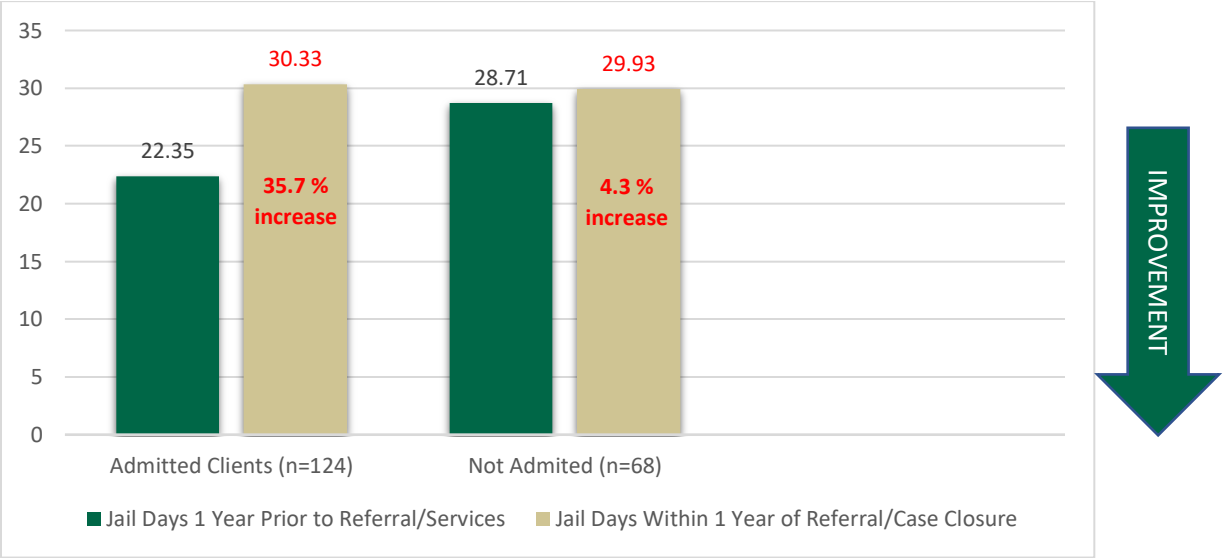

Figure 9. Average Number of Jail Days

To provide a more accurate idea of these outcomes, this analysis was repeated for clients whose case has been closed at least a year. These findings examine arrests and days in jail for a full year before referral and a full year after cases are closed. Overall, these data continue to show a slight decrease in the number of arrests for clients who received PIC Team services. The difference, however, is not significant (see Figure 10). **A 10.1% decrease in arrests was observed for PIC clients compared to a 10.1% decrease for clients referred but not admitted.** The number of days in jail increased significantly for PIC Team clients. **A 95% increase in days in jail was observed for PIC clients compared to a 169.3% increase for clients referred but not admitted.** Further, the average number of days in jail in the year following case closure is almost triple the number of days in jail in the year prior to PIC Team intervention (see Figure 11). While PIC Team client arrests were reduced overall, it is unclear why days in jail increase for those who still were arrested. The evaluation team inquired about why this pattern might be occurring after an increase was observed during the previous report period, but there were no clear insights provided to explain the increases in jail days.

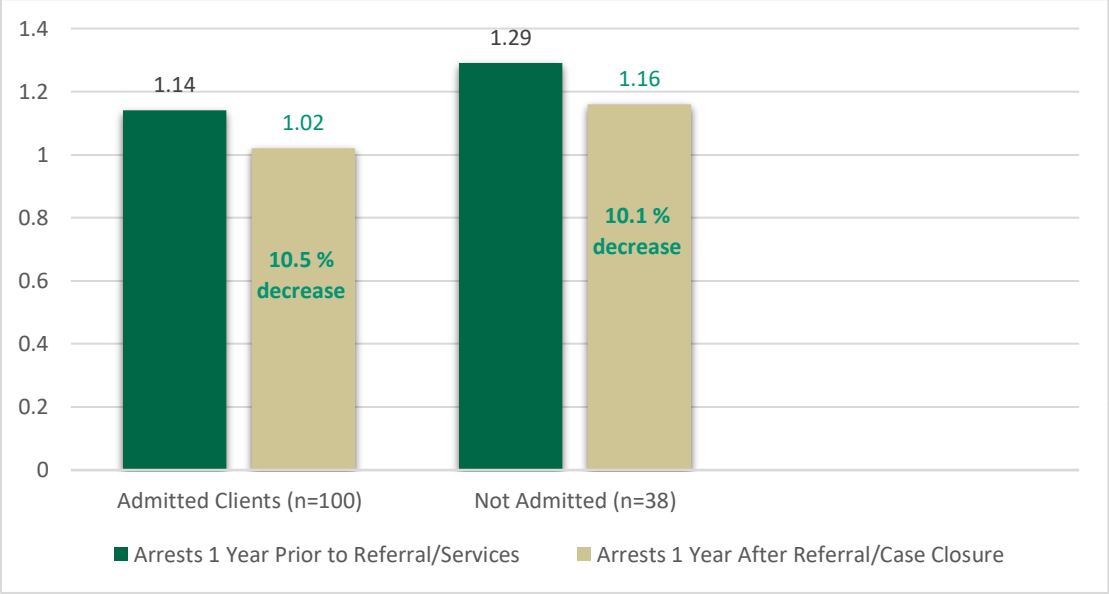

Figure 8. Average Number of Arrests for Cases Closed at Least 1 Year

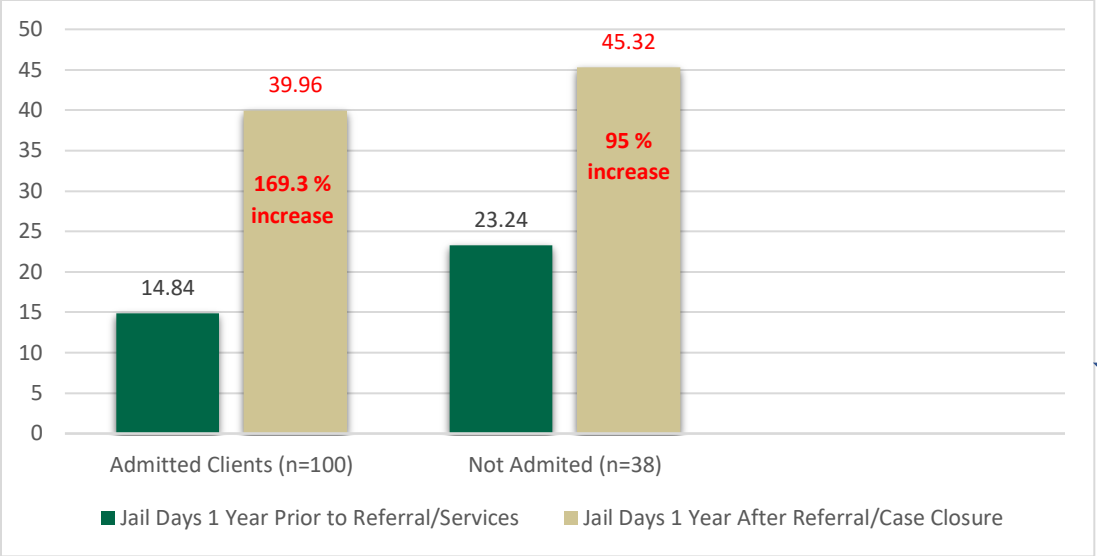

Figure 11. Average Number of Jail Days for Cases Closed at Least 1 Year

Baker Act Exam Initiations

Another outcome of interest used to measure the impact of the PIC Team is a reduction in involuntary Baker Act exam initiations. Data on Baker Act exam initiations were obtained from the Baker Act Reporting Center (BARC) at USF most recently in February 2021. Baker Act exam initiations one year prior to clients' engagement with the PIC Team and one year following case closure were recorded. As with the arrest outcomes detailed previously, for comparison, this data was also obtained for clients who were referred but not admitted for PIC Team services. Referred clients in pre-admission and those currently being engaged were not included in this analysis. Further, clients who never received a Baker Act exam initiation or for whom data were not available were omitted from this analysis. Taken together, data on 489 clients who received Baker Act exams at least once and whose case has closed are included in this analysis. Of these, 318 engaged in PIC Team services (65%) and 171 did not (35%). Paired t-tests, mean comparison analyses, were used to assess for significant reduction in the number of Baker Acts.

Figure 12 shows the average number of Baker Act exam initiations across clients the year prior to being referred for PIC Team services and one year following services. For those who were referred but not engaged in services, the number of Baker Act exam initiations one year after being referred was recorded. **A 44.4% decrease in Baker Act exams was observed for PIC clients compared to a 65.9% decrease for clients referred but not admitted.** On average, Baker Act exam initiations decreased significantly for clients whose case was not opened as well as for clients who did receive PIC Team services. Although there

was not a significant difference between groups in Baker Act exams in the year prior to referral, clients who were admitted had significantly more exams within a year after PIC Team engagement.

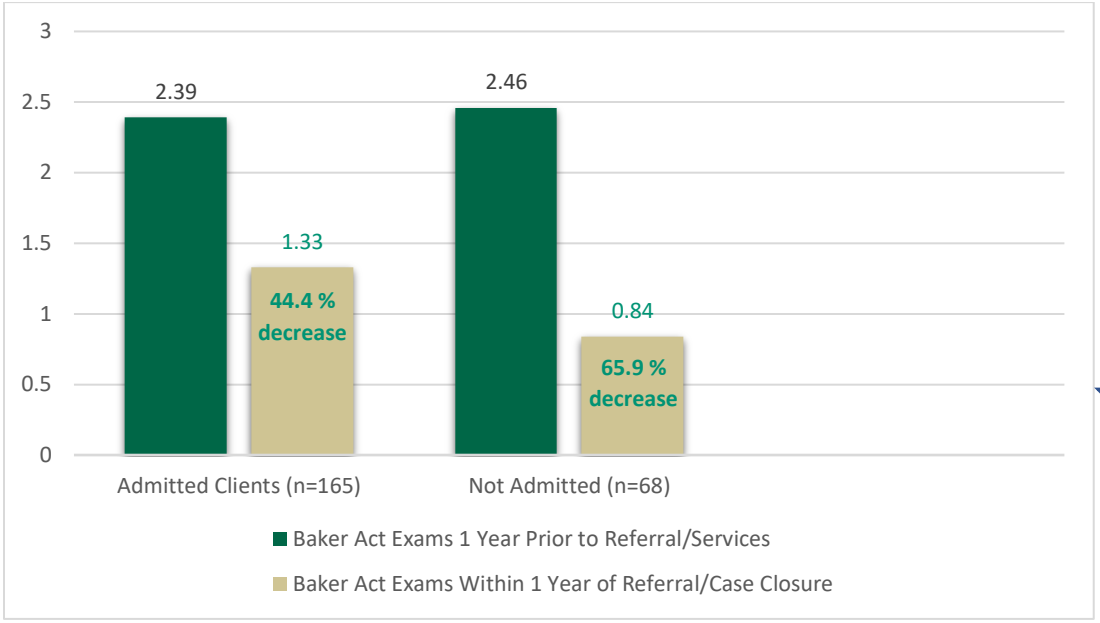

Figure 12. Average Number of Baker Act Exam Initiations

For clients engaged in PIC Team services, a decrease in Baker Act exam initiations is expected, as system coordinators work with clients to maintain stability and prevent mental health crises. However, it is unclear why individuals who are only referred, but not engaged in services would also have a significant decrease in Baker Act exam initiations. As previously inferred, one possibility might be that, through their initial engagement, they are prompted to seek services or support, or because of continued engagement by the MHU.

As with findings on arrests and jail days, this analysis was repeated for clients whose case has been closed at least one year to provide a more accurate idea of Baker Act exam initiations. These findings present Baker Act exam initiations for one full year before referral and one full year after cases are closed. These data continue to show a significant decrease in the number of Baker Act exam initiations for clients who received PIC Team services (see Figure 13). Significantly fewer Baker Act exam initiations are also observed for referred clients who did not receive PIC Team intervention. **A 44.4% decrease in Baker Act exams was observed for PIC clients compared to a 72.7% decrease for clients referred but not admitted.** Although there was not a significant difference between groups in Baker Act exams in the year prior to referral, clients who were admitted had significantly more exams within a year after PIC Team engagement.

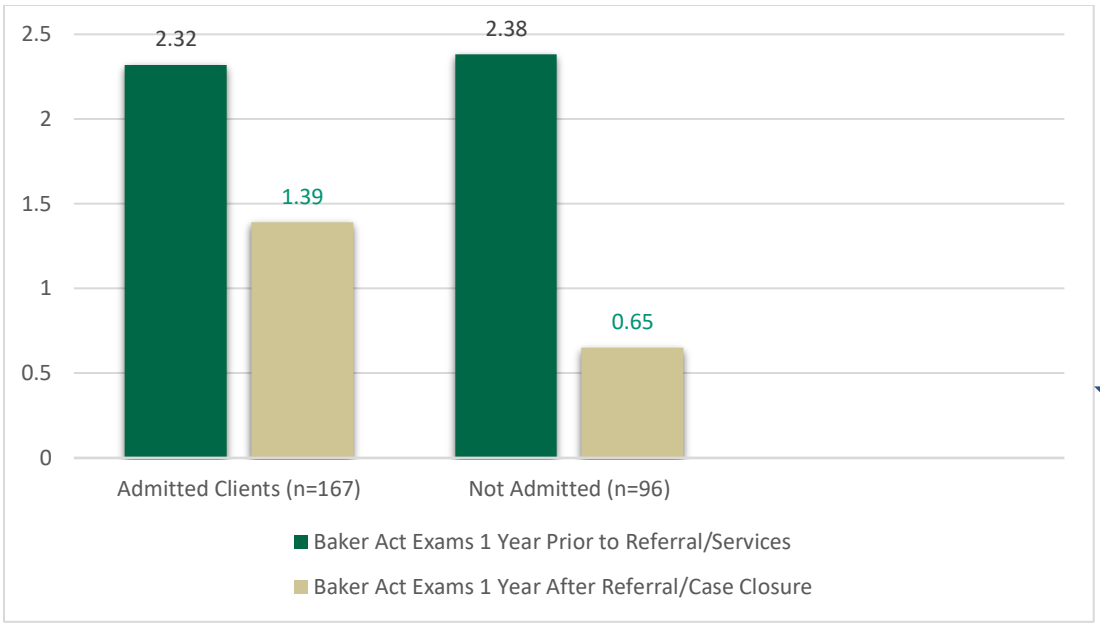

Figure 13. Average Number of Baker Acts for Cases Closed at Least 1 Year

Case Closure and Re-Admissions

Since the first client was admitted in July 2018, 472 clients have been discharged from PIC Team services. At discharge, PIC Team staff made determinations as to how successfully clients progressed during care coordination. Discharge status categories were aggregated to indicate a "successful close," "unsuccessful close," or other closing classification. Appendix B details how discharge status categories were recoded for this analysis. Approximately 40% of cases were closed successfully, 37% were considered unsuccessful, and roughly 15% of cases had other closure classifications. Results of mean comparison tests indicated that clients whose cases were successfully closed were significantly older (43.2 years old on average) compared to clients with an "other" case closure status (36.5 years). Clients whose case was closed unsuccessfully were 43 years old on average. The length of time clients received PIC Team services also differed significantly. Clients whose case was successfully closed received care coordination services for a significantly longer time (5.2 months on average) compared to clients whose case was closed unsuccessfully (3.4 months) and those clients whose case was closed for some "other" reason (3.0 months). There was no relationship between the reason for referral and how cases were closed.

According to FARS domains assessed, successful clients had significantly fewer problem severity scores at discharge for Disability, Emotionality, Relationships, and Personal Safety compared to clients with an "other" case closure status. Significant differences were found across FARS domains such that **less**

problem severity was observed for successfully closed cases compared to cases closed unsuccessfully and cases closed for "other" reasons (see Table 7). Findings from the Self Sufficiency Matrix show clients whose case was successfully closed were stable or thriving for significantly more domains compared to those whose case was unsuccessfully closed or closed for another reason.

Table 7.
Average Discharge FARS and Self-Sufficiency Scores by Case Closure Type

	Successful Close (n=159)	Unsuccessful Close (n=85)	Other Close (n=40)
FARS Disability	$\overline{X}$= 3.0	$\overline{X}$= 3.3	$\overline{X}$= 4.0
FARS Emotionality	$\overline{X}$= 3.8	$\overline{X}$= 4.7	$\overline{X}$= 5.0
FARS Relationship	$\overline{X}$= 3.0	$\overline{X}$= 3.8	$\overline{X}$= 4.3
FARS Personal Safety	$\overline{X}$= 2.5	$\overline{X}$= 3.1	$\overline{X}$= 3.8
Self Sufficiency	$\overline{X}$= 6.8	$\overline{X}$= 4.5	$\overline{X}$= 3.9

NOTE: Each FARS functional domain is rated on a scale from 1 ("no problem") to 9 ("extreme problem") to describe problem severity within the previous three weeks. **Higher FARS scores indicate greater problem severity.** Self-Sufficiency scores range between 0 and 13 indicating the number of domains clients are stable or thriving at discharge. **Higher SSM scores indicate greater cumulative self-sufficiency.**

There was widespread interest across PICA partners and the evaluation team in better understanding why some clients return for services with the PIC Team after being discharged. Outcomes data was extracted for re-admitted clients to assess for any noticeable patterns in demographics, length of services, and changes in functioning. Demographic characteristics of these clients as well as outcomes related to functioning and arrest history is detailed below.

Eighty-eight clients whose cases were closed following PIC Team intervention were referred again or re-admitted (14.7%). Almost 55% were male (54.5%; n=48) and 92% were White (n=81). Seven readmitted clients identified as Hispanic (8.0%). Clients ranged from 18 to 76 years of age with an average age of 42.8 years. Over 60% were single (62.7%) and most clients were unemployed at the time they initially presented for services (60%). Twenty-one clients experienced homelessness (23.9%). These patterns closely resemble the overall demographics of the PIC Team clientele.

There was no relationship between the reason clients were referred and the readmission for PIC Team services. The period of engagement prior to clients

being first admitted for PIC Team services ranged from one day to just over eight months. Further, the length of services when these clients were first admitted ranged from about a week to a year of care coordination. On average, clients were engaged in services for 3.8 months.

Forty-one of the 52 discharged clients who were referred back to the PIC Team services were re-admitted for services (59.1%). The other clients who were referred again were not re-admitted (38.6%) or are currently being engaged (2.3%). Functioning was assessed via the FARS and the Self-Sufficiency Matrix. Baseline FARS scores when clients were first admitted were compared to FARS scores at case closure and initial FARS scores when clients were re-admitted. Trends in domain scores were similar to those observed with all PIC clients (refer to Figure 4). Domain scores significantly improved across domains indicating improvement in functioning following PIC Team intervention. Even though clients were re-admitted, reassessed FARS scores did not show evidence that functioning decreased between the time that clients' cases were closed and when they were re-admitted. Sustained functioning was also observed with data from client's SSM scores. A question remains as to why clients were readmitted even though improvement in functioning was maintained.

Findings from previous analyses also indicated the number of arrests, days in jail, and Baker Act exam initiations in the year prior to engagement did not predict readmissions and re-referrals. Further, neither the length of time clients received PIC Team services nor discharge outcomes from clients' first admission were related to whether clients were re-admitted or re-referred.

Summary

Functioning outcomes, arrest data, and Baker Act exam initiations were used to assess how PIC Team services impacted clients. Since July 2018, almost 600 clients were referred to the PIC Team. FARS scores decreased significantly over time for each factor, indicating greater functionality. Further, the proportion of PIC Team clients who were stable or thriving increased appreciably from baseline to closing assessment across all self-sufficiency domains. Data on the arrest history showed the number of arrests decreased significantly for clients who received care coordination with the PIC Team. Days in jail, however, increased for clients who received care coordination with the PIC Team, though not significantly. Lastly, Baker Act exam initiations, on average, decreased significantly for clients as well. The number of arrests and Baker Act exam initiations significantly decreased for clients who did not receive care coordination through the PIC Team. Taken together, these functioning outcomes provide some evidence of effective service provision by the PIC Team. However, given improvements also observed for clients who did not receive PIC Team services, these improvements cannot be attributed solely to the PIC Team intervention.

IMPLEMENTATION ANALYSIS

The evaluation team conducted an assessment of the implementation of the PICA Initiative to understand the environment of implementation as well as stakeholder perceptions of effectiveness, challenges, and facilitators. The evaluation team used several methods to gather feedback from stakeholders over a three-year implementation period, including interviewing or conducting focus groups with steering committee members, PIC Team and MHU staff, and PIC Team clients; observing steering committee and PIC Team/MHU meetings; and disseminating a collaborative stakeholder surveys.

Methods

Interviews were conducted with steering committee members during Years 1 and 2 using questions derived from an implementation science and systems change framework (WPIC, 2009) (Appendix C). Focus groups were conducted during Year 2 for the PIC Team and MHU staff to obtain feedback on staff members' understanding of their role in the PICA initiative and their perceptions of the service environment and the policies and procedures that guide their work. During Year 3, the evaluation team conducted focus groups with the steering committee, the PIC Team, and the MHU using evaluation findings as prompts for discussion. The evaluation team attended monthly steering committee meetings each year to observe decision-making processes. PIC Team/MHU meetings were also observed on a quarterly basis to gain insights into front-line experiences with client engagement, system coordination processes, and barriers and successes. For client interviews, the evaluation team randomly selected 10 clients per year to interview at baseline (approximately one month after enrollment) and follow-up (within three months after discharge). The purpose of these interviews was to understand client experiences with PIC Team services, their perceptions of the impact PIC Team services have had on their mental health, substance use, and related conditions, and the extent to which clients feel able to manage their treatment independent of the PIC Team. Table 8 provides an overview of evaluation methods and intervals.

Table 8

Overview of Evaluation Activities and Intervals

Year	Method	Intervals
1	Steering Committee Meeting Observations	Monthly
	PIC Team/MHU Meeting Observations	Quarterly
	Steering Committee Interviews	Annual
	Client Interviews (Baseline and Discharge)	Annual
	Collaborative Activities and Network Analysis Survey	Annual
2	Steering Committee Meeting Observations	Monthly
	PIC Team/MHU Meeting Observations	Quarterly
	Steering Committee Interviews	Annual
	Client Re-Admission Sub-Study	Ad Hoc
	PIC Team/MHU Focus Groups	Annual
	Client Interviews (Baseline and Discharge)	Annual
3	Steering Committee Meeting Observations	Monthly
	PIC Team/MHU Meeting Observations	Quarterly
	Equity Data Analysis	Ad Hoc
	Collaborative Activities and Network Analysis Survey	Annual
	Steering Committee Focus Group	Annual
	PIC Team/MHU Focus Groups	Annual
	Client Interviews (Baseline and Discharge)	Annual

A retrospective analysis of leadership and core staff perspectives was conducted for this report, which includes steering committee interviews from Years 1 and 2, Year 2 PIC Team and MHU focus groups, Year 3 focus groups for both the steering committee and the PIC Team and MHU, a quarterly sample of the steering committee observations, and all PIC Team/MHU meeting observations. Findings from Year 3 client follow-up interviews are presented here, with summaries of previous findings at baseline and follow-up for all three years of the evaluation. All interviews and focus groups were recorded with permission and professionally transcribed into electronic documents, and detailed notes were taken by evaluation team members at each of the meeting observations. Transcripts and meeting notes were analyzed using thematic coding in Atlas.ti qualitative data analysis software. For data related to the steering committee and PIC Team/MHU staff, codes were derived from a framework used to assess key elements for sustaining systems change (WPIC, 2009) (Appendix D). For client interviews, codes were developed by the study team based on the interview protocols. Two members of the study team took part in coding after agreeing on coding definitions and guidelines. The resulting themes that emerged across data sources are included below.

Steering Committee and Core Staff Perspectives

Themes that emerged most consistently across data sources and evaluation years were concentrated in the following areas of the implementation framework used to assess leadership and core staff perspectives: Vision and Values, Service Environment, Organizational Capacity and Infrastructure, Barriers to implementation, and Facilitators of implementation. A description of how these domains changed over the course of the three years of the evaluation is provided.

Vision and Goals

Across each year of the evaluation, there was strong agreement that there was a **shared vision** for the PICA initiative. Steering committee respondents shared that several of their agencies had increasingly worked together to address barriers to the behavioral health system—particularly on engaging individuals who had frequent contact with crisis stabilization services and the law enforcement—and that the vision was clarified further when the group applied for a grant to establish the PIC Team. Steering committee, PIC Team, and MHU members shared agreement of the multi-part vision: to improve coordination and collaboration within Pinellas County's behavioral health system, to identify and address barriers and gaps in services, and ultimately make the system easier to navigate for consumers. The PIC Team was seen as a core initial component of the initiative, which would provide care coordination for individuals with behavioral health disorders who are identified by the PCSO MHU. It was also widely agreed that the standalone, interagency case management model was a crucial part of addressing historical challenges of provider silos and competition, and this model was also seen as a way to "identify issues in real time to steer system improvement efforts." Steering committee members were consistently seen as having strong buy-in to the PICA initiative, and many respondents attributed the effectiveness of the initiative to the commitment PICA leaders have made to making improvements to the system.

> ***I think around this particular initiative and improving care coordination across the system, there has been a shared vision. We applied for the grant with a shared vision.***

Year 1. During the first year of PIC Team implementation, the focus was on staffing the team and establishing administrative functions, policies, and procedures. With regard to these concrete goals and strategies, there

was consensus that everyone was “on the same page.” However, there was some lack of clarity around how the initiative would move from these specific activities to broader **system and population change**. Steering committee members agreed that the initiative was on the right track during this early stage, but many were eager to have a more concrete understanding of what impact their efforts would have, and whether their planned activities would make large-scale changes, such as county-wide reductions in opioid overdose and suicide.

Year 2. During year 2, there were some discrepancies in understanding about the **target population**, such as whether clients should have health insurance and what level of care they would need. Some steering committee members assumed clients would be considered “indigent” and not have health insurance while others felt that any clients who were identified by the MHU were equally in need of being served by the PIC Team, especially since there was no method for determining whether clients were insured based on the criteria the MHU used for identifying candidates for service (arrests involving mental health, Baker Acts, and frequent 911 calls). The committee discussed whether the PIC Team was duplicating efforts that insurance providers should be responsible for, however, it was widely agreed that the level of case management that insurance providers offer is extremely limited and insufficient for PIC Team clientele. Several committee members reaffirmed assertions that the PIC Team was filling a dire need for centralized case management in the County. Additionally, some steering committee members suggested that the PIC Team clientele had more complex and intense needs than what was initially anticipated, as they did not think this group would necessarily be “high utilizers.”

Another area that received significant attention during Year 2 was how **expansion of the PIC Team** would align with the overall vision and goals of PICA. Expanding the PIC Team was seen as a PICA goal that would be pursued after the original PIC Team was stable. Initial discussions centered around partnering with other law enforcement municipalities while still maintaining the referral mechanism through PCSO’s MHU, with no resolution on whether this was the best route. Representatives at steering committee meetings also discussed multiple options for addressing other system barriers through this increased capacity, such as serving individuals with behavioral health disorders who were homeless, individuals exiting the Empowerment Team, or individuals who received Marchman Act assessments. System coordinators saw opportunities for potentially partnering with other agencies, such as housing services, or other law enforcement municipalities that serve a higher proportion of racial and ethnic minorities. There was no clear determination of

readiness for any of these options over the course of the evaluation, and discussions over whether or how to expand the team waned over the third year as issues of sustaining the original team took precedent.

Also during Year 2, there were some minor challenges in determining how or when steering committee agencies should act independently when there are **overlapping initiatives** of interest between their agency and the steering committee. For instance, there was some concern that there were initially divergent activities that were initiated by different steering committee agencies to address the need for a central receiving system. There were some perceptions that the steering committee would address this issue by working directly with providers to develop a plan, but when the County hired a consultant to assess readiness for a central receiving system, this steered the committee in a different direction. However, steering committee members ultimately agreed that this strategy was beneficial and that the group was collaboratively involved in the process. Overall, there was an emphasis on the need to ensure that any newly funded initiatives would fit into the vision of PICA and complement existing efforts to improve behavioral healthcare.

Year 3. During Year 3, respondents perceived the PIC Team to be effective in meeting its goals of diverting individuals with behavioral health disorders from law enforcement and providing effective system coordination. This was further evidenced by the reductions in arrests and Baker Act exam initiations, improvements in client functioning, and from first hand experiences seeing improvements in care coordination. Because of the PIC Team's effectiveness, **sustaining the model** was seen as a foundational part of having a functional behavioral health system, especially given that the crisis-oriented approach the system had historically operated under was described as insufficient and as leading to a "revolving door" of crisis service utilization.

> ***..the Baker act system, the receiving facility, the crisis stabilization unit system, is not a treatment system, it's not a problem-solving system, it's to temporarily deescalate something from the highest level to something lower than the highest level that somebody can live with. And if all we're doing is that and then waiting for the next time they get into extreme crisis and reenter them into the system at the same entrance point, exit them at the same entrance point and keep going, we're not doing anything.***

Regarding the **future of PICA** and how the vision can be sustained, numerous points of discussion during Year 3 offered insights. Some steering committee members see a coordinated access model as a

pathway to integrated care that addresses many of the barriers identified during the implementation of the PIC Team and continue to collaborate around efforts to increase access to care through increasing practices such as telehealth; partner with hospitals, urgent care providers, and emergency medical services; and utilize emerging practices to improve client engagement, such as integrating peer specialists in service models. There were also suggestions by respondents from multiple groups to strategically expand or replicate the PIC Team to include a greater number of racial and ethnic minorities.

Service Environment

The evaluation team assessed perspectives on how well the service environment supported implementation of the PIC Team and related PICA initiatives. Overall, steering committee members and core staff felt there was a **basic level of service sufficiency** for carrying out the goals of the initiative, and that there was strong internal and external support for the initiative from a variety of stakeholders—including the steering committee, core program staff, behavioral health providers, funders, local government representatives, and some legislators. Regarding the behavioral health service array, several gaps services in or barriers to accessing services were identified that interfered somewhat with more comprehensive service coordination and treatment for behavioral health consumers.

Year 1. During the first year of the PICA initiative, steering committee members asserted that that there was **clear support among leadership** and suggested there was a **sense of hope among providers** for the initiative's potential to improve collaboration and address long-standing barriers in the behavioral health system. Many respondents spoke of a deeply engrained historical problem of providers not collaborating—despite recognizing the need to. One respondent stated that, absent local policies to encourage collaboration among providers, the PICA initiative used funding as the pathway to take ownership of the problem and ensure collaboration at a structural level. It was widely perceived that, despite some initial resistance, provider agencies were supportive of PICA's goals and activities, and ultimately of working together to address system barriers.

Many respondents noted that the service environment was somewhat adequate, at least for the initial implementation of the PIC team, but they were unsure of the extent to which it could support wider scale changes. **Numerous barriers were identified** during the first year of the PIC Team's implementation, including challenges accessing 211 services such as financial assistance, significant wait times for mental health

services, barriers to obtaining housing for clients with complex needs, lack of streamlining of intake assessments, a need for Marchman Act beds or facilities to serve individuals with substance use conditions who are incarcerated, and difficulties with providers being able to "see" what services clients have been engaged in from other agencies. One respondent suggested that there weren't enough services for system coordinators to refer clients to, and without appropriate services, individuals in need of behavioral health services would continue to rely on law enforcement and end up involved the criminal justice system. PIC Team members also discussed the need for a walk-in clinic for people who feel suicidal, given the county's Zero Suicide Initiative, and reported that the walk-in services offered by several provider agencies fill up immediately or are insufficient for meeting the needs of clients. Several of these issues were addressed immediately by the steering committee through the development of work groups, such as assessing wait times to understand patterns and initiating an exploration of a Health Information Exchange system to enable providers to see client referrals. Other barriers were addressed through specific actions, such as the County's intervention to meet with individual 211 providers and update information across the system to improve accessibility, and the committee's exploration of readiness for securing a Marchman Act facility in the county.

Year 2. Perceptions of strong leadership and community support continued into Year 2, and leaders and core staff gained a better understanding of service and resource utilization by the PIC Team. Feedback suggests that PIC Team clients were being effectively connected to services, and the team had become very **proficient in identifying and utilizing community resources**. However, there was some concern that this kind of service coordination was still inaccessible to the "average person," or those without interactions with crisis services or law enforcement. There were also some perceived challenges to getting the broader behavioral health community to understand the initiative. To address this challenge, PIC Team staff members began providing informal education to hospitals and other providers to share information about the team's services as well as inviting behavioral health agencies to their weekly meetings to learn directly about how the team can utilize different services. Steering

> **Working together has made a difference…When you have representatives from each of those major mental health systems sitting at our meeting weekly and hearing us talk about the struggles and being able to connect with them. They take that information back to their agency. And, I think that's really helped them try to develop better systems to get the clients in to meet their needs.**

committee members have continuously discussed PICA's efforts at related behavioral health meetings, such as the System of Care meetings.

PIC Team staff reported **unique challenges of the clientele** being served, several of which were related to the North Pinellas County region many clients resided in, which was described as lacking in services and service availability compared to other parts of the county that were more typically associated with higher needs. The transportation barriers many clients faced compounded difficulties accessing services, as did the need for many clients to have in-home services, which were seen as scarce. Several respondents pointed out that it can take between one to three months to begin a psychotherapy appointment, and that in-home therapy and telehealth service (at that time) were very limited. This gap is temporarily filled by PIC Team staff while clients are waiting, but there was concern that this pattern would contribute to long-term problems when clients are expected to make and maintain appointments on their own. Increased targeted or intensive case management was suggested as a solution to address the need many clients have in managing their treatment.

Some other key **services that were identified during Year 2 as difficult to access** were the FACT Team, outpatient treatment, short-term residential treatment, assisted living facilities, specialty therapies such as EMDR, and housing services for sex offenders. Several respondents shared that, many times, clients will initiate a Baker Act call on themselves in order to receive priority treatment. This workaround highlights the problems with wait times for crucial behavioral health services and the lack of providers' abilities to effectively triage based on clients' needs. Several respondents pointed out the need for standalone walk-in clinics for non-crisis services and noted that the first come, first-served walk-in services offered by some providers are insufficient and fill up immediately. Many clients are reported to have severe anxiety about going to and waiting for appointments, which presents a barrier for these limited appointment timeframes: "If we're referring a client who is right out of crisis and still not stable, I can't expect them to wait eight hours just to get told, 'Try again tomorrow.'"

> ***…they know, well, "if I go to, say PEMHS or this Baker Act facility, I'm gonna get my medication right away." That kind of bumps you to the front of the line, so to speak.***

Year 3. Few new barriers were identified during Year 3, and steering committee members began to focus more on **broader systems**

> **There's still a huge need, there's a void. Absent PICA, I don't see that much has changed, maybe the needles moved slightly, but absent PICA, I don't think there's been much change as far as what I consider to be master case management, effective discharge planning, care coordination…**

initiatives, in addition to prioritizing the sustainability of the PIC Team. One steering committee representative commented that the reason PICA was started was to keep key funders and decision-makers updated on what each agency is funding and insure that behavioral health efforts are cohesive going forward. Opioid use and overdoses, for example, had gotten worse, and the committee wanted to keep this topic central to the group in order to have some oversight over how providers are responding to this problem. There was some concern that services for mental health and substance use, which often go hand-in-hand, are still being approached separately, though it was suggested by others that new initiatives are utilizing a more integrated approach. The need for case management services outside of the PIC Team was also reiterated, with recognition that there are many others who need enhanced engagement in behavioral health services. There was significant activity related to aligning contracts and data across the system to streamline service coordination and outcome measurement. As a result of recommendations made in KPMG's *Elevate Behavioral Health* Pinellas report commissioned by PCHS, steering committee members prioritized the task of developing an Optimal Data Set (ODS) in collaboration with providers that would be part of their contractual agreement when they receive funding, thus ensuring service indicators are being uniformly assessed and reported. Steering committee members saw their role during the end of the third year as connecting various initiatives and ensuring a comprehensive response to needs and barriers.

Organizational Capacity and Infrastructure

This domain reflects the organizational and system-wide capacity to support ongoing implementation, including factors such as staffing, data assessment and communication processes, oversight and monitoring, funding, and sustainability.

Year 1. There was consensus during the first year of the PIC Team evaluation that **capacity was sufficient** in terms of what was needed to establish and support the PIC Team, including hiring and training qualified staff, engaging clients, developing oversight and monitoring processes at the team and steering committee level, and securing funding for the initial stages of implementation (though funding was lacking overall). There was some lack of clarity over how outcome data would be monitored; CFBHN

was developing a database to capture most outcomes of interest, though the system was not yet functioning during this year. The PIC Team utilized several data systems initially (from each of the behavioral health provider agencies) until later in the first year when everyone migrated to PEMHS's data system. Respondents reported early success during the first year with clearing the congestion in the system that was caused by chronic use of 911 for mental health crises.

Year 2. During the second year of PIC Team implementation, several **capacity challenges** were identified, including a need to provide informal training to PIC Team staff to ensure that system coordinators had an extensive awareness of community resources. Several respondents emphasized the importance of engagement to the PIC Team's work, and while it was widely agreed that PIC Team and MHU staff effectively engaged clients, there was a suggestion to support these efforts by adding peer specialists, especially given the complex conditions many clients had that made them hesitant or paranoid about accepting or engaging in services. Steering committee members revisited whether there was sufficient capacity to expand the PIC Team, with the understanding that each of the four behavioral health provider agencies agreed to commit one additional full-time staff member to the team. One idea for this expansion was to have the new staff members serve high utilizers of Emergency Medical Services (EMS) due to opioid overdoses, though the group ultimately felt there wasn't sufficient understanding of how or whether this mechanism would work to pursue the option. Another capacity challenge identified during the second year was that CFBHN's data system, PICA 2, was still not "live," which meant that data was being collected from various sources rather than being streamlined into one system. Finally, while respondents agreed that there were multiple oversight processes in place (e.g., supervisory meetings, provider agency supervision, steering committee representation at staff meetings), there were suggestions that quality improvement processes needed to be improved.

Year 3. Capacity issues discussed during the third year of the PIC Team implementation were clearly related to **sustainability and funding**. Steering committee members discussed challenges with providing adequate mental health training to law enforcement officers, as there had been reductions to the number of Crisis Intervention Team (CIT) trainings over the past couple years. The PCSO was only able to send 8 officers to the local training in 2019. This component of addressing criminal justice involvement by individuals with behavioral health needs was seen as crucial to address by the committee and system as a whole, not just law enforcement. The PCSO representative shared that an agreement was in

place with the agency that manages CIT training to increase the number of classes offered. Additionally, a new policy was implemented in 2021 that all PCSO deputies will complete a Mental Health First Aid 8-hour training (a significant increase in the number of officers trained, but a decrease in the intensity of training compared to the 40-hour CIT training).

Regarding **staffing changes** during Year 3, the PCSO added staff to the MHU and also made a structural change to the model where clinical staff would no longer be staffed by a behavioral health agency but instead would be hired internally and overseen by a clinical supervisor. It was unclear whether there would be appropriate capacity to handle additional cases coming from an expanded MHU. There were some concerns that PIC Team caseloads would increase without additional staff on the team, and system coordinators would not be able to be as effective if they had reduced engagement time with clients. Steering committee members commented that expansion of the PIC Team should still happen simply based on the effectiveness of the team, but this depends on being able to secure funding for expansion.

There were several challenges identified with continuously **funding the PIC** Team. First, many of the clients served by the PIC Team cannot be funded by CFBHN because of stipulations that require recipients of their funding to meet income eligibility criteria; this limits CFBHN's capacity to contribute funding to the team. Additionally, the funding from Foundation for a Healthy St. Petersburg (FHSP) was unrestricted and could be used for any individuals who were designated as PIC Team clients, yet this funding will not be renewed after March, 2021. The PCSO has agreed to fund uncovered expenses after this point to sustain the team in the near future, but they will not have the funding capacity to do this long-term. The steering committee and administrative agency, PEMHS, is investigating whether the team may be able to bill insurance providers for certain services; however, there may be differences in how engagement is conducted, since there have thus far not been limitations on how much time and how many interactions system coordinators can have with clients. As one respondent noted, "Nobody funds getting people into care…" indicating that a significant amount of work goes into engaging clients in care, yet this aspect of the system is not considered in funding streams. While initial funding from FHSP and CFBHN has lapsed, the steering committee is actively working to identify funding streams for the PIC Team to complement PCSO's ongoing funding so the team can at least remain at the same capacity.

Barriers

Barriers described below were shared by the steering committee and core staff during interviews and focus groups, as well as during steering committee and PIC Team/MHU meetings. Challenges that were identified range from program-specific to system-wide factors and are organized by implementation year.

Year 1. During the first year of implementation, the majority of barriers that were noted related largely to initiating an interagency system coordination team. There were some suggestions that provider agencies weren't initially in favor of developing a centralized team and faced some challenges in working together, though they eventually supported the collaboration. This merging of agencies also required a review of contract alignment and funding to ensure there weren't overlapping initiatives funded by multiple sources.

Year 2. Feedback from the second year of PIC Team implementation was oriented around the need to better address the lack of integration of mental health, substance use, and physical health. Substance use services, in particular, were highlighted as inadequate, with the need for them outweigh their availability. It was suggested that social services, such as financial assistance and transportation services, should be better integrated with behavioral health services to more comprehensively address clients with complex needs who were often left to "piecemeal" together services. Some respondents expressed frustration with some lingering issues, such as a continued sense of competition among providers. It was also noted that there was a lack of progress with defining needs for an HIE system. Although the steering committee spearheaded several meetings with programming and IT staff and held a professionally facilitated system-wide workshop, there was no evidence of decisions made from these activities to move the project forward.

> **…if you get a person that has complex needs, then you're kind of left to piecemeal together services. And that shouldn't be a thing. I would like to see it if we had like a one stop shop for people. Just go in there, you can see the doctor, see the nurse, you know, see your therapist, get your rent paid, the whole thing.**

Other barriers were more specific to different components of client engagement. Some respondents shared that sometimes individuals are hesitant to engage with law enforcement upon initial visit. There was acknowledgment that the unit's presence can make people uncomfortable, especially because initial engagements are unannounced

and because vulnerable information is being shared without having any kind of relationship established. If this happens, the MHU said they may respond in numerous ways, such as using strategies to ease tensions or build rapport, or in some cases having the officer temporarily step away. On the other end of the engagement spectrum, PIC Team respondents shared that a major barrier the team faces is that many clients who are discharged from the team face challenges effectively and independently managing their treatment without the same level of system coordinator support that was received while enrolled. It was noted that some clients continue to end up in the "revolving door" of crisis services after falling into crisis again. The "warm touch" that was experienced with the PIC Team is reportedly lost after discharge and not replicated elsewhere in the system.

Year 3. Given the focus on sustainability during the third year of implementation, some of the barriers that were highlighted were related to the lack of funding mechanisms available to comprehensively address behavioral health. Respondents described **funding distribution at the state and local level as problematic**, noting that Florida continues to have a dismal record of adequately funding mental health services. It was also suggested that the short-term nature and specific criteria required for private foundation funding made it difficult to sustain initiatives. These challenges were exacerbated by an anticipated increase in mental health and substance use problems after the COVID pandemic wanes, with one representative citing that some of the highest rates of substance abuse in the county occurred in 2020. Further, steering committee members pointed out a lack of legislation in place that supports behavioral health improvements.

There were numerous discussions of some of the **challenges of engaging racial and ethnic minorities** through the PIC Team. Many respondents described barriers to engaging communities where there are negative experiences with or cultural norms against reaching out to the police (such as African American or Latino communities). Some respondents suggested that law enforcement can sometimes be a hindrance to engagement in these communities because clients may feel pressured to agree to services initially to avoid what they see as further involvement with the police, but then not want to engage once they are assigned a system coordinator. Other areas where there were concerns about law enforcement engagement were with individuals with autism spectrum disorder—who may be easily misunderstood if police don't recognize their behaviors—and individuals who have experienced sexual assault and are especially vulnerable to interactions that involve

perceived force. More training for law enforcement in these areas was suggested.

Additionally, PIC Team respondents pointed out a need to better **understand and have a trusted presence with the support networks** that many racial and ethnic minorities rely on when they have behavioral health crisis, such as families and faith-based organizations. Respondents also noted that "just because [services] are there" doesn't mean people will reach out for help, especially if there are cultural values or beliefs that conflict with acknowledging or seeking help for mental illness. Finally, it was suggested that there is a lack of racially diverse representation among service providers in the field in general, and for some clients, not seeing case managers, therapists, and psychiatrists who "look like them" may be a barrier to engaging in services.

> **And we have struggled referrals for Hispanic Americans or some African American families—they do feel like they have everything under control, and that they're gonna, you know, keep their services within their family or their comfort level. So reaching out to different programs—it's not as acceptable.**

Facilitators

Year 1. There was strong agreement during the first year of establishing the PIC Team that one of the greatest facilitators of successful implementation was the **collaboration among the steering committee and core staff**. The interagency partnership model was seen as a strength, particularly in that the partners were all committing funding and effort to the initiative and combining resources. Having key decision-makers at the table together was seen as facilitating streamlined responses to persistent barriers.

Year 2. During Year 2 responses focused more on recognizing the **importance of client engagement** as a key facilitator of successful implementation. The PIC Team was seen as very effective in providing clients needed care and as working well with each other and learning from each other's areas of expertise. Some respondents pointed to the importance of in-depth and consistent engagement as a factor in meeting the needs of clients that required a high level of care, suggesting that both engagement during services and follow-up engagement were critical components of success. With regard to leadership during Year 2, responses indicated that collaborative efforts had become more "operational" rather than just conceptual, which had a positive impact on the behavioral health environment. Some examples of these efforts

included interagency involvement in the County's behavioral health environmental assessment and emerging initiatives to streamline care coordination and improve access to care. It was also noted that, by consistently attending monthly meeting, the steering committee was able to understand and address problems and initiatives in a more integrated way, and to provide better oversight over system functioning.

Year 3. During the third year of implementation, the benefits of PIC Team engagement were emphasized again, though with a more comprehensive understanding of how it positively impacted outcomes and what made this team different from any other type of case management. Intense, in-home engagement was seen as unique to this model, and as foundational to its effectiveness. Several respondents shared that having smaller caseload sizes contributed to their success, especially in being able to serve clients with intense needs. It was widely agreed that what was **crucial to the team's success was the flexibility** they had in working with clients, something system coordinators had not experienced in other case management positions. For instance, respondents discussed being able to spend much more time with clients and meet more frequently with them than what would otherwise be allowable if they were billing for services and reporting engagements to an insurance provider. This flexibility was seen as beneficial to clients, who often needed to reach out to system coordinators frequently, adding to the "warm embrace" and the team has become known for.

System coordinators described being able to meet any client's level of care because they had less stringent criteria and no restrictions on the resources they used and referrals they made; there were generally less political concerns that complicated service delivery. Additionally, clients didn't have to wait to be assigned a system coordinator, unlike with other services. Respondents said that there was no other service like the PIC Team that can work as comprehensively with clients, and that they aren't forced to "abandon" or "give up" on clients if they are not ready to engage, as they can continue checking in on them. Likewise, system coordinators appreciated the freedom to re-engage discharged clients who faced challenges managing their treatment on their own. There was some acknowledgement that these multiple attempts at engagement can

> **…the level of intensity we can provide, there's nothing else out there that can do that. If [a provider] simply gives someone a piece of paper and says, go to this mental health treatment center, there are many obstacles and things that come in the way of that, including just the client's readiness.**

be time consuming and potentially expensive, but that they are necessary and appropriate for clients with some of the highest levels of need.

Finally, there were many ways that **MHU engagement and efforts** were seen as facilitators of effective implementation. Some respondents emphasized that MHU involvement continues beyond the initial referral to the PIC Team, and that it also continues indefinitely for individuals who do not engage in services. The unit will place a "watch" on individuals they refer for services, and if there are future incidents of law enforcement engagement, officers will see that the MHU is working with the client and, in many cases, divert any actions to the MHU for further engagement. It was suspected that this mechanism has prevented many Baker Acts or arrests, which is one potential explanation for why similar outcomes are seen in these areas for both admitted and referred clients. Some respondents also suggested that having a social worker in plain clothes helps to de-escalate potential fears of law enforcement presence. Building trust with the community was seen as extremely important, particularly for individuals who have had negative experiences with law enforcement in the past. MHU respondents shared that this is something they take seriously and they make many efforts to improving the relationship between law enforcement and the broader community.

> **I know on the law enforcement side, and as an agency, we are always, always trying to better the relationship between law enforcement and the citizens in the community. So, we take pride in working hard to better that relationship.**

One respondent felt that because of the skill and characteristics of the MHU staff, they are proficient at addressing concerns about their presence: "a lot of the clients, when we engage them, they do get really nervous. But by the time we're done with our conversations, they always thank us for coming out. They typically love us when we come out after that." PIC Team respondents also felt they had an important role in building trust by listening to people share their past negative experiences with law enforcement and validating their feelings. They suggested that this strategy, in combination with their partnership with the MHU, contributed to improving trust with law enforcement.

Summary

Table 9 outlines major themes covered by data sources for the implementation analysis, including interviews, focus groups, and meeting observations with steering committee members and core staff. Themes are organized into four sections: Barriers Identified, Facilitators of Implementation, Activities Accomplished, and Efforts in Progress.

Table 9

Summary of Barriers, Facilitators, Activities, and Efforts in Progress

Barriers Identified	Facilitators of Implementation	Activities Accomplished	Efforts In Progress
Service wait times, especially for psychotherapy Opioid/EMS overdoses Poor accessibility/stringent criteria with some services Lack of follow-up on referrals Lack of detox beds Lack of mid-level care/treatment Challenges getting data from providers Some negative experiences or hesitancies with law enforcement Lack of integrated care overall	Collaborative focus Pooled funding and resources Interagency models Steering committee oversight PIC Team intensive and frequent engagement Flexibility of system coordination model MHU ongoing engagement and monitoring of all referred individuals "Warm embrace" and support experienced by clients	Installation of PIC Team Development of initial HIE workgroup Initial meetings with CEO providers to address collaboration Collaborative Labs HIE session to determine system needs Initiation of workgroup to develop Optimal Data Set (ODS) Expansion of MHU Collaboration on *Elevate Pinellas* behavioral health environmental assessment	Determining PIC Team expansion Determining needs/process for HIE Identifying sustainable funding pathways for PIC Team Aligning contract elements Establishing Optimal Data Set Reviewing potential for billing insurance for some services Refining data collection and monitoring system for PIC Team outcomes Determining indicators of system-level and population level change Developing initiatives to coordinate and improve access to care

Client Perspectives

The evaluation team conducted discharge interviews from September 2020 to January 2021 with ten PIC Team clients, most of whom were discharged prior to participation. We used a semi-structured interview protocol (Appendix E) to inquire about clients' duration of enrollment, their involvement in discharge planning, their ability to find help (if needed) since discharge, and their recommendations to improve services. Interviews lasted up to 20 minutes and were audio-recorded with verbal consent from participants, and professionally transcribed. Participants were compensated with $25 in cash after completion. The evaluation team conducted thematic analysis using a coding scheme (Appendix F) guided by domains inherent in the interview protocol using *Atlas.ti* qualitative data analysis software.

Year 3 Client Discharge Interviews

Enrollment. Seven participants were discharged at the time of interview and reported being enrolled in services from three to six months in their most previous treatment cycle, although some were re-enrolled in service twice in the past few years. Participants were referred to a variety of services, such as financial assistance, transportation assistance, substance use treatment, and group therapy. They were also provided psychoeducation about their mental illness when applicable, such as one client who learned about their diagnosis of bipolar disorder. Participants' family members received assistance on occasion, such as one participant who shared that, "[My system coordinator] gave me resources to help get bills paid. She even made phone calls for me to help get [my family member's] bills paid..." Before and after discharge, participants gave updates about their well-being and unmet needs. System coordinators provided help developing coping skills, creating support systems, and getting connected to financial and healthcare resources. After discharge, system coordinators contacted participants once a month, though participants could reach out more often if needed. Three participants said they were still enrolled in services at behavioral health agencies such as Directions for Living.

Service History. Seven participants reported previously receiving behavioral healthcare services. Two did not share whether they thought services were an improvement over past services, but felt positive about their involvement with the PIC Team. Three participants reported profound improvements in the way they received care and followed treatment. These clients explained that they were more knowledgeable about their diagnoses and they had increased confidence. One client shared, "…I always used to call myself stupid or sad or dumb…And [system coordinator] put it in my head that no you're not. No, I'm no different than nobody else." They also felt more motivated to complete treatment; one participant shared that they used to have difficulty "following a rule" but found their system coordinator to be an "inspiration." They received more

comprehensive services that were appropriate for themselves and their families. One compared her interactions with the PIC Team to other services:

> **[The PIC Team is] so much better than a lot of your other community resources that are out there. They treat you and they respect you with fairness and kindness, and no judgement.… other agencies, to try and get help with my parents, my dad, they just wanna slam the door right in your face … Whereas the PIC Team, from the jump street they were on top of everything and helping me and guiding me.**

One client was particularly grateful for the "one-on-one" attention they received, which was uncommon for them. Two participants reported dissatisfaction with services and felt that other services they had received either before or after enrollment with the PIC Team were more suitable. One felt that services needed to be more intensive. The other described "butting heads" with their system coordinator frequently over decision-making before switching to a support coordinator from another provider.

Finding Help After Discharge. Eight participants felt that their enrollment with the PIC Team positively changed their approach to seeking behavioral healthcare, including those who had lingering unmet needs or felt dissatisfied with services. These participants reported having more knowledge of local resources. One shared that their system coordinator "showed me every route for therapy, or relief, or ideas, or groups, and communication." They felt more motivation to seek out or continue treatment, including one who continued treatment even after being disrupted by hospitalization. They said, "…they had me in there for three to five days. But when I got out, I started coming right back to class." A few pointed out that they now had a greater recognition of their personal supports and strengths, which allowed them to make changes in their life. One participant reflected on how life had changed since the beginning of treatment, such as how they were able to find housing and employment.

> **I left and I hit the streets in the middle of the pandemic. [My previous relationship] was that bad. …I was on the street again. It was awful, it was very difficult. Had to change a lot of the people who I used to hang out with.…I had to find a way out. I had my unemployment which really helped, and I was able to get out of the shelter [and] vehicle, able to get some work.**

Three participants reported having unmet needs. One wanted assistance from their system coordinator in arranging a burial for their parent and felt confident they would receive help. One participant was facing problems with housing and income but did not want to reopen their case due to

previous decision-making disagreements. They explained, “But [the PIC Team] said that that was the only reason why they would take me back if I did that and to reopen up my case. That’s when I said, ‘No, I’m not doing that,’ so they’re not going to reopen my case.” One participant said they were never assigned a new trauma counselor at the provider agency they were receiving services at, even with help from their system coordinator: “I called [Suncoast] and left [a message] on their answering machine, but I don’t know if she ever got it or not. But I haven’t heard from anyone in months.”

Challenges and Recommendations. Four participants observed lapses in communication among professionals involved in their cases. One participant complained that on four occasions, “I couldn’t get ahold of the on-call number for somebody to talk to me.” One said that, “Directions for Living wasn’t exactly keeping up with [my system coordinator] more” which required the participant to step in more often than they thought was necessary. They did not feel that this was a serious problem, however, and said, “that’s to be expected, really. No one’s perfect.” One participant said that their case manager at the agency at which they were receiving services was not up to date about their case and did not communicate regularly with their PIC Team system coordinator. This participant blamed the lapse on caseload demands: “She’s not quite up to date as far as [my system coordinator] right now because we have to call and leave messages, and she has so many people to deal with.” One participant felt that there were communication difficulties from multiple people on their case. They said some phone calls went unreturned and there were disagreements about how care was prioritized, since both the participant and their daughter were receiving assistance from the PIC Team: “So, they were trying to help my medical condition as well as trying to help my daughter. Which I’m okay with that but at the same time, I don’t think they were doing right by her at all.”

When asked for recommendations to improve services, participants routinely suggested greater frequency of contact during and after treatment: “Check up on them frequently. Make sure they're okay.” This was an important aspect of treatment even for those who were dissatisfied with the care they received or who had re-enrolled in services. One emphasized the need to show those with lower income that behavioral healthcare help was still available. Another suggested that more immediate access to medical care was a crucial part of recovery. One participant strongly suggested that health professionals include family members in decision-making. They reflected on recent experiences, saying, “We're in the home, we know what's happening and that's my biggest fail-through right now, is the doctors letting certain things happen and slip through the cracks. And in the future that's the main thing that needs to happen, is they need to be more open to listening to people who know their patients better than them.” Another participant made similar comments about including family in decision-

making. A few said that professionals needed to listen and empathize with participants. This included one participant who described feeling judged by their system coordinator, "…you're saying I'm making bad choices. Well if I make bad choices, you know what I mean, I wouldn't even be alive right now."

Summary. The majority of participants shared that they had positive experiences during enrollment. These participants reported strong rapport with their system coordinators, greater knowledge of illness and treatment, improved ability to manage problems, and gratitude for the help they received. They generally did not have any unmet needs (or significant challenges solving new problems). Their most common suggestion to improve services was to keep in regular contact with clients during care and after discharge. Two participants, however, were mostly dissatisfied with services. One had difficulty finding a new counselor and felt they needed more services. The other described having a difficult time communicating with professionals and feeling that their decisions about their family were not being respected. These participants suggested that healthcare professionals work harder to listen to participants, acknowledge family input, empathize with their decisions and situations, and help to destigmatize mental illness and treatment-seeking.

Years 1-3 Client Perspectives Summary

Key themes from client interviews over the three-year evaluation have been summarized below and are organized by the stage of services clients were in. Experiences during PIC Team services refers to the baseline interviews, which took place approximately one month into services. Experiences post-discharge refers to the follow-up interviews that were conducted within approximately three months after discharge. (See previous reports for a detailed review of client feedback for each period).

Experiences During PIC Team Services. When asked about their history of treatment, participants frequently reported that they had never been or had infrequently been connected to care prior to contact with the PIC Team or PCSO Mental Health Unit. A handful of the 30 participants interviewed at baseline over three years reported consistent access to treatment when needed, such as those who had been connected to a psychiatrist for several years before enrollment. Those who received behavioral healthcare services were treated by Suncoast, Florida Behavioral Health, Windmoor, PEMHS, and Directions for Living and were often referred through other professionals, such as doctors or case workers. When they were unable to find care, participants cited a lack of awareness of local resources, confusion navigating through various resources, transportation, and stigma. One client cited a lack of "openness," saying that they were "always on the phone trying to get help. Even trying [to get] referrals. No answers." One participant sought informal care from a healthcare professional they knew personally.

Several clients discussed a lack of health insurance, which may indicate they were uninsured, that they didn't have coverage for the services or treatments they needed, or that they didn't understand their benefits (more than half of all interviewees indicated they had medical coverage when they needed it upon enrollment).

Participants were nearly unanimous in their praise for their system coordinators. Even those who were dissatisfied with service found their system coordinators to be helpful, empathetic, and proactive. System coordinators shared their vast knowledge of local resources, scheduled appointments, and taught organization skills and coping mechanisms. They met participants at a location convenient to them, often in the home. They helped with "all aspects of your life" such as transportation, housing, and employment. Most importantly, they gave participants an opportunity to talk through their frustrations and worries. Several participants reported that their system coordinator was one of the most significant reasons they were able to make progress in treatment; one participant shared, "I think I'd still be stuck in the same spot if [system coordinator] didn't show up." When asked what they disliked about the PIC Team, the most common complaints were that system coordinators sometimes appeared without prior notice, provided an overwhelming number of resources, or did not call as frequently as participants wanted. One had more serious complaints that their system coordinator was not as involved in the treatment enrollment process as they could have been, saying, "recently [my system coordinator] has been trying to get me involved in this program… I don't feel like [my system coordinator] has done a lot in the course of getting that all set up." For such cases, the evaluation team suggests clarifying roles and responsibilities among practitioners and clients.

Experiences Post-Discharge. The evaluation team interviewed 23 participants after discharge, including a few who had re-enrolled in services. Participants were connected to a variety of organizations to continue care, including PEMHS, WestCare, Windmoor Healthcare, Directions for Living, Substance Use Disorder Intervention Program (SUDI), and Vincent House. They received counseling, support group, medication management, and other services. Most found that their time enrolled in services with the PIC Team enhanced their ability to seek care when needed. Participants became more knowledgeable about resources available to them, which had previously been a serious barrier to many. They reported feeling more confident about using coping mechanisms, managing personal relationships, and using budgeting skills. A few with serious mental illnesses became more knowledgeable about their condition due to support from their system coordinator, including one who was diagnosed with schizophrenia for the first time during enrollment. Some said they developed greater interpersonal skills, such as one client whose system coordinator taught them to respond to various situations

without aggression. Some participants, however, reported no change, such as those who had been previously connected to treatment providers.

While many did not report any unmet needs, or any unmet needs that they felt incapable of handling, several participants experienced serious difficulties managing their care after discharge. These clients had difficulty finding employment or care, keeping up with appointments, continuing medication, arranging transportation, and finding financial assistance. One participant relapsed. Others complained that they felt unprepared to leave the PIC Team. Some of these challenges reveal an overreliance on system coordinators to arrange and manage care, indicating a need for greater role clarity in the future. A few participants shared that they had not been connected to new providers, including one client who never received a replacement counselor when their previous counselor was promoted. When asked about how services could be improved, participants suggested that practitioners provide behavioral healthcare from a young age, offer education and training across healthcare system sectors so professionals could better identify those in need, connect clients from one point of care to another immediately, educate clients about their conditions in language they can understand, and call or text frequently even after discharge.

Collaboration and Systems Change

The collaborative structure established for PICA was developed as a tiered structure (see Figure 14). Major funders and policy-makers make up the top tier, Tier 1, of the partnership and include Central Florida Behavioral Health Network (CFBHN), the Pinellas County Sheriff's Office (PSCO), Pinellas County Human Services, and the Pinellas County Health Department. These executive partners govern the PICA initiative. Tier 2 stakeholders are experienced in providing services and supports for persons with mental health challenges in Pinellas County and are represented by administrators of the agencies. PEMHS, BayCare, Suncoast, and Directions for Living play an active role in informing activities of PICA and are engaged in steering committee meetings and other related meetings. Tier 3 consists of the PIC Team. Lastly, ancillary service providers make up a fourth tier and include mid-level management staff such as program directors. These stakeholders provide services and supports throughout the county and are engaged on an as needed basis for PICA clients.

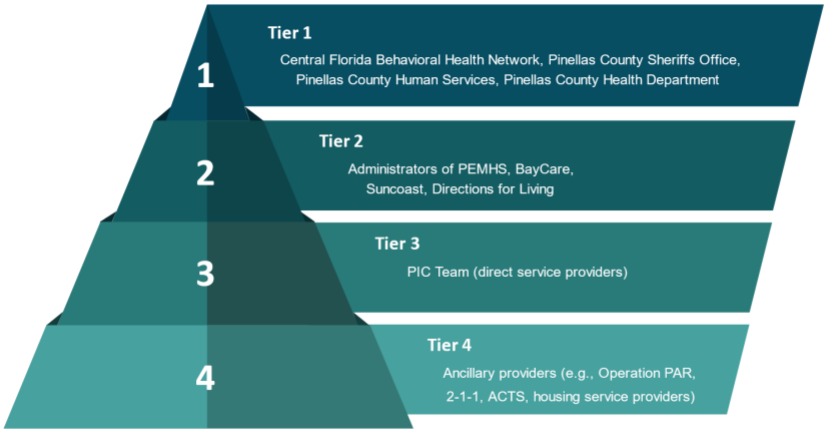

Figure 14. PICA Tiered Model

An overarching goal of the PICA initiative is to develop a collaboration between major funders, policy-makers, and health care providers to improve the long-term efficacy of the Pinellas County System of Care for adults with mental health needs. Specifically, one of the targeted outcomes of PICA is to improve coordination of services among partners and providers. A three-fold approach was used to assess this. First, a standardized collaboration measure—the Interagency Collaboration Activities Scale (IACAS)—was used to assess how collaboration is occurring between stakeholders (Greenbaum & Dedrick, n.d.). Survey respondents were also asked to identify factors that were seen as both challenges and facilitators to effectively collaborating with other agencies. A Network Analysis Survey was administered to supplement the IACAS by examining patterns of communication and collaboration among stakeholders. Lastly, a stakeholder survey focused on understanding perspectives on the planning and development processes for the initiative including the effectiveness of project leadership, specific strategies and activities, and the long-term sustainability of the project.

Survey findings were detailed in the previous report submitted in September 2020. Findings are summarized here.

In what ways did PICA Partners and Providers Collaborate?

The USF evaluation team used a standardized survey—the Interagency Collaboration Activities Scale (IACAS) (Greenbaum & Dedrick, n.d.)—to assess collaboration among stakeholders and providers represented in PICA. The IACAS measures interagency collaboration within the following domains: financial and physical resources, program development and evaluation, client services, and collaborative policies. This 17-item scale asked respondents to indicate the extent to which their organization

shares with other agencies for each of these domains on a 5-point Likert scale ranging from “1”- “not at all” to ‘5”- “very much.” Therefore, higher values reflect greater levels of collaboration.

This survey was administered within the first year of the PICA initiative and again in the final yead. At both time points, most collaborative activities involved strategies and process that pertained to Program Development and Collaborative Policy (see Figure 15). Data also indicate there was an increase in collaborative activities related to Financial and Physical Resources and Client Services Activities. Overall, respondents perceived collaborative activities increased over the course of PICA implementation.

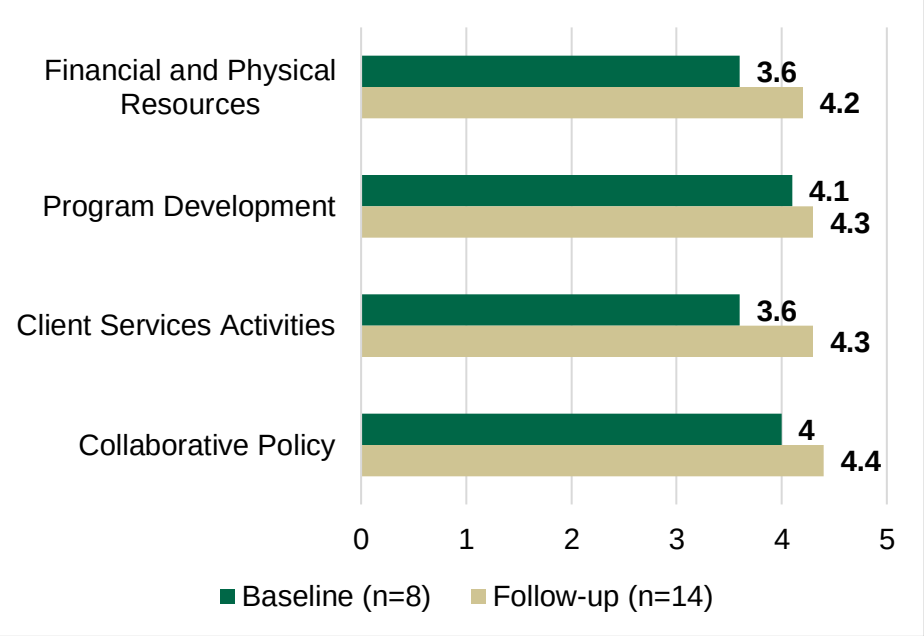

Figure 15. IACAS: Average Domain Scores

Within these domains, collaborative activities mostly endorsed in the follow-up assessment were participation in standing interagency committees, informing the public about services, providing clients information about services, and convening case conferences or staffings.

How did Stakeholder Perceive Implementation of the PICA Initiative?

Stakeholders involved in PICA provided their perspectives on the planning and development processes for the initiative including the effectiveness of project leadership as well as specific strategies and activities, the impact of local contextual and environmental factors (e.g. social, political, cultural), and the long-term sustainability of the project.

This survey assessed perspectives of PICA stakeholders across five domains: Leadership and Commitment; Shared Vision, Values and Mission; Environment, Stakeholder Involvement; and Organizational Capacity and Infrastructure. The Leadership and Commitment domain asks respondents to rate his or her level of agreement on buy-in from various stakeholders, commitment to the goals of PICA, and capacity to provide oversight and monitoring, for example. Shared understanding of the vision and goals of the initiative is assessed in the second domain. The Environment domain describes support for the initiative within the community as a whole and across various sectors such as funders, policy makers, and stakeholders. To assess Stakeholder Involvement, respondents were also asked to rate their level of agreement on stakeholders', community members', and clients' involvement in planning and decision-making for PICA. Lastly, the Organizational Capacity and Infrastructure domain describes the alignment of policies and procedures with the goals of the initiative, sufficient resources to support PICA, and a sustainability plan.

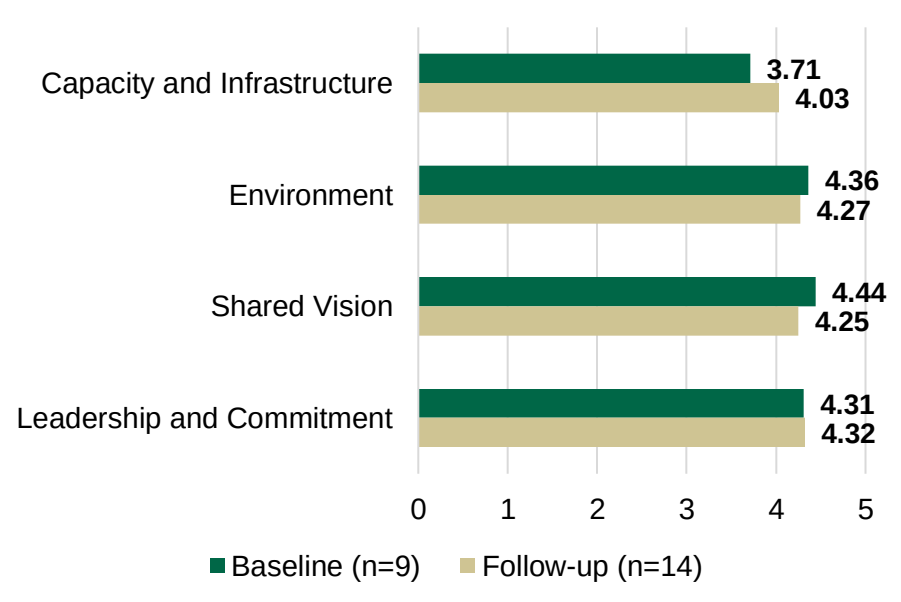

Figure 16. Average Domain Scores for the Stakeholder Survey

Overall, results suggest that stakeholders largely agreed with many of the statements included in the survey (see Figure 16). Shared Vision, Environment, and Leadership and Commitment were the highest rated domains at baseline and follow-up assessment. Specifically, respondents felt that there was a shared understanding of the vision, mission and goals for PICA, that there was substantial support among stakeholders, and that steering committee partners demonstrated a high level of

commitment in carrying out the goals of the initiative. Respondents also felt strongly that there was clear and frequent communication regarding implementation of PCA activities. Results also indicated that respondents somewhat agreed with statements included to assess Organizational Capacity and Infrastructure. Although slight differences are observed in comparing baseline and follow-up assessment scores, these differences are not statistically significant.

How well did Partners and Providers Work Together?

A Network Analysis was conducted with stakeholders engaged with PICA to understand the structure of the collaborative relationship pertaining to coordination of services and commitment to PICA work. Stakeholders were asked questions about their agency's relationship with other stakeholders in an effort to map the relationships and understand barriers and facilitators to implementing the objectives of PICA.

Network analysis findings indicated a given agency or partner was connected to five other stakeholders on average for coordination of services and supports for clients, suggesting that coordination was not widespread among all PICA stakeholders included in the network. Further, there was some consensus that those involved with PICA were committed to the work of the initiative. Data suggested agencies were "somewhat" to "very committed" to PICA work and that services were "somewhat" coordinated among network stakeholders.

Network diagrams provide a visual of the collaborative partnerships. Stakeholders with more connections (i.e., ties) to other stakeholders are more influential (i.e., more central) in the network. In the PICA network, stakeholders with a greater number of connections, as reported by other stakeholders, have greater prominence compared to stakeholders with fewer connections. Influential stakeholders are indicated by larger nodes (red nodes). Less prominent but still somewhat influential stakeholders have medium sized nodes (yellow nodes) and the least influential network stakeholders have the smallest sized nodes (blue nodes). Acronyms for each partner representing each node is presented in each network diagram. Refer to Appendix G for more detail on network stakeholders represented in the diagrams below.

PICA stakeholders reported the extent to which they perceived their agency coordinated with other agencies to provide services for clients. Figure 17 shows the network diagrams illustrating the PICA network as it pertains to coordinating services and supports for clients. Two Tier 1 stakeholders—CFBHN and the PCSO—and two Tier 2 stakeholders—

PEMHS and DFL—were among the most influential stakeholders according to survey responses.

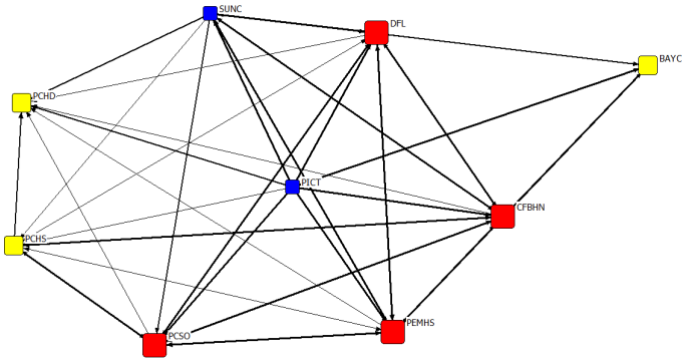

Figure 17. Network Diagram for PICA: Coordination

PCHS, PCHD, and BayCare were also observed to be influential, but to a lesser extent, in coordinating services and supports for clients. Given that the coordination of services also refers to client staffings, case management, treatment plan development, and client referrals, the finding that PEMHS is an integral partner is expected especially given their role as the main care coordination agency. It is not expected that Tier 1 stakeholders such as PCHS would be among the most integral. SunCoast and the PIC Team are shown to be slightly less integral to this network in coordinating services and supports for clients. Findings suggest that Tier 3 stakeholders were the least influential. Even though a primary responsibility of the PIC Team is to coordinate services for clients, responses to this survey may reflect higher level coordination (e.g., data sharing, facilitating meetings, referring clients) rather than providing direct supports. Weighted connections between stakeholders show the strength of the connection in that heavier ties indicate a stronger connection. Stronger connections are observed among Tier 1 and Tier 2 stakeholders.

The Network Analysis Survey also asked PICA stakeholders to indicate the extent to which they perceived other agencies were committed to the work PICA is undertaking. Commitment could be expressed through support of the PICA mission and participation in meetings, trainings, and activities, for example. Figure 18 shows the network diagrams illustrating the level of commitment of PICA stakeholders. Three of the four Tier 1 stakeholders, along with PEMHS, were observed to be stakeholders most committed to PICA according to survey responses. Fewer connections for other Tier 2 providers suggest that they may be less slightly committed to PICA work. It is unexpected that a Tier 1 partner—PCHD—is observed to be less committed compared to other stakeholders.

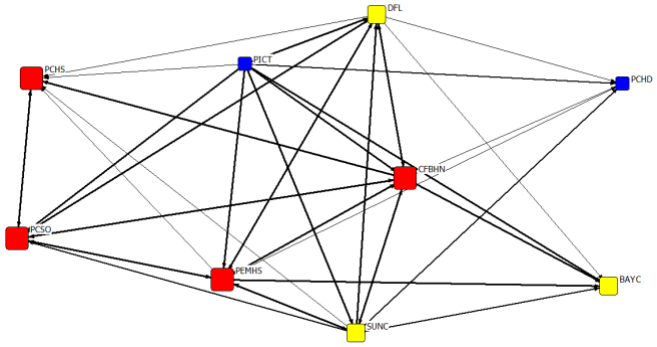

Figure 18. Network Diagram for PICA: Commitment

The network diagram also shows strong connections among the majority of stakeholders indicating perceptions that these stakeholders were highly committed. This finding may reflect commitment contextualized as funding, time, and/or human resources invested in PICA. Also, regular meetings are convened between Tier 1 and Tier 2 stakeholders in an effort to effectively implement PICA. Further, representatives from Tier 2 such as PEMHS, Directions for Living, BayCare, and Suncoast regularly provide oversight with regard to managing client cases.

Challenges and Facilitators

PICA providers were asked to identify challenges and facilitators associated with collaborating with other agencies. Stakeholders indicated that concerns related to insufficient resources to support interagency collaboration, infrequent or inconsistent communication, and frequent changes in staff posed challenges. Failure to establish a common framework and confusion regarding members' roles and responsibilities were also noted by the PIC Team.

Respondents indicated several facilitators to collaboration. Communication, convening regularly scheduled meetings, stakeholder's willingness to commit resources, shared purpose and vision, and having effective leadership promoted collaboration. Most stakeholders also indicated ongoing efforts to keep stakeholders engaged and agency values that supported interagency collaboration were also frequently cited facilitators.

Perspectives on Sustainability from Stakeholders

Stakeholders were also asked for suggestions on strategies and processes that might improve the PICA initiative. Reiterating the mission of the initiative and improving communication regarding the goals and objectives of PICA were suggestions made by a few respondents. Clearly defining the roles of various stakeholders and differentiating the

responsibilities of MHU behavioral health staff from law enforcement and the PIC Team staff were also noted. Stakeholders also stated that notifying other agencies of the PIC Team and its purpose would be beneficial to the initiative. Involving insurance companies and related funders in the steering committee and having increased access to detox beds, specifically, were also suggested. To sustain and continue the work started by the PICA initiative, respondents also stated that additional funding is necessary.

Systems Change

A Framework for Evaluating Systems Initiatives (Coffman, 2007) was used to assess evidence of systems change with the PICA initiative (see Figure 19). This framework utilizes five focus areas to assess change: Context, Components, Connections, Infrastructure, and Scale. **Context** includes improvements in the political environment to improve policy and funding changes that lead to sustainability. **Components** refer to the establishment of high-quality programs and services that impact system beneficiaries or consumers. **Connections** describe the linkages across system components that lead to improvements in service delivery and care. **Infrastructure** refers to the system supports that are required for quality and effective functioning. And **scale** represents efforts to reach as many beneficiaries as possible through expansion and replication to ensure system inclusivity. The table is not intended to be exhaustive of all activities and outcomes, but rather an overview of key components to understand progress in each domain and identify areas where future efforts may be focused.

The five components of the systems initiatives framework were assessed by determining a level of focus spanning three categories: **Highest Focus, Substantial Focus, or Some Focus (**there were no components that did not yet have activities or outcomes at some level, so the Not Yet a Focus level was excluded from scoring). Levels of focus were determined based on the evidence for each area that was available to the evaluation team, and there may be additional indicators of activity or achievement that can be applied to the framework outside of this evaluation. The items listed under each component were adapted from the framework to specifically address behavioral health systems. Items that are bolded in green indicate activity or achievements that have been demonstrated throughout the evaluation of the PICA initiative. Items in normal print represent no or little evidence of activity or achievement. This does not necessarily mean that there is insufficiency in these areas, as systems changes happens at multiple levels and over long periods of time. Therefore, it is expected that there will be more focus in some areas than in others.

Areas that were determined to have the highest focus were Components and Connections. This is appropriate given the purpose and aims of PICA, which are

oriented around collaboration and coordination, and establishing the PIC Team as a core component. The Infrastructure domain was seen as having a Substantial level of focus; many activities have been initiated in this area (such establishing the steering committee, and leveraging funding), though some are still under development, and some have not yet been initiated. For Context, there is little evidence of explicit efforts or strategies to engage policymakers, the media, and the public, yet this component is critical to sustaining systems changes and would be an appropriate area to focus additional efforts on. Finally, it was determined that there was Some Focus on the Scale domain, as there have been some efforts addressed here, such as identifying and providing new services to clients through the PIC Team and some shifts in systems ownership have been identified by stakeholders. Given numerous discussions about expanding the PIC Team, this would also be a beneficial area to address by making determinations about additional constituents that would best be served by system coordination and identifying partner agencies to collaborate with.

PICA Systems Change Indicators

Highest Focus | Substantial Focus | Some Focus

	Context	Components	Connections	Infrastructure	Scale
ACTIVITIES	**Developing a vision** Educating policymakers Engaging the public Engaging the media **Doing social media campaigns**	Expanding high quality programs **Developing new programs or services** Expanding eligibility Increasing access and availability	**Creating forums for cross-sector planning** **Aligning outcome indicators** **Connecting data systems** **Promoting collaboration and referral coordination** **Streamlining intake processes/assessments**	**Developing new governance supports** Improving quality of programs and services Improving state and local connections **Implementing monitoring and oversight strategies**	Increasing or expanding system services **Increasing the number of beneficiaries served** Driving system sustainability Ensuring program integrity and service quality is high enough to be consequential
OUTCOMES	**Increased evidence base about the system and its needs (HIE and ODS initiatives, KPMG assessment)** **Shared behavioral health vision** State and local political leadership engagement New and mobilized behavioral health advocates Changed policies	**Expanded programs or services** **New programs (PIC Team)** **Better access (coordinated care initiatives)** **Higher-quality programs and services (updated 211)**	**Interagency work/planning groups (HIE, ODS, SOC)** Shared data systems **Improved system coordination** Cross-system training **Co-located programs (e.g., "one-stop" integrated services) (PIC Team)** Increased referrals between providers **Memoranda of agreement between system partners**	**Governance entities that oversee and coordinate subsystems (Steering Committee)** **Leveraged use of funding (PICA)** **Research and monitoring of cross-system data (Steering Committee, USF)** Aligned standards (ODS) Efficient service delivery Professional development and staff technical support	System spread System depth System sustainability **Shifts in system ownership**
IMPACT	*Outcomes are not expected to show direct impacts for behavioral health consumers*	**Improved behavioral health system outcomes in relevant domains (reduced Baker Act exams/arrests)**	**Improved consumer outcomes where system components are connected (MHU/PIC Team model)**	*Outcomes are not expected to show direct impacts for behavioral health consumers*	

Figure 19: Systems Change Indicators (Adapted from Coffman, J. (2007), *A Framework*

CONCLUSIONS AND RECOMMENDATIONS

The conclusions and recommendations outlined below have been distilled from evidence and analysis presented in this report and from previous reports, which span the three-year evaluation period.

Client Outcomes Analysis

Functioning outcomes, arrest data, and Baker Act exam initiations were used to assess how PIC Team services impacted clients. Since July 2018, almost 600 clients were referred to the PIC Team. FARS scores decreased significantly over time for each factor, indicating greater functionality. Further, the proportion of PICA clients who were stable or thriving increased appreciably from baseline to closing assessment across all self-sufficiency domains. Data on the arrest history showed the number of arrests decreased significantly for clients who received care coordination with the PIC Team. Days in jail, however, increased for clients who received care coordination with the PIC Team, though not significantly. Lastly, Baker Act exam initiations, on average, decreased significantly for clients as well. The number of arrests and Baker Act exam initiations significantly decreased for clients who did not receive care coordination through the PIC Team. Taken together, these functioning outcomes provide some evidence of effective service provision by the PIC Team. However, given improvements also observed for clients who did not receive PIC Team services, these improvements cannot be attributed solely to the PIC Team intervention. Further assessment is warranted to make clear determinations about impact by using a comparison group.

Recommendations

- ➔ It is plausible that client success and other client outcomes may depend on the complexity of needs. Although reasons for referral were analyzed in this report, data did not capture co-occurring mental health and substance misuse challenges. Examining outcomes of clients with co-occurring disorders may help in determining how the PIC Team might better serve more complex client needs.

- ➔ Determine how to optimize use of PICA 2 to maintain and track data on clients referred to the PIC Team. The evaluation team is open to continuing discussions toward this purpose.

- ➔ Consider collecting more comprehensive information on discharged clients. Appendix H shows where clients were referred once discharged. However, tracking whether clients engaged with referral agencies

will help determine whether PIC Team intervention achieved the goal of care coordination.

Implementation Analysis

The implementation analysis includes a mixed-methods assessment of the implementation of the PIC Team and related initiatives to understand the environment of implementation as well as stakeholder perceptions of effectiveness, challenges, and facilitators. Data from the three year evaluation was gathered through interviews and focus groups with steering committee members, PIC Team and MHU staff, and PIC Team clients; observations of steering committee and PIC Team/MHU meetings; and dissemination of a stakeholder survey to assess collaborative activities and network connectivity. *Ad hoc* analyses were conducted when relevant understand contextual factors of implementation, such as an analysis of re-admissions and an equity analysis.

Steering Committee and Core Staff Perspectives

Key themes that were assessed include Vision and Goals, Service Environment, Organizational Capacity and Infrastructure, Barriers to implementation, and Facilitators of implementation. With regard to **Vision and Goals**, the majority of responses indicated that a shared vision for the PICA initiative was established. Concerted efforts were made to streamline efforts across agencies and within the system and to ensure that future efforts were integrated. There was some lack of clarity of how existing initiatives would lead to population change, and there were some discrepancies about who the target population should be and how potential PIC Team expansion should be carried out.

Regarding the **Service Environment**, feedback and observations indicated that respondents felt there was a basic level of sufficiency to carry out implementation of the PIC Team, and there was support among other providers and system stakeholders for the initiative. Some respondents suggested that there was an increased sense of hope for collaboration and improvement within the system. There was strong consensus that the PIC Team had become very proficient in identifying community resources and services and worked effectively to engage clients. Numerous barriers were identified through the PIC Team that affected system-wide functioning, including difficulties accessing needed services, lengthy wait times for psychiatric appointments, a lack of substance use treatment facilities and treatment, and difficulties with service coordination and data sharing processes. Other barriers were more specific to PIC Team clientele, who generally had complex conditions and intensive needs. These included a lack of availability of services in North Pinellas County, a need for in-home services and targeted case management, insufficient short-term residential treatment facilities, and difficulty accessing intensive services like the FACT team, assisted living facilities, and housing for individuals with sex offenses. Attention was given to developing system-wide integration efforts, such as aligning contracts and initiating an Optimal Data Set (ODS) to better assess outcomes across the system.

Organizational Capacity and Infrastructure was considered to be sufficient on several levels, including staffing, communication processes, and oversight and monitoring. Other areas, such as data assessment, funding, and sustainability were seen as in need of further development. Particular challenges to implementation capacity included difficulties identifying a strategy or funding support for expansion of the PIC Team. With regard to data systems, the PICA 2 data set that was intended to capture streamlined outcomes data from the PIC Team was not fully functioning until the third year, though data was still available from different sources. Some staffing changes related to the expansion of the PCSO MHU have led some respondents to question whether the PIC Team will have sufficient capacity to manage increased caseloads. And finally, funding and sustainability were key themes that highlighted challenges with being able to continue long-term implementation and expansion of system coordination efforts.

Overall **Barriers to Implementation** spanned a wide range of issues. There were some early challenges with moving towards a standalone, interagency system coordination team, especially in an environment of provider competition. Many respondents pointed to problems with having behavioral health services that operate in silos and lack integration, which is especially difficult for clients who need multiple services. Some barriers to engagement were noted, including some hesitancies engaging with law enforcement as a first point of contact for mental health services. Additionally, several respondents shared that many clients faced significant challenges trying to maintain treatment on their own after being discharged from the PIC Team. Barriers to engaging racial and ethnic minorities were also discussed, with two predominant reasons. One is that some racial and ethnic minority communities have experienced negative interactions with law enforcement and are reluctant to engage with them as an entry point into services. The other reason is that individuals from racial and ethnic communities may have cultural beliefs that prevent them from seeking help for mental illness, especially when service providers are predominantly White. Respondents also highlighted some barriers to trust between the community and both law enforcement and behavioral health service providers.

Respondents described many **Facilitators of Implementation**, perhaps most significantly the collaborative efforts of both the steering committee and the PIC Team/MHU. For the steering committee in particular, it was seen as highly beneficial to have representation from key behavioral health agencies meeting regularly and assessing system functionality and needs. With regard to the PIC Team, the level of client engagement they provided was considered not only unique to their role in the system, but also crucial to the team's effectiveness. Much of this had to do with the flexibility of being able to provide services and interactions without restrictions like other case management models. The MHU staff were also described as being effective in their role of providing numerous pathways of diversion from criminal justice, as well as making efforts to improve community perceptions of law enforcement.

Client Perspectives

Client interviews were conducted at baseline (approximately one month after PIC Team enrollment) and follow-up (approximately one to three months after discharge) for each evaluation Year. Key themes from each interval are highlighted below.

Experiences During PIC Team Services indicate that many clients had never been or had infrequently been connected to care prior to contact with the PIC Team. A handful of the 30 participants interviewed at baseline over three years reported consistent access to treatment when needed, such as those who had been connected to a psychiatrist for several years before enrollment. Those who received behavioral healthcare services were often referred through other professionals, such as doctors or case workers. When they were unable to find care, participants cited a lack of awareness of local resources, confusion navigating through various resources, lack of insurance coverage, transportation, and stigma. Participants were nearly unanimous in their praise for their system coordinators. Even those who were dissatisfied with service found their system coordinators to be helpful, empathetic, and proactive, and client reported support in identifying local resources, scheduling appointments, and teaching organization skills and coping mechanisms. System coordinators were said to help with "all aspects of your life" such as transportation, housing, and employment. Most importantly, they gave participants an opportunity to talk through their frustrations and worries through intensive engagement. Several participants reported that their system coordinator was one of the most significant reasons they were able to make progress in treatment. When asked what they disliked about the PIC Team, the most common complaints were that system coordinators sometimes appeared without prior notice, provided an overwhelming number of resources, or did not call as frequently as participants wanted.

The evaluation team interviewed 23 participants about their **Experiences Post-Discharge**, including a few who had re-enrolled in services. Participants were connected to a variety of mental health, substance use, and housing agencies to continue care. Most found that their time enrolled in services with the PIC Team enhanced their ability to seek care when needed. Participants became more knowledgeable about resources available to them, which had previously been a serious barrier to many. They reported feeling more confident about using coping mechanisms, managing personal relationships, and using budgeting skills. A few with serious mental illnesses became more knowledgeable about their condition due to support from their system coordinator. Some participants, however, reported no change. While many did not report any unmet needs, or any unmet needs they felt incapable of handling, several participants experienced serious difficulties managing their care after discharge. These clients had difficulty finding employment or care, keeping up with appointments, continuing medication, arranging transportation, and finding financial assistance, and several complained that they felt unprepared to leave the PIC Team. Some of these challenges reveal an overreliance on system coordinators to arrange and manage care, indicating a need for greater role clarity in the future. A few

participants shared that they had not been connected to new providers. When asked about how services could be improved, participants suggested behavioral healthcare should be integrated from a young age, and training should be provided across healthcare systems so professionals can better identify those in need, connect clients from one point of care to another immediately, educate clients about their conditions in language they can understand, and provide more comprehensive follow-up engagement.

Recommendations

- Identify strategies to expand case management and/or system coordination efforts based on consistent feedback across groups that this is a significant gap in services, and based on engagement outcomes associated with the PIC Team.
- Consider ways to increase availability of in-home services without strict criteria, given that many clients with complex behavioral health conditions struggle to travel to appointments outside the home.
- Determine concrete steps and/or a timeframe to make progress towards developing the Health Information Exchange initiative, and ensure that the appropriate stakeholders and decision-makers are involved in the process.
- Consider integrating support positions such as peer support specialists and community health workers more broadly to help with needs around client engagement, particularly in communities with cultural or trust barriers to reaching out for help.
- Based on indicators of systems initiative activities, determine strategies to increase political engagement and focus on media and community outreach efforts to build a stronger context for behavioral health improvements.
- Feedback suggests there are few policies to encourage system collaboration or sustain behavioral health initiatives, therefore it would be warranted to explore policy changes that could support these efforts.
- Determine a process or plan for making determinations about scaling programs or initiatives, such as the PIC Team to expand the reach of these initiatives.
- Explore whether there is a need to strengthen discharge planning or post-discharge follow-up for PIC Team clients (e.g., focusing on educating clients on care management or concrete needs resources, or increasing follow-up engagement).

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APPENDIX A: Outcomes Data Collection Sources

	Data Source	Date Pulled	Dates Covered
Demographics	PEMHS	1/20/2021	7/1/2018 – 1/20/2021
Administrative Data *	PEMHS	1/20/2021	7/1/2018 – 1/20/2021
Engagement Period	PEMHS	1/20/2021	5/31/2019 – 1/20/2021
Functioning Outcomes	CFBHN	1/20/2021	7/1/2018 – 1/20/2021
Arrest and Jail Data	CFBHN	2/3/2021	7/1/2018 – 1/23/2021
Baker Act Exams	USF BARC	2/19/2021	7/1/2017 – 12/30/2020

* Administrative data includes admission status, dates of admission, and closing status

APPENDIX B: Recoding of Closing Status for PIC Team Clients

Recoded Close Status	Original Close Status	% (n)
Successful Close	Successful	39.6% (n=187)
	No Further Services Needed	1.7% (n=8)
Unsuccessful Close	Unsuccessful	2.3% (n=11)
	Lack of Progress	2.5% (n=12)
	Refused Services	19.1% (n=90)
	Dropped Out of Services	10.6% (n=50)
	Against Medical Advice	0.2% (n=1)
Other Closure	Incarcerated	1.5% (n=7)
	Moved Out of Area	6.6% (n=31)
	Services Unavailable	0.4% (n=2)
	Transferred to another facility	3.6% (n=17)
	Death	2.3% (n=6)

*Discharge Status categories not included are “Pre-admit discharge” and “Reason unavailable” which were both recoded as missing data.

APPENDIX C: Steering Committee Interview Protocol

1. How would you describe the overall vision of the PICA initiative?
    a. What are the goals that will help realize that vision?
2. To what extent has there been a shared vision for change among the steering committee?
3. To what extent has there been buy-in among all leadership for the PICA initiative?
4. How frequent or open has communication been among leaders of PICA?
5. To what extent has there been shared accountability among the steering committee? (e.g., each partner acknowledging their expected role and responsibilities and responding to the needs of the initiative)
6. What has the environment of this project been like throughout the implementation?
    a. Has there been support from partners, staff, policy makers, funders, and the broader community?
    b. Have there been adequate community resources and services to implement the project according to the vision?
7. How have stakeholders at all levels been included in the planning and decision-making of the implementation?
    a. Leadership
    b. Staff
    c. Clients
8. To what extent are current policies and procedures in alignment with project goals?
9. Do the partner organizations that make up the initiative have the appropriate capacity to provide what is necessary for implementation?
    a. Staffing, training, supervision
    b. Client engagement
    c. Quality improvement processes (e.g. case reviews, evaluation, etc.)
    d. Oversight and monitoring (e.g., supervision/management, data collection and analysis, etc.)
    e. Funding

f. Sustainability

10. What have been some of the strengths of the implementation?

11. What have been some of the challenges of the implementation?

12. Overall, how would you rate the effectiveness of the implementation of PICA at this point?

APPENDIX D: Coding Scheme for Implementation Assessment

LEADERSHIP

Leadership Buy-In—discussion of ways leaders at various levels hold sufficient or insufficient buy-in for the PICA initiative

Internal Communication—discussion of ways leaders of PICA communicate frequently or openly **or discussion of challenges and barriers to communication**

Shared Vision—discussion of the extent to which there is a shared vision for change about the steering committee

Shared Accountability—the extent to which there is a sense of shared accountability among members of the steering committee

ENVIRONMENT

External Support—the extent to which there is support for the project among partners, staff, policy makers, funders, and the broader community

Service Array/Resources—discussion of community resources that are used, and/or ongoing service and resource needs

STAKEHOLDER INVOLVEMENT

Leadership Involvement—inclusion of leadership in planning, decision-making, and implementation of the PICA initiative

Staff Involvement— inclusion of PIC Team in planning, decision-making, and implementation of the PICA initiative

Client involvement—inclusion of clients in planning, decision-making, and implementation of the PICA initiative

ORGANIZATIONAL CAPACITY/INFRASTRUCTURE

Policies & Procedures – discussion of the extent to which policies and procedures are aligned with the initiative's goals, changes/revisions that have been made to align policies and procedures, or changes that are still needed in order to align them

Training – discussion of training and supervision that has been provided to prepare staff/stakeholders to implement the initiative, and additional or on-going training needs

Client engagement – discussion of issues pertaining to client engagement, including successful engagement strategies as well as barriers to and challenges with engagement

Quality Improvement Processes – discussion of the use of data to inform decision-making and identify areas for practice improvement, and processes for the development of improvement plans based on the data (e.g., efforts to improve practice)

Oversight & Monitoring – discussion of processes for the collection and review of data, but without a clear connection to implementation of practice improvement processes (procedural/compliance oriented)

Funding – discussion of how services are funded, strategies being used to find new/different ways to fund needed services, how positions are funded, and how assessments are funded, etc.

Sustainability—discussion of steps that have been taken to reach sustainability of the initiative

CONCLUSION

Strengths—discussion of strengths regarding the initiative's planning and development process

Challenges—discussion of challenges regarding the initiative's planning and development process

Effectiveness—discussion of the initiative's effectiveness so far

APPENDIX E: PIC Team Client Interview Protocol - Discharge

Post-Enrollment Questions (3 months post-discharge)

1. How long have you been enrolled with the PIC Team?

2. What kinds of discussions have you had with your system coordinator about preparing to be discharged?

3. What kind of improvements, if any, have you noticed since being involved in PIC Team?

    a. Do you feel that you have received better care than before you were enrolled in PIC Team?

    b. If you are receiving services from more than one provider agency, have you noticed if the providers are in communication with one another about your care coordination? (i.e., different providers communicating with each other to coordinate services)

4. Has your experience with PIC Team changed the way you get mental health care? If so, in what ways?

5. Are there any things you feel unprepared for after being discharged from PIC Team?

6. How do you think mental health care providers can make sure that people who need mental health care do not slip through the cracks?

APPENDIX F: Client Discharge Interview Coding Scheme

Time	Length of time since discharge from PIC team
Follow-up contact	Communication with PIC Team case manager post discharge
Discharge plan	Post discharge plan discussed with case manager
PostPIC Finding help	Strategies for getting help post PIC team
PostPIC Hard to get help	Challenges getting bh services post PIC team
PostPIC Improvement	Client improvement since PIC team
PostPIC Service Array	How PIC is different from previous MH care in terms of service array
Provider Interaction	Different providers communicating with each other to coordinate services and improve care coordination
PIC Experience	How PIC team experience changed the way client receives MH care (in terms of advocacy, education, and willingness to accept services)
PostPIC Challenges	Challenges faced since being discharged from PIC team
MH Care Suggestions	How MH care providers can ensure that clients in need of help do not go unnoticed

APPENDIX G: Abbreviated PICA Agencies and Stakeholders

	Abbreviation	Stakeholder
Tier 1	CFBHN	Central Florida Behavioral Health Network
	PCHS	Pinellas County Human Services
	PCSO	Pinellas County Sherriff's Office- Mental Health Unit
	PCHD	Pinellas County Health Department
Tier 2	BAYC	BayCare
	DFL	Directions for Living
	PEMHS	Personal Enrichment through Mental Health Services
	SUNC	Suncoast Center
Tier 3	PICT	PIC Team Staff
Tier 4	Insufficient response; omitted from analysis	

APPENDIX H: Referrals Made Post-Discharge from PIC Team Services

Referral	n
Substance Abuse Provider	51
No Referral Made	36
Directions Appointment	29
Other Community Referral	15
Suncoast-Clwr/Largo	12
Other Non-Listed Social Services	11
Other Non-Listed Mental Health	10
Suncoast-South	10
Directions Case Mgt	8
Pinellas Hope-Tent City	8
Mental Health Services	6
Private Therapist	6
Suncoast Case Mgt	6
Directions-Homeless Program-Safe Harbor	4
Largo Med Ctr of Indian Rocks	4
Other Private Referral	4
Suncoast Information	4
Baycare Behavioral Health Out PT Service	4
Death	4
Fact Team-Suncoast	3
Homeless Outreach	3
Jail Diversion Program	3
Other CBC Agency	3
Pinellas County Jail	3
Windmoor Hospital	3
Employment Assistance	2
Group Home	2
Gulfcoast Community	2
Half-Way Homes	2
Largo Medical Center	2
Nursing Home	2
PAR DETOX	2
Private Practice MD	2
Ready for Life Pinellas	2
Salvation Army	2
Sequelcare Former Gift of Life	2
Shelter Services	2

Substance Abuse-Adult	2
Agency for Persons with Disabilities	2
Alcoholic Anonymous	2
Bay Pines - VA	2
Boley	2
CASA	2
Directions Information	1
Doctor's Appointment	1
Fact Team-Boley	1
Gracepoint	1
Home / Self / Family	1
Housing Program	1
Non Psychiatric MD	1
North Tampa Behavioral Health	1
Operation PAR Out	1
Out of State/County	1
PAR Inpatient	1
PAR Methadone	1
PAR Out Patient	1
PICA-PEMHS	1
Pinellas County Health Dept	1
Private Drug TX	1
Private Health Services	1
Probation/Parole	1
Profess. Psy Services	1
Refused Referral	1
St Vincent DePaul Shelter	1
Suncoast Focused Outreach Program	1
Support Groups	1
TFS-Suncoast Total Family Strategies	1
Turning Point (DETOX)	1
Unknown-Non Listed	1
Vocational Rehab	1
Westcare Residential Program	1
Windmoor Non Baker Client	1
ACTS DETOX-TARPON SPRINGS	1
Baycare Behavioral Health ISU	1
Bayside Health Clinic	1
Boley Arms	1
Boley Oaks Apartments	1
CSU B - ES HOLD CSU B HOLD	1