Evaluation of the Pinellas Integrated Care Alliance (PICA) Implementation

Interim Report Year 3
For the Period 4/1/20 – 9/30/20

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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, and as of October 1, 2020, the MHU will be comprised of deputies and clinical staff hired internally. In all, the PIC Team consists of a supervisor, nine system coordinators, and one certified peer recovery specialist (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.

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 PICA implementation and outcomes. The evaluation approach is grounded in a systems change theoretical framework, which assumes that addressing systems-level problems related to coordination of care will improve client access to services as well as collaboration within systems of care. Qualitative and quantitative analyses will address both client and system-level aspects of Pinellas County's behavioral health system of care. 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 will examine whether 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 will also continuously gather feedback from clients on their experiences with

care coordination services through the PIC Team. Outcomes data on re-admitted clients have been assessed for this report.

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 will continue to uphold 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.

COVID-19

Florida Governor Ron DeSantis issued a Safer At Home Executive Order on April 3, 2020, encouraging self-isolation among workers and individuals, with the exception of essential services and activities. In adapting to these changes, many agencies and organizations re-prioritized activities and initiatives, and therefore some interruption was evident in regular functioning during this period. In this report, we highlight instances where explicit changes were made to PICA implementation and any effects this may have had on progress, though in general, there were few instances of direct interruption observed.

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 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 yet been fully available. Information on utilization of housing resources, assessment of emergency department outcomes, and engagement in follow-up services, for example, were intended to be captured in the PICA 2 database. Although the self-sufficiency matrix does ask clients to report on their housing circumstances, neither this data nor data on ED services and follow-up services are being captured in a way that allows for measurability. The evaluation team has had frequent communication with the PICA project manager, PIC Team supervisor, and data specialists from PEMHS and CFBHN around these issues, and all parties have taken steps to ensure that appropriate protocols are followed when sharing data. Given recent steps that have been taken by CFBHN to ensure full functioning of the PICA 2 database, it is anticipated these data will be available for the final report. Outcomes that can be reported on at this time include demographic characteristics, functioning outcomes, arrests, jail stays, Baker Act exam initiations, and case closure and re-admission patterns. Appendix B shows detailed statistical tables for outcomes assessed.

Demographic characteristics of clients were retrieved from the PEMHS EHR database, Avatar. As of August 14, 2020, 501 clients were referred for services through the PIC Team, and of those 325 were admitted. Characteristics of these clients are detailed in Table 1. Slightly more clients are male (55.7%) than female (44.3%). The majority of clients identify as White or Caucasian (88.6%), and Black and Other racial minorities make up just over 10% of clients referred. About 8% of clients reported their ethnicity as Hispanic. Just over 20% of clients resided in St. Petersburg at the time they were referred and another 18.5% lived in Clearwater. Other referrals were for clients who lived in Largo (13.7%), Palm Harbor (12.7%), Seminole (6.9%), and Pinellas Park (7.6%). Almost 20% of referred clients experienced homelessness at some time.

Table 1
Characteristics of Clients Referred to and Admitted to PIC Team

Characteristic	All Referred % (n)	Admitted Clients % (n)
Sex		
Male	55.7% (n=220)	52.6% (n=163)
Female	44.3% (n=175)	47.4% (n=147)
	Total n = 395 [a]	Total n = 310
Race/ Ethnicity		
White	88.6% (n=350)	89.0% (n=276)
Black	6.3% (n=25)	5.8% (n=18)
Other	5.1% (n=20) [b]	5.2% (n=16)
Hispanic	7.9% (n=31)	8.4% (n=26)
	Total n = 395 [a]	Total n = 310
City of Residence		
St. Petersburg	21.8% (n=86)	23.2% (n=72)
Clearwater	18.5% (n=73)	20.3% (n=63)
Largo	13.7% (n=54)	12.3% (n=38)
Palm Harbor	12.7% (n=50)	12.3% (n=38)
Pinellas Park	7.6% (n=30)	7.1% (n=22)
Dunedin	7.4% (n=29)	6.5% (n=20)
Seminole	6.9% (n=27)	7.4% (n=23)
Safety Harbor	3.8% (n=15)	4.8% (n=15)
Oldsmar	3.6% (n=14)	2.3% (n=7)
Other [c]	4.1% (n=16)	3.9% (n=12)
	Total n = 395 [a]	Total n = 310
Ever Homeless	18.8% (n=94 of 500)	19.4% (n=63)

[a] Demographics are missing for 106 clients (21.2%). Client characteristics represent valid data only.
[b] "Other" race category includes Asian/Pacific Islander (n=3), American Indian (n=2), multi-racial (n=7), and Other/Not specified (n=8)
[c] "Other" City of Residence category includes Tarpon Springs (n=7), Belleair (n=3), Holiday (n=1), Indian Rocks (n=1), Madeira Beach (n=1), New Port Richey (n=2), and Sarasota (n=1).
Note- Most recent data provided includes clients referred through July 30, 2020

Figure 1 shows the age ranges of current PICA clients. Clients ranged from 18 to 86 years of age with an average age of 41.4 years. The majority of PICA clients were 25 to 34

years of age at the time they were referred for services (27.2%). About 17% of clients were 45 to 54 years of age (16.9%) and another 16.9% were 55 to 64 years old. About 8% of referred clients were greater than 65 years of age.

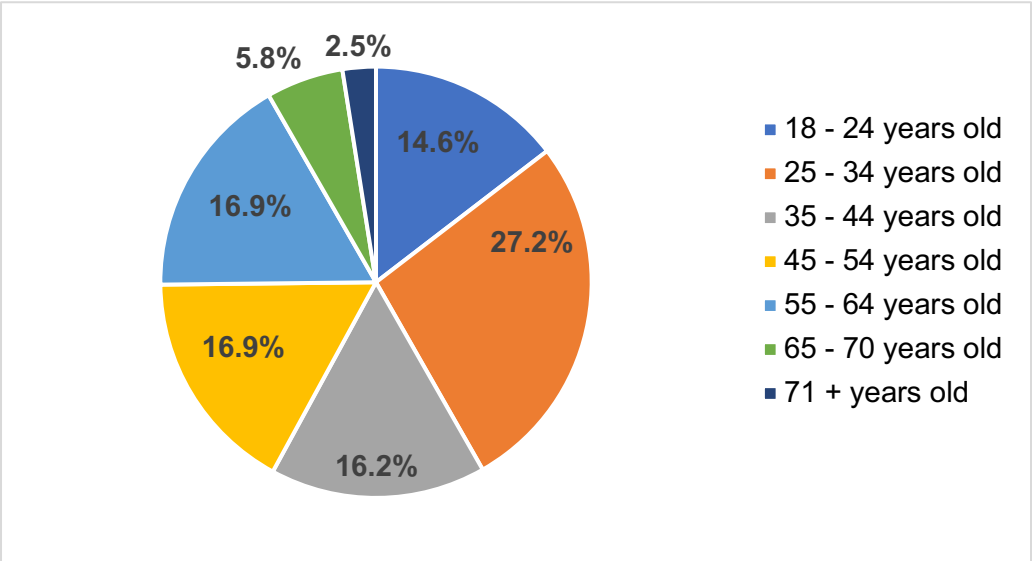

Figure 1. Age range of all clients referred to PICA (n=445).

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 (64.7%) and many others were divorced (17.8%). Less than 8% of referred clients indicated they were married (7.8%). Almost half were unemployed (47.1%) and 26.9% were disabled or unable to work. A significant number of clients obtained less than a high school education (33.9%) but over a quarter graduated high school (31.6%). Many others obtained some college-level education.

Table 2

Other Characteristics of All Clients Referred to PICA

	Characteristic	% (n)
Marital Status (n=348)	Single	64.7% (n=225)
	Married	7.8% (n=27)
	Widowed	4.9% (n=17)
	Divorced	17.8% (n=62)
	Separated	4.9% (n=17)
Employment (n=342)	Employed	14.3% (n=49)
	Retired	5.8% (n=20)
	Unemployed	47.1% (n=161)
	Disabled	26.9% (n=92)
	Other	5.8% (n=20)
Education (n=316)	Less than High School	33.9% (n=107)
	High School Graduate	31.6% (n=100)
	Vocational/Special School	5.1% (n=16)
	Some College	17.4% (n=55)
	Associate or Bachelor Degree	9.8% (n=31)
	Graduate Degree	2.2% (n=7)

Engagement and Length of Services

The length of time referred clients were engaged was recorded by PIC Team staff, along with how engagement occurred and the how much time 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 form the date clients were referred to the date the engagement period was closed. As shown in Figure 2, the engagement period lasted less than one week for 39.8% of clients referred. For another 23.0%, the engagement period took place over one to two weeks. For a small percentage of clients, engagement persisted for longer than three months.

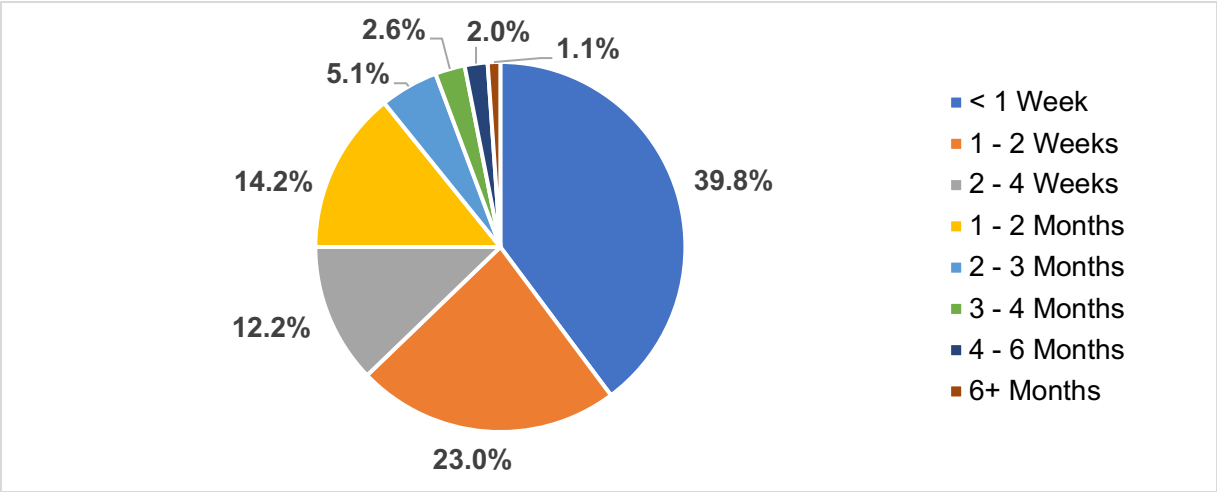

Figure 2. Engagement period (n=352).

The engagement period was shorter for referred clients who were admitted compared to referred clients whose case was not opened to receive PIC Team services. Table 3 compares the average number of engagement contacts and the average amount of time spent engaging potential clients. Fewer contacts occurred for clients whose case was opened for PIC Team services compared to those whose case was not opened. 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 3

Number of Engagement Contacts and Time Spent Engaging Referred Clients

	Referred Only (n=75) $\overline{X}$	**Admitted (n=113)** $\overline{X}$
Engagement Contacts	$\overline{X}$= 5.41 contacts	$\overline{X}$= 3.73 contacts
Time Spent Engaging	$\overline{X}$= 3.55 hours	$\overline{X}$= 2.58 hours

Engagement occurred via telephone, through face to face communication, “activity on behalf,” or “collateral contact.” Within the last six months, “telehealth” was added as an engagement strategy due to COVID-19. “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 4, although slight differences are observed, engagement via telephone and "activity on behalf" occurred most frequently for all referred clients.

Table 4

Engagement Strategies

	First Contact	Second Contact	Third Contact
Admitted	n=113	n=85	n=58
Phone	43.4%	38.8%	41.4%
Face to Face	11.5%	15.3%	12.1%
Activity on Behalf	37.2%	29.4%	29.3%
Collateral Contact	7.1%	10.6%	15.5%
No show/ cancelled	---	2.4%	1.7%
Telehealth	0.9%	3.5%	---
Referred Only	n=75	n=67	n=57
Phone	38.7%	29.9%	28.1%
Face to Face	9.3%	20.9%	22.8%
Activity on Behalf	37.3%	32.8%	35.1%
Collateral Contact	13.3%	13.4%	10.5%
No show/ cancelled	---	1.5%	1.8%
Telehealth	1.3%	1.5%	1.8%

Referred clients were not admitted for various reasons. Valid data were only available for 69 referred clients. 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%).

Client needs may dictate the length of time the PIC team is providing care coordination. Specifically, cases of clients with more complex or compounding conditions would understandably remain open for a longer period of time. Reasons for referrals were unavailable at the time of this report. The length of service across clients is shown in Figure 3. Care coordination with the PIC team lasted less than one month for about 8% 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.

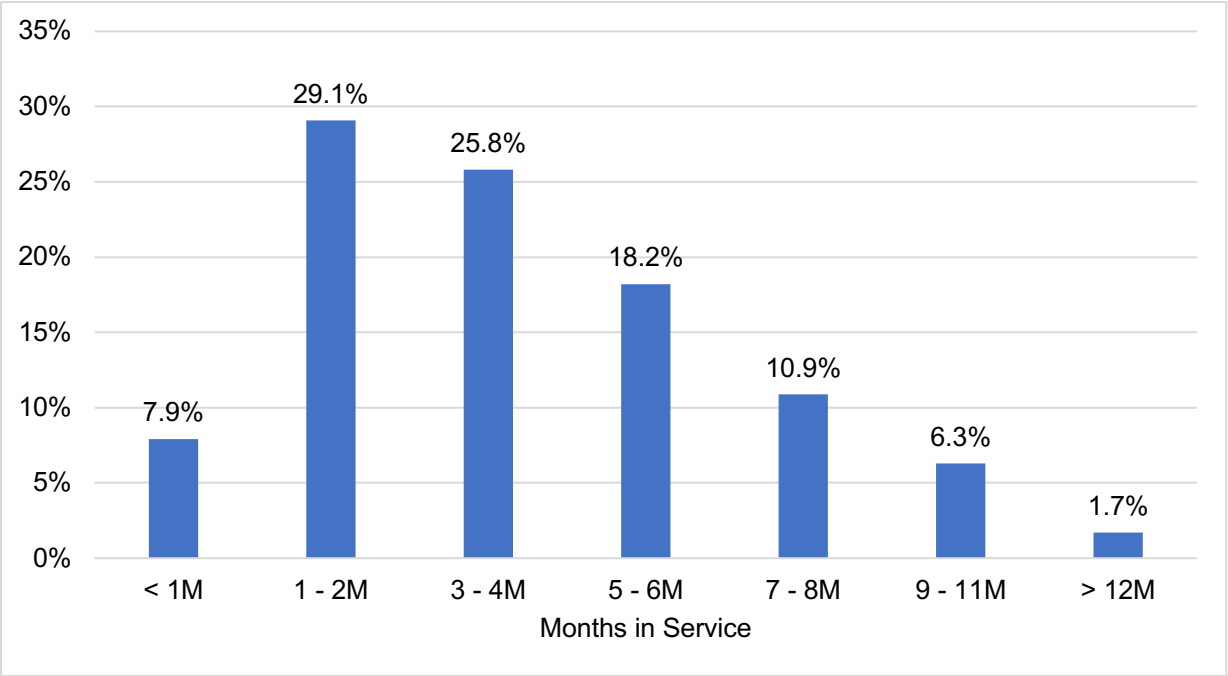

Figure 3. Length of care coordination service time for admitted clients (n=302).

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 235 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 overtime for each factor—Disability, Emotionality, Relationship, and Personal Safety. 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.

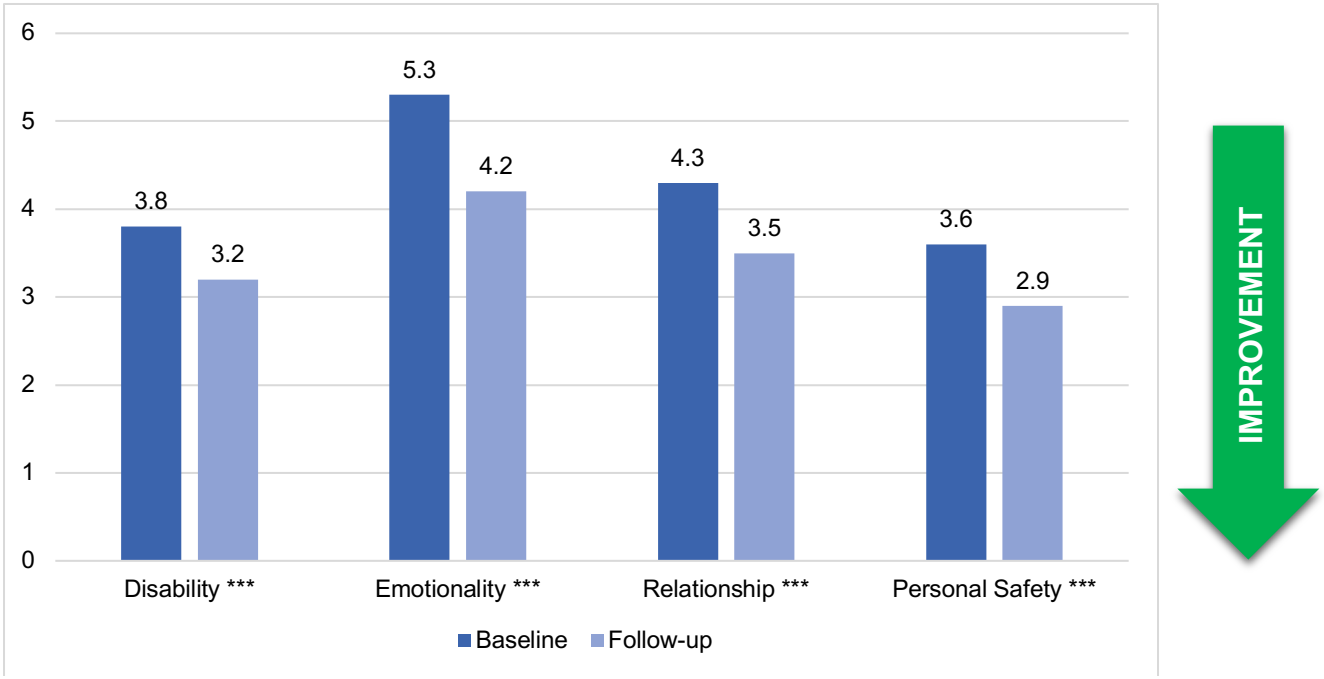

Figure 4. Average FARS Factor Scores at Baseline and Follow Up (n= 235)

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.

Figure 5 illustrates how PIC Team services impacted client's self-sufficiency by examining 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. 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 (58.8%) and Safety (55.9%). However, less than a quarter of clients were stable or thriving regarding Access to Services (22.5%), Life Skills (15.3%), Income (14.2%), Mental Health (7.8%), and Employment (3.8%) at baseline. These were the areas in which clients had the greatest needs. As a result of PIC Team intervention, more than half of PICA clients were stable or thriving across eight self-sufficiency domains: Access to Services (56.9%), Housing, (59.6%), Support System (54.2%), Substance Use (54.7%), Safety (63.2%), Family Health Care Coverage (66.8%), and Family Physical Health (53.4%).

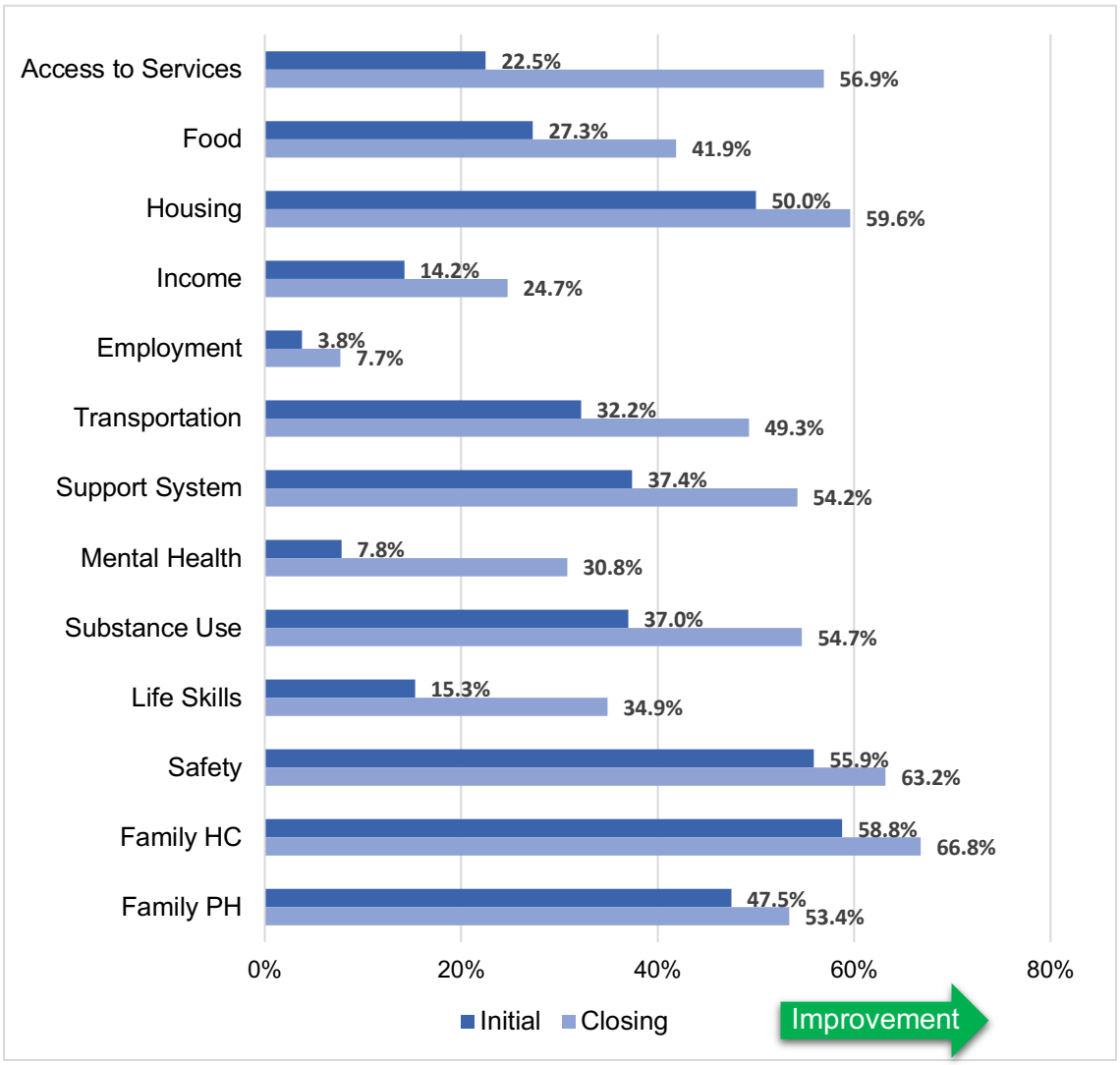

Figure 5. Self Sufficiency Matrix: Proportion of Clients Stable or Thriving (n ≈ 320)

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 August 7, 2020. Two of the outcomes used to measure the impact of the PIC Team are reduction in the number of arrests for PICA clients and a decrease in the number of days in jail for PICA 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 referred clients were ever arrested. Of these, 124 were admitted to PIC Team services (72.1%) and 48 were not (27.9%). Paired t-tests, mean comparison analyses, were used to assess for significant reduction in the number of arrests and days in jail.

Table 5 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 arrest one year after being referred was recorded. Arrests decreased significantly overtime, generally. Arrests for clients who were referred but not admitted decreased from 1.31 arrests on average to 0.73 arrests. A decrease was also observed for the number of arrests for clients who received care coordination with the PIC Team (1.35 arrests to 0.80 arrests).

Table 5

Average Number of Arrests

	Referred Only (n=48)	**Admitted Clients (n=124)**
# of Arrests 1 Year Prior Referral/ Services	1.31 arrests	1.35 arrests
# of Arrests Within 1 Year Post Referral/ Case Closure	0.73 arrests	0.80 arrests

Overall, jail days decreased for both groups (see Table 6). Clients who received care coordination with the PIC Team experienced an increase in days in jail on average (19.59 days to 26.85 days. Days in jail decreased slightly from 24.90 days on average to 22.94 days for

clients who were referred but not admitted. Neither of these changes were found to be statistically significant according to mean comparison tests.

Table 6

Average Number of Days in Jail

	Referred Only (n=39)	**Admitted Clients (n=104)**
Days in Jail 1 Year Prior Referral/ Services	24.90 days	19.59 days
Days in Jail 1 Within 1 Year Post Referral/ Case Closure	22.94 days	26.85 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. However, the reduced sample size may limit interpretation of these findings. 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 Table 7). The number of days in jail increases significantly for PIC Team clients. Further, the average number of days in jail in the year following case closure is more than double the number of days in jail in the year prior to PIC Team intervention (see Table 8).

Table 7

Average Number of Arrests for Cases Closed at Least 1 Year

	Referred Only (n=21)	**Admitted Clients (n=78)**
# of Arrests 1 Year Prior toReferral/ Services	1.10 arrests	1.19 arrests
# of Arrests 1 Year Post Referral/Services	1.19 arrests	1.04 arrests

Table 8

Average Number of Days in Jail for Cases Closed at Least 1 Year

	Referred Only (n=20)	Admitted Clients (n=68)
Days in Jail 1 Year Prior Referral/ Services	18.85 days	19.25 days
Days in Jail 1 Year Post Case Closure	42.95 days	43.32 days

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)[1] at the University of South Florida most recently on August 14, 2020. 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 345 clients who received Baker Act exams at least once and whose case has closed are included in this analysis. Of these, 224 engaged in PIC Team services (64.9%) and 121 did not (35.1%). Paired t-tests, mean comparison analyses, were used to assess for significant reduction in the number of Baker Acts.

Table 9 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. On average, Baker Act exam initiations decreased

[1] Per the BARC at USF, the use of "Baker Acts" is inaccurate, as "Baker Act" could mean an examination or the longer-term involuntary inpatient placement or outpatient services orders. For this report, the standalone phrase "Baker Act" has been modified to "involuntary Baker Act exam initiation," which is sometimes abbreviated to "Baker Act exam initiation," or in tables, "Baker Act exams." Also, involuntary Baker Act exam initiations is distinguished from Baker Act admissions because data captured reflects exam initiations, but initiations may not lead to admissions. This language has been clarified throughout the report.

significantly for clients whose case was not opened (2.45 Baker Act exam initiations on average to0.52 initiations) as well as for clients who did receive PIC Team services (2.62 initiations to0.85 initiations).

Table 9

Involuntary Baker Act Exam Initiations

	Referred Only (n=121)	**Admitted Clients (n=224)**
# of Baker Act Exams 1 Year Prior Referral/ Services	2.45 initiations	2.62 initiations
# of Baker Act Exams 1 Year Post Referral/ Services	0.52 initiations	0.85 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, even if it is not through the PIC Team.

As with findings on arrest and jail days, this analysis was repeated for clients whose case has been closed at least a 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 Table 10). Significantly fewer Baker Act exam initiations are also observed for referred clients who did not receive PIC Team intervention.

Table 10

Average Baker Act Exam Initiations for Cases Closed for at Least 1 Year

	Referred Only (n=67)	**Admitted Clients (n=125)**
# of Baker Act Exams 1 Year Prior Referral/ Services	2.39 initiations	2.50 initiations
# of Baker Act Exams 1 Year Post Referral/ Services	0.58 initiations	1.13 initiations

Case Closure and Re-Admissions

Since the first client was admitted in July 2018, 280 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. Results of mean comparison tests indicated that clients whose cases were successfully closed were older ($\bar{}$ = 43.8 years old) compared to clients who were closed unsuccessfully (39.2 years old) and clients with an "other" case closure status (35.0 years old). 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 (5.01 months) compared to clients whose case was closed unsuccessfully (3.17 months) and those clients whose case was closed for some "other" reason (2.34 months). 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 at discharge such that less problem severity was observed for successfully closed cases compared to cases closed unsuccessfully and cases closed for "other" reasons (see Table 11). Findings from the Self Sufficiency Matrix show clients whose case was successfully closed were stable or thriving for significantly more domains at discharge compared to those whose case was unsuccessfully closed or closed for another reason.

Table 11

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

	Successful Close (n=119)	Unsuccessful Close (n=62)	Other Closure (n=31)
FARS Disability [a]	3.00	3.17	3.84
FARS Emotionality [b]	3.76	4.56	4.86
FARS Relationship [c]	3.07	3.88	4.15
FARS Personal Safety [d]	2.52	3.11	3.53
Self Sufficiency	7.47	4.86	3.73

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 scores indicate greater severity. Self-Sufficiency scores range between 0 and 13 indicating the number of domains clients are stable or thriving at discharge. Higher scores indicate greater cumulative self-sufficiency.

The number of arrests, days in jail, and involuntary Baker Act exam initiations by type of case closure was also assessed. Although the number of arrests decreased for clients within each group on average, a significant decrease was observed only for clients whose case was closed successfully (see Table 12). Fewer arrests were observed for successfully closed cases in the year after PIC Team services compared to cases closed unsuccessfully (0.27 average arrests and0.55 average arrests, respectively). The number of days in jail was greater in the year after PIC Team services for each group. These increases were not significant (see Table 13). Noticeably fewer days in jail were observed for successfully closed cases in the year after PIC Team services compared to cases closed unsuccessfully (6.40 days in jail and 18.99 days in jail, respectively); however, this difference was not significant. Lastly, the number of Baker Act exam initiations decreased significantly for clients within each group (see Table 14).

Table 12

Average Number of Arrests by Case Closure Type

	Successful (n=135)	**Unsuccessful (n=77)**	**"Other" (n=41)**
# of Arrests 1 Year Prior Referral/ Services	0.51 arrests	0.78 arrests	0.56 arrests
# of Arrests 1 Year Post Referral/ Services	0.27 arrests	0.55 arrests	0.41 arrests

Table 13

Average Number of Days in Jail by Case Closure Type

	Successful (n=135)	**Unsuccessful (n=77)**	**"Other" (n=41)**
Days in Jail 1 Year Prior Referral/ Services	6.04 days	11.01 days	11.61 days
Days in Jail 1 Year Post Referral/ Services	6.40 days	18.99 days	13.80 days

Table 14

Average Number of Baker Act Exams by Case Closure Type

	Successful (n=135)	**Unsuccessful (n=77)**	**"Other" (n=41)**
# of Baker Act Exams 1 Year Prior Referral/ Services	2.23 initiations	1.99 initiations	1.68 initiations
# of Baker Act Exams 1 Year Post Referral/ Services	.80 initiations	.55 initiations	.56 initiations

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.

Seventy-one clients whose cases were closed following PIC Team intervention were referred again or re-admitted. Almost 60% were male (59.2%; n=42) and 90.1% were White (n=64). Five clients identified as Hispanic (7.0%). Clients ranged from 18 to 75 years of age with an average age of 42.04 years. Over 60% were single (64.2%) and most clients were unemployed at the time they initially presented for services (59.4%). Sixteen clients experienced homelessness (22.9%).

The period of engagement prior to clients being first admitted for PIC Team services ranged from one day to just over eight months and averaged 28.3 days. 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 3.81 months.

Forty-one of the 71 discharged clients who were referred back to the PIC Team services were re-admitted for services. The other clients who were referred again were not re-admitted or are currently being engaged. 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 in Table 15. Paired t-tests also compared discharge FARS scores to initial FARS scores when clients were re-admitted. Average domain scores at baseline are very similar to those observed with all PIC clients (refer to Figure 4). For re-admitted clients, the greatest problem severity was observed for the Emotionality domain followed by the Relationship domain when they were first admitted. By discharge assessment, domain scores significantly improved for all domains with the exception of the Relationship domain: Disability, Emotionality, and Personal Safety. Recall that lower scores at discharge indicate improved functioning over time. When clients were re-admitted, average baseline FARS domain scores were significantly lower than discharge scores when clients were first admitted. As such, the FARS scores do not show evidence that functioning decreased between the time that clients' cases were closed and when they were re-admitted. Given that the average length of time between initial case closure and readmission was about five months (151.09 days on average), these results suggest that functioning continued to improve significantly after PIC Team intervention.

Table 15

Initial FARS Scores for Re-Admitted Clients (n=24)

	1st Admission			2nd Admission
Factor	**Baseline**	**Discharge**		**Baseline**
Disability	3.79	3.45		2.98
Emotionality	5.47	4.79		4.14
Relationship	4.33	3.92		3.36
Personal Safety	3.67	3.19		2.69

Functioning was also assessed via the Self Sufficiency Matrix. These data were not available for all re-admitted clients so some scores may not be representative of re-admitted clients. Table 16 shows the proportion of clients who were stable or thriving across SSM domains at case closure compared to the proportion stable or thriving when readmitted for PIC Team services. Overall, a greater proportion of clients are stable or thriving at readmission for most SSM domains. This might suggest that that clients' functioning continue to improve after PIC Team intervention. Sufficient data are not yet available to examine these data according to discharge outcome.

Table 16

Proportion of Re-admitted Clients Stable or Thriving on Self-Sufficiency Domains

SSM Domain	1st Admission (Discharge Scores)	2nd Admission (Initial Scores)
Access to Services	33.3%	52.0%
Food	25.0%	38.0%
Housing	62.5%	72.0%
Income	12.5%	22.0%
Employment	4.2%	6.1%
Transportation	33.3%	54.0%
Support Systems	45.8%	66.0%
Mental Health	8.3%	32.0%
Substance Use	36.8%	61.5%
Life Skills	16.7%	34.3%
Safety	52.6%	60.5%
Family Health Care Coverage	66.7%	66.0%
Family Physical Health	58.3%	54.0%

Note: 1 = In Crisis; 2 = At Risk; 3 = Safe; 4 = Stable; and 5 = Thriving
Note: n's varied for every SSM domain at both time points assessed; these data include up to 24 discharge FARS assessments and 50 initial FARS assessments when clients were readmitted

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, about 500 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, slightly 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.

These outcomes will continue to be gathered over the next several months through the end of the evaluation period (March 30, 2021). A plan to regularly collect outcomes data has been developed in collaboration with the evaluation team, PEMHS staff, and CFBHN staff. Given progress with the development of the PICA 2 database, outcomes may be derived from this system soon.

IMPLEMENTATION ANALYSIS

The goal of the implementation analysis is to provide an understanding of what factors support or inhibit efforts to execute the project. This includes factors at both the systems level, at which overarching project decisions are made, and the client level, through which project goals are carried out.

Steering Committee Observations

The evaluation team conducted observations of monthly PICA steering committee meetings to understand how leaders assessed functioning at the project and system level and how key decisions were made as they relate to implementation goals. For this report period, five meetings were observed between April and September 2020 (all held remotely), and meeting minutes were reviewed. One or more representatives from the three key funding agencies (CFBHN, PCSO, and PCHS) were present at each meeting. The Pinellas County Department of Health representative was not at meetings during this period as COVID-19 concerns became priority. Evaluation team members took thorough notes at each meeting, resulting in an electronic document for each meeting observation. These documents were compiled into Atlas.ti, qualitative data analysis software, and analyzed by domain for common themes. The evaluation team developed a coding protocol and definitions based on key domains of systems change developed by researchers in the Department of Child and Family Studies at USF (Western and Pacific Child Welfare Implementation Center, 2009). These domains include Leadership and Commitment, Vision and Values, Environment, Stakeholder Involvement, and Organizational Capacity and Infrastructure (see Appendix C). Insights from a broader group of stakeholders were analyzed using these same domains from the Stakeholder Survey; however, the Steering Committee meeting observation provides more nuanced insight from the decision-making level. Multiple team members took part in coding the observations. The coded notes were then organized into output by domain, which serves as the basis for the findings below.

Environment

This domain addresses the broader supports and barriers that exist among other partners in the behavioral health and related systems, as well as political and social factors that may influence implementation.

COVID-19. One crucial environmental factor during this period has been the impact of COVID-19 on service provision, healthcare, and funding. The PIC Team has reported no disruption to service provision, as the transition to remote services was relatively smooth, and

team members continued to safely provide in-person services when needed (when newly engaging with hesitant clients, for example). It was reported that CFBHN conducted a survey with the PIC Team on the benefits and challenges with Telehealth, and some of the challenges noted were with engagement in difficult circumstances, not having enough phones for clients to communicate in a timely manner, and coordinating appointments with provider agencies. The PIC Team temporarily had some difficulties placing clients in housing and substance use treatment facilities as many agencies had halted or reduced admissions in the early stages of the COVID-19 outbreak. Otherwise, System Coordinators were said to be able to communicate easily with clients remotely, and in some cases reported increased communication.

System Functioning and External Supports. The Steering Committee considered numerous data sources in determining how to prioritize action steps for PICA. For instance, findings from the *Elevate Behavioral Health Pinellas County* strategy document provided by KPMG (2020), and coordinated by PCHS, provided several insights into system functioning that were discussed and used for guidance during meetings. One key finding of relevance was that there was lack of consistency in what data was being produced in terms of outputs and outcomes, as well as in systems that are in place to capture information on performance, both of which are indicators of healthy system functioning. The steering committee made it a priority to address this issue and, with support from KPMG, began to develop a process for determining core data elements that could be standardized across providers, thereby improving data transfers. The importance of ensuring that providers are on board with these efforts was emphasized.

An overlapping data initiative is PICA's efforts to establish a system-wide Health Information Exchange (HIE) that will ideally provide a more streamlined and robust way to share data, enhance coordination, and improve system efficiency. A facilitated workshop held at Collaborative Labs in January, 2020 provided concrete data points to consider in developing a data sharing system. Some discrepancies in understanding were expressed during discussions of progress on this initiative, particularly in terms of whether there is agreement on how to go forward (keep existing Care Connect system or determine if other systems would better address needs). There was also lack of clarity on which type of model would be best for the stakeholders' needs—one that enables streamlined data sharing, or one that serves as a data "warehouse." A next step is to schedule an information sharing session with a legal expert and key system representatives.

Several external behavioral health initiatives were being developed throughout this report period that build on the existing behavioral health system structure and improve efforts to

increase access to services and consistently provide a warm hand-off to clients across providers. These initiatives complement the activities being undertaken specifically by PICA steering committee members, and in many instances, PICA leaders had involvement in the initiatives and made efforts to ensure that processes were not being duplicated.

Service Array and Resources. The issue of service access and provision as it relates to substance use was also discussed, particularly in the context of Marchman Act admissions and initiatives to address opiate problems. The steering committee assessed issues of criteria, referrals, and admissions at the Agency for Community Treatment Services (ACTS) residential treatment facility, and the effectiveness of redirecting Marchman clients from jail to ACTS. The committee invited the CEO of ACTS to discuss admissions and service patterns and found that some of the beds were not being utilized and that many Marchman Act clients refused residential care. The group agreed to continue reserving some beds for PCSO referrals but to consider opening up other referral sources, such as hospitals with a high volume of individuals seeking substance use care.

With regard to opioid response, the steering committee engaged in numerous efforts to identify emerging best practices and develop programs in Pinellas County that address gaps in care. For instance, several members of PICA agencies (PCHS, PCSO, PCHD) were invited to Erie County, NY to observe the county's demonstration of an opioid overdose prevention model. Strategies from this model include 1) Emergency room induction of Buprenorphine for patients' substance related admissions, 2) Overdose response programs with utilization of peers, law enforcement and treatment providers, 3) Opioid Drug Court, 4) Parent/Family Network Groups who assist with eliminating barriers to treatment, and 5) Opioid Task Force and associated workgroups as well as increased availability of Narcan within all programs and strategies. Additionally, members of the steering committee also observed an opioid response model implemented at Tampa General Hospital. This model provides patients who present at the Emergency Department (ED) with overdose or withdrawal symptoms with assessment for induction of Buprenorphine, followed by connection to a medication assisted treatment (MAT) provider and a peer support specialist. Both of these models were presented at steering committee meetings and discussed in conjunction with recent efforts to enhance programs and services related to opioid overdose in Pinellas County.

Furthermore, a Substance Abuse manager from CFBHN was invited to share information about a State Opioid Response (SOR) project in Pinellas County intended to reduce opioid deaths through evidence-based practices, provide medication assisted treatment (MAT), and provide recovery support services. The hospital bridge program serves indigent, uninsured,

and underinsured individuals who seek care from a hospital for opioid overdose. In one partnership between Operation PAR and St. Anthony's Hospital, the model includes having a peer recovery specialist available to provide a warm hand-off from the emergency room (ER) to service coordination or treatment. In the 10 months the program has been operating, 105 individuals have been screened, 77 were referred to providers, and 40 were linked to treatment; 1,294 individuals were served across partners. The program is still very new and initial data patterns may not be reliable from the past year, especially given interruptions from COVID-19 and overcoming some initial resistance by doctors to work with peer specialists. The committee discussed a need to determine appropriate numbers and demographics served through the program, funding streams that would support further development, and how these efforts align with broader goals of PICA.

Peer services were also addressed in other contexts, including the development of a peer mentorship program through a PEMHS/NAMI partnership and the effectiveness of the peer specialist on the PIC Team. Some of the key functions of the peer specialist on the PIC Team have been to help clients develop support plans and outline goals, teach clients to advocate for themselves, help clients find social supports, work with their families, motivate them, and provide hope by sharing recovery experiences. This position was seen as an example of an effective model of incorporating peers into service coordination. Though most meeting attendees spoke optimistically of efforts to expand peer involvement in behavioral health care in the county, some discouragement was expressed over the slow pace of their integration, given extant literature on the effectiveness of utilizing peer positions for service enhancement.

Organizational Capacity and Infrastructure

This domain pertains to discussions of whether there is sufficient organizational capacity and infrastructure for carrying out the agreed upon goals and activities of the PICA initiative. Funding and sustainability were key topics discussed during this report period.

Data and Assessment. In response to previous evaluation reports showing a high percentage of White clients being served through the PIC Team, the Steering Committee requested further assessment of service equity among the PIC Team. USF collaborated with PCHS to compile data illustrating patterns of service by race and ethnicity across several behavioral health providers. Although this analysis was not comprehensive, and precise comparisons were not possible due to categorical differences, general patterns showed that the proportion of White clients served by the PIC Team (approximately 90%) is higher than other providers (between approximately 69% and 77%). One possible reason for this that has been discussed at meetings is that the PCSO jurisdiction reflects a similar proportion of White

residents, and therefore the referral source is likely the main contributing factor. Demographic data for most PCSO cities does reflect a proportion of White residents of close to 90% on average; however, demographic data for parts of unincorporated Pinellas County served by PCSO are not available, and without that, a comprehensive comparison cannot be made. Requests to examine broader PCSO service numbers to understand which factors may contribute to the demographic patterns for the PIC Team were deemed irrelevant to the goals of the assessment.

Upon the suggestion to examine sources of data that illustrate mental health care need, rather than just geographic population, county-level data from the Florida Behavioral Risk Factor Surveillance System (BRFSS) and Florida Health CHARTS were consulted (Florida BFRSS, 2016). The BRFSS data for Pinellas County indicates that nearly 14% of White respondents, 22% of Black respondents, and 25% of Hispanic respondents reported ever being told they have a depressive disorder. Furthermore, almost 12% of White respondents, 18% of Black respondents, 10% of Hispanic respondents, and 7% of Native Hawaiian/Pacific Islander respondents reported poor mental health on 14 of the past 30 days from when they were surveyed. With regard to those who reported "good mental health," 88.5% were White and 81.6% were Black. Finally, hospitalization data from CHARTS indicates that, per 100,000 patients, 1,200 White patients, 1,644 Black patients, 654 Hispanic patients, and 514 patients categorized as "Other" were hospitalized for mental disorders. Demographic data on demographic patterns of Baker Act exam initiations throughout the county were requested, but data is still forthcoming. Put succinctly, the service patterns of the PIC Team show an overrepresentation of White clients compared to several county-wide indicators of mental health need.

PIC Team Sustainability. An assessment of sustainability was conducted at the August and September 2020 steering committee meetings, with some members emphasizing the importance of maintaining the PIC Team model. Pinellas County Human Services, which provides funding for four system coordinators and one supervisor, has committed to continuing to provide that funding to support the model. However, funding for four system coordinators, one peer specialist, and PEMHS operating costs was provided by a grant from the Foundation for a Healthy St. Petersburg (FHSP) to CFBHN for a three-year period, ending in March 2021. Because continuous funding for these positions and expenses would not be possible through the same funding mechanism, the steering committee assessed the concrete funding needs in order to determine an appropriate funding strategy. It was estimated that approximately $324,000 ($224,000 for four system coordinators from PEMHS and $100,000 in overhead at

PEMHS) would need to be secured to continue funding all PIC Team staff members. Without these staff, the team would operate at half capacity, serving roughly 90-100 fewer clients per year. Several steering committee members agreed to conduct further meetings to discuss funding possibilities.

Funding. Additional funding-related issues were addressed, such as the remaining funds from the $200,000 allotment for incidentals by PCSO. Only a fraction of this amount was utilized by the PIC Team because their instruction was to exhaust all other resources before tapping into it. Some ways the team has used the funds are to help obtain housing for clients, to provide clothing and other immediate concrete needs, and to pay for the first month of medication. The identification and utilization of existing resources was seen as an unanticipated success, and shows the effectiveness of using community resources when there are staff available to identify them. PCSO restricted use of the funds for staffing but was open to considering other uses based on need. A brief needs assessment of the PIC Team revealed that the highest need was for cell phones for new clients, as the team often doesn't have a way of maintaining contact during the crucial engagement process and other services are time consuming and difficult to access. There was also general discussion about budget reductions related to the COVID-19 recession that would affect PICA partner agencies as well as provider agencies in the broader system, though it is unclear at this stage what this would mean for specific services or how it might directly affect the PICA initiative.

Leadership

Steering committee members continued to assess indicators of behavioral health system functioning and improvement, such as PIC Team effectiveness, utilization of substance use programs and Marchman Act admissions, integration of peer specialists across agencies, data coordinating efforts, and other initiatives to streamline care and improve access to behavioral health care. Some initiatives progressed at a more consistent rate than others. Two components stood out as being affected by a lack of clarity or momentum during this period. One is the sustainability of the PIC team, and although the need to address this was discussed at various points during previous years, concrete steps have not yet been made to identify ongoing sources of funding outside what PCHS will continue to commit. The other component that has had some lack of continuous progression is the HIE initiative. Although some meetings have been convened by key system representatives and the project manager since the Collaborative Labs workshop was held in January, the discussion about which path to take to move forward is still being decided. Despite several requests to track the progress of tasks and activities using a centralized workplan during meeting, this process was not implemented.

Progress was instead tracked through a review of action steps at each meeting. It is possible that COVID-19 changes that caused re-prioritization of tasks among all system agencies interfered with some efforts to be more productive with some components.

However, steering committee members were in agreement on a majority of efforts and there were many examples where they worked together to make evidence-based decisions (e.g., acting on recommendations from the *Elevate* report); investigate barriers to services (e.g., understanding referral and admissions challenges with ACTS); build on existing relationships with providers across the system (e.g., ensuring that hospitals and providers were on board with determining core data elements); and advocating for system improvements (e.g., integrating peers into services, supporting initiatives to improve access, and prioritizing needs for funding).

Summary

During this report period, discussions at steering committee meetings have centered largely around substance use initiatives, racial equity across the system, strategies for identifying system-wide performance indicators, and generally on developing initiatives and partnerships that support integrated care and better access to care. Though discussions of how or whether to expand the PIC Team were not a significant part of meetings, funding and sustainability of the existing PIC Team model was prioritized in recent meetings.

PIC Team Meeting Observations

PIC Team meetings were held weekly to discuss issues related to implementation of services, engagement among clients, structural challenges, provider partnerships, and treatment outcomes. Although it varied by meeting, participants were generally comprised of the PIC team supervisor, the PICA project manager, supervisors and system coordinators from contracted providers, and the PCSO Mental Health Unit. Guests from relevant provider agencies were frequently invited to share information about their services as well. The evaluation team observed five PIC Team meetings from June 2020 to September 2020. We recorded electronic notes detailing attendance and discussion, resulting in one document for each observed meeting. We then compiled these documents into Atlas.ti, a qualitative analysis software program, and conducted a theme analysis using a pre-existing coding protocol (Appendix D). We examined client characteristics, enrollment procedures, treatment outcomes, PIC Team capabilities, and service provision.

Client Characteristics

The PIC Team worked with clients who had intensive medical, behavioral, and financial needs. This included clients diagnosed with neurological disorders, mental illness, and

substance use disorders; clients in need of nursing home or residential care facility placement; clients unable to pay for housing and utilities; clients facing legal charges, including felonies; and clients who were more socially isolated, such as those who were disconnected from family members. The PIC Team addressed medical and behavioral needs by connecting clients to care providers. They used local and state resources, such as 2-1-1, to help with financial resources. They monitored those who had become more socially isolated during the pandemic and did not have "someone checking in on them." They also tried reconnecting clients to their families; in one case, the team used an ancestry tracing website to locate the family of one client who had lost contact with them several years earlier.

Engagement and Enrollment

The PIC Team faced some challenges during the initial engagement period (after receiving referrals from the PCSO MHU) with several clients, including an inability to contact clients regularly. Team members used a variety of tactics to re-engage such clients, such as involving family members in care, meeting clients in "neutral" locations like grocery stores, and reaching out to attorneys. In instances where clients were resistant or noncompliant for an extended period of time, the PIC Team considered ways that Assisted Outpatient Treatment (AOT) processes might be initiated (i.e., via Baker Act and court order). Team members frequently gave updates about changes to care caused by the pandemic, like the transition to remote care and the impact of organizational closures. By September, the Team found that remote work was causing some delay in services. They also discussed having less time to interact with their clients once they were enrolled: "We can't cover everybody and by the time we get them again, they're on another episode." Several members cited problems with referrals made to Suncoast, such as referral processes taking longer than anticipated, lack of follow up with clients by the provider, and lack of clarity about what clients' appointments were for (it was pointed out in a September meeting that there was a new supervisor at Suncoast, which may have led to some of the changes in routine referral processes). "They're not staying connected. We're hanging on to people much longer at this point." These delays were creating a "caseload problem" and Team members found it more difficult to engage clients, who were discouraged by longer wait times. The PIC Team discussed strengthening the enrollment process by more efficiently setting up appointments for clients referred to PEMHS. The Team found that peer support—both on the PIC Team and from other agencies—was a useful means of connecting clients to formal services.

Baker Act Exams

Three clients required medical care (two as a result exposure to the COVID-19 virus). The PIC team discussed providing care to clients infected with the virus, including the need to isolate them in hotel rooms and wear protective equipment while interviewing them. At one meeting, the team discussed clients who had recently been arrested or had an involuntary Baker Act exam. Although they were generally able to re-engage these clients and monitor their cases, one case in which engagement was difficult reflects a greater need to ensure appropriate use of the Baker Act. According to discussion at a PIC Team meeting, a client with Autism Spectrum Disorder (ASD) called law enforcement to report being sexually assaulted, but the responding officer instead initiated a Baker Act exam. It was perceived that the officer who handled this incident lacked awareness of typical behaviors of adults with ASD and misinterpreted the client's actions when they had their hands over their ears and were screaming. The concern discussed at the meeting was that this was not an indicator of intent to harm oneself or others and thus not indicative of a need for an involuntary mental health examination. The PIC Team pursued alternative responses, such as a mobile crisis unit or a sexual trauma team at a provider agency; however, the client is reportedly now afraid of calling for help because of a fear of being blamed and having a Baker Act exam initiated again.

PIC Team

PIC Team members reinforced their knowledge of treatment possibilities with several providers during meetings in order to clarify treatment options and criteria for referral. For instance, regarding placement options, several Team members shared concerns about a group home, which left system coordinators confused about its status as an Assisted Living Facility. They hoped to gain clarity on who was eligible for admissions at the facility but plans or updates were not observed in later meetings. Also, a representative from the Public Defender's (PD) jail diversion program was invited to share information about program eligibility. The Team used this opportunity to better understand how to streamline psychological or biopsychosocial assessment processes to minimize delays in placement, how criminal records affect participation, and generally how they could best collaborate with the PD's Office to better meet clients' needs and prevent them from going to jail.

The Team provided updates about funding, data monitoring, and program advertising. In September, the PIC Team shared its status on incidentals funding provided by PCSO and brainstormed ways to use the funds to provide clients with temporary housing, holistic coaching, phones and laptops, transportation, and more. They also updated job descriptions, offered trainings on managing remote data, and prepared client satisfaction surveys to send to all

engaged clients as a quality control measure. The Team also created a resource sheet for guardians to help support family members with mental health needs.

Services and Resources

The PIC Team shared several success stories about clients who successfully enrolled in services that met their needs. The Team shared their success in connecting one client with the FACT Team: “This is the first case in five years that we’ve been able to get a client on the FACT team when they weren’t on their way to a state hospital.” They also helped connect clients to care post-discharge, attend court and therapy, and avoid eviction. The PIC Team cited a few challenges that both providers and clients faced. Regarding service provision, Team members dealt with restrictions in referral acceptance such as one provider who, at the time, was only accepting referrals from law enforcement. They faced the loss of a provider because Healthy Transitions was losing federal funding. The Team suggested contacting Healthy Transitions staff to maintain connections to that resource. One Team member described a limitation in managing non-compliant clients, many of whom were re-admitted to the PIC Team via Baker Act exam. It was widely agreed that initiating another Baker Act exam was not the preferred method of re-engagement, but PIC Team members still wanted non-compliant clients to come back for help. This Team member shared another issue: homeless clients, as a result of temporary restrictions concerning COVID-19 safety precautions, were unable to enroll in AOT unless they could secure housing in a short timeframe. With organizational closures under the COVID-19 pandemic, this presented a challenge. The Team discussed potential solutions, such as setting up future meetings dedicated to sharing information on providers who accept clients with intensive needs.

Client Interviews

The evaluation team interviewed clients about their experiences accessing services. Interviews were conducted in June 2020 with ten clients, most of whom were discharged prior to meeting the evaluation team. We used a semi-structured interview protocol (Appendix E) that asked about clients’ experiences receiving services before, during, and after enrollment with the PIC Team; their level of satisfaction with care; suggestions they have to improve services; and how their experiences with the PIC Team differ from their experiences with previous providers. Interviews lasted less than 30 minutes, after which participants were compensated with $25. With written informed consent, interviews were audio-recorded and transcribed. We conducted thematic analysis using a pre-existing coding protocol (Appendix F) using *Atlas.ti* qualitative data analysis software.

Enrollment

The duration of involvement in services varied by participant, ranging from two to twelve months. Two participants were involved in care more than once, such as one who was enrolled in services in 2018 and then re-enrolled in services in 2020. Of the participants that shared why they were referred to services, most explained that they were enrolled immediately after being Baker Acted. One stated that her involvement was caused by frequent involvement with law enforcement—"[The system coordinator] just showed up one day… because I had had the police out here so many times for different things that happened." Another shared that it was during a period of mental and emotional deterioration. Participants previously received care from multiple providers, including Suncoast Center, Directions for Living, and St. Anthony's Hospital.

Service History

Participants told us about their history of involvement with behavioral and medical healthcare. Six out of 10 formally received behavioral and/or medical healthcare services prior to involvement with the PIC Team. One out of 10 sought out informal care while working in a pharmacy. This participant was sometimes incoherent and forgetful during the interview and said that their medication was causing problems with alertness. However, we included the data to highlight potential instances in which a person goes outside the formal behavioral health system to get help: "I was actually going to a private psychiatrist where I was basically, I mean the guy was basically just a dope dealer." Three out of 10 were not previously enrolled in services, aside from having receiving Baker Act exams, either because they were unsure how to seek help or did not feel they needed help. About half of our interviewees said getting help was easy while the other half said it was difficult. Finding help was made easier when participants were enrolled in services in the area (such as one who sought counseling directly on their college campus), enrolled in services continuously (such as one who had been enrolled in services since childhood), or were immediately connected to services after being Baker Acted. Finding help was made difficult when services were inaccessible due to price, coverage, or location; when treatment was limited to physical healthcare and medication management; when clients were referred to resources that they did not know how to use, such as being sent to the State Attorney's Office for sexual assault; and dealing with high turnover among therapists. Of the four participants that shared how they were referred to the PIC Team, three were referred after a first or second Baker Act exam and one was referred due to a chronic neurological condition.

Interactions with the PIC Team

Participants generally felt respected and understood by PIC Team staff, which many said was a refreshing change from their interactions with previous providers. Staff made themselves available by call and text, regularly checked up on clients, were empathetic and insightful about a client's condition, and allowed clients to vent. Having someone reach out was cited by nearly all participants as the most visible difference between care from the PIC Team and care from previous providers. "I don't have to reach out so much. Because when you're in depression, you're tryin' to not reach out as much." Several participants said they had a positive relationship with their system coordinator, with one expressing that they were better able to talk to their system coordinator than with friends or family. System coordinators gave clients greater decision-making power: "Since I've ran into [the system coordinator] I've totally felt like I've had more of decision-making abilities in my life." They framed illness within a new context, such as explaining that panic was a reasonable reaction the pandemic. They also took steps to make sure that clients could navigate services and resources. This included providing many new resources and making sure clients understood their diagnosis: "[My system coordinator] said, 'Do you have an understanding of what you've been diagnosed with?' And I'm, like, '[system coordinator], no one ever asked me that. Thank you so much for asking me because I don't.'" One participant said that it was hard to contact their system coordinator near the beginning of care. They believed it was because of caseload size and suggested hiring more staff. Another said that they did not fully connect with their system coordinator due to differences in personality, but still found their help meaningful: "This is work, work, work. I'm hurting here. But in the long run, she gave me all the tools I needed…she's been my biggest cheerleader." Participants praised the ability of a system coordinator to refer them to a wide variety of services, from receiving stimulus checks to connecting with sexual assault victim advocacy centers. Participants cited availability, empathy, proactiveness, and resourcefulness as the most significant qualities of positive relationships between staff and clients.

Strengths

According to interviews, PIC Team staff consistently engaged each client using a variety of methods. They contacted clients weekly. They incorporated positive coping mechanisms into a client's pre-existing interests, such as exercise or art. They connected clients to events in the community, such as organized group tours of local museums. They worked to minimize difficulties that clients had with transportation. They offered clients services tailored to their needs, such as one client who opted out of group therapy for individual therapy. Participants were more trustful of system coordinators, especially those who had experiences with being

disbelieved--“Once I try telling [previous providers] something, they always think that I’m an attention seeking person”—or changing therapists due to turnover—“I end up having to get a new counselor every so often and with having abandonment issues that kind of sucked.” Services were free, which made them accessible to clients. All clients felt that service provision by the PIC Team was an improvement over previous care, especially for one who felt like they had been helped out of an “abyss”: “We [patients with medical or behavioral health problems] sometimes fall into these little abysses and we can't get out. And it's hard. It's really hard from my standpoint, which I'm sure it has been for other patients as well, to get out of that.”

Challenges and Suggestions for Improvement

One client was uncomfortable with how system coordinators were introduced, seemingly out of nowhere, upon engagement, “Because at first, you're very scared, skeptical.” This participant suggested that clients receive prior warning about first contact with a system coordinator. Some clients shared ways that their previous experiences with behavioral health services influenced their perceptions of the system. For instance, one participant shared a negative experience with a law enforcement officer (not from the PCSO MHU) whom they felt took a domineering approach to initiating a Baker Act petition: “I was having a [medical emergency] in the lobby and he's going to me, ‘I'm just gonna send you to PEMHS.’ I said, ‘No, you're not. I'm not going to PEMHS. I've been there. I'm not going.’ He goes, ‘You're gonna go wherever I tell you.’” Another participant was generally critical of the care provided to patients with mental illness, especially in Florida. The client said that they have been mistreated by health professionals; have had difficulty finding a provider who worked overnight, on weekends, and on holidays; were delayed or denied medication because of fears that “everyone's going to turn people into drug addicts;” and dealt with therapists who showed waning empathy for patients. This complaint was not directed toward service provision by the PIC Team but reflects clients’ perceptions of the lack of cohesion across the behavioral health system, which was also evident in other client histories.

Summary

Although their histories are unique, most clients faced difficulty finding care prior to their referrals to the PIC Team for a variety of reasons. Some were unsure of where to go or how to navigate their insurance plans. One sought out informal (and perhaps illegitimate) methods of treatment. Several were not connected to care in-between calls to law enforcement. One explicitly stated that they did not believe they needed help until they received a Baker Act exam. There are noticeable lapses in care among several clients. One was not enrolled in services until their second Baker Act exam and another knew how to get counseling but did not know

how to seek out other types of help, such as legal help for sexual assault. The few clients who said obtaining prior help was “easy” were usually the ones who were immediately connected to care, had been receiving care for an extended period of time, or had received care from organizations in their area. Service provision was highly regarded among all participants, who viewed it as a noticeable improvement over service provision from previous providers. Participants connected with their system coordinators, who were empathetic, proactive, and resourceful. Discharged clients said they gained healthy coping mechanisms and were linked to continuing care.

Collaboration and Systems Change Assessments

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 behavioral health system for adults with mental health needs. Specifically, one of the targeted outcomes of PICA is to improve coordination of services among 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 partners and providers (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 partners. Lastly, a stakeholder survey was included, that 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.

The collaborative structure established for PICA was developed as a tiered structure (see Figure 6). 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 partners are experienced in providing services and supports for persons with mental health challenges in Pinellas County and are represented by administrators of the agencies. Administrators of 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 members of the PIC Team and PCSO MHU. Lastly, ancillary service providers make up a fourth tier and include mid-level management staff such as program directors. These partners

provide services and supports throughout the county and are engaged on an as needed basis for PICA clients.

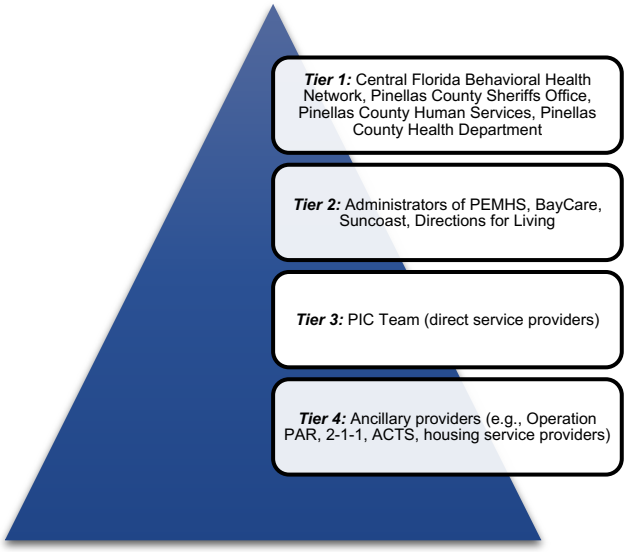

Figure 6. PICA Tiered Partnership

Agencies representing each tier were invited to participate in the collaboration surveys. The representatives for each tier were determined by the PIC team and PICA project manager, with input from the steering committee. Given the specific focus on collaborative activities, such as program development, evaluation, and collaborative policies assessed through the IACAS and stakeholder survey, only Tier 1, Tier 2, and Tier 3 partners completed these surveys. Partners of all four tiers were asked to complete the section related to challenges and barriers to collaboration and the Network Analysis Survey. Survey components were combined into a single survey and administered via a web-based survey software program, Qualtrics, in September 2020. As a follow-up, reminder emails were sent to ensure prospective respondents were able to participate.

IACAS

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.

Figure 7 reports the average scores of respondents who completed the IACAS portion of the collaboration survey. Fourteen respondents completed this section including four Tier 1 representatives, two Tier 2 representatives, and eight PIC Team staff. Significant differences in responses between tiers were assessed, however, given the small number of Tier 1 and Tier 2 respondents, all responses were aggregated (see Appendix G for responses by tier). Findings of these surveys are compared to the baseline assessment of collaborative activities assessed during Year 1 of the PICA initiative evaluation. The highest scored domains at baseline were Program Development and Evaluation ($\overline{X}$ = 4.1) and Collaborative Policies ($\overline{X}$ = 4.0). Domain scores for Financial and Physical Resources ($\overline{X}$ = 3.6) and Client Services Activities ($\overline{X}$ = 3.6) were only slightly lower. The extent to which respondents saw collaboration activities across all domains increased over the course of PICA implementation. Domain scores averaged between $\overline{X}$ = 4.2 and $\overline{X}$ = 4.4 with Collaborative Policies scoring slightly higher than the other domains.

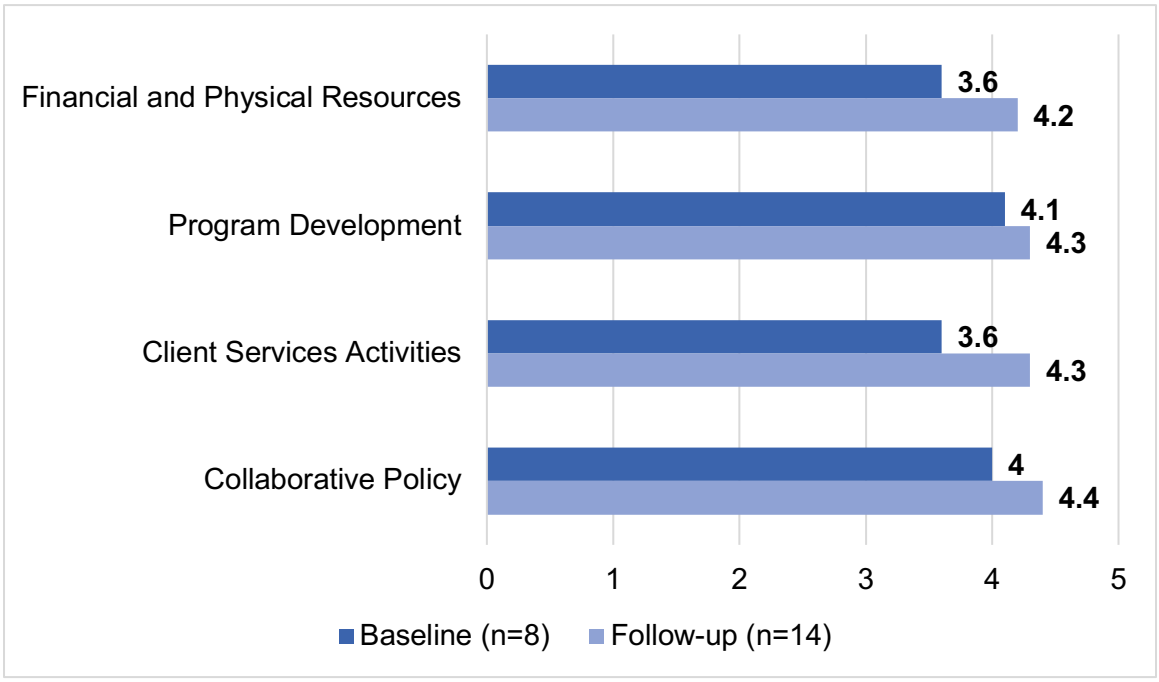

Figure 7. IACAS- Average Domain Scores

Within these domains, collaborative activities mostly endorsed in the follow-up assessment were participation in standing interagency committees ($\overline{X}$ = 4.79), informing the public about services ($\overline{X}$ = 4.79), providing clients information about services ($\overline{X}$ = 4.79), and

convening case conferences or staffings ($\overline{X}$ = 4.64) (see Figure 8). Purchasing services ($\overline{X}$ = 3.86), conducting evaluations and assessments for the purpose of making diagnoses ($\overline{X}$ = 3.86), and having common intake forms ($\overline{X}$ = 3.79) were the least endorsed collaborative activities. Overall, respondents indicated an increase in collaborative activities from baseline to follow-up assessment.

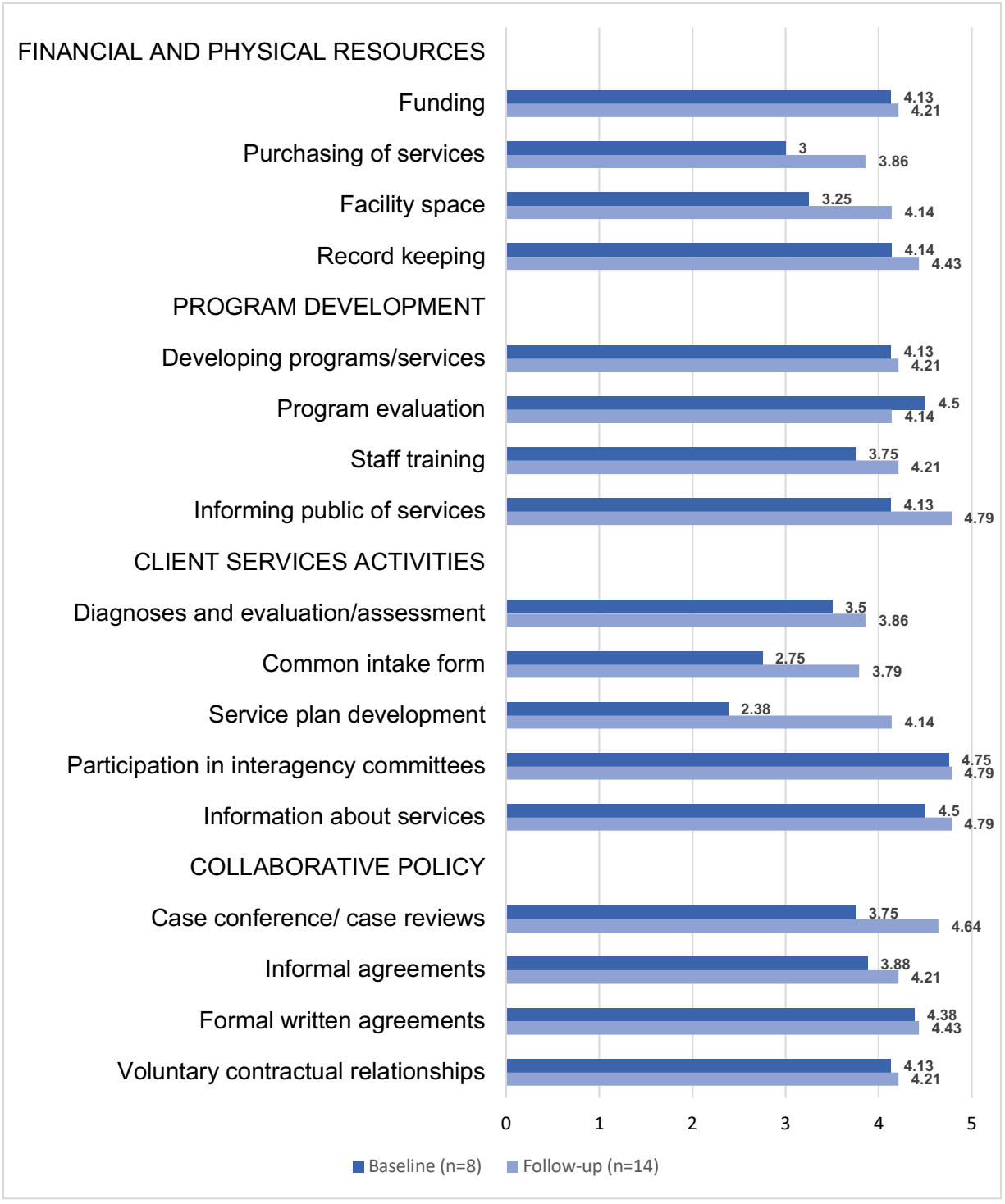

Figure 8. IACAS- Average Item Scores by Analysis Year

Stakeholder Survey

Partners and providers 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.

Development of the Stakeholder Survey was largely informed by the systems change framework described by a framework of key elements for implementing sustainable systems change[2] (WPIC, 2009). Accordingly, this survey assesses 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 partners, 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 partners. To assess Stakeholder Involvement, respondents were also asked to rate their level of agreement on partners', 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.

Survey respondents rated their level of agreement of statements on the development and implementation of PICA on a scale of 1 (strongly disagree) to 5 (strongly agree). The anticipated outcome is that, over the course of the grant, there is demonstrated improvement across the domains assessed. The findings included in this report compare the baseline assessment of stakeholder perspectives from Year 1 to the follow-up assessment recently administered.

Fourteen stakeholders completed the Stakeholder Survey. This included responses from four Tier 1 representatives, two Tier 2 representatives, and eight PIC Team staff. Initially, results of the Stakeholder Survey were analyzed by tiers to examine whether there were discernable differences in the way partners of the three tiers responded to items. However, negligible differences were observed and the number for respondents was too small to analyze separately. Figure 9 reports aggregate average domain scores for stakeholders who completed the survey. Results by tier are appended for reference (see Appendix H).

[2] Based on feedback from the steering committee, the evaluation team removed an item assessing decision-making with the understanding that this domain was not appropriate for stakeholders outside of the four members of the Steering Committee.

Overall, results suggest that stakeholders largely agreed with many of the statements included in the survey. 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 stakeholders 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 PICA activities. Results also indicate that respondents somewhat agreed with statements that assess Organizational Capacity and Infrastructure. Although slight differences are observed in comparing baseline and follow-up assessment scores, these differences are not statistically significant.

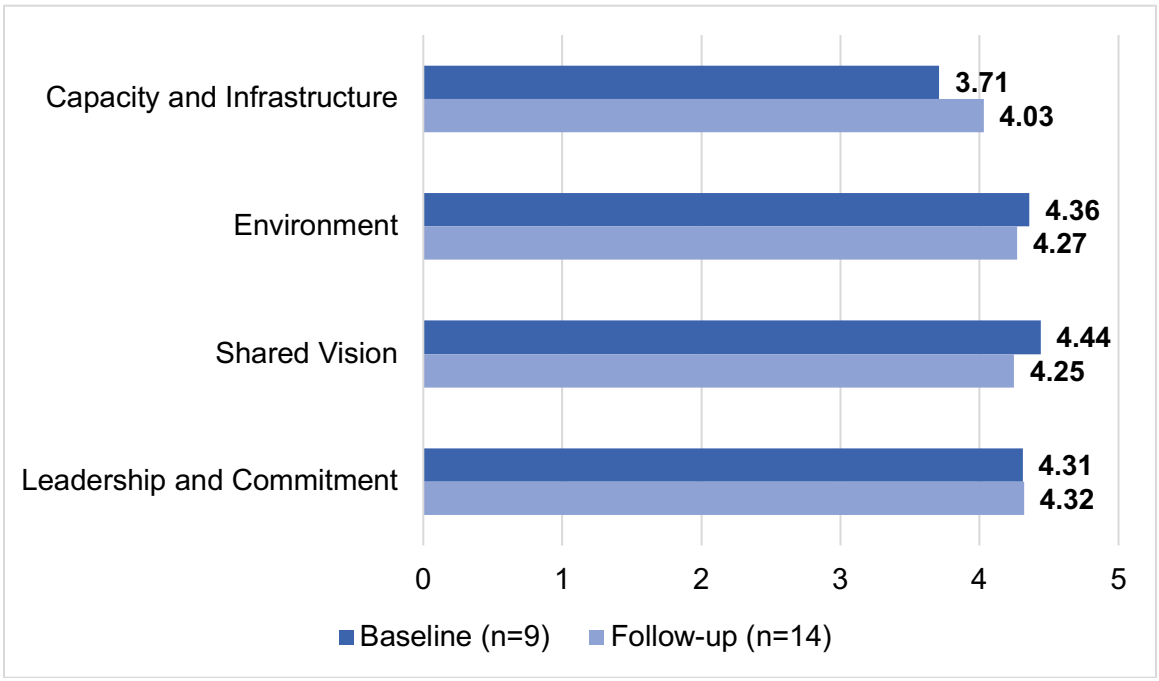

Figure 9. Average Domain Scores for the Stakeholder Survey

Network Analysis

A Network Analysis was conducted with partners engaged with PICA to understand the structure of the collaborative relationship pertaining to coordination of services and commitment to PICA work. This network analysis represents the third year of the PICA initiative and serves as a follow-up to the Year 1 network analysis, with the aim of understanding whether or how collaboration and coordination within the behavioral health system in Pinellas County has changed throughout the past two and a half years. Data collection and analysis included stakeholders from each of the tiered levels of partners (refer to Figure 6). Partners were asked

questions about their agency's relationship with other partners in an effort to map the relationships and understand barriers and facilitators to implementing the objectives of PICA.

The Network Analysis Survey assessed the following research questions:

1) How many agencies are currently engaged in PICA?
2) How cohesive are PICA stakeholders in terms of relevant collaboration factors—specifically, coordination of services and commitment to PICA work?
3) Which stakeholders work best with other agencies across both collaboration elements assessed?

The first research question indicates the size of the PICA network at the time the survey was administered. The second research question pertains to the cohesiveness of the collaboration. These elements are examined for both components of an effective collaboration assessed: coordination of services and supports and commitment to the work, mission and vision of PICA. Lastly, the third research question helps identify key agencies within the collaborative integral to implementing PICA work in terms of the dimensions of collaboration assessed through this survey.

Methods. Prior to the administration of the survey, a roster of all active stakeholders engaged in providing mental health and related services through PICA was obtained from the project's leadership. The USF evaluation team and PICA steering committee members helped ensure that all active stakeholders were included in the rosters. A Network Analysis Survey was constructed to include the roster of active stakeholders. For each network analysis question, a given agency assessed the extent to which they collaborated with each of the other agencies relative to the given element of collaboration. For example, the first network analysis question asks respondents to rate the extent to which the agency or entity they represent coordinates with each of the other agencies to provide services for PICA clients. The second question asks respondents to rate the level of commitment for each of the other agencies in the coalition.

Strategies were employed to ensure PICA stakeholders were prepared to participate in the Network Analysis Survey. For example, an explanation of the purpose of the survey and what to expect was shared with the steering committee members prior to the survey being administered. The steering committee and other stakeholders were also given the chance to review the surveys and provide feedback on multiple occasions. Surveys were administered via a web-based software program so that partners could complete the survey online at their leisure. The evaluation team obtained email addresses for representatives from each agency in order to administer the survey. To increase response rate, reminder emails were sent one week

and two weeks after the survey link was first sent to prospective survey participants and a member of the evaluation team joined a PIC Team meeting to remind members of the survey.

Analysis. Although network analysis was used to collect data from individual respondents, the interactions assessed are among partner agencies and organizations rather than individuals. In cases when more than one respondent participated in the survey from the same agency, responses were combined and the mean (average) response was used for analysis.

Table 17 defines the statistics collected through the Network Analysis Survey. The first research question pertained to the size of each network (coalition) and is represented as the number of stakeholders and/or agencies in each coalition. To assess the cohesiveness of the network, the density, average degree, average strength, and degree of centralization were recorded. Findings for the third research question are presented in network diagrams for each of the three dimensions of collaboration assessed. UCINET 6 was used to analyze network analysis data and construct network diagrams (Borgatti, Everett, & Freeman, 2002).

Table 17

Definition of Network Analysis Statistics

Statistic	Definition
Network Level	
Network Size	Number of stakeholders/ agencies engaged in PICA
Density	Number of ties (connections) in the network as a proportion of the number of possible ties; depicted as a percentage ranging from 0-100%
Degree	Average degree- average number of ties for each node (stakeholder/ agency); A higher average degree indicates a denser network. Average strength- average value for ties across nodes with a possible range from 0 to 3
Degree centralization	Extent to which a network is dominated by a single node; depicted as a percentage ranging from 0-100% where lower percentages are more ideal

Results. Findings from the Network Analysis Survey are detailed below. Project leadership for the PICA initiative identified 22 stakeholders currently working together to achieve the goals of the initiative. Each of these stakeholders representing each of the four tiers of

partners were invited to participate in the network analysis survey. However, only one of the 14 providers encompassing Tier 4 participated in the survey. Due to the excessive missing data for this group, Tier 4 was not included in this analysis. It should be noted that this severely limits interpretation of the PICA network as a whole. Representatives from three of the four Tier 1 agencies (75%), three of the four Tier 2 agencies (75%), and the PIC Team are included in this report. Responses from PIC Team staff were aggregated to represent the PIC Team as one entity, which is also representative of the team's approach to care coordination.

As shown in Table 18, network density, degree, and degree centralization scores were calculated for the questions related to Coordination and Commitment. According to surveys completed, the density score for Coordination was slightly greater than that of Commitment indicating 63.9% and 55.6% of all possible ties (connections), respectively, were observed. For the tiered model of collaboration specific to PICA, it is not expected that a density of 100%, where all stakeholders are connected to each other, is ideal for this partnership. The hierarchal, tiered structure of the PICA collaborative does not necessitate, for instance, that Tier 1 partners directly and fully engage with the Tier 3 stakeholders. Instead, Tier 2 stakeholders can be regarded as intermediaries between Tier 1 partners and the PIC Team which makes up Tier 3. For this baseline assessment, these statistics should only be regarded as descriptors of the network.

Of the nine partners surveyed, on average, a given agency or partner was connected to $\overline{X}$ = 5.11 other partners for coordination of services and supports for clients, suggesting that coordination was not widespread among all PICA stakeholders included in the network. The average degree score of $\overline{X}$ = 4.44 out of a possible nine for Commitment indicates that there was some consensus that those involved with PICA were committed to the work of the initiative. The greatest average strength of these ties was observed for commitment to the initiative ($\overline{X} =$ 2. 50) suggesting agencies were "somewhat" to "very committed" to PICA work. The average degree strength for coordination of services $\overline{X} = 2.40$ indicating that services were "somewhat" coordinated among network partners.

Table 18

Network Characteristics

	Density	Degree		Degree Centralization
		Avg. Degree (range 0-9)	***Avg. Strength (range 0-3)***	
Coordination (n=7)	63.9%	$\overline{X}$ = 5.11	$\overline{X}$ = 2.40	46.4%
Commitment (n=7)	55.6%	$\overline{X}$ = 4.44	$\overline{X}$ = 2.50	57.1%

The tiered partnership structure of the PICA collaborative provides that Tier 1 partners are more influential than Tier 2 stakeholders, who are then more influential than Tier 3 stakeholders. Although stakeholders included in all three tiers are important for the PICA initiative, there is a hierarchy such that some stakeholders are intended to provide financial resources and guide activities of the initiative to a greater degree than other stakeholders. With this in mind, findings related to degree centralization are in line with the collaborative structure of PICA. Recall that degree centralization refers to an element of collaboration being dominated by a single agency/stakeholder. Given the relatively high degree centralization scores, these results suggest that coordination of services and commitment to PICA work is also observed to be highly centralized or dominated by a core group of stakeholders.

Figures 10-11 illustrate the network characteristics detailed above via a network diagram for both dimensions of effective collaborations assessed. 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 stakeholder representing each node is presented in each network diagram. Refer to Appendix I for more detail on network stakeholders represented in the diagrams below.

Coordination. PICA stakeholders reported the extent to which they perceived their agency coordinated with other agencies to provide services for clients. Figure 10 shows the network diagrams illustrating the PICA network as it pertains to coordinating services and supports for clients. Two Tier 1 partners—CFBHN and the PCSO— and two Tier 2 partners—PEMHS and DFL—were among the most influential partners according to survey responses. 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 stakeholder is expected especially given their role as the administrative agency for the care coordination model. It is not expected that Tier 1 partners 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. Figure 10 also shows stronger connections among Tier 1 and Tier 2 stakeholders.

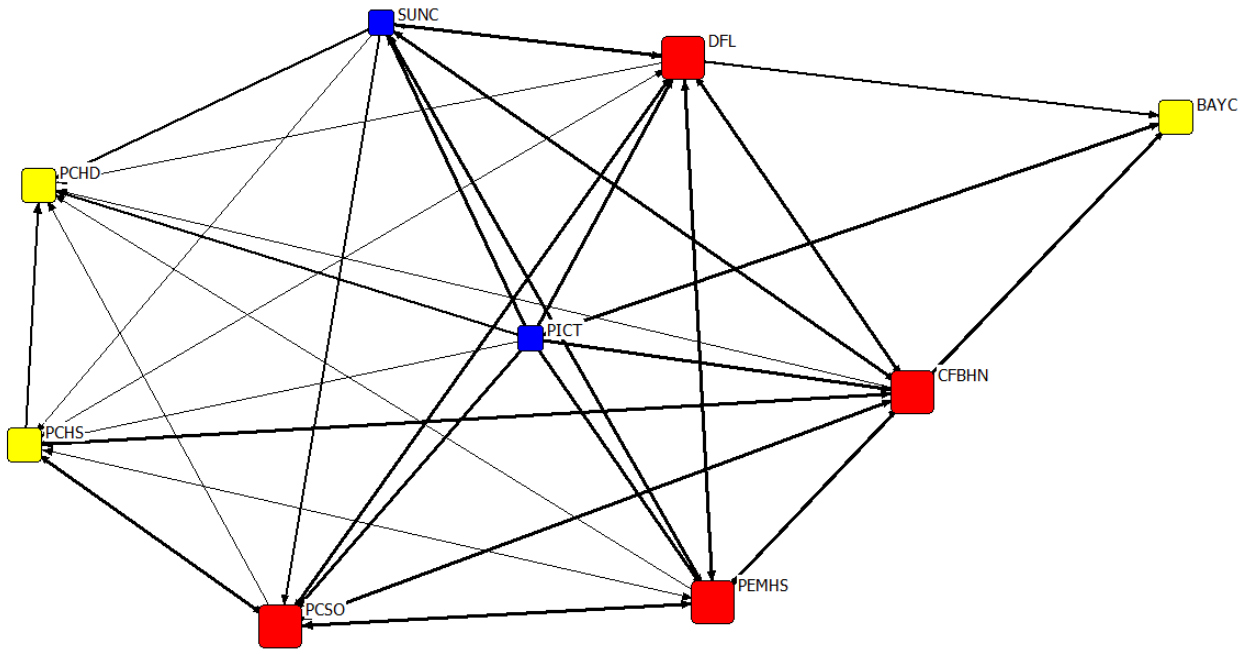

Figure 10. Network Diagram for PICA: Coordination

Commitment. 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 11 shows the network

diagrams illustrating the level of commitment of PICA stakeholders. Three of the four Tier 1 partners, 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 slightly less committed to PICA work. It is unexpected that a Tier 1 partner—PCHD—is observed to be less committed compared to other stakeholders.

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.

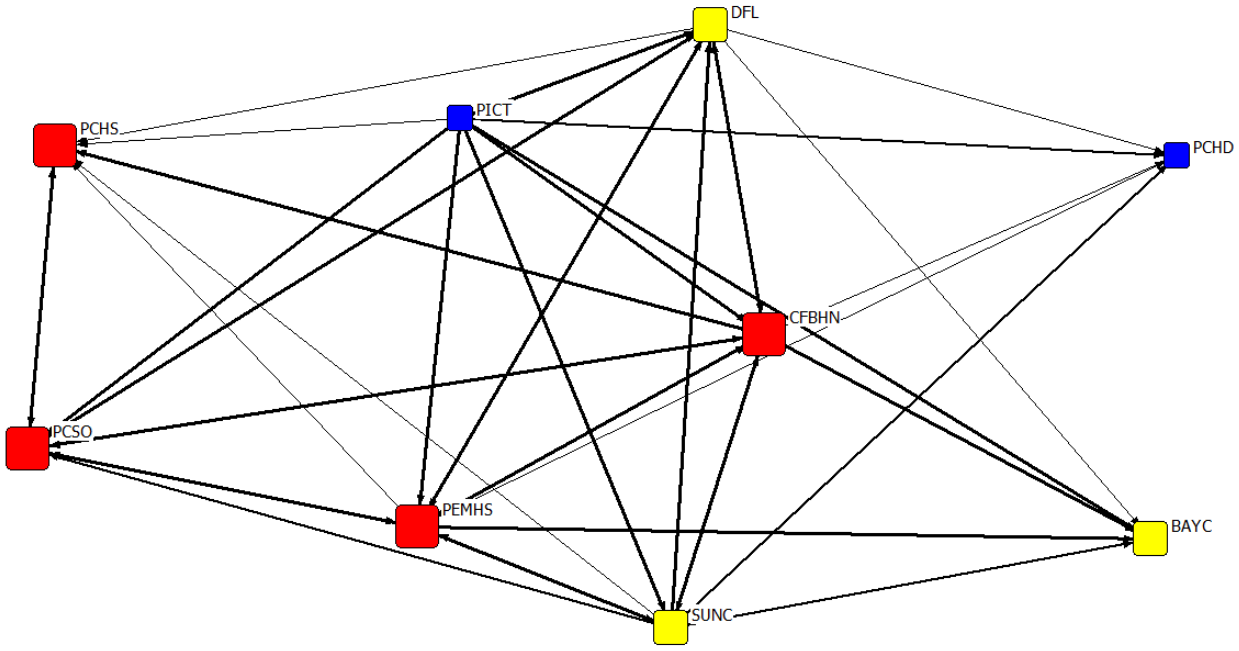

Figure 11. Network Diagram for PICA: Commitment

Limitations. Results of the network analysis should be interpreted with caution. One limitation of the analysis is that it did not allow for stakeholders to identify the PIC Team as a cohesive entity but rather by the agencies that make it up. The evaluation team collapsed responses to create a "PIC Team" node, but there may have been some confusion over how to indicate relationships with the team as a whole. Furthermore, the lack of responses from Tier 4,

auxiliary providers, meant that agencies who would be expected to report strong ties to and coordination with the PIC Team were not included in the network.

Challenges and Facilitators

To supplement the IACAS and the network analysis, respondents were asked to identify challenges and facilitators associated with collaborating with other agencies. Respondents were able to select from a list of challenges and facilitators compiled by the USF evaluation team that was informed by a literature review on barriers and facilitators of interagency collaboration.

Challenges. PICA stakeholders indicated several facilitators and challenges to their agencies' efforts to collaborate with other agencies who participated in the initiative. In the Year 1 survey, stakeholders indicated that 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 posed challenges. These same challenges were noted in the Year 3 assessment. Failure to establish a common framework and confusion regarding members' roles and responsibilities were also noted by representatives from the PIC Team. Few challenges were noted by Tier 1 respondents whereas considerably more challenges were noted by members of the PIC Team. In fact, challenges pertaining to infrequent or inconsistent communication, frequent changes in staff, and confusion regarding roles and responsibilities were indicated only by PIC Team staff. In response to an open-ended question on challenges, Tier 1 respondents pointed out restrictions in CFBHN funding criteria that limited how much funding could be dedicated to PIC Team clients. They also stated that certain providers, specifically, substance use providers were difficult to collaborate with. PIC Team staff added that there was often disagreement on what level of care was appropriate for clients, that there was a lengthy period of time between referral and when some agencies connect with a client, and that insured clients were being discharged from CSUs before receiving the level of care necessary. A lack of resources for clients with sex offenses and lack of sufficient resources for clients with substance abuse issues who do not require detox services were also noted as challenges. It was also suggested that some communication challenges stemmed from inconsistent attendance from all levels of PIC Team staff at weekly meetings.

Facilitators. The majority of respondents indicated several facilitators to collaboration. In fact, every potential facilitator was endorsed by more than half of survey respondents. This was also the case when the survey was first administered in March 2019. Communication, convening regularly scheduled meetings, stakeholders' willingness to commit resources, shared

purpose and vision, and having effective leadership were all seen as effectively promoting collaboration. Continuing efforts to keep stakeholders engaged and upholding agency values that support interagency collaboration were also frequently cited facilitators. In response to an open-ended question on challenges, Tier 1 respondents added that it was helpful to have a point of contact at each agency for PIC Team clients, to use multi-party releases and Care Connect referrals, and to have representatives from community agencies attend PIC Team meetings to notify them of available services and resources also helped.

Improvements. 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 clarifying the responsibilities of members of the MHU and PIC Team 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 to the work started by the PICA initiative, respondents also stated that additional funding is necessary.

Summary

Overall, collaboration and coordination were reported to be strong among stakeholders who participated in the surveys, though there were some perceived deficits evidenced by the survey data, network analysis, and open-ended feedback. According to the Interagency Collaborative Activities Survey (Greenbaum & Dedrick, n.d.), stakeholders reported an increase in all collaboration activities over the course of the PICA Implementation (domains include financial and physical resources, program development and evaluation, client services, and collaborative policies). Additionally, the results of the Stakeholder Survey indicate that respondents felt there was a shared understanding of the vision, mission, and goals for PICA, that there was substantial support among stakeholders, and that stakeholders demonstrated a high level of commitment in carrying out the goals of the initiative. There was consistent agreement that PICA stakeholders had clear and frequent communication, and slightly less agreement that PICA has the appropriate organizational capacity and infrastructure to carry out goals.

From the Network Analysis, strong connections and high levels of influence were perceived for Tier 1 and Tier 2 agencies with regard to coordination, and the PIC Team showed many connections to other agencies in this area but was seen as least influential than Tier 1

and Tier 2 agencies. Most of the Tier 1 partners, along with PEMHS, were perceived by respondents as the most committed to PICA, while Tier 2 agencies showed fewer connections in this area. The network diagram indicates strong connections among the majority of stakeholders, suggesting that PICA stakeholders are highly committed to the initiative.

Feedback provided by respondents suggests that roles and responsibilities need to be clarified, among the PIC Team/MHU in particular, that levels of care need to be more firmly established across providers to improve client care, and decision-making and support for care coordination should to be strengthened. Some challenges indicated by stakeholders speak to a need to better understand referral patterns during the three-month period after discharge. Communication and activity between the care coordination level and decision-making level was seen as a facilitator of collaboration, as well as efforts to improve consistency in system-wide processes and generally support inter-agency collaboration values and activities.

CONCLUSIONS AND RECOMMENDATIONS

Implementation Drivers and Systems Change

Based on all available evidence, the evaluation team examined drivers of implementation for PICA that fall within three broad categories defined by the National Implementation Research Network (2016): 1) competency drivers (staff selection, training and coaching, and performance assessment); 2) organizational drivers (administrative supports, data system supports, funding, policies and procedures); and 3) leadership drivers (identification of technical and adaptive challenges by leaders) (Bertram et al., 2015). Though the implementation analysis has taken into consideration the system-wide goals of the PICA initiative, the evaluation has focused largely on the implementation of the PIC Team as a central point of focus.

In Table 19, the key strengths and challenges of each domain in the implementation driver framework is outlined (items in the strengths and challenges columns do not necessarily follow from one another). Although most of the data obtained for this evaluation is related specifically to the PIC Team, measures of system-wide processes, interactions, and initiatives were assessed through meeting observations, stakeholder surveys and network analysis, and to an extent, client interviews. This framework is designed to support systems change, in that assessment of a centralized care coordination model helps to identify gaps in care and in system functioning. By effectively addressing these challenges, pathways to coordination and collaboration are improved.

Table 19

Implementation Drivers and Challenges for PICA

Domain	Strengths	Challenges
Competency Drivers	Ongoing formal and informal training and education among PIC Team	Perceptions of inappropriate use of Baker Acts and lack of training with individuals with ASD by law enforcement
	Consistency in service delivery and team cohesion among PIC Team	Lack of clarity in roles and miscommunication among PIC Team and MHU staff
	Indicators of effective coordination as evidenced by the network analysis	Difficulties in engaging or referring non-compliant clients
	Perceptions of effective PIC Team care among clients	
Leadership Drivers	Positive stakeholder perceptions of PICA implementation (collaboration and systems change domains)	Challenges securing continuous funding for PIC Team
	Consistent use of data in decision-making processes	Lack of clarity around concrete development of PICA initiatives (HIE system, expanding PIC Team)
	Identification of and advocacy for innovative and best practices to develop behavioral health infrastructure	
Organizational Drivers	Strong overall performance outcomes (improvements in client functioning, decreases in arrests and Baker Acts)	Inconsistencies in “level of success” of outcomes and relatively high rate of re-admissions (14%)
	Supportive environment for developing behavioral health systems interventions	Stalled utilization of PICA 2 data system to more efficiently and comprehensively measure success
	Effective targeting of vulnerable individuals in terms of homelessness, disability, and unemployment.	Lack of county-wide racial equity addressed by existing model

Client Outcomes

Approximately 500 clients were referred to the PIC Team between July 2018 and July 2020. Data on client functioning, arrests and jail days, and Baker Act exam initiations were assessed. For client functioning, significant improvements were seen over time in both the

FARS and Self-Sufficiency Matrix. Even for clients who were re-admitted several months after being discharged, these patterns held, indicating a relatively long-term impact on client functioning and self-sufficiency. However, the fact that 71 clients have been re-admitted warrants further scrutiny of the care coordination model and what the expected pathways for long-term success are for clients with complex needs. In terms of county-wide demographic representation, the referral process currently used for the PIC Team does not achieve racial equity in service and should be expanded to serve a greater proportion of racial and ethnic minorities.

Clients who received care coordination with the PIC Team had significant decreases in the number of arrests they've had since being admitted, as well as the number of Baker Act exam initiations. The number of arrests and Baker Act exam initiations significantly decreased for clients who did not receive care coordination through the PIC Team, indicating that there may be an unidentified factor contributing to decreases in these areas. Furthermore, there were slight increases in days in jail for PIC Team clients, though this wasn't significant. So while the functioning outcomes, in particular, provide some evidence of effective service provision by the PIC Team, Baker Act exam and arrest outcomes are complicated by the fact that clients who did not engage in services also experienced decreases.

Another data component addressed during Steering Committee meetings that reflects organizational capacity and infrastructure is the ability to efficiently and comprehensively assess PIC Team data. The system initially designated for this process, PICA 2, has been developed, but it is not used and does not function as a stand-alone tool. Multiple data requests and transfers are necessary to compile reports across key variables, and these requests place a burden on staff members that would otherwise be unnecessary if PICA 2 was fully functioning. While the data needed to assess fundamental outcomes and make decisions are available, the processes for obtaining these data are not clearly understood across key staff responsible for obtaining and sharing data.

Recommendations:

- Determine a strategy for finalizing and utilizing the PICA 2 data system more extensively to more effectively assess PIC Team client outcomes.
- Explore data sources or strategies that can be used to better understand which services clients are connected to at discharge and the outcomes of these referrals are.
- Assess whether Peer Specialist services can be strategically used to increase "successful" case closure or prevent re-admissions for clients with complex needs.

- Consider targeted efforts to address racial and ethnic disparities in behavioral health care and improve cultural responsiveness (e.g., working collaboratively with grass roots organizations or faith-based communities, or increasing the presence of community health workers or peer specialists who can serve as trusted representatives in underserved communities).
- Determine whether further data assessment on PIC Team client arrests would help to better understand why an increase in jail days was observed for clients during this report period.

Implementation Outcomes

Data gathered from PICA Steering Committee and PIC Team meeting observations, client interviews, stakeholder surveys, and document review informed the implementation analysis. Some of the key challenges identified from meeting observations are the impending need to identify sources of funding to continue to support all members of the PIC Team, determine a concrete process for streamlining data sharing and referral processes, and improve system-wide responses to individuals in need of mental health care. Steering Committee members were aligned in their prioritization of several key behavioral health efforts, including aligning contracting processes and identifying core data performance elements across providers; having a multi-faceted approach to substance use treatment using innovative outreach and programs; and advocating for the integration of peer specialists throughout the behavioral health system to improve engagement and quality of care.

Evidence from client interviews indicates that clients saw the PIC Team as supportive and beneficial, particularly in terms of navigating care and improving independent treatment management. Some experiences highlighted during the interviews indicate gaps in the system of care, such as a lack of knowledge by clients of how to obtain care prior to a crisis or involuntary Baker Act examination, some perceptions that law enforcement practices are not consistent with standards of care in responding to individuals with mental health or developmental disorders, and long wait times for service initiation.

Responses from stakeholder surveys and the network analysis indicate that collaboration among the key behavioral health agencies connected to PICA is generally strong, and that a high level of coordination and commitment exist among agencies that make up the steering committee and the PIC Team. Some patterns that were unexpected were that there was a lack of responses from auxiliary providers; not all of the partner agencies for the steering committee were seen as equally involved in coordination and commitment; and though the PIC Team was central to many connections in the network, it was perceived as being the least

influential. Some of these patterns may have to do with confusion and limitations with responses to the survey.

Model Change

The PCSO recently announced that, beginning October 1, 2020, they would no longer contract with Directions for Living to provide clinical staff for the co-responding teams who do initial engagement of PIC Team clients. Instead, the PCSO will hire clinical staff to fulfill these roles internally and who will be overseen by a clinical director at the agency. The MHU will have increased capacity to respond to behavioral health needs of the constituents served by the PCSO, as it will be expanded to include six teams: four response teams and two follow-up teams. It is unclear what impact this change might have on the existing model, as it changes the nature of the inter-agency (mental health provider and law enforcement) co-responding teams. Strong partnerships with behavioral health agencies and community support are two factors identified in the research literature on co-responding police mental health programs that contribute to effective reduction of arrests and diversion from hospitalization (Shapiro et al., 2015). It is also unclear how the increase in capacity to engage potential clients and make referrals will affect the PIC Team's caseloads.

Recommendations:

- Prioritize collaborative activities that engage other providers and auxiliary agencies in new and existing behavioral health initiatives and best practices.
- Identify sustainable funding options for maintaining the PIC Team's staffing structure and service capacity, including expansion.
- Ensure processes are in place for clear pathways of communication among PIC Team and MHU staff and that roles are clearly defined.
- Develop concrete steps or plan for implementing/improving HIE system and expanding PIC Team model
- Enhance law enforcement training on conducting appropriate Baker Act exams and interacting with individuals with autism spectrum disorder (ASD), which often coincides with mental health conditions.
- Conduct community outreach efforts to share ways that PCSO has the training and ability to address mental health and substance use issues to coincide with the expansion of PCSO MHU, and continue developing collaborative partnerships with behavioral health providers.

Next Steps

In preparation for the final evaluation report, due April 10, 2021, the evaluation team will continue coordinating data with PEMHS and CFBHN to assess client outcomes. In addition to ongoing meeting observations, other components of the final report will include steering committee interviews or a focus group, Year 3 discharge interviews with clients, and a focus group with the PIC Team and PCSO MHU. Key findings from the previous report periods will be briefly presented during steering committee interviews and focus groups to gather input on perceptions of how goals have been met and on how evaluation outcomes may be used in informing future activities related to PICA.

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APPENDIX A: Outcomes Data Collection Sources

	Data Source	Date Pulled	Dates Covered
Demographics	PEMHS	7/29/2020	7/1/2018 – 7/29/2020
Administrative Data *	PEMHS	7/29/2020	7/1/2018 – 7/29/2020
Engagement Period	PEMHS	7/29/2020	5/31/2019 – 7/29/2020
Functioning Outcomes	CFBHN	7/29/2020	7/1/2018 – 7/29/2020
Arrest and Jail Data	CFBHN	8/7/2020	7/1/2017 – 8/7/2020
Baker Act Exams	USF BARC	8/14/2020	7/1/2017 – 4/30/2020

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

APPENDIX B: Outcomes Data Statistical Tables

Table A1
Number of Engagement Contacts and Time Spent Engaging Referred Clients

	Referred Only (n=75) $\overline{X}$ (SD)	**Admitted (n=113) $\overline{X}$ (SD)**
Engagement Contacts	$\overline{X}$= 5.41 contacts (4.5)	$\overline{X}$= 3.73 contacts (3.8) **
Time Spent Engaging	$\overline{X}$= 3.55 hours (2.7)	$\overline{X}$= 2.58 hours (2.4) *

** $p < .01$; Engagement contacts- $t_{(186)} = -2.76$, $p < .01$
* $p < .05$; Time spent engaging- $t_{(186)} = -2.54$, $p < .05$

Table A2
Average Number of Arrests

	Referred Only (n=48) $\overline{X}$ (SD)	**Admitted Clients (n=124) $\overline{X}$ (SD)**
# of Arrests 1 Year Prior Referral/ Services	1.31 (1.08)	1.35 (1.31)
# of Arrests 1 Year Post Referral/ Services	0.73 (.98) **	0.80 (1.19) **
	$t_{(47)}$= 2.863; p=.006	*$t_{(123)}$= 3.523; p=.001*

* p < .05; ** p < .01; *** p < .001

Table A3
Average Number of Days in Jail

	Referred Only (n=39) $\overline{X}$ (SD)	**Admitted Clients (n=104) $\overline{X}$ (SD)**
Days in Jail 1 Year Prior Referral/ Services	24.90 (41.1)	19.59 (33.5)
Days in Jail 1 Year Post Referral/ Services	22.94 (47.4)	26.85 (61.3)
	ns	*ns*

Table A4

Average Number of Arrests for Cases Closed at Least 1 Year

	Referred Only (n=21) $\overline{X}$ (SD)	**Admitted Clients (n=78) $\overline{X}$ (SD)**
# of Arrests 1 Year Prior Referral/ Services	1.10 (1.0)	1.19 (1.2)
# of Arrests 1 Year Post Case Closure	1.19 (1.1)	1.04 (1.4)
	ns	*ns*

Table A5

Average Number of Days in Jail for Cases Closed at Least 1 Year

	Referred Only (n=20) $\overline{X}$ (SD)	**Admitted Clients (n=68) $\overline{X}$ (SD)**
Days in Jail 1 Year Prior Referral/ Services	18.85 (37.7)	19.25 (32.6)
Days in Jail 1 Year Post Case Closure	42.95 (59.8)	43.32 (78.1) **
	ns	$t_{(67)} = -2.67; p < .01$

Table A6

Involuntary Baker Act Exam Initiations

	Referred Only (n=121) $\overline{X}$ (SD)	**Admitted Clients (n=224) $\overline{X}$ (SD)**
# of Baker Act Exams 1 Year Prior Referral/ Services	2.45 (2.1)	2.62 (2.7)
# of Baker Act Exams 1 Year Post Referral/ Services	0.52 (1.7) ***	0.85 (1.8) ***
	$t_{(120)} = 8.62; p < .001$	$t_{(223)} = 10.31; p < .001$

* p < .05; ** p < .01; *** p < .001

Table A7

Average Baker Act Exam Initiations for Cases Closed for at Least 1 Year

	Referred Only (n=67) $\overline{X}$ (SD)	**Admitted Clients (n=125) $\overline{X}$ (SD)**
# of Baker Act Exams 1 Year Prior Referral/ Services	2.39 (2.2)	2.50 (1.7)
# of Baker Act Exams 1 Year Post Referral/ Services	0.58 (2.0) ***	1.13 (1.8) ***
	$t_{(66)} = 5.36; p < .001$	$t_{(124)} = 6.81; p < .001$

* p < .05; ** p < .01; *** p < .001

Table A8

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

	Successful Close (n=119)	**Unsuccessful Close (n=62)**	**Other Closure (n=31)**
FARS Disability [a]	$\overline{X}$= 3.00	$\overline{X}$= 3.17	$\overline{X}$= 3.84
FARS Emotionality [b]	$\overline{X}$= 3.76	$\overline{X}$= 4.56	$\overline{X}$= 4.86
FARS Relationship [c]	$\overline{X}$= 3.07	$\overline{X}$= 3.88	$\overline{X}$= 4.15
FARS Personal Safety [d]	$\overline{X}$= 2.52	$\overline{X}$= 3.11	$\overline{X}$= 3.53
Self Sufficiency	$\overline{X}$= 7.47	$\overline{X}$= 4.86	$\overline{X}$= 3.73

[a] $F_{(2)} = 3.62$; p<.05; [b] $F_{(2)} = 8.98$; p<.001; [c] $F_{(2)} = 11.03$; p<.001; [d] $F_{(2)} = 7.76$; p<.01

Table A9

Average Number of Arrests by Case Closure Type

	Successful (n=135) $\overline{X}$ (SD)	**Unsuccessful (n=77) $\overline{X}$ (SD)**	**"Other" (n=41) $\overline{X}$ (SD)**
# of Arrests 1 Year Prior Referral/ Services	.51 (98)	.78 (1.40)	.56 (.81)
# of Arrests 1 Year Post Referral/ Services	.27 (.69)	.55 (1.15)	.41 (.97)
	$t_{(134)} = 3.12; p < .01$	*not significant (ns)*	*ns*

Table A10

Average Number of Days in Jail by Case Closure Type

	Successful (n=135) $\overline{X}$ (SD)	**Unsuccessful (n=77) $\overline{X}$ (SD)**	**"Other" (n=41) $\overline{X}$ (SD)**
Days in Jail 1 Year Prior Referral/ Services	6.04 (21.7)	11.01 (26.2)	11.61 (24.5)
Days in Jail 1 Year Post Referral/ Services	6.40 (33.3)	18.99 (54.1)	13.80 (33.1)
	ns	*ns*	*ns*

Table A11

Average Number of Baker Act Exams by Case Closure Type

	Successful (n=135) $\overline{X}$ (SD)	**Unsuccessful (n=77) $\overline{X}$ (SD)**	**"Other" (n=41) $\overline{X}$ (SD)**
# of Baker Act Exams 1 Year Prior Referral/ Services	2.23 (2.3)	1.99 (2.0)	1.68 (1.6)
# of Baker Act Exams 1 Year Post Referral/ Services	.80 (1.9)	.55 (1.3)	.56 (1.3)
	$t_{(134)} = 7.54; p < .001$	$t_{(76)} = 5.59; p < .001$	$t_{(40)} = 4.25; p < .001$

Table A12

Initial FARS Scores for Re-Admitted Clients (n=24)

	1st Admission			**2nd Admission**
Factor	**Baseline $\overline{X}$ (SD)**	**Discharge $\overline{X}$ (SD)**		**Baseline $\overline{X}$ (SD)**
Disability	3.79 (1.52)	3.45 (1.35) *		2.98 (1.40) *
Emotionality	5.47 (1.34)	4.79 (1.28) *		4.14 (1.66) **
Relationship	4.33 (1.53)	3.92 (1.47)		3.36 (1.65) **
Personal Safety	3.67 (1.23)	3.19 (1.35) **		2.69 (1.42) *

* $p < .05$; ** $p < .01$; *** $p < .001$

APPENDIX B: Recoding of Closing Status for PIC Team Clients

Recoded Close Status	Original Close Status	% (n)
Successful Close	Successful	49.8% (n=130)
	No Further Services Needed	2.3% (n=6)
Unsuccessful Close	Unsuccessful	3.1% (n=8)
	Lack of Progress	2.3% (n=6)
	Refused Services	9.2% (n=24)
	Dropped Out of Services	14.6% (n=38)
	Against Medical Advice	0.4% (n=1)
Other Closure	Incarcerated	2.3% (n=6)
	Moved Out of Area	5.7% (n=15)
	Services Unavailable	0.4% (n=1)
	Transferred to another facility	4.6% (n=12)
	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 Meeting Observation Coding Definitions

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 D: PIC Team Meeting Observation Coding Protocol

FAMILY: PIC CLIENT ENROLLMENT

Referrals – Discussion of the referral process, number of referrals, and problems related to referrals or referring agencies.

Enrollment – Discussion of number of clients enrolled and any logistical issues related to the enrollment process (i.e., intake process, paperwork, data systems), eligibility requirements, any barriers or facilitators to enrollment.

Discharge – Discussion of client discharge process, including number of clients discharged, reasons for discharge, and status of clients at the time of discharge.

Follow-Up – Discussion of follow-up care for discharged clients. May include attempts to follow up, status of client after discharge, or general care coordination post-discharge.

FAMILY: PIC TEAM

Goals and Vision – Discussion related to the purpose, mission, and goals of the PIC Team.

Capacity – Discussion of the PIC Team's capacity to effectively coordinate care, which may include the team's abilities to find appropriate resources and provide necessary services while the client is enrolled, as well as brainstorming ideas to address client-specific challenges.

Engagement – Discussion of the challenges, successes, and needs around engaging clients.

Turnover – Discussion of staff turnover within the PIC Team.

Caseload – Discussion of caseload size and any barriers or opportunities related to the number of cases staff carry.

Quality Assurance and Monitoring– Discussion of formal case review processes or other quality assurance or monitoring of PIC Team procedures.

FAMILY: SERVICES AND RESOURCES

Service/Resource Challenges – Discussion of challenges with existing services and resources as well as ongoing needs for services and resources.

Effective Services/Resources – Examples of services and resources that have been effective with PIC Clients.

Potential Solutions – Discussion of opportunities for potential services or resources (i.e., suggestions offered during case reviews that have not been attempted yet).

FAMILY: CLIENT CHARACTERISTICS

Demographics – Discussion of patterns of clientele demographics, including race, ethnicity, language, sex, region, income, education, work status, family role, etc.

Service Refusal – Discussion of reasons clients refuse or discontinue services and their characteristics.

Functionality – Discussion of level of cognitive, intellectual, or behavioral functioning of clientele.

Diagnoses – Discussion of mental health diagnoses of clients, as it relates to general client characteristics and functioning of the project.

Family Support – Discussion of the extent to which clients have family support, including whether family acts as a facilitator or barrier to treatment.

FAMILY: OUTCOME INDICATORS

Arrests/Jail – Discussion of the frequency of arrests or jail days among clientele.

CSU/Detox Facilities – Discussion of the use of crisis stabilization units or detox facilities among clients.

ER Visits – Discussion of the frequency of emergency room visits among clients.

Housing – Discussion of the utilization of housing services among PIC clients.

Medical Services – Discussion of access to medical services among PIC clients.

Baker Acts – Discussion of the frequency of Baker Act exams among clients.

APPENDIX E: Client Baseline Interview Protocol

Baseline Questions (0-6 months)

1. How long have you been involved in mental health services through the PIC Team?
2. Can you talk about any other mental health care you have had in Pinellas County before starting services with the PIC Team?
    a. How did you find help?
    b. How did you find a provider?
    c. How easy or difficult was it to get the help you needed?
3. What has your experience been like receiving mental health services through PIC Team?
    a. How do you feel about the way PIC Team case managers have engaged with you (i.e., in terms of communication, respect, cultural awareness)?
4. How does your experience with PIC Team compare to your experiences with previous mental health services in Pinellas County?
    a. What, if anything, is different about PIC Team?
    b. What do you like about PIC Team?
    c. What do you dislike about PIC Team?
5. Thinking about the mental health treatment you've had since being involved in PIC Team, how well do you feel your needs are being met?
    a. If you do not think your needs are being met, what could be done differently to make sure you are getting the help you need?
6. Can you talk about what your plans are for continuing treatment are after your time with PIC Team is over?

APPENDIX F: Client Baseline Interview Coding Protocol

Time	Length of time with PIC team
Reasons for PIC	Reasons why involvement with PIC team
PrePIC Finding help	Strategies for getting help pre PIC team
PrePIC Easy to get help	Successes getting bh help pre PIC team
PrePIC Hard to get help	Challenges getting bh services pre PIC team
PIC Communication	PIC team---communication with case manager
PIC Respect/Understanding	PIC team----treated with respect and understanding by cm
PIC Cultural awareness	PIC team----cultural awareness of cm
PIC Engagement	PIC team---engagement with cm
PIC Differences	PIC team---how PIC is different from previous services
PIC Like	PIC team---what is working
PIC Dislike	PIC team----what is not working
PIC Satisfaction	PIC team----overall satisfaction with PIC
PIC Recommendations	PIC team---change recommendations
Future	Plans for getting help post-PIC

APPENDIX G: Average Domain Scores for the IACAS by Tier

	Tier 1 (n=4)	**Tier 2 (n=2)**	**Tier 3 (n=8)**
Financial and Physical Resources	$\overline{X}$ = 4.31	$\overline{X}$ = 4.25	$\overline{X}$ = 4.06
Funding	$\overline{X}$ = 4.75	$\overline{X}$ = 4.50	$\overline{X}$ = 3.88
Purchasing of Services	$\overline{X}$ = 4.25	$\overline{X}$ = 3.50	$\overline{X}$ = 3.75
Facility Space	$\overline{X}$ = 3.25	$\overline{X}$ = 4.50	$\overline{X}$ = 4.50
Information Systems Data Management	$\overline{X}$ = 5.00	$\overline{X}$ = 4.50	$\overline{X}$ = 4.13
Program Development	$\overline{X}$ = 4.88	$\overline{X}$ = 4.00	$\overline{X}$ = 4.16
Developing Programs/Services	$\overline{X}$ = 4.75	$\overline{X}$ = 4.50	$\overline{X}$ = 3.88
Program Evaluation	$\overline{X}$ = 4.75	$\overline{X}$ = 3.00	$\overline{X}$ = 4.13
Staff Training *	**$\overline{X}$ = 5.00**	**$\overline{X}$ = 4.00**	**$\overline{X}$ = 3.88**
Informing Public of Services	$\overline{X}$ = 5.00	$\overline{X}$ = 4.50	$\overline{X}$ = 4.75
Client Services Activities	$\overline{X}$ = 4.30	$\overline{X}$ = 3.70	$\overline{X}$ = 4.40
Diagnosis and Assessment	$\overline{X}$ = 3.50	$\overline{X}$ = 3.00	$\overline{X}$ = 4.25
Common Intake Forms	$\overline{X}$ = 3.75	$\overline{X}$ = 3.00	$\overline{X}$ = 4.00
Service Plan Development	$\overline{X}$ = 4.25	$\overline{X}$ = 3.00	$\overline{X}$ = 4.38
Participation in Interagency Committees	$\overline{X}$ = 5.00	$\overline{X}$ = 5.00	$\overline{X}$ = 4.63
Sharing information about services	$\overline{X}$ = 5.00	$\overline{X}$ = 4.50	$\overline{X}$ = 4.75
Collaborative Policy	$\overline{X}$ = 5.00	$\overline{X}$ = 4.13	$\overline{X}$ = 4.13
Case conferences/reviews	$\overline{X}$ = 5.00	$\overline{X}$ = 4.00	$\overline{X}$ = 4.63
Informal agreements	$\overline{X}$ = 5.00	$\overline{X}$ = 4.00	$\overline{X}$ = 3.88
Formal written agreements	$\overline{X}$ = 5.00	$\overline{X}$ = 4.50	$\overline{X}$ = 4.13
Voluntary Contractual Relationships	$\overline{X}$ = 5.00	$\overline{X}$ = 4.00	$\overline{X}$ = 3.88

* $p < .05$

APPENDIX H: Average Domain Scores for Stakeholder Survey by Tier

Domain	Tier 1 (n=4) $\overline{X}$ (SD)	Tier 2 (n=2) $\overline{X}$ (SD)	Tier 3 (n=8) $\overline{X}$ (SD)
Leadership and Commitment	4.15 (.52)	3.63 (.63)	4.58 (.57)
Shared Vision	3.75 (.52)	3.50 (.58)	4.69 (.71)
Environment	4.00 (.49)	3.83 (.70)	4.52 (.59)
Organizational Capacity *	**3.25 (.65)**	**4.57 (.69)**	**4.36 (1.11)**

APPENDIX I: Abbreviated PICA Agencies and Stakeholders by Tier

	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	