Annual

Pinellas Integrated Care Alliance

Client Outcomes

Enrollment and engagement data, functioning outcomes, arrest and jail data, and involuntary mental health exam initiation (Baker Act) data were used to assess how the PIC Team has impacted clients. Since July 2018, 599 clients were referred to the PIC Team and of those 382 (63.8%) were admitted for care coordination services. W3(e)-11(s.)5( )5(W3(e)-11(s.)5( )5(W3(e)-11(s.)5( )) 284.1W* n1(r)15(d)-

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

Self-Sufficiency

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

Table 1a.
Client Improvement in Functioning

SSM Domain	% Improved
Access to Services	59.9%
Life Skills	49.7%
Substance Use	43.7%
Safety	43.6%
Mental Health	41.5%
Support Services	37.8%

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

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

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

> « WKH OHYHO RI LQWHQVLW\ WKHUH¶V QRWKLQJ HOVH RX **that. If [a provider] simply gives someone a piece of paper and says, go to this mental health treatment center, there are many obstacles and things that come in the way** RI WKDW LQFOXGLQJ MXVW

Client Perspectives

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

Indicators of Systems Change

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

Recommendations

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

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

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

- ➔ Consider collecting more comprehensive information on discharged clients. Appendix H

Other key stakeholders that are central to the implementation of PICA goals include the key provider agencies that are receiving funding to contribute personnel to the Pinellas Integrated Care Team (PIC Team). Personal Enrichment through Mental Health Services (PEMHS) serves as a centralized site that provides facilities and administrative oversight for the PIC Team, as well as four system coordinators and a certified recovery peer specialist (CRPS) who are funded through a grant with the Foundation for a Healthy St. Petersburg (FHSP). The Suncoast Center and BayCare Medical Group have been contracted through PCHS to provide system coordinators for the PIC Team. Directions for Living was contracted by the PCSO to provide clinical personnel for the co-responding MHU through September 30, 2020. As of of October 1, 2020, the MHU was comprised of deputies and clinical staff hired internally. In all, the PIC Tea aoun tio3 11 Tf8a suspervisom, -4(n)-11(i)17(n)-11(e)-11( )5(syst)5(e)11(m)-7( )5(o)-11(

OUTCOMES ANALYSIS

The outcomes evaluation was designed to assess client-level progress across numerous targeted outcomes. Client-level outcomes measure and assess the extent to which the PICA initiative achieves proposed client outcomes through the PIC Team care coordination component outlined in the evaluation plan. The intended method of data collection for PIC Team client outcomes was to draw from a database developed specifically for PIC Team clients (PICA

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

Characteristic	All Referred % (n)	Admitted Clients % (n)
Sex		
Male	52.4% (n=314)	50.8% (n=194)
Female	47.6% (n=285)	49.2% (n=188)
	Total n = 599 [a]	Total n = 382
Race/ Ethnicity		
White	87.2% (n=517)	88.5% (n=338)
Black	8.1% (n=48)	6.3% (n=24)
Other	4.7% (n=28)	5.2% (n=20)
	Total n = 593 [a]	Total n = 382
Hispanic	9.7% (n=51)	7.9% (n=30)
City of Residence		
St. Petersburg	24.7% (n=128)	24.9% (n=95)
Clearwater	19.1% (n=99)	21.0% (n=80)
Largo	12.1% (n=63)	11.5% (n=44)

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

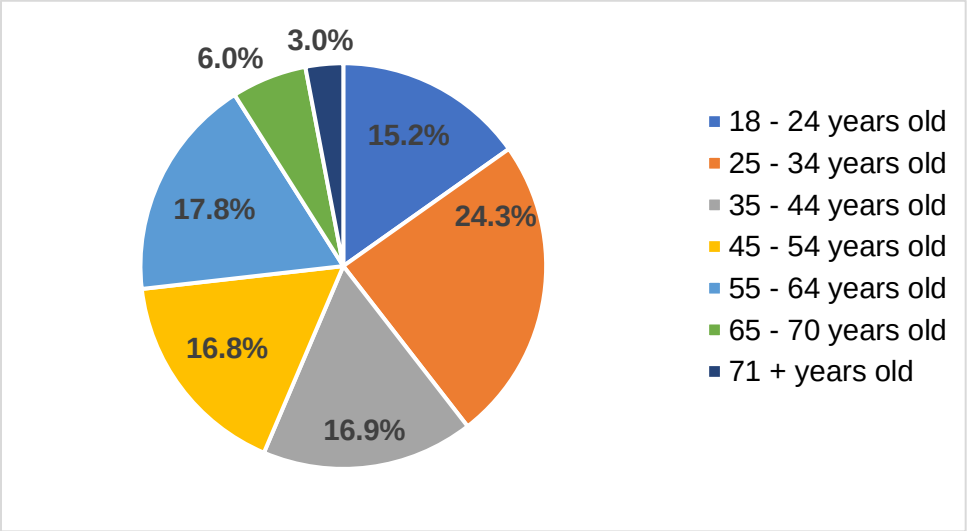

Figure 2. Age range of all clients referred to the PIC Team (n=595).

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

Table 2

Other Characteristics of All Clients Referred to the PIC Team

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

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

Table 4

Number of Engagement Contacts and Time Spent Engaging Referred Clients

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

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

Table 5

Engagement Strategies

	First Contact	Second Contact
Admitted	n=175	n=129
Phone	23.4% (n=41)	28.7% (n=37)
Face-to-face	8.0% (n=14)	10.9% (n=14)
Activity on ward	37.2% (n=80)	32.6% (n=42)
Collateral Contact	7.1% (n=11)	11.6% (n=15)
Telehealth	2.3% (n=4)	3.9% (n=5)
No show/ cancelled	0.6% (n=1)	2.3% (n=3)

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

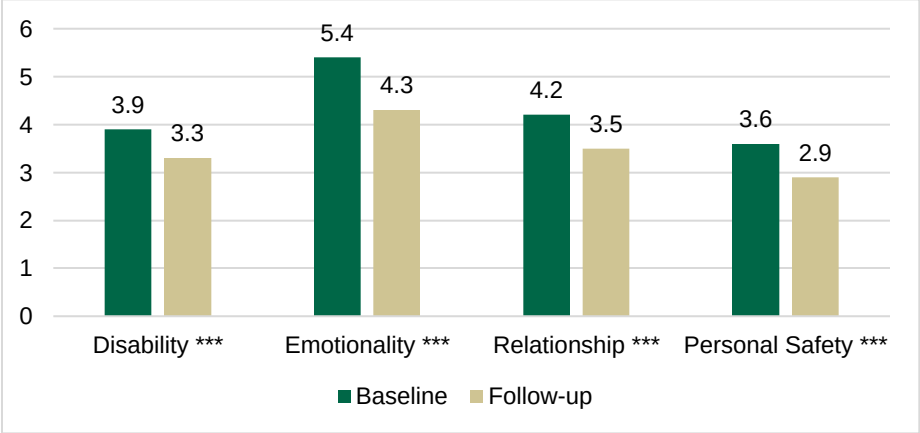

Figure 5. Average FARS Factor Scores at Baseline and Follow Up (n= 292)
Note- Updated FARS assessment data were provided on January 20, 2021

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

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

Functioning: Self-Sufficiency

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

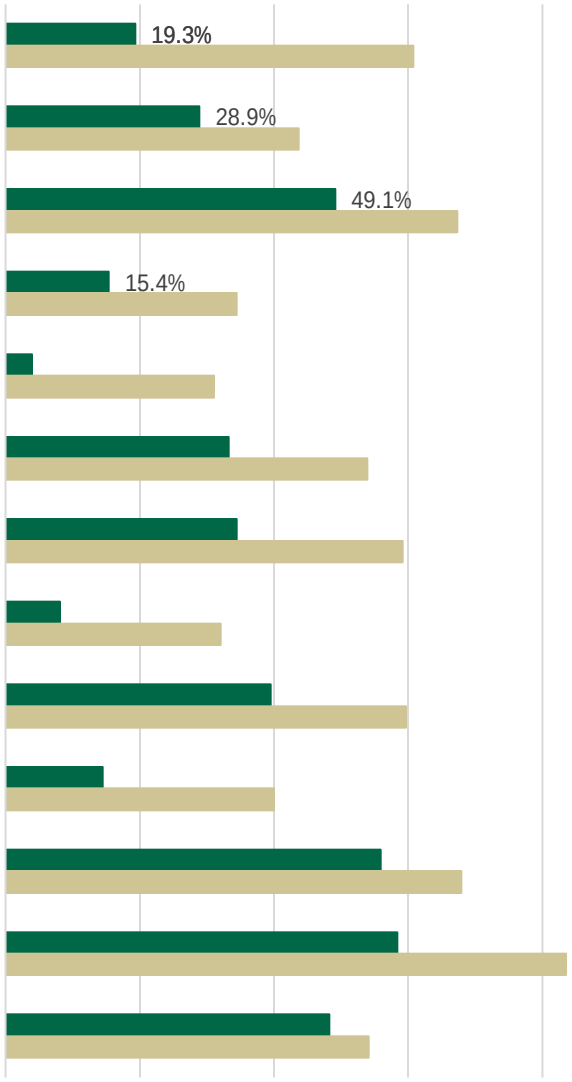

Figure 7. Proportion of Clients Stable or Thriving (n ≈ 275)

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

Table 6.
Client Improvement in Functioning

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

Arrests and Days in Jail

Administrative data on arrests of all individuals referred for PIC Team services was obtained from CFBHN. These data detail dates of arrest, arrest charges, and the number of days individuals were incarcerated. The most recent data was shared with the evaluation team on January 23, 2021. Two of the outcomes used to measure the impact of the PIC Team are reduction in the number of arrests for PIC Team clients and a decrease in the number of days in jail for PIC Team clients. Arrest and jail days were recorded for one year prior to clients' engagement with the PIC Team and one year following case closure. For comparison, this data was also obtained for clients who were referred but not engaged (not opened). Clients currently being engaged or served and those who were nev11(se)-11( )] T8 >4ef*396.4 4911(r)-7(r)15(e)-11(d)-11( )28(b)-11(u)-11(t)5( )5(n)1-11(t)

To provide a more accurate idea of these outcomes, this analysis was repeated for clients whose case has been closed at least a year. These findings examine arrests and days in jail for a full year before referral and a full year after cases are closed. Overall, these data continue to show a slight decrease in the number of arrests for clients who received PIC Team services. The difference, however, is not significant (see Figure 10). **A 10.1% decrease in arrests was observed for PIC clients compared to a 10.1% decrease for clients referred but not admitted.** The number of days in jail increased significantly for PIC Team clients.

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

Baker Act Exam Initiations

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

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

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

Figure 12. Average Number of Baker Act Exam Initiations

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

Case Closure and Re-Admissions

Since the first client was admitted in July 2018, 472 clients have been discharged from PIC Team services. At discharge, PIC Team staff made determinations as to how successfully clients progressed during care coordination. Discharge status categories were aggregated to indicate a “successful close,” “unsuccessful close,” or other closing classification. Appendix B details how discharge status categories were recoded for this analysis.

problem severity was observed for successfully closed cases compared to cases closed unsuccessfully and cases closed I R U ³ R W K H U ´(see H D V R Q V Table 7). Findings from the Self Sufficiency Matrix show clients whose case was successfully closed were stable or thriving for significantly more domains compared to those whose case was unsuccessfully closed or closed for another reason.

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

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

NOTE: Each FARS functional domain is rated on a scale from 1 (“no problem”) to 9 (“extreme problem”) to describe problem severity within the previous three weeks. **Higher FARS scores indicate greater problem severity.** Self-Sufficiency scores range between 0 and 13 indicating the number of domains cl004577nttT3m0s8tabl77ntt ore e3(ge. TJETQq0.00000912 0 612 792 reW* nBT/F5 9 Tf1 0 0 1 1

numsiciency 77ntcl TJETQq0.00000912 0 612 792 reW* nBT/F3 9 Tf1 0 0 1 288.94 381.83 6m0 0.404 0.278 rg0 0.404 0.278 RG 0.

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

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

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

Summary

Functioning outcomes, arrest data, and Baker Act exam initiations were used to assess how PIC Team services impacted clients. Since July 2018, almost 600 clients were referred to the PIC Team. FARS scores decreased significantly over time for each factor, indicating greater functionality. Further, the proportion of PIC Team clients who were stable or thriving increased appreciably from baseline to closing assessment across all self-sufficiency domains. Data on the arrest history showed the number of arrests decreased significantly for clients who received

Table 8

Overview of Evaluation Activities and Intervals

Year	

Steering Committee and Core Staff Perspectives

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

Vision and Goals

Across each year of the evaluation, there was strong agreement that there was a **shared vision** for the PICA initiative. Steering committee respondents shared that several of their agencies had increasingly worked together to address barriers to the behavioral health system—particularly on engaging individuals who had frequent contact with crisis stabilization services and the law enforcement—and that the vision was clarified further when the group applied for a grant to establish the PIC Team. Steering committee, PIC Team, and MHU members shared agreement of the multi-part vision: to improve coordination and

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

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

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

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

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

Some other key **services that were identified during Year 2 as difficult to access** were the FACT Team, outpatient treatment, short-term residential treatment, assisted living facilities, specialty therapies such as EMDR, and housing services for sex offenders. Several respondents shared that, many times, clients will initiate a Baker Act call on themselves in order to receive priority treatment. This workaround highlights the problems with wait times for crucial behavioral health

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

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was developing a database to capture most outcomes of interest, though the system was not yet functioning during this year. The PIC Team utilized several data systems initially (from each of the behavioral health

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

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

included interagency involvement

Table 9

Client Perspectives

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

Year 3 Client Discharge Interviews

Enrollment. Seven participants were discharged at the time of interview and reported being enrolled in services from three to six months in their most previous treatment cycle, although some were re-enrolled in service twice in the past few years. Participants were referred to a variety of services, such as financial assistance, transportation assistance, substance use treatment, and group therapy. They were also provided psychoeducation about their mental illness when applicable, such as one client who learned about their diagnosis of bipolar disorder. Participants' family members received assistance on occasion, such as one participant who shared that, "[My system coordinator] gave me resources to help get bills paid. She even made phone calls for me to help get [b ^ r> n

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

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

Figure 14

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

This survey was administered within the first year of the PICA initiative and again in the final yead. At both time points, most collaborative activities involved strategies and process that pertained to Program Development and Collaborative Policy (see Figure 15). Data also indicate there w EMs4q0.e

This survey assessed perspectives of PICA stakeholders across five domains: Leadership and Commitment; Shared Vision, Values and Mission; Environment, Stakeholder Involvement; and Organizational Capacity and Infrastructure. The Leadership and Commitment domain

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

Figure 18. Network Diagram for PICA: Commitment

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

Challenges and Facilitators

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

Respondents indicated several facilitators to collaboration.

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

Systems Change

A Framework for Evaluating Systems Initiatives (Coffman, 2007) was used to assess evidence of systems change with the PICA initiative (see Figure 19). This framework utilizes five focus areas to assess change: Context, Components,

PICA Systems Change Indicators

Highest Focus | Substantial Focus | Some Focus

	Context	Components	Connections	Infrastructure	Scale
ACTIVITIES	**Developing a vision** Educating policymakers Engaging the public Engaging the media **Doing social media campaigns**	Expanding high quality programs **Developing new programs or services** Expanding eligibility Increasing access and availability	**Creating forums for cross-sector planning** **Aligning outcome indicators** **Connecting data systems** **Promoting collaboration and referral coordination** **Streamlining intake processes/assessments**	**Developing new governance supports** Improving quality of programs and services Improving state and local connections **Implementing monitoring and oversight strategies**	Increasing or expanding system services **Increasing the number of beneficiaries served** Driving system sustainability Ensuring program integrity and service quality is high enough to be consequential
OUTCOMES	**Increased evidence base about the system and its needs (HIE and ODS initiatives, KPMG assessment)** **Shared behavioral health vision** State and local political leadership engagement New and mobilized behavioral health advocates Changed policies	**Expanded programs or services** **New programs (PIC Team)** **Better access (coordinated care initiatives)** **Higher-quality programs and services (updated 211)**	**Interagency work/planning groups (HIE, ODS, SOC)** Shared data systems **Improved system coordination** Cross-system training **Co-located programs (e.g., ³RQWRS´LQWRservices) (PIC Team)** Increased referrals between providers **Memoranda of agreement between system partners**	**Governance entities that oversee and coordinate subsystems (Steering Committee)** **Leveraged use of funding (PICA)** **Research and monitoring of cross-system data (Steering Committee, USF)** Aligned standards (ODS) Efficient service delivery Professional development and staff technical support	System spread System depth System sustainability **Shifts in system ownership**
IMPACT	Outcomes are not expected to show direct impacts for behavioral health consumers	**Improved behavioral health system outcomes in relevant domains (reduced Baker Act exams/arrests)**	**Improved consumer outcomes where system components are connected (MHU/PIC Team model)**	Outcomes are not expected to show direct impacts for behavioral health consumers	

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

CONCLUSIONS AND RECOMMENDATIONS

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

Client Outcomes Analysis

Functioning outcomes, arrest data, and Baker Act exam initiations were used to assess how PIC Team services impacted clients. Since July 2018, almost 600 clients were referred to the PIC Team. FARS scores decreased significantly over time for each factor, indicating greater functionality. Further, the proportion of PICA clients who were stable or thriving increased appreciably from baseline to closing assessment across all self-sufficiency domains. Data on the arrest history showed the number of arrests decreased significantly for clients who received care coordination with the PIC Team. Days in jail, however, increased for clients who received care coordination with the PIC Team, though not significantly. Lastly, Baker Act exam initiations, on average, decreased significantly for clients as well. The number of arrests and Baker Act exam initiations significantly decreased for clients who did not receive care coordination through the PIC Team. Taken together, these functioning outcomes provide some evidence of effective service provision by the PIC Team. However, given improvements also observed for clients who did not receive PIC Team services, these improvements cannot be attributed solely to the PIC Team intervention. Further assessment is warranted to make cle11( )5(ca)-71(n)-11(t)5(s)]an112 792 reW* nBT[(12 0 612 792 reW* nBT2

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

Implementation Analysis

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

Steering

Client Perspectives

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

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

The evaluation team interviewed 23 participants about their **Experiences Post-Discharge**, including a few who had re-enrolled in services. Participants were connected to a variety of mental health, substance use, and housing agencies to continue care. Most found that their time enrolled in services with the PIC Team enhanced their ability to seek care when needed. Participants became more knowledgeable about resources available to them, which had previously been a serious barrier to many. They reported feeling more confident about using coping mechanisms, managing personal relationships, and u

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APPENDIX A: Outcomes Data Collection Sources

	Data Source	Date Pulled	Dates Covered
Demographics			

APPENDIX B: Recoding of Closing Status for PIC Team Clients

Recoded Close Status	Original Close Status	% (n)
Successful Close	Successful	

f. Sustainability

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

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

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

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

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

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

CONCLUSION

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

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

Effectiveness—discussion of the initiative's effectiveness so far

APPENDIX E: PIC Team Client Interview Protocol - Discharge

Post-Enrollment Questions (3 months post-discharge)

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

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

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

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

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

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

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

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