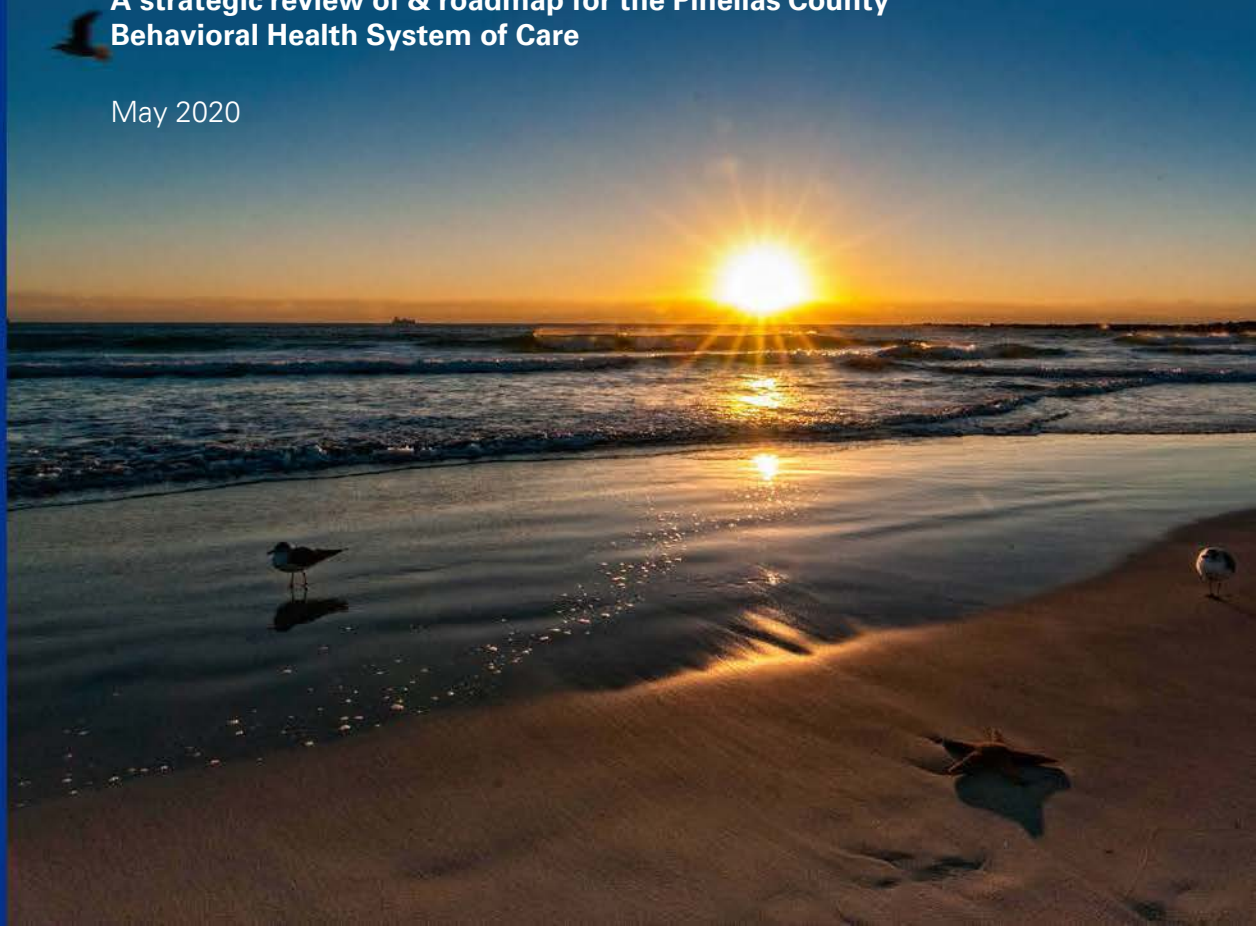
KPMG

Elevate Behavioral Health Pinellas County

A strategic review of & roadmap for the Pinellas County Behavioral Health System of Care

May 2020



Executive summary

Introduction

Pinellas County (County) engaged KPMG in December 2019 to undergo a roughly three-month project to scan the behavioral health system, interview stakeholders, review leading practices, and bring back to the County a new vision to improve the system of care around behavioral health in Pinellas. This has led to this strategic report to "Elevate Behavioral Health," with this being the foundational step in moving the County in a new direction in patient-centric services, enhanced governance, funding, and performance management aimed at improved outcomes for the County's residents.

Overview

The Pinellas Project Planning Team provided KPMG with the following Top 5 questions to guide the analysis. High-level responses to each of these questions are provided in the following pages of the executive summary, with additional details contained throughout the report.

Question 1: Do we have the data to know how well our system of care is performing in terms of access, capacity, productivity, and quality outcomes?

Question 2: Should we build a new Marchman facility or expand current capacity?

Question 3: Should we increase case management compliment to better accommodate the Baker Act population to ensure no one falls through the cracks?

Question 4: Should we consolidate all our contracts and funding into fewer providers?

Question 5: Should we be doing more as a system of care to combat the opioid crisis?

Based on answers to the Top 5 Questions above, KPMG recommends that the County take immediate action and consider investment in the following foundational issues:

1) Establish a systemic performance management approach in terms of access, quality, capacity, productivity, and outcomes—grounded on a Minimum Data Set (MDS) across all providers, allowing for benchmarking comparison and trend analysis. This requires establishing a contractual MDS requirement for all providers arising from collective development of an MDS with behavioral health funders within the County.
2) Establish a robust Coordinated Access Model that allows for increased transparency in how clients, families, caregivers, and professionals can access the right services within the system. This requires various enabling elements including a 1-800 number; standardized screening, triage and scheduling practices; and an evaluation of the current systems in place by providers to ensure interoperability and exchange of information to allow for a consolidated view of consumer demand, level of need, available capacity, and access to care.

Impacts of COVID-19 on our report and recommendations

While the fieldwork and analysis of this engagement concluded in early March 2020, KPMG believes the current circumstances surrounding COVID-19 make the strategy and recommendations put forth in this report even more relevant and urgent. For instance, increasing access in primary care and other community-based settings to improve prevention and early intervention will rely even more heavily on scaling up telehealth channels and infrastructure. Additionally, economic and emotional stressors may drive an increase in community need for mental health and substance abuse services both during and long after social distancing guidelines abate. Finally, the impact of distancing guidelines in the clinical setting for both consumers and providers may cause significant challenges in access, capacity, and timeliness of care – all under-scoring the need for an enhanced model of coordinated access across all settings of care in the County's behavioral health system.

Executive summary

Background

KPMG's scope centered on scanning the existing continuum of programs and services across the County's Adult Behavioral Health System of Care to identify high-level gaps, and inform a future-state vision and roadmap for action, considering both County and State-funded providers and programs.

The County asked KPMG to provide a new vision for the County in how it could meet the requirements of its residents. The County is in a unique position as it is not the direct provider of services nor the primary funder of the services described in this report. The County instead funds services that fill three buckets:

1. **Matched funding:** The State of Florida (State) funds some behavioral health services and requires a 25% match by County governments within those programs.
2. **Gap funding:** The County identifies gaps in services throughout the system and proactively contributes to enhancing funding for existing programs and services. Grants are also used for this purpose.
3. **County programs:** The County develops and contracts for its own programs or is required to fund services such as those medical and behavioral health services provided in the County jails.

The County allocates two types of funds across the behavioral health system: general funds from the County's budget and grant funding acquired through a variety of sources. The County is active in pursuing grants to deliver enhanced services to residents; however, these grants often come with significant restrictions that do not allow for sufficient flexibility in allocation or distribution to services to fit the specific needs of the County. These funds and the County's current strategy described above have allowed the County, along with community and State partners, to deliver a wide breadth of services to its residents.

The scope of behavioral health services observed by KPMG is consistent with those found in other jurisdictions with a more mature continuum of care. KPMG's recommendations focus on improved analysis, optimization, and coordination of existing programs before further investments are considered.

Approach

KPMG has identified a need for better coordination, management, and alignment of strategy across the services being provided. It is important to note that KPMG did not conduct a review or analysis of the third-party providers and their delivery of services. Our findings reflect the perspectives of a broad range of stakeholders interviewed and system-level information reviewed. The foundational questions asked of the 50 organizations interviewed were:

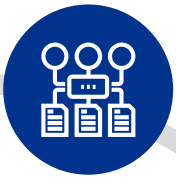
- What is going well in the Pinellas County Behavioral Health system?
- What can be improved for residents needing services?
- What are the pain points in the current system?
- What can the County do to improve the governance and funding structure?
- What services and/or capabilities (if any) are missing?
- How does the County measure performance?

This report is the collated result of these questions. There are no findings, solutions, or options presented herein that were not discussed or supported by input from and discussions with County stakeholders. KPMG filtered those perspectives and assessed them against the available performance and budgetary data that was provided. A further narrowing of issues, options, and recommendations was accomplished by reviewing the existing literature and leading practices to assess the viability and validity of our recommendations.

Executive summary (continued)

Commendations

KPMG was consistently impressed by the input, passion, and dedication of the County and its stakeholders who were engaged in this process. The County operates a broad and mature set of programs and services, resulting in KPMG's desire to highlight the following selection of commendable practices observed.



Cross-systems leadership and collaboration

The County has continued to embrace system-wide collaboration through the Pinellas Integrated Care Alliance (PICA) and focus on alignment across agencies and providers to improve long-term outcomes.

Investment in high utilizers

The County has further invested in programs to address the needs of highest-need clients, such as the Pinellas Community Empowerment Team and Health Care for the Homeless Co-occurring Assistance Recovery & Empowerment Team.

Cross-system data sharing

The County has made progress in enabling interagency data sharing within and outside of behavioral health by investing in the Data Collaborative and Care Connect.

Focus on supportive services

The County has continued to invest in programs providing supportive services for homeless individuals and aimed at ending the Opioid Crisis, such as the Co-operative Agreement to Benefit Homeless Individuals and Opioid Site Based Grant for Strategic Information Partnerships.

Investment in receiving and diversion

The County has shown a strong commitment to expanding and enhancing receiving and diversion options away from hospitals and jails through programs such as Personal Enrichment Through Mental Health Services (PEMHS) and Westcare Turning Point Homeless Inebriate Shelter.

Executive summary (continued)

Key findings

The KPMG team presented our independent findings to County leadership periodically and validated the information and recommendations contained within this report. This validation serves not as an endorsement of KPMG findings but helps to ensure that the information contained herein is County-focused and is consistent with the Statement of Work for this project. KPMG identified five core findings, which guided the solution development for the County's consideration. Those findings are as follows:

Finding 1: Primary entry into behavioral health services is through crisis care settings (e.g., emergency department, jail, receiving facilities).

Finding 2: Silos persist such that the behavioral health system functions more as a set of programs than a coordinated system of care.

Finding 3: There is a lack of data-driven transparency and accountability on how well behavioral health providers and services are performing collectively, and in some cases individually.

Finding 4: Funding structures and reporting requirements are siloed, causing a lack of the flexibility and transparency needed to follow patients through the system of care.

Finding 5: The unique geographic dimensions and population density of the County limit the practicality of one central receiving facility to effectively serve an ever-growing population.

From challenges to strategic options

While not all-encompassing of the varying perspectives of County stakeholders, the challenges illuminated from these five findings have resulted in a robust set of strategic options to improve the behavioral health system. The options presented on the following page have been validated against leading practices and available performance and quality data, with a key focus on outcomes for County residents. While provider service and treatment-level data was not accessible or available for this strategy and visioning process, we do understand that the County's system of care faces three critical and growing community problems. Challenges include:

1. Increased suicide deaths of 10% from 199 in 2015 to 219 in 2018 [1]
2. Increased opioid-related overdose deaths increased by 78% from 2015 to 2018 [2]
3. Decreased count of homeless individuals from 3,387 in 2015 to 2,415 in 2019, but an increase in certain sub-groups such as those with disability status, homeless veterans, chronically homeless and homeless individuals residing in Pinellas County Jail [3]

These key system-level challenges guided the "why" and "why now" for developing possible options and strategies, leveraging leading practices and strategies in place and under consideration by other jurisdictions. The options presented on the following page are presented in two categories: System Management and Service Delivery.

[1] **Florida Health for Suicide Deaths** http://www.flhealthcharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0116

[2] **The Opioid Epidemic in Pinellas County** https://www.arcgis.com/apps/Cascade/index.html?appid=8c02b926f02c4498b1dda55f00e4a1aa

[3] **Analysis of Pinellas County Point in Time (PIT) Data from 2015 through 2019** https://www.pinellashomeless.org/performance

Executive summary (continued)

A vision for the system of care

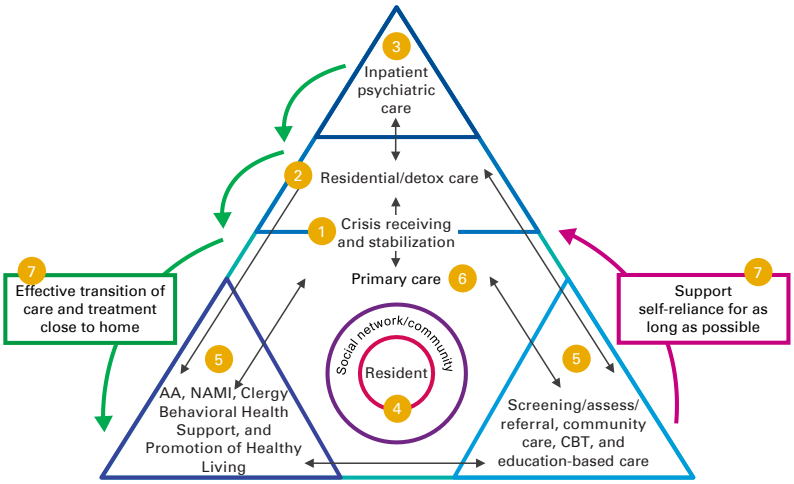
The figure below visualizes the future-state vision for the County's behavioral health system in two parts. The top of the triangle representing acute and subacute services, and the base focuses on prevention, early intervention, and community treatment models.

Top of the triangle: Acute and subacute interventions

1. Crisis Receiving and Stabilization: Includes services that are open 24/ 7 days a week, 365 days a year for clients whose needs are not met through traditional outpatient methods of care. These clients may have gone into a crisis that requires immediate attention by a psychiatrist, nurse, social worker, or other staff. Crisis programs make every effort to stabilize the client, and if deemed safe, discharge patients back to lower acute care for treatment and follow-up. It is only for clients that the crisis program is unable to stabilize that are transferred to subacute or acute care.

2. Residential/Detox Services: Includes services for clients who require a stabilization period from substance abuse. These programs differ from a short-stay admission to a long-stay admission based on client presentation and willingness to engage in treatment. Clients typically reside in the facility and engage in these services through voluntary admission.

3. Inpatient Psychiatric Care: It is important to note that clients who are admitted directly from the crisis stabilization unit to inpatient psychiatric care are often those with a serious mental illness (including those with a co-occurring disorder). Clients are admitted either voluntarily or under the mental health act (i.e., Bakers Act) for a 72-hour for assessment and observation. An interdisciplinary team works with the client to stabilize them and transition them back to lower acute care, that is often a step-down program within the base of the triangle.



Base of the triangle: Prevention and early intervention

4. The center of the triangle is where the resident sits with a strong social network and community surrounding them. This is a crucial part of the patient journey, where social support is what keeps them engaged with community-based services and supports.

5. The left and right corners represents prevention and/or early intervention programs that the majority of the population can be served through. Once clients enter these programs, the majority of their needs are met if programs are able to offer timely access and evidence based care.

6. Primary care is sought for early symptom detection, diagnosis, referrals to name just a few. They stand before the crisis receiving and stabilization components, because if the client is attached to a primary care team and can stabilize without seeking a more intrusive measure of care, then that is the preferred treatment approach.

7. The goal is for client to be self-reliant for as long as possible and for services to be available in order to effectively transition care and treatment close to home once they have completed their subacute/acute treatment.

Based on research from the KPMG Global Center of Excellence for Healthcare, it is estimated that 96% of a typical community (not accounting for high-risk populations) needs are met by an effective "base" in a healthcare system.

Executive summary (continued)

Options considered

KPMG developed a set of strategic options across six categories for change, at both the System Management and Service Delivery levels. We recommend the County and its stakeholders consider these options from left-to-right, enhancing Performance and Coordination before considering Funding or Receiving and Diversion.

System management

Performance management

PM-1	Develop County Minimum Data Set
PM-2	Develop System wide Minimum Data Set
PM-3	Integrate County Minimum Data Set with Funding

Governance

G-1	Enable Performance-Based Contracting at County Level
G-2	Engage a Managed Entity at County Level and/or State

Funding

F-1	Consolidate Funding Across County & State Sources
F-2	Hybridize Funding Across County & State Sources

Service delivery

Coordination

C-1	Establish a County & Provider-Managed Model of Coordinated Access for Consumers
C-2	Establish a Managed Entity & Provider-Managed Model of Coordinated Access

Prevention & early intervention

PE-1	Enhance Existing Prevention & Early Intervention Services

Receiving & diversion

D-1	Enhance Existing Public Receiving Service Capability
D-2	Standardize Across Public & Private Receiving Model
D-3	Enhance Existing Public Receiving Capacity

From strategic options to pathways for action

KPMG validated the above options with the County and organized options into five pathways to implementation. Even in isolation, each recommendation would be impactful if adopted; however, KPMG recommends a more comprehensive program of transformation to enhance overall potential impact on systemic efficiency and resident outcomes. The recommendations also cannot be viewed as an a la carte menu of options. These options ask the County to consider these fundamental changes:

System management

- **Performance Management:** Develop a more robust strategic performance management framework.
- **Governance:** Enact performance-based contracting and consider the assistance of a third party.
- **Funding:** Consider consolidation of funding into high-performing programs and service providers.

Service delivery

- **Coordination:** Reduce silos and improve resident navigation of the behavioral health system.
- **Prevention:** Expand and enhance prevention services building on existing County and State services.
- **Receiving and Diversion:** Enhance services for individuals in crisis leading to increased clarity on capacity needs.

The pathways described on the following page all imply a shift in existing capacity and/or additional effort/ funding not currently present in the system. As noted previously, the County does not directly provide services to consumers nor is it the lead funder of services—that role falls to Central Florida Behavioral Health Network (CFBHN) on behalf of the State. The successful adoption of these recommendations necessarily falls on the entire system of care, which includes the providers, the State through its departments and its Managing Entity, and multiple County agencies as well. A coordinated approach to change across stakeholders is necessary if the County and its partners are to be successful in improving resident outcomes.

Executive summary (continued)

Implementation pathways

The five pathways below integrate the strategic options into logical groups based on the interdependencies and represent significant multiyear efforts. For instance, consolidated funding being predicated on performance-based contract governance and a system-wide Minimum Data Set. Similarly, investment in expanded public receiving capacity should be predicated on residual needs once Coordinated Access Models and enhanced prevention services are in place. Implementation pathways include:

Pathway 1 System-wide	Pathway 2 County-focused comprehensive	Pathway 3 Focus on prevention	Pathway 4 Enhanced	Pathway 5 Enhanced plus new capacity
This implementation pathway emphasizes system-wide collaboration between County and State funders and providers for performance management and the coordinated access model of care. A hybrid approach is taken to contracting, funding, and receiving and diversion.	This implementation pathway focuses on what the County can independently influence, including a consolidated approach to contracting, funding and performance management, and further investment in receiving and diversion, coordination, and prevention and early intervention.	This implementation pathway focuses on investing further in prevention and early intervention services, while enhancing performance-based contracting and the existing public receiving facility.	This implementation pathway focuses on enhancing existing contractual frameworks and their public receiving facility, and developing a County Minimum Data Set requirement for all providers.	This implementation pathway focuses on creating net new capacity across diversion programs and receiving facilities, while enhancing critical components in contracting and funding.
PM-2 Develop System-Wide Minimum Data Set	**PM-3** Integrate County Minimum Data Set with Funding	**G-1** Enable Performance-Based Contracting at County Level	**PM-1** Develop County Minimum Data Set	**PM-1** Develop County Minimum Data Set
+	+	+	+	+
G-2 Engage a Managed Entity at County Level and/or State	**G-2** Engage a Managed Entity at County Level and/or State	**F-2** Hybridize Funding Across County & State Sources	**G-1** Enable Performance-Based Contracting at County Level	**G-1** Enable Performance-Based Contracting at County Level
+	+	+	+	+
F-2 Hybridize Funding Across County & State Sources	**F-1** Consolidate Funding Across County & State Sources	**PE-1** Enhance Existing Prevention & Early Intervention Services	**D-3** Enhance Existing Public Receiving Capacity	**D-1** Enhance Existing Public Receiving Service Capability
+	+	+		
C-2 Coordinated Access Model – Managed Entity & Provider Managed	**C-1** Coordinated Access Model – County & Provider Managed	**D-1** Enhance Existing Public Receiving Service Capability		
+	+			
D-2 Standardize Across Public & Private Receiving Model	**PE-1** Enhance Existing Prevention & Early Intervention Services			
	+			
	D-2 Standardize Across Public & Private Receiving Model			

- Performance Management
- Governance
- Funding
- Coordination
- Prevention & Early Intervention
- Receiving & Diversion

Executive summary (continued)

Implementation pathways (continued)

The pathways in the previous page are presented left-to-right in terms of level of impact and required stakeholder collaboration. High-level duration, complexity, and costs indicated above are summarized in the figure below and further detailed in the body of this document. Finally, in our view, the adoption of one pathway by the County would not preclude shifting direction to another in the future as circumstances and drivers may change.

	Pathway 1 **System wide**	Pathway 2 **County-focused Comprehensive**	Pathway 3 **Focus on prevention**	Pathway 4 **Enhanced**	Pathway 5 **Enhanced plus new capacity**
Level of Impact	High	High	Medium	Low	Low
Level of Effort	High	Medium	Low	Low	High
Level of Investment	$2–3M (>20% current budget)	$2–3M (>20% of current budget)	$500–1M (>10% current budget)	$500K to $1M (<10% current budget)	$3–10 M (>30% current budget)

- **How much change does the County need?** If the County believes significant change is needed to achieve its expected outcomes, the County must consider pathways 1 and 2. Pathways 3 and 4 would be the best fit if the County is seeking more incremental change.
- **What level of impact does the County expect?** Pathways 1, 2, and 3 would provide the highest impact to the County. The changes would drive fundamental changes to treatment delivery and strategic performance management.
- **What level of investment is available?** Pathways 3 and 4 come at the lowest cost, with pathways 1 and 2 representing about an equal level of additional investment in new and enhanced services. Pathway 5 has the possibility to be the highest cost.
- **What will the level of effort be?** Pathway 1 represents a high level of effort due to its implied systematic changes. Pathway 2 falls in the middle, and 3 and 4 are low effort options that still can provide great benefits to the County. Pathway 5 could represent significant effort if the County goes down the path to build a new facility.

Executive summary (continued)

Implementation phases

The KPMG team believes that the County needs to engage in a systematic implementation program that is sequenced in decision-making, is considerate and inclusive of stakeholders, and designed for long term sustainable change. Regardless of the County's selected Pathway, KPMG recommends the following sequence of change to provide for a period of evaluation, optimization of existing resources, and incremental identification of investment thereafter in enhanced services and/or expanded capacity.

Decide	Evaluate	Optimize	Innovate	Sustain
The first phase is about determining and deciding on the most optimal implementation pathway for Pinellas County between: 1) System wide 2) County-Focused Comprehensive 3) Focus on Prevention 4) Enhanced 5) Enhanced Plus New Capacity	The second phase is about ensuring effective evaluation and performance management structures are implemented across all programs within the County. Without this foundational element, program leaders will be unable to make informed decisions on where to invest and address gaps in the behavioral health system.	The third phase is about using the existing assets available within the system and ensuring Pinellas County is optimizing care coordination between them. This process begins to shift the incentives towards a performance-based environment.	The fourth phase is predicated on the idea that you have built a foundational performance management system and have optimized existing resources. Once that is complete, the innovation phase is about identifying new programs or expanding existing initiatives that address identified gaps in the system.	The fifth phase is focused on monitoring the newly implemented recommendations to confirm they function according to intended outcomes in a consistent, repeatable manner. This involves monitoring post-implementation performance monitoring and continuous improvement

Executive summary (continued)

Top 5 questions

The Pinellas Project Planning Team provided KPMG with 5 top questions to guide the analysis. The following provides high-level responses to each of these questions, with additional details contained throughout the report.

Question 1: Do we have the data to know how well our system of care is performing in terms of access, capacity, productivity, and quality outcomes?

No, the system does not, based on the data reviewed. There is a lack of data-driven accountability regarding the performance of behavioral health providers at both an individual and system level. As a result, provider performance remains largely opaque to the County and system stakeholders due to lack of transparency around efficiency and effectiveness of processes and outcomes—making it difficult to consistently and continuously evaluate quality of care, access to care and value of care for the level of investment. Various stakeholders have commented on the need for performance-based and data-informed funding, so that return on investment can be more accurately assessed based on a "true" understanding of the cost and outcomes of care.

Question 2: Should we build a new Marchman facility or expand current capacity?

No, not until we have better system-level data on capacity, utilization, and productivity. Stakeholders in Pinellas County have asked the question of whether they need a new facility to address the behavioral health needs of their residents. At first glance, it appears the increase in suicides and substance-abuse-related deaths may indicate that the current system is not managing the problem well and a new public receiving facility might be needed. However, it is unclear if Pinellas County citizens are not accessing the right level of care at the right time by the most appropriate clinicians, with treatment that is aligned with standards of care, or if the high volume that accesses care through crisis services is not well transitioned into appropriate follow-up services due to the current fragmented care system. Until these questions are answered, it is difficult to state whether the solution is a new Marchman facility or an expansion of current capacity. It is noteworthy than the practice of forced detention of substance abuses has mixed results and there is disagreement regarding the efficacy of this practice.

Question 3: Should we increase case management compliment to better accommodate the Baker Act population to ensure no one falls through the cracks?

No, not until further evaluation of how existing case management capacity is utilized. We caution against funding additional case management without properly evaluating current capacity, effectiveness and models in place. The recent study conducted by University of Southern Florida on the Pinellas County Empowerment Team (PCET) program of the top 33 high utilizers of CSU and jails, demonstrated good outcomes with a reduction in jail costs (decreased by 52%), crisis stabilization unit services (decreased by 82%), Medicaid costs (decreased by 58%), and shelter costs (decreased by 94%). Of interest, is that through the collaboration with partners and leveraging existing resources, "only 69% of the funding allocated by the Board of Commissioners for PCET was expended during year one." Prior to funding additional case management, we would encourage a full evaluation of current case management services.

Question 4: Should we consolidate all our contracts and funding into fewer providers?

Potentially yes, once a better view of system performance is achieved. Behavioral health entities across the country are consolidating to drive efficiencies, increase effectiveness and save money. The private industry and providers are leading these changes nationwide. Governments are following to ensure that funding is tied to a unified strategy. The core to those strategies involves holistic wraparound care of patients. The leading practitioners have realized that funding silos result in operational and programmatic silos—a situation in which Pinellas County is a case study. In order to deliver world class service aligned with leading practices providers and government entities are using consolidated funding tied to strategic holistic care, which includes coordination and case management. To achieve this, the County should consider consolidating its services into fewer contracts to align its vision for patients with the practical tools for programmatic and performance management.

Executive summary (continued)

Top 5 questions (continued)

Question 5: Should we be doing more as a system of care to combat the opioid crisis?

Potentially yes, building on the County's existing efforts and with improved models of coordinated access and management of system performance. While KPMG did not conduct a detailed operational scan of interventions currently in place by providers, the County and its stakeholders should consider the use of physician training, peer support, and data and analytics in line with localized initiatives and national trends in Opioid Crisis prevention and early intervention. Additionally, the County should consider more closely integrating behavioral health efforts (i.e., mental health and substance use) to achieve greater outcomes. Leading practices show that treatment of co-occurring disorders demonstrate better outcomes than treatment conducted in silos of care.

Top recommendations

Based on answers to the Top 5 Questions above, KPMG recommends that the County take immediate action and consider investment in the following foundational issues:

1) Establish a systemic performance management approach in terms of access, quality, capacity, productivity, and outcomes—grounded on a Minimum Data Set (MDS) across all providers, allowing for benchmarking comparison and trend analysis. This requires establishing a contractual MDS requirement for all providers arising from collective development of an MDS with behavioral health funders within the County.
2) Establish a robust Coordinated Access Model that allows for increased transparency in how clients, families, caregivers, and professionals can access the right services within the system. This requires various enabling elements including a 1-800 number; standardized screening, triage and scheduling practices; and an evaluation of the current systems in place by providers to ensure interoperability and exchange of information to allow for a consolidated view of consumer demand, level of need, available capacity, and access to care.

Once the above foundational issues are addressed, KPMG recommends that the County reevaluate its needs and appropriate levels of investment in the following service delivery and system management elements.

— Explore the County's receiving and diversion needs in terms of capacity by optimizing utilization of current bed capacity or contracting for additional flex beds within its existing provider network, as appropriately evidenced by data-driven performance management and coordinated access across the system of care.

— Evaluate, enhance and/or expand existing case management services—specifically through focusing on the individual's strengths, promoting the use of informal supportive networks, and utilizing either transitional case management (up to 3 months) or long-term case management to effectively bridge clients and assist in navigating a complex behavioral health system of care.

— Consolidate the County's services into fewer performance-based contracts and collaborate with funding partners to identify ways to reduce silos of care based upon established performance management and coordinated access capabilities.

Executive summary (continued)

Taking action

We believe the County and its stakeholders are in a great position for change. KPMG was consistently impressed by the people and teams who contributed to this effort and were dedicated to improving the system of care in the County. Our view is that the recommendations presented will take the County from a capable funder of services to a much more involved actor driving change that would push the County to be a leading innovator in the nation. The State's unique system of care underscores for KPMG that the County's continued focus on performance, governance, coordination and prevention remain critical paths to improve the system. The County should consider the following questions as it moves forward with its path to implementation:

Stakeholders and funders

- How does the County continue to build consensus with County and State-level stakeholders on the path forward?
- What discussions and flexibilities does the County wish to explore with the State in choosing its path?

Sustainment and investment

- How will the County sustain a multiyear change effort?
- How well is the County's budget process aligned year over year for such a change program?
- Where will further investment in the behavioral health system come from?
- What is the investment threshold for the recommendations noted in this document?

Skills and resources

- Does the County currently have the organizational capacity to drive comprehensive systems change?
- How will the County align the organizational skills and people needed to drive implementation? Including:
  - Performance management: resources to design and implement performance-driven management approaches described in strategic options and implementation pathways
  - System of care management: resources to design and implement elements of coordination, prevention, receiving and diversion, governance, and funding as described in implementation pathways
  - Data/analytics management: resources to identify, merge, and analyze system performance and capacity to support ongoing decisions in system design implementation of selected pathways
  - Program/change management: resources to detail and manage action plans, escalate risks, communicate changes, and generate stakeholder involvement and buy-in

This report is designed to be a forward-looking decision-making tool as the County seeks to improve outcomes for its residents, and is crafted to be a framework of recommendations to be considered in a future system of behavioral care. KPMG makes no conclusions as to the performance of individual providers, as that was not intended by the County nor included within the Statement of Work. This document should not be considered a criticism of any particular organization or individual, and should be viewed constructively to aid in discussions of the future model and the selected pathways to achieve a vision to ***Elevate Behavioral Health Pinellas***.

Contents

KPMG

Section 1: Project overview

County overview

County's mission and vision

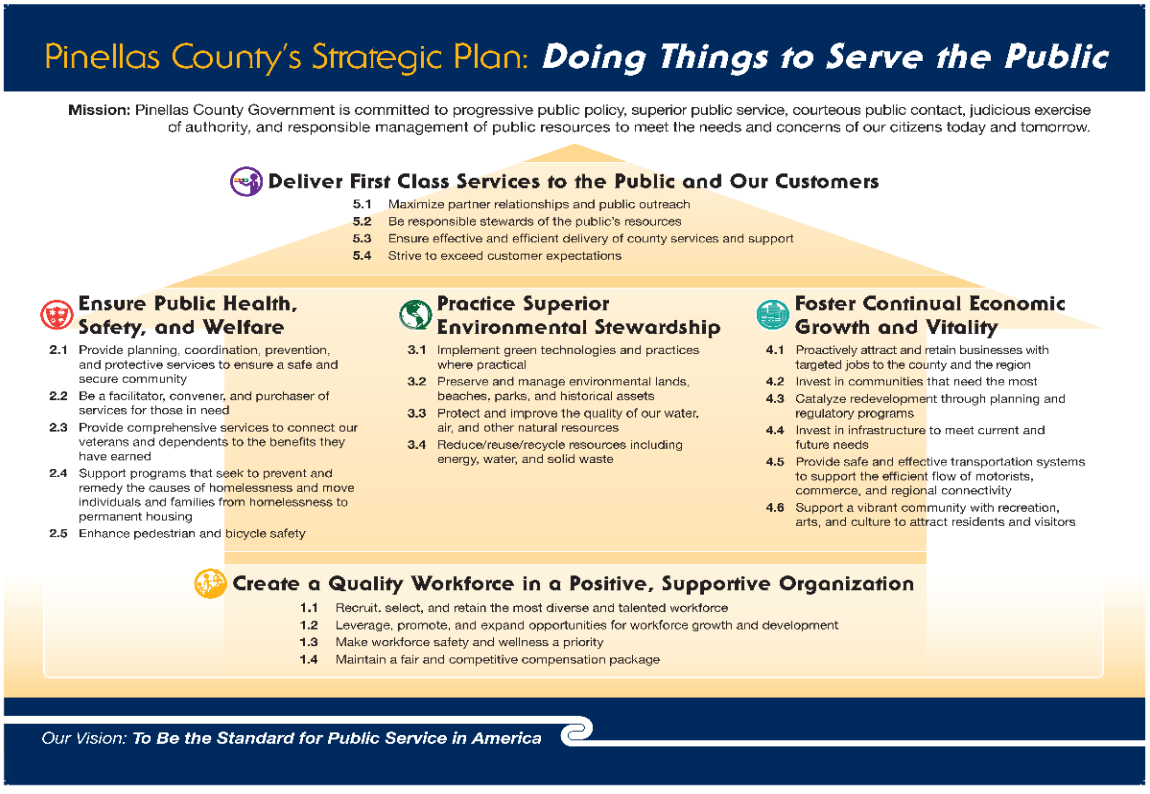
Pinellas County Government aims to be the standard for public service in America, and is committed to progressive public policy, superior public service, courteous public contact, judicious exercise of authority, and responsible management of public resources to meet the needs and concerns of residents today and tomorrow.

The Pinellas County Strategic Plan in the figure below was developed to enable the most efficient and effective use of public resources, provide the highest quality customer service, and create a supportive, rewarding work environment. The plan incorporates five strategic goals that reflect the elements of sustainability and contribute to the County's ability to fulfill its mission.

County's role

The Pinellas County Human Services (PCHS) Department is responsible for programs and activities focused on supporting disadvantaged County residents in meeting essential needs and achieving maximum potential for self-sufficiency. The County manages various programs, related financial obligations (including Medicaid Match and other State mandates), and contracts to ensure health, safety, and welfare for County residents. Target areas include physical and behavioral health, homelessness prevention and assistance, rapid rehousing, and financial assistance.

Human Services programs and activities are closely aligned with the Board of County Commissioners Strategic Plan as seen in the figure below.



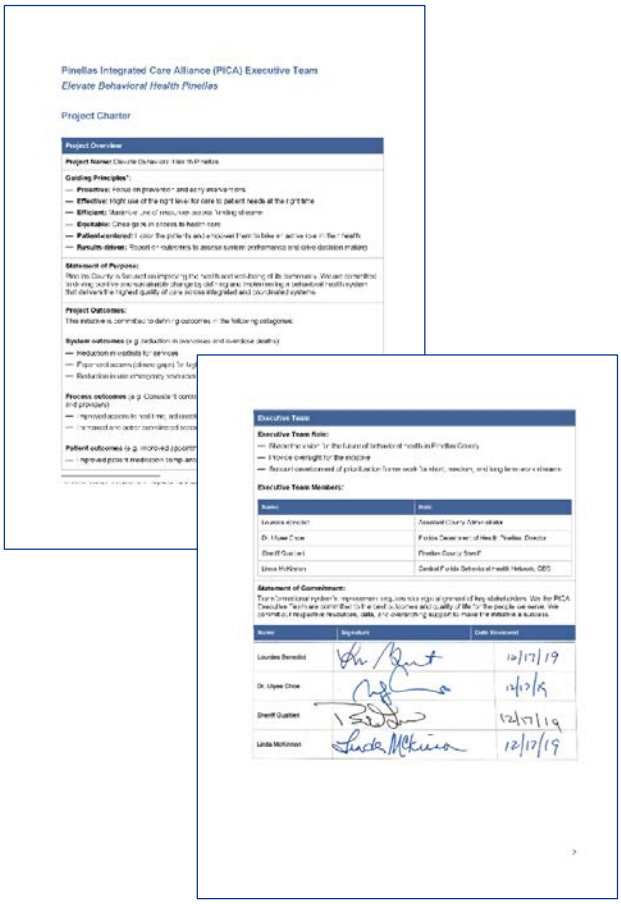
Project overview

Project overview

Pinellas County (County) engaged KPMG in December 2019 to undergo a roughly three-month project to scan the behavioral health system, interview stakeholders, review leading practices, and bring back to the County a new vision to improve the system of care around behavioral health in Pinellas.

The project was formally initiated after the project charter was presented and endorsed by the Pinellas Integrated Care Alliance (PICA) Team, including Lourdes Benedict (Pinellas County Assistant County Administrator), Dr. Ulyee Choe (Director of Florida Department of Health Pinellas), Linda McKinnon (CEO of Central Florida Behavioral Health Network), and Sheriff Gualtieri (Pinellas County Sheriff). Individuals interviews were also conducted with all members of the PICA Team, as well as Barry Burton, the County Administrator.

This deliverable builds upon the options and recommendations identified and validated with the Pinellas Project Planning Team and County Administration through a number of working sessions.


Pinellas Integrated Care Alliance (PICA) Executive Team

Elevate Behavioral Health Pinellas

Project Charter

Executive Team

Executive Team Role:

Executive Team Members:

Statement of Commitment:

Project objective

The objective of the project is to develop recommendations for system enhancement, integration, and improved outcomes within the Pinellas County Adult Behavioral Health System of Care.

These recommendations take the form of this deliverable, which consists of two primary components:

1 System design of behavioral health innovation in Pinellas County and roadmap to integrated continuum of care

2 Prioritization framework for implementation of the system design

Project scope and limitations

Project scope

KPMG's scope centered on scanning the existing continuum of programs and services across the County's Adult Behavioral Health System of Care to identify high-level gaps and inform a future-state vision and roadmap for action that considers both County and State-funded providers and programs.

Limitations

KPMG understood that certain limitations were placed on this effort considering the breadth, depth and scope of the system being reviewed. Behavioral health systems of care are complex, from their funding to the breadth of their treatment services—with a wide variance seen across jurisdictions. A behavioral health system has to have a grip on a wide range of factors when considering any change program. While the below considerations will remain important to the future vision and strategy of the County's system of behavioral care, the functions as limitations to this engagement are as follows:

The County will not become a provider of direct services to patients.

The County made clear at the onset of the engagement that it does not intend to change its system of contracted provider-based care and begin to deliver direct services to consumers. Unlike other jurisdictions, the County remains only a funder of services and not the provider itself. This limits the control the County has over quality, consistency, and efficiency of care. The impact on this report and our process is that the KPMG team did not consider options for County-provided services.

This was not a community behavioral health needs assessment.

A leading practice for adoption of change in a behavioral health system starts with a community needs assessment. This has been conducted by the State and we assume the information to be reliable and robust. The County should rely on this and other sources of information in conjunction with this report when making decisions about its behavioral health system. The impact on this report is that KPMG considered reported outcomes instead of underlying needs. A study that examines more thoroughly the needs of County residents may result in further recommendations for change.

This was not an assessment of County, State, or provider performance.

As any system of care is a sum of its component parts, the efficiency and effectiveness of the County, State, or their respective contracted providers is critical to delivering the appropriate access, quality, and cost of care. We observed certain provider self-reporting that had been performed in recent years, and reviewed aggregate performance information on a provider basis to understand and identify gaps as well as improvements in the system of care. The impact on this report is that recommendations for discrete improvement of provider performance are not contained herein, and instead is intended to be a forward-looking guide to improve outcomes regardless of where performance currently stands.

This was not an organizational needs assessment of the County or providers.

An organizational needs assessment considers aspects of financial, operational, and governance-related performance of an organization. Typically, the front- and back-office operation is reviewed to understand efficiency and effectiveness, and technology utilization and enablement is assessed at a detailed level. The engagement team was not asked to review PCHS or their providers in this way; however, this level of information may further assist in improving services to residents at appropriate points in the future to better optimize the use of existing resources by the County and its providers.

Project approach and methodology

This deliverable summarizes findings from stakeholder engagement, data and documentation request, review and analysis, literature review, and options and recommendations identified and validated with the PCHS leadership team and County Administration.

Over a 12-week period, the KPMG team conducted the following activities:

- Individual interviews, focus groups, and tours were conducted with 50 organizations and their stakeholders identified by the County and scheduled based on participant availability and representation of a cross-systems view of behavioral health, including: Board of County Commissioners, DCF-contracted Managing Entity (CFBHN), providers, justice agencies, homeless services, community leadership and advocates, and other government agencies.
- A survey was distributed to all participants of the System of Care meeting on January 13, 2020 to gather stakeholder input on the following topics:
    1) If Elevate Behavioral Health Pinellas is successful in improving behavioral health for the community, what does that success look like?
    2) What do you see as the largest gap in Pinellas County's behavioral health system?
    3) What do you see as the greatest successes or strengths in Pinellas County's behavioral health system?
    4) What opportunities do you see for improving Pinellas County's behavioral health system?
    5) Do you have any additional comments, questions, or concerns you would like to share?
- A leading-practice review was conducted on the six categories for change based on counties recognized for innovative models of care within behavioral health.
- Six volumes of documentation and data (e.g., intercept mapping, studies, reports), all PCHS program budgets and contracts, and provider reporting (based a limited number of responses) were reviewed.

List of stakeholders/organizations engaged			
1	211 Tampa Bay Cares	26	HCA Largo Medical Center
2	Agency for Community Treatment	27	Homeless Empowerment Program
3	ALPHA House of Pinellas County	28	Homeless Leadership Alliance
4	Bay Pines Veterans Affairs	29	Judiciary
5	Baycare Behavioral Health	30	Juvenile Welfare Board
6	Board of County Commissioners	31	Local and Statewide Baker Act Experts
7	Boley Centers	32	Magistrates
8	Catholic Charities of the Diocese of St. Petersburg	33	Manatee County
9	Central Florida Behavioral Health Network (CFBHN)	34	Medical Examiner's Office
10	Circuit Court Judges	35	NAMI Pinellas
11	City of St. Petersburg	36	Northside Hospital
12	Clearwater Police Department	37	Operation PAR
13	Community Action Stops Abuse (CASA)	38	PCSO Jail Health Services
14	Community Health Centers of Pinellas	39	PCSO Safe Harbor
15	County Administration	40	Personal Enrichment Through Mental Health Services (PEMHS)
16	Daystar Life Center	41	Pinellas County Schools
17	Directions for Living	42	Pinellas County Sheriff's Office (PSCO)
18	Eckerd Connects	43	Pinellas Integrated Care Alliance (PICA) Team
19	Emergency Medical Services	44	Pinellas Public Defender
20	Faith and Action for Strength Together (FAST)	45	Religious Community Services
21	Family Resources	46	Society of Saint Vincent De Paul
22	Florida Department of Children and Families	47	Suncoast Center
23	Florida Department of Health	48	Vincent House
24	Foundation for Healthy St. Petersburg	49	Westcare-Gulfcoast of Florida
25	Gulf coast Jewish Family Services	50	Windmoor Healthcare

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Section 2: System overview

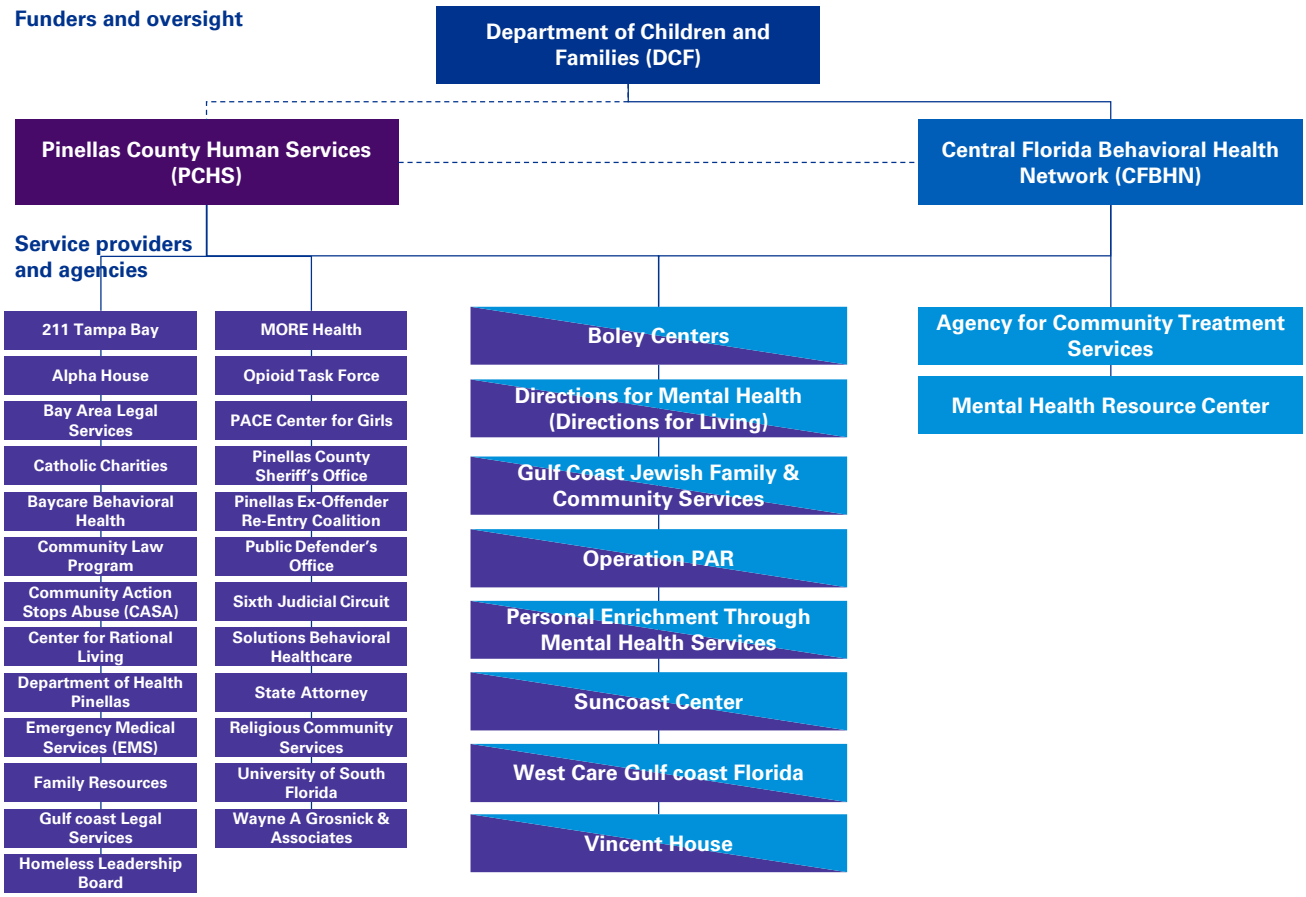
Governance overview

Governance

The governance structure of the County's behavioral health system consists of the following organizations and relationships. Department of Children and Families (DCF) acts as a high-level "purchaser" of services and has a contract with Central Florida Behavioral Health Network (CFBHN) to act as the regional Managing Entity for 14 counties in the Suncoast and Central Regions, including Charlotte, Collier, DeSoto, Glades, Hardee, Hendry, Highlands, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk, and Sarasota. The major goals of this contract are to improve access to care, promote service continuity, and to support efficient and effective delivery of services.

Central Florida Behavioral Health Network (CFBHN) acts as a "contractor" for DCF and is responsible for the planning, coordination, and subcontracting of Network Services Providers (NSPs) for the delivery of community mental health and substance abuse services—in effect, these NSPs represent approximately 75% of the funding and services provided to County residents, forming the majority of the County's continuum of behavioral care which is inclusive of both state and County-funded services (not accounting for the private system in the County). NSPs are subcontracted by CFBHN as a direct service agency to provide a comprehensive array of behavioral health services and programs that are designed to meet the local need; are accessible and responsive to the needs of individuals served, their families, and community stakeholders; and including the essential elements of a coordinated system of care (as specified in 394.4573(2), Florida State).

Pinellas County Human Services (PCHS) collaborates with CFBHN and contracts with many of the same community behavioral health providers to help enhance access to and continuity of care. The current efforts of the County include supplemental funding to expand services and reduce system gaps, collaboration on key system initiatives and grants, and regular participation and leadership in system meetings and discussions.



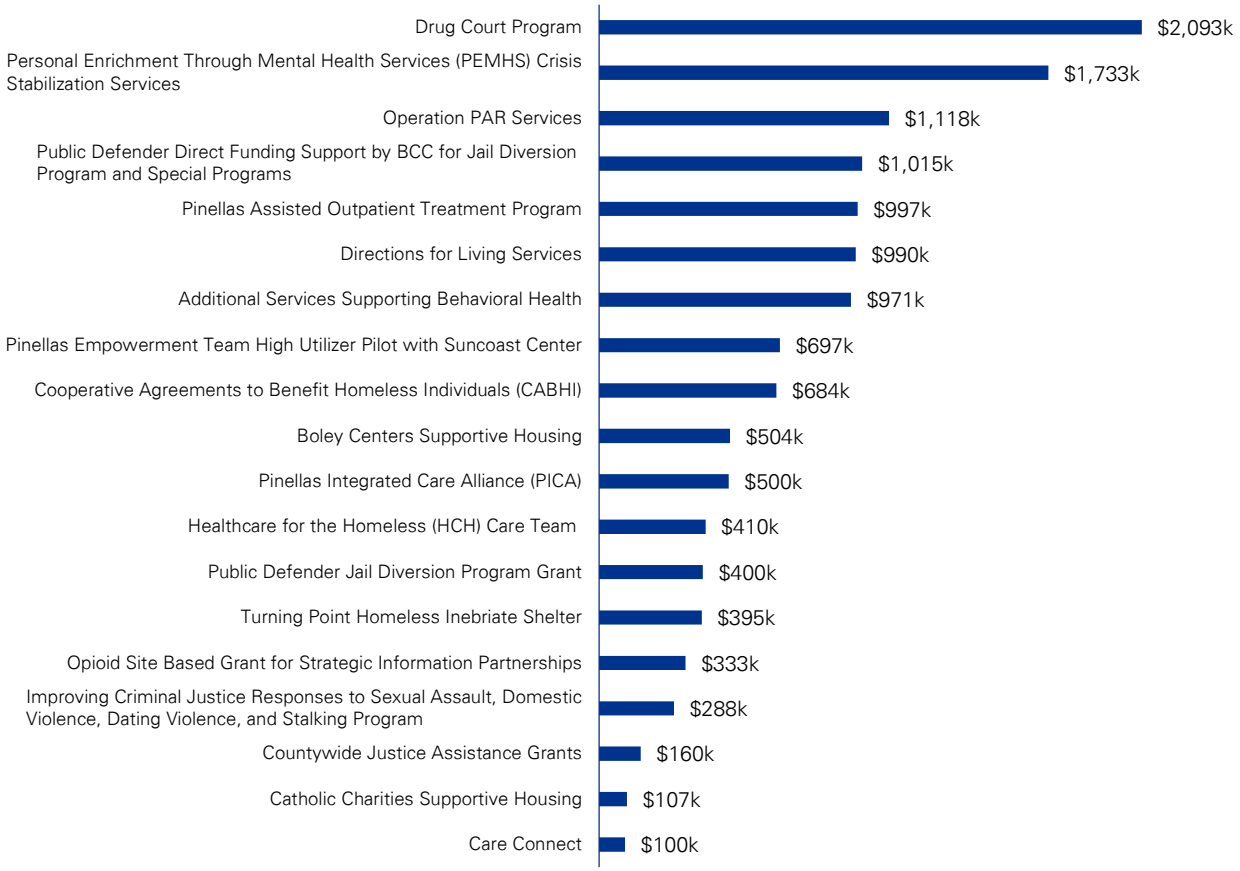
Financial structure

The provider network in Pinellas County is funded by a combination of State funding (i.e., DCF and CFBHN), Medicaid, Federal, local (e.g., Juvenile Welfare Board), County, self-pay, third-party insurers, and other sources.

PCHS had a behavioral health budget that amounted to $13.5M during FY20 as seen in the figure below. PCHS provides supplemental funding and grants for behavioral health programs and services through several sources outlined in the figure below. PCHS also manages Medicaid Match, and other State mandates, and the County's share of juvenile detention costs.

CFBHN provided $30.55M in contracted behavioral health funding for County residents and consumers during 2019 to 2020. Most of the NSPs subcontracted by CFBHN to provide services are publicly funded under the DCF Substance Abuse and Mental Health (SAMH) grant.

FY20 funding by program [1]



[1] **Behavioral Health Memo (September 20, 2019). Note: The above figure does not include Healthcare, Homeless Outreach, Homeless Emergency Shelter and Rapid Rehousing, Emergency Financial Assistance, pass through grants to PCSO, specific Article V Court investments, Youth Empowerment, and other community support programs.**

Program overview

Program structure

PCHS is responsible for programs and activities focused on supporting disadvantaged County residents in meeting essential needs and achieving maximum potential for self-sufficiency. For behavioral health programs as one of the department's target areas, PCHS takes two programmatic roles:

1) **Funder:** Provides supplemental funding to expand access to care and reduce system gaps
2) **Oversight:** Provides oversight and participates in collaborations for key system initiatives, grants, meetings, and discussions

Programs with County funding	
1	Assisted Outpatient Treatment Program
2	Co-occurring Assistance Recovery Empowerment Team
3	Cooperative Agreements to Benefit Homeless Individuals
4	Medicated Assisted Treatment
5	Pinellas County Empowerment Team High Utilizer Pilot Program
6	Pinellas Integrated Care Alliance
7	Pinellas County Recovery Project (Public Defender Jail Diversion Program)
8	Various Drug Court Programs

Programs with County oversight	
1	Local Match Funding for Housing Projects and Supportive Housing Services
2	SAF Shelter & Supportive Services to Homeless Youth and Impact Team
3	Transitional Housing, Counseling, and Victim Advocacy
4	Permanent Supportive Housing Case Managers
5	Detoxification (Detox) Beds
6	Crisis Stabilization Unit (CSU)
7	Youth Therapist Ready For Life

Services overview

PCHS and CFBHN work in collaboration with community agencies and partners to ensure there is a comprehensive array of services across the various levels of interventions that are necessary in the community.

CFBHN subcontracts with NSPs for the delivery of behavioral health services, including: emergency, acute care, residential, outpatient, recovery support, consumer support, and prevention services. To further expand access to effective care and reduce system gaps in the community, PCHS also contracts with providers and agencies to deliver additional behavioral health services. Outlined in the figure below is a high-level mapping of behavioral health services funded by CFBHN and PCHS using categories defined by DCF for "service array" and 394.4573(2), Florida State for "essential elements" of a coordinated system of care.

Behavioral health services funded by CFBHN and PCHS	
Emergency services	
C P	Crisis Stabilization
C P	Crisis Support/Emergency
C P	Medical Services
Prevention services:	
C	Indicated Prevention
C	Selective Prevention
C	Universal Direct Prevention
C	Universal Indirect Prevention
C P	Outreach
Residential services	
C P	Residential Level 2, 3 or 4
C P	Room & Board with Supervision Level 2 or 3
C	Medical Services
Recovery support services	
C P	Recovery Support
C	Supported Employment
C P	Aftercare
C P	Supported Housing/Living
C P	Mental Health Clubhouse Services
C	Room & Board with Supervision Level 2 to 3
Outpatient services	
C P	Outpatient
C P	Substance Abuse Detox
C P	Case Management
C	Intensive Case Management
C	Florida Assertive Community Treatment (FACT)
C	Family Intensive Treatments (FIT)
C	Day Care and Treatment
C	In-Home and On-Site
C P	Medical Services
C P	Medication-Assisted Treatment
Cross-functional services	
C P	Information and Referral
C P	Assessment
C P	Intervention

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Section 3: Key findings

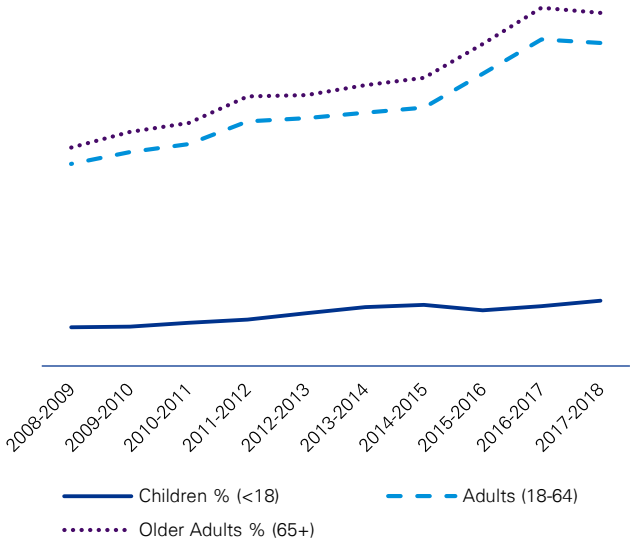
Key finding 1

Primary entry into behavioral health services is through crisis care settings.

Crisis response components of the behavioral health continuum of care in Pinellas County (e.g., hospital emergency departments, crisis stabilization units, jail, emergency medical services) currently serve as the primary entry points for individuals needing treatment.

While behavioral health services and resources are available across the existing system of care, stakeholders expressed concerns that individuals may only be able to access services if their conditions continue to deteriorate. As a result, Baker Act may be over-utilized to gain faster access to services and address gaps in capacity for more appropriate services. As seen in the adjacent figure, the number of involuntary examinations has steadily increased from 2008 to 2016, only declining slightly between 2016 to 2018. The consequences of well-developed crisis responses paired with inaccessible routine care is an over-reliance and intentional overuse of acute services to substitute for the lack of more proactive, lower-cost, and less intensive services.

Pinellas County Involuntary Examinations by Age Group and Fiscal Year[2]



Timely access to care: There are significant concerns among stakeholders regarding the length of time it takes to access outpatient services—despite hearing that wait times are not an issue from various community providers. KPMG requested data from all community providers and CFBHN to assess wait times across the system. However, there was limited data available and/or shared in response to this request (lack of data transparency further described in following findings). . Self-reported data on wait times ranged from an average of 25 days for adult outpatient services and 26 days for the next available psychiatric appointment.

The disconnect between providers and other stakeholders on wait times may be due to the nuances around what qualifies as the "first appointment," Although individuals may receive initial screening/assessment in a timely manner, there may still be long wait lists for a first appointment with a psychiatrist and to receive post screening/assessment services.

Provider workforce capacity: It is also widely recognized by stakeholders that the shortage of behavioral health staff, especially psychiatrists, is a barrier to accessing services for uninsured individuals, and even for some underinsured or insured individuals. Based on United Health Foundation 2019 data on behavioral health providers, Florida is ranked 41st at 160.5 providers per 100,000 population, which is 35.1% below the national average. While particularly acute in Florida, this challenge underscores how provider productivity remains a key area of focus given such shortages.

Prevention and early intervention: Stakeholders recognize that the current system is focused on managing crises through acute services, while less intensive and lower-cost interventions remain underdeveloped. Prevention and early intervention were described as lacking throughout the community, other than school-based programs. There is an opportunity to reduce downstream dependence on acute services by "shifting upstream" and better serving the in-between populations—defined as those who do not yet require acute services, but may be at risk of escalating into the cyclical use of emergency rooms, crisis psychiatric facilities, and jails. This will help to prevent the need for crisis, residential, or institutional care; and help manage chronic behavioral health conditions, including both mental health and substance abuse issues—resulting in better outcomes for patients and lower cost for the broader system.

[2] **The Baker Act Florida Mental Health Act Fiscal Year 2017/2018 Annual Report** https://www.usf.edu/cbcs/baker-act/documents/ba_usf_annual_report_2017_2018.pdf

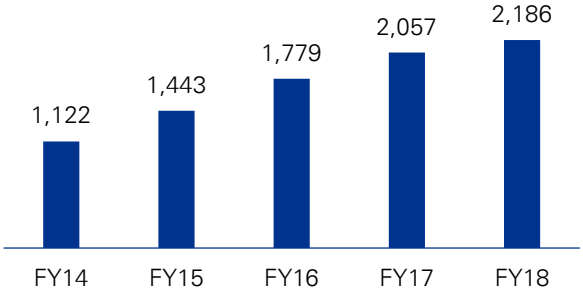
Key finding 2

Silos persist such that the behavioral health system functions more as a set of programs than a coordinated system of care.

Despite acknowledgement that the County is resource rich, there is a need to "connect the dots" on these resources by improving the awareness and visibility on what services are available and most appropriate, and how to best access them in a timely manner. Stakeholders noted the difficulties that individuals face when seeking help (e.g., redirected between facilities, reaching voicemail only, lack of warm handoffs), and even expressed their own inability to navigate the behavioral health system for their loved ones. There is a clear need for more coordination and communication between agencies and providers on client information as well as centralization of resource information across all care options to reduce barriers regarding access to services and make use of existing capacity more effectively.

Continuity of care: Stakeholders noted the pronounced gaps in continuity of care and discharge planning after crisis stabilization (e.g., step-down, residential, supportive housing and living), which impacts long-term recovery and improvement and contributes to exacerbation of symptoms, readmissions and chronic crisis. Stakeholders raised examples such as those who overdose and are administered Narcan repeatedly. As seen in the adjacent figure, 911 transports involving administering of Narcan has steadily increased over a five-year period since 2014. Although Narcan is recognized for its appropriate lifesaving applications, it is a temporary solution without diligent and timely follow-up care.

Emergency transports with Narcan intervention



Case Management: Stakeholders expressed the need for stronger referral/hand-off processes and additional case management staff capacity to help ensure individuals can access follow-up care in a timely manner—especially for the indigent populations that may require more transitional supports. There may also be an opportunity for the County to alleviate this shortage by supporting the expanded use of peer supports and the settings in which they are employed, as well as through policy advocacy for those who have experience in the criminal justice system.

Information sharing: Information sharing and communication between different agencies is a major barrier to care coordination—especially at different levels of care (e.g., acute care and outpatient care, and behavioral health and primary care). Stakeholders noted that the lack of a common and routine approach to collecting and sharing client information contributed to duplication of services (e.g., redundant screenings and assessments among different providers), inconsistent diagnoses and treatments, and slow referral processes. Although there are existing health information exchange efforts in place (e.g., CareConnect pilot), several stakeholders stressed the need for "true" exchange of information in digital format as opposed to scanned documents.

Key finding 3 & 4

There is a lack of data-driven transparency and accountability on how well behavioral health providers and services are performing collectively, and in some cases individually.

Within areas that receive County supplemental funding support, PCHS manages provider agreements for defined services and ensures accountability of outcomes through regular reporting, performance tracking and program monitoring processes. However, due to the lack of "common ground" for reporting requirements between funding partners, the County is not able to gain a comprehensive and shared understanding of the performance and outcomes across all behavioral health services and programs and especially those outcomes specific to County residents.

Existing reporting by PCHS tends to focus on process and output-based measurement by program and/or provider, instead of system-level measurement of outcomes tied to patient care. Although CFBHN does report on some outcomes-based measures, they are also limited to provider-specific views across the 14-County region (not specific to County residents), and appear to lack mitigation strategies when targets are not met. Standardized benchmarks of successful service delivery are also not readily available or regularly reported, such as appointment retention, wait times for initial and follow-up appointments, and provider/staff productivity. As a result, provider performance remains largely a black box to other stakeholders and the community due to lack of transparency around efficiency and effectiveness of processes and outcomes—making it difficult to consistently and continuously evaluate quality of care, access to care, and value of care for the level of investment.

Although the County has made progress on interagency data sharing and cross-system reporting, such as the Data-Driven Justice Initiative and the Pinellas Data Collaborative—these efforts take a point-in-time or annualized approached to data collection and reporting, which is not frequent enough to allow the County to respond to changing patient needs and system conditions. This also results in lag times of data usage for decision-making, such that the County is limited in understanding performance and outcomes but continues to fund providers and programs regardless. Various stakeholders have commented on the need for performance-based and data-informed funding, so that return on investment can be more accurately assessed based on a true understanding of the cost and outcomes of care.

Funding structures and reporting requirements are silo'd and lack the flexibility and transparency to follow patients through the system of care.

Stakeholders commonly voiced that the County's behavioral health system has silo'd funding structures that lack the flexibility to follow clients through different levels and settings of care. This may lead to restrictive and exclusionary funding criteria that limit certain population groups from receiving care—raising further concerns over how funding can be better allocated to respond to shifting community needs.

With reporting requirements and geographic scope varying widely by funder, achieving a systemic understanding of the what resources are available and accessible to which populations becomes challenging. Several stakeholders noted the need for a more streamlined and meaningful set of reporting requirements, so more time can be spent focused on delivering services. Current reporting requirements should undergo restructuring to encourage accurate and consistent reporting. When data is aggregated in this fashion, the outcome produced will likely yield better treated clients with less data leakage in the system where certain funders and/or providers thoroughly report information while others may not.

The multiple-provider environment has created an element of competition among providers. This has contributed to a system that is more provider insulated, rather than one that is mission driven at system level with the theme being to see a patient's path to recovery be as fluid as possible. Instituting a performance-based funding structure may encourage funds being directed to the parties creating the most benefits to stakeholders in the system, and should be based upon reasonable yet thorough reporting requirements so data points can be tracked. Better data coordination will result in further iterations to the behavioral health system oriented towards patients being served best.

Key finding 5

The complex variance in community needs across the unique geographic dimensions and population density of the County limit the practicality of one central public receiving facility to effectively serve a fast-growing population.

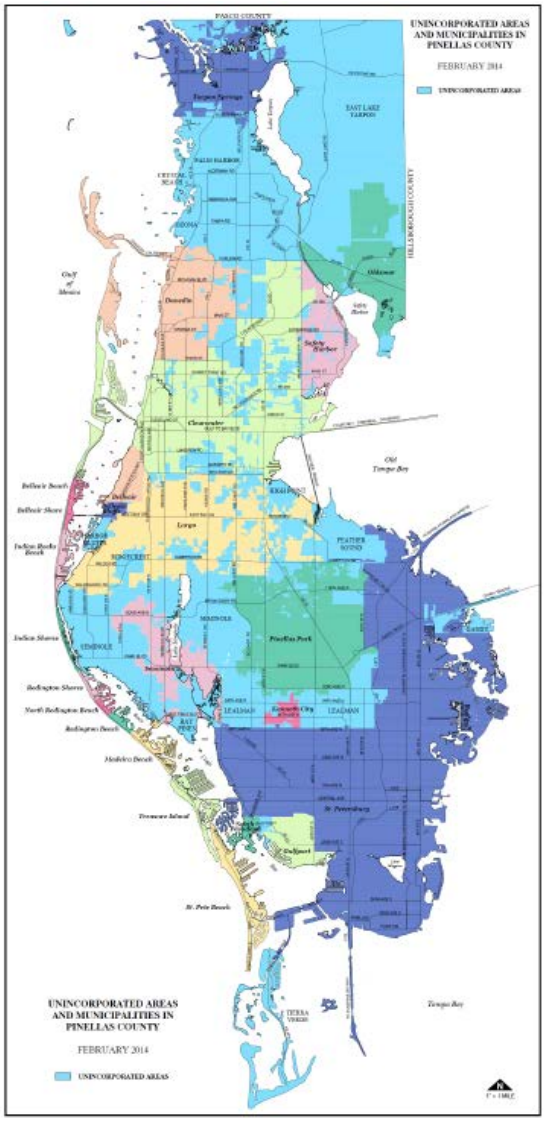
Pinellas County has a population of roughly 917,000 residents. They live in 608 square miles with the County having two major city centers, Clearwater and St. Petersburg. The County is the most densely populated County in the State of Florida at 1271 persons per km. This is combined with unique geographic distributions based on socioeconomic factors in varying communities. The various communities across the County have dissimilar needs across the behavioral health spectrum.

The KPMG team was told in interviews that new capacity would assist the system managing the growing needs of the community. A solution presented was the development of a single facility that would holistically bring more capacity, in the form of beds, for those being cared for because of substance abuse and/or mental health disorders where the person is a threat to themselves and or others.

This option is often found in major cities where a higher population density, convenience of public transportation, and lower distances allow for easy public access. The location of this type of facility would also need to be easily accessed by emergency services and police. If a centralized facility were built it would undoubtedly create an inefficiency for some emergency service agencies who would spend a considerable time transporting residents in crisis.

The leading practices for provision of these services are to create a convenience of multiple "doors" that are easily accessible for clients. In order to reduce barriers for treatment, localization of services provides the best outcomes, particularly when patients are not impaired by distance to services. In addition, because a portion of the service population will likely have associated risk factors, such as homelessness and joblessness that are known to contribute to the inability to receive treatment, the cost of transportation could impair receipt of treatment, particularly outpatient or follow-up services.

Finally, a decentralization of facilities allows for tailoring of services based on the needs of that community. This is known to create a positive impact on efficiency and effectiveness of services being provided. In addition, as the County continues to grow, a centralized public receiving facility may isolate growing parts of the County because of distance to that facility. This report recommends an integrated system of clinics and beds that are managed through a coordinated access model.



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Section 4: Future-state vision

Guiding principles

Development approach

The following guiding principles were developed with input from and in consultation with the Pinellas Integrated Care Alliance (PICA) Team to guide the evaluation of the County's behavioral health system. These guiding principles are aligned with industry recognized standards such as the Institute for Healthcare Improvement (IHI) six aims for changing healthcare systems.

Guiding principles

1. Proactive

Focus on prevention and early interventions

2. Effective

Right use of the right level for care to patient needs at the right time

3. Efficient

Maximize use of resources across funding streams

4. Equitable

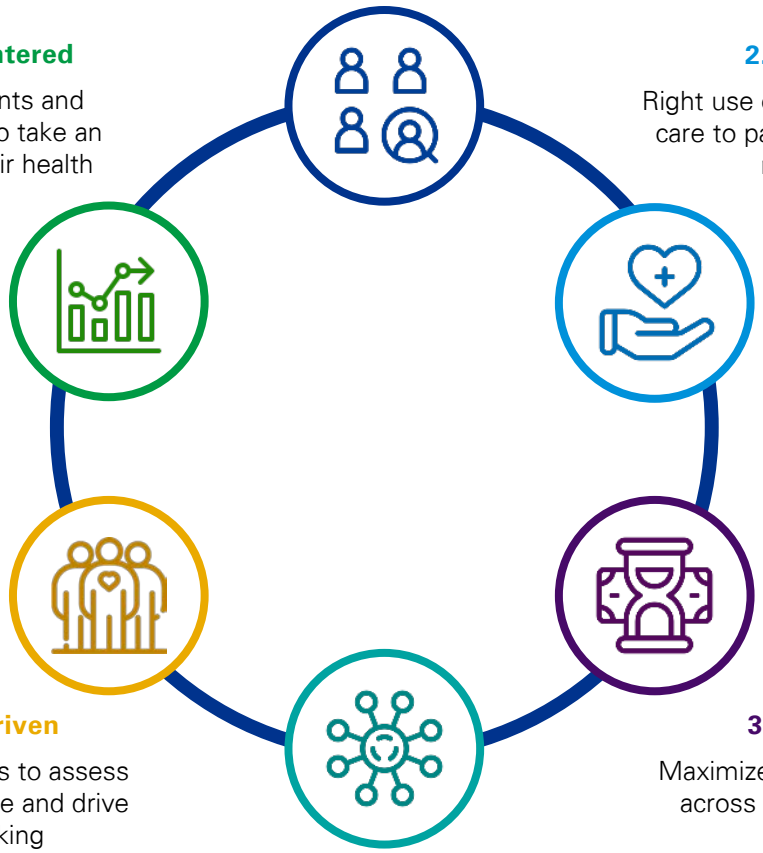
Close gaps in access to health care

5. Results driven

Report on outcomes to assess system performance and drive decision making

6. Patient centered

Honor the patients and empower them to take an active role in their health



Future state of behavioral health

Overview

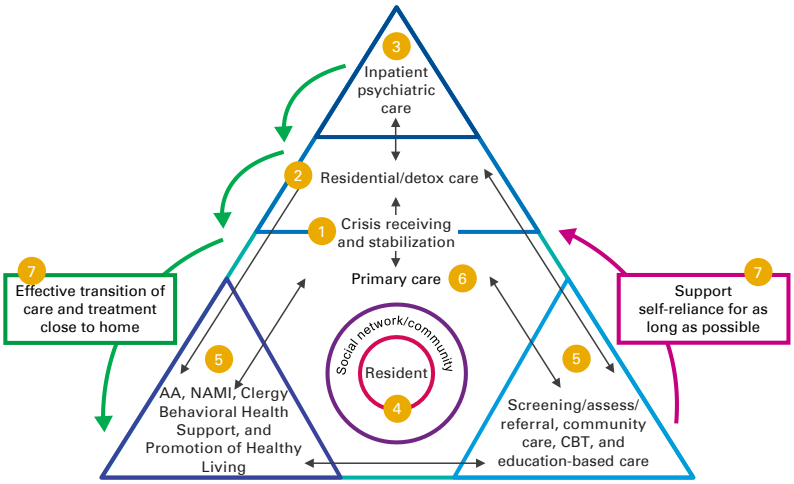
The figure below visualizes the future-state vision for the County's behavioral health system in two parts. The top of the triangle representing acute and subacute services, and the base focuses on prevention, early intervention, and community treatment models.

Top of the triangle: Acute and subacute interventions

1. Crisis Receiving and Stabilization: Includes services that are open 24/ 7 days a week, 365 days a year for clients whose needs are not met through traditional outpatient methods of care. These clients may have gone into a crisis that requires immediate attention by a psychiatrist, nurse, social worker, or other staff. Crisis programs make every effort to stabilize the client, and if deemed safe, discharge patients back to lower acute care for treatment and follow-up. It is only for clients that the crisis program is unable to stabilize that are transferred to subacute or acute care.

2. Residential/Detox Services: Includes services for clients who require a stabilization period from substance abuse. These programs differ from a short-stay admission to a long-stay admission based on client presentation and willingness to engage in treatment. Clients typically reside in the facility and engage in these services through voluntary admission.

3. Inpatient Psychiatric Care: It is important to note that clients who are admitted directly from the crisis stabilization unit to inpatient psychiatric care are often those with a serious mental illness (including those with a co-occurring disorder). Clients are admitted either voluntarily or under the mental health act (i.e., Bakers Act) for a 72-hour for assessment and observation. An interdisciplinary team works with the client to stabilize them and transition them back to lower acute care, that is often a step-down program within the base of the triangle.



Base of the triangle: Prevention and early intervention

4. The center of the triangle is where the resident sits with a strong social network and community surrounding them. This is a crucial part of the patient journey, where social support is what keeps them engaged with community-based services and supports.

5. The left and right corners represents prevention and/or early intervention programs that the majority of the population can be served through. Once clients enter these programs, the majority of their needs are met if programs are able to offer timely access and evidence based care.

6. Primary care is sought for early symptom detection, diagnosis, referrals to name just a few. They stand before the crisis receiving and stabilization components, because if the client is attached to a primary care team and can stabilize without seeking a more intrusive measure of care, then that is the preferred treatment approach.

7. The goal is for client to be self-reliant for as long as possible and for services to be available in order to effectively transition care and treatment close to home once they have completed their subacute/acute treatment.

Based on research from the KPMG Global Center of Excellence for Healthcare, it is estimated that 96% of a typical community (not accounting for high-risk populations) needs are met by an effective "base" in a healthcare system.

Overview of options

KPMG developed a set of strategic options across six categories for change, at both the System Management and Service Delivery levels.

- **Performance Management:** Develop a more robust strategic performance management framework
- **Governance:** Enact performance-based contracting and consider the assistance of a third party
- **Funding:** Consider consolidation of funding into high-performing programs and service providers
- **Coordination:** Reduce silos and improve resident navigation of the behavioral health system
- **Prevention:** Expand and enhance prevention services
- **Receiving and Diversion:** Expand and enhance services for individuals in crisis

We recommend the County and its stakeholders consider these options from top-to-bottom, enhancing Performance and Coordination before considering Funding or Receiving and Diversion. Each of these categories is explored in further detail in the following sections.

Performance management

PM-1	Develop County Minimum Data Set
PM-2	Develop System-wide Minimum Data Set
PM-3	Integrate County Minimum Data Set with Funding

Governance

G-1	Enable Performance-Based Contracting at County Level
G-2	Engage a Managed Entity at County Level and/or State

Funding

F-1	Consolidate Funding Across County & State Sources
F-2	Hybridize Funding Across County & State Sources

Coordination

C-1	Establish a County & Provider-Managed Model of Coordinated Access for Consumers
C-2	Establish a Managed Entity & Provider-Managed Model of Coordinated Access

Prevention and Early intervention

PE-1	Enhance Existing Prevention & Early Intervention Services

Receiving and Diversion

D-1	Enhance Existing Public Receiving Service Capability
D-2	Standardize Across Public & Private Receiving Model
D-3	Enhance Existing Public Receiving Capacity

KPMG

Section 4.1: Performance management

Performance management

The challenge

There is **a lack of data-driven accountability** regarding the performance of behavioral health providers at both an individual and system level. In order for Pinellas County to allocate resources to address gaps in the system, it is imperative that the County develop a performance management approach, grounded on a **Minimum Data Set (MDS)** allowing for benchmarking comparison and trend analysis.

Why is this a problem?

1. **A focus on output vs. outcome measurement:** such that targets set in short-, medium-, and long-term are not linked to the collected data, making it difficult to assess performance.
2. **Lack of system-level view:** impedes the County from properly deploying resources based on capacity, effectiveness, funding, demographics, trends, etc.
3. **A lack of evidence to evaluate leading practice:** such that without the appropriate minimum data set, it is difficult to evaluate quality of care delivered.
4. **Lag time in decision-making:** due to poor data usage such that the County is limited in understanding performance but continues to fund providers anyway.

Recommendations/options

1. **Behavioral Health County Funded Outcome Measures:** The County should develop an MDS requirement for all providers and establish a standard collection process that allows the County to evaluate the utilization and effectiveness of the program.
2. **Cross-County Behavioral Health Providers Outcome Measures:** The County should collaborate with all Behavioral Health Funders within Pinellas County and collectively develop a Minimum Data Set (MDS), establishing a new standard collection processes that allows all funders to evaluate the utilization and effectiveness of the Behavioral Health Programs. This should lead to integrated data systems across providers.

What is performance management?

Performance management or measurement-based care is a system of measuring and reporting patient outcomes through a standardized process across a jurisdiction. Developing a performance management system involves collecting data, engaging stakeholders in interpreting findings, and implementing solutions to address gaps. Effective performance management involves regular reflection on purpose and process, including formal evaluation and the flexibility to respond to emerging issues. The following considerations must be addressed when developing a system for Pinellas County:

1. **Validate measures** – Behavioral health funders need a portfolio of validated measures with patient-centered outcomes across a spectrum of conditions.
2. **Develop Minimum Data Set (MDS)** – Common data elements should be developed and implemented for diagnoses and embedded within existing, contracts, funding frameworks, as well as digital tools such EHRs and smartphones/tablets (when applicable).
3. **Routinely assess outcomes** – Outcomes need to be assessed routinely, where measurement-base care is not only embedded within tech, but should be embedded within the overall culture of the health system.
4. **Invest in leadership & coordination** – Health systems need to provide investment, leadership, and coordination to improve and link data sources in order to measure quality across settings.
5. **Identify gaps** – Stratify quality measures in order to address gaps in specific populations and identify the areas most in need of support.

Performance management (continued)

What is a minimum data set?

MDS is a valuable performance management tool that defines the most important indicators to be tracked and reported on to promote evidence-based decision-making and future-state system planning. The MDS defines the indicators, establishes common definitions for data elements and terms, and specifies the methodology for data collection (e.g., data sources) and reporting (e.g., frequency).

Key characteristics of a MDS:

1. **Indicators are relevant** (i.e., what is in fact important to track and report on), **timely** (i.e., current and as close to real-time as possible), and **actionable** (i.e., stakeholders know what to do with the information collected).
2. The information requirements are effectively driven by the **consumers of the information**.
3. **It is not exhaustive** – Rather, the emphasis is on quality over quantity by incorporating only indicators that bring value to clients and/or improve quality of care.

Why develop a minimum data set?

The value proposition for Pinellas County in undertaking this work can be summarized in three high-level benefits of the MDS, as depicted below.

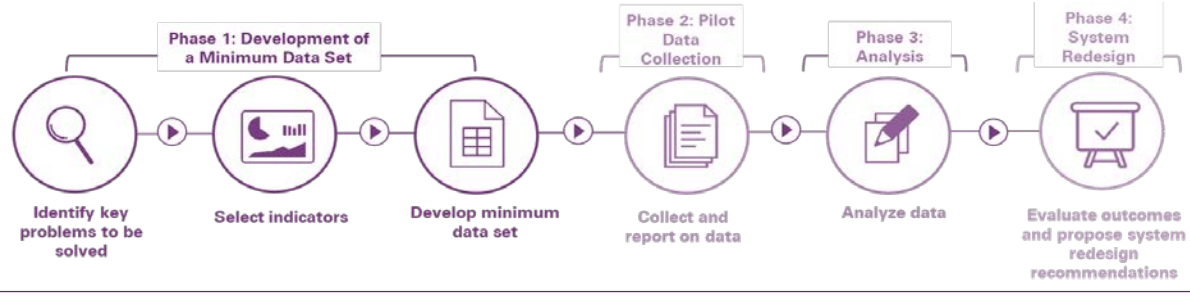
You can't understand what you don't measure – The County does not currently have a comprehensive view of the client journey across the mental health and addictions system. Further, without high-quality data, the County is not able to conduct organizational, regional or national comparisons, trend analyses, or data-driven decision-making and future-state planning.

High-quality data leads to better outcomes – If the County is better able to measure, track, and understand capacity, access, and quality challenges, then the County will be better able to allocate the appropriate resources that align with the acuity levels to address these pressures across the mental health and addictions system.

Enabling continuous improvement – This is not intended to be a point-in-time data collection strategy/approach but rather is intended to evolve over time as client and system needs change. An evolving MDS, with new "driver metrics" to address pressing issues, while continuing to monitor "watch metrics" to ensure that they continue to perform at target, will drive intelligent continuous improvement through prioritization and implementation of change initiatives.

Improve evaluation of funding requests – Currently, Pinellas County receives frequent last-minute requests to fund programs whose grants have expired. With an effective MDS and evaluation framework, the County will be able to evaluate requests quickly and effectively based on performance and determine if investment is truly warranted.

High-level approach



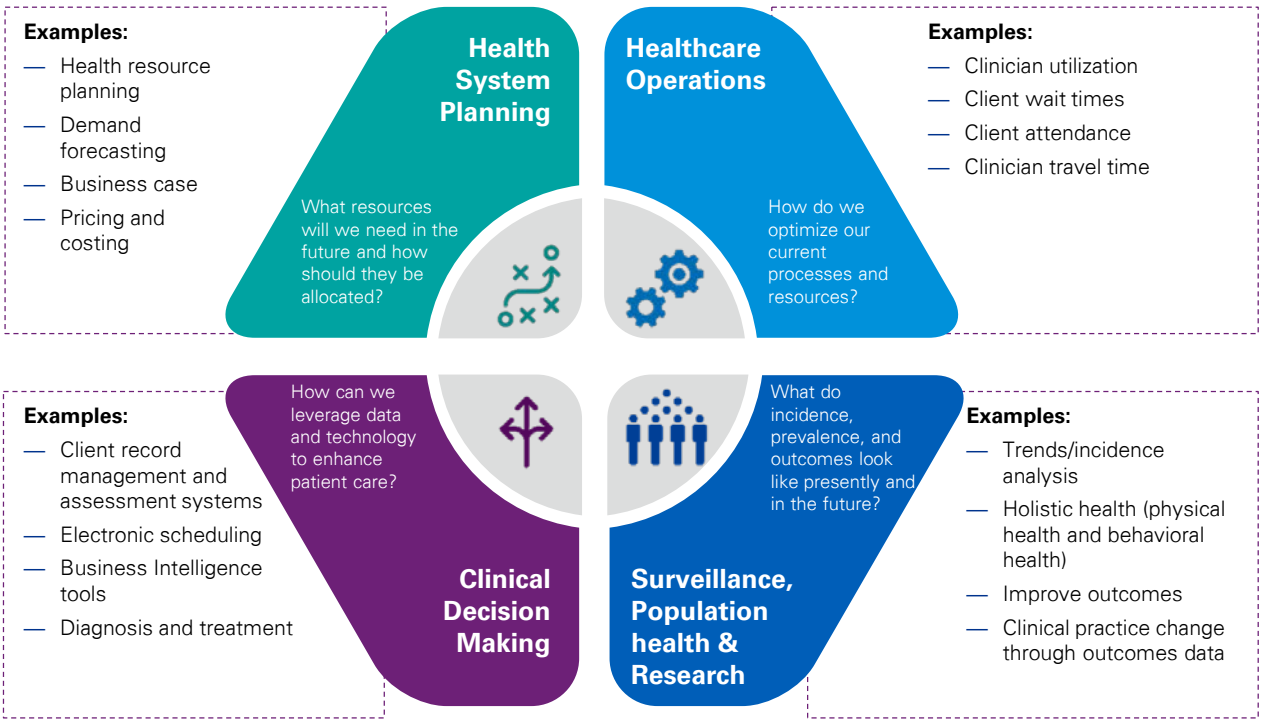
Performance management (continued)

Key problems performance management aims to solve

These three problem statements represent the foundation for performance management and can drive the selection of the key performance indicators (KPIs), measures, and corresponding data elements that comprise the MDS. The Statement problems have been derived from the initial stakeholder engagement conducted by the firm.

Access challenges	Quality challenges	Capacity challenges
There was consensus that clients experienced challenges with accessing the right services at the right time in Pinellas County. Stakeholders have indicated that this has caused clients to seek care through Crisis Services.	Some clients may not be receiving the right services based on need. There is a lack of visibility into client service suitability and/or appropriateness. Pinellas County has a higher rate of suicide then the State, which may be attributed to lack of access or quality of care received.	Some providers have stated that they experience challenges with discharging and/or transitioning clients to other services due to service bottlenecks. There is also a lack of visibility into system capacity and bottlenecks.

Impacts of performance management on the health system



Performance management (continued)

In order to develop the MDS for Pinellas, a series of steps must be undertaken to work with other funding partners and align on a common set of defined indicators as well as the data elements that would comprise the MDS for services that already are leading practice for both service delivery and evaluation outcomes, i.e., Assertive Community Teams, alignment on data collection and reporting needs to be reached. This approach is outlined below:

1. Work with the ***Pinellas County Data Collaborative*** and the ***Central Florida Behavioral Health Network*** to identify existing common data elements and priority indicators aligning with leading practices—minimizing disruption in collection efforts. New contractual requirements may need to be developed to formalize these initiatives.
2. Workshop and define prioritized indicators. Develop an indicator description, calculation, and inclusion/exclusion criteria for the minimum data set. For example the **Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) Kit**[1] developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) can be leveraged to identify priority indicators.
3. Identify all data elements required for indicator calculations and develop a data model to define all categories of data elements as well as their relationships.
4. Define data elements by reviewing current standards of care to agree on common reporting structures and outcome measurements.
5. Identify any technology/reporting gaps and identify requirements needed to address gaps in reporting at the provider level.

Case studies

The following case studies represent the power and impact of measurement based care or performance management approaches in behavioral health.

Case study: Department of Veterans Affairs[2]

The Department of Veterans Affairs (VA) supports the health and well-being of the nation's veterans and their families. Central leadership sets quality measures and data requirements for VA to implement across 160 medical centers. The VA Behavioral Health Laboratory uses Measurement Based Care (MBC) in 20 Veterans Affairs facilities using a platform of standardized, software-aided mental health assessments and clinical care managers to deliver evidence-based treatments for depression, anxiety, and substance abuse in a primary care setting. The program has shown great results in providing continuous, coordinated, and efficient behavioral health care for patients, grounded in a culture of continuous improvement.

Evidence-Based Treatments – VA provides treatments that are proven to be effective for behavioral health issues that are informed based on the outcome measures outlined in their MDS. These treatments are time-limited and focus on helping Veterans meet their goals.

Measurement-Based Care (MBC) – In MBC, health providers use proactive data collection to provide patient-centered care plans. Given the transparency that MBC can provide, this program helps Veterans take an active role in their care. VA is working to ensure MBC is part of the care in all its behavioral health programs.

Case study: State of Minnesota "DIAMOND" Initiative[3]

The State of Minnesota, *Depression Improvement Across Minnesota, Offering a New Direction (DIAMOND)* initiative is a program that has used measurement-based care to benchmark quality improvement programs and efforts across the State as part of a bundled payment initiative for depression care management.

The DIAMOND model was implemented in nearly 100 clinics across the State and pioneered a bundled payment model that drove performance outcomes including an improved response and remission rate, as well as other benefits including greater engagement among providers and improved face-to-face communication between physician care teams.

Standardized Care Procedure – The DIAMOND model had seven components including a nine-item patient questionnaire (PHQ-9) depression scale, systematic patient follow-up tracking, treatment intensification, relapse prevention, care coordination, scheduled caseload review with a consulting psychiatrist, and monthly descriptive data submissions.

Bundled Payment Structure – The DIAMOND model used a bundled payment model such that best practices were maintained in order to secure payment, a tool used commonly for other chronic conditions.

[1] **Substance Abuse and Mental Health Services Administration (2008),** https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/sma08-4344

[2] **Journal of Psychological Services (2019), Measurement-based care implementation in a Veterans Affairs primary care-mental health integration program** https://www.ncbi.nlm.nih.gov/pubmed/31318239

[3] **World Psychiatry (2018), Measuring and Improving the Quality of Mental Health Care: A Global Perspective:** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5775149/#wps20482-bib-0052

Performance management (continued)

What are the questions the MDS will help the health system answer?

- Is the right mix of behavioral health services being offered within each geography?
  - Is there reasonable access to behavioral health services and urgent services within each geography or sub region?
- Are clients being transitioned to a step-down or a step-up service when clinically appropriate?
- How long are behavioral health clients waiting to access assessment and treatment?
- Are clients receiving high-quality care based on leading practice standards of care?
- Are service providers making the best use of resources available to serve population needs?

Key takeaways of performance management models

Effective performance management is a foundational element of building a high-functioning behavioral health system. The following are multiple key takeaways for performance management models:

Patient centered	**Performance management models place the patient at the center of care.** — Improving client experiences and outcomes — Providing greater transparency for clients about their care, so they can act as their own greatest advocate
System-level quality outcomes	**Performance Management establishes clear, standardized, evidence-informed, quality outcomes that can be tracked using regular data pulls.** — Promotes higher-quality data in behavioral health — Considers performance management at the system level rather than at the provider level
Proactive knowledge & empowerment	**Performance Management creates transparent public processes that shift care towards proactive, preventative initiatives.** — Promotes transparency in public reporting of system performance — Leverages effective early intervention and prevention resources
Effective, efficient & adaptable	**Performance management must drive efficiencies, be practical, and be forward looking.** — Accounts for system resource constraints and leverages existing resources where possible — Anticipates the needs of tomorrow, not just today's
Results driven	**Performance management drives leaders towards the most pressing areas of concern to drive results.** — Easy to identify where greatest impact areas exist
Equitable	**Performance management can promote equity in care delivery by tracking performance.** — Performance management models can provide a standardized level of care across geographic areas and ensure care is delivered equitably.

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Section 4.2: Governance

Governance

The challenge

Performance based contracting is lacking and/or not enforced by the County. The County has the ability to drive outcomes for stakeholders and enable greater efficiency and effectiveness by its structure of governance. Since the County contracts out its services, the main mechanism to ensure strong programmatic governance is through both robust contracts and the enforcement and incentive regime for which the behavioral health system is managed.

Why is this a problem?

1. **Historical lack of accountability:** for the reporting the County is currently receiving from the service providers. The County does receive information from the providers but their lacks evidence that poor outcomes have resulted in changes.
2. **Lack of incentives:** because the County has been unable to develop true performance based contracts because of their lack of long term budgeting for service provider rewards if targets are met.
3. **A need for improved reporting systems:** that would enable systematic provider and system based accountability of outcomes and KPI's over time.
4. **De-consolidated funding:** has resulted in no single entity having the authority to drive change. The County only funds a minority of services in the County which does not enable strong governance.

Recommendations/options

1. **Enable Performance-Based Contracting:** The County should revamp most or all contracts consistent with a more robust performance based contracting structure. The contracts should be tied to the counties enhanced reporting and performance based measures and should incentivize innovation and effectiveness by service providers.
2. **Engage a Managed Entity:** to support the County's governance overhaul and possible enablement of additional services described in this document such as coordinated access to care. The County can leverage the expertise, systems and capability of a managed entity to accelerate the changes needed. This could involve consolidation of contracts and development of a system-wide performance regime.

Enhanced governance

A robust performance and data driven governance structure would enable the County to take a more strategic grip on services provided throughout Pinellas County and funded by the board of commissioners. In its current State the effectiveness of services being provided appear to be falling being leading and innovative County practices. The disconnect being funding, strategy, governance and deployment of treatment has resulted in a system that has little systematic governance. Even within County government funding is siloed and subject to the direction of multiple independent officials without a clear picture as to the counties treatment strategy. The County should take should consider taking these steps:

1. **Develop a clear strategy** – The County funds services to residents but outcomes in some areas are poor and in others no information as to what is working is available based on leading practices. This document provides guidance on developing core components of a new County strategy that should be followed.
2. **Align contracts to the counties strategy** – Ensure that the County's contracts a streamlined to reflect a unified strategy across all of criminal justice, behavioral health and homeless services. The contracts should focus on what works, consistent with leading practices and enabled by the providers that deliver results.
3. **Develop clear and enforceable measures of system and programmatic KPI's** – These KPI's will be the key to an enforcement and incentive program engrained into the County's service provider contracts.
4. **Develop the right systems** – Ensure that the County has the tools to track performance at the right intervals and can react to underperformance, inefficiency or success in a timely manner with the right levers which should include penalties and incentives.
5. **Consider third-party support** – A third party such as a managed entity can bring all of the above tools to the table now, enabling a faster transition to the future state.

Governance (continued)

The Case for a Local Managed Entity (LME)

The County does not deliver services and this report recommends a range of improvements to service and capability that would require the County to get closer to the delivery of services. The improvements to the system would also require development of capability over an extended period of time. A local managed entity would allow the County to bypass the pains of change and implementation in developing the capabilities required to become a national leader in local behavioral health outcomes.

Advantages of LMEs

1. **Capability delivered now –** A managed entity allows the County to deliver better outcomes for residents in a more focused time period. It would be expected that a managed entity would have the systems, resources, and experience to deliver transformation to County processes now. While an LME would come at a premium, the cost of internal change programs and capability development could ultimately cost more; take longer; and without the experience, the solutions when implemented may not be the quality that could be delivered by an experienced entity.
2. **Expertise on hand –** The skill sets needed for the road ahead will be key to enabling the County to deliver the needed change for residents. The County will need system integrators, technologists who understand telehealth, program and project managers, performance-based contracting specialists, and behavioral health specialists with experience in building local performance frameworks that are enforceable.

LME Delivered Options

A local managed entity could deliver some or all of the below options for the County.

1. **Performance-Based Contracting –** The County can utilize a managed entity to manage the majority of their programs and contracts with a focused on enhanced performance.
2. **Coordination of care** – The County can use a managed entity to enable the coordination of care recommendations in this report.
3. **Case management** – The County can utilize an LME to be the main point of contact for enhanced case management services for residents receiving care within the behavioral health system.
4. **Deliver telehealth and telepsych options** – If the County recognizes the need for these services, the County should consider an third party to deliver the services or manage the contract for delivery of services.
5. **Deliver or manage new capacity** – Where the County believes new capacity (beds) is needed the County should consider a third-party entity to manage the acquisition of those beds or deliver the beds.

Case study: Broward County Behavioral Health

Broward's public behavioral health system is under the jurisdiction of the Florida Department of Children and Families (DCF). DCF privatized its service system through the development and contractual relationships with local managing entities to provide the administration, management, support, and oversight of the State and federally funded behavioral health services. In 2011, DCF designated the Broward Behavioral Health Coalition, Inc. (BBHC) as Broward's local Managing Entity, which is responsible for the contracting, monitoring, clinical quality oversight, and performance improvement of the DCF/State-funded behavioral health services.

- The County has reported an increase in housing for residents receiving BH services.
- The County has reported an increase in patients completing programs.
- The County has reported an increase in employment of persons receiving who are receiving services.
- The County has reported a decrease in utilization of crisis services.

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Section 4.3: Funding

Funding

The challenge

Deconsolidated funding presents governance, enforcement, and efficiency issues for the County. Pinellas County manages more than 25 contracts within its behavioral health system. This funding structure limits the County's ability to develop the most robust enforcement structure because it is not the direct provider of services to residents and it rarely is the main funder of services within any one provider. The deconsolidation also creates increased management complexity of the contracts—complexity that likely is not being overcome.

Why is this a problem?

1. **Funding not tied to what works:** There is not a historical framework to benchmark if services provided by the County's providers have in fact been effective for Pinellas.
2. **Funding deconsolidation:** Funding deconsolidation by service providers is inconsistent with the most recent industry trends of consolidation of behavioral health providers.
3. **Source of funding:** The County's allocated funding has different governance regimes for grants, general funds, and monies allocated to criminal justice departments.
4. **Funding not tied to performance:** The County's continued funding, which should include incentives to providers, are not year-over-year tied to performance of those providers.

Recommendations/options

1. **Consolidated Local Funding:** The County should consider increased consolidation of funding for similar services under fewer or even a single contract, enforced by contracts that are performance driven to better effect efficiency, effectiveness, and outcomes within the system.
2. **Coordinated Local-State Grant Funding:** To enable multiple options presented within this report, the County should consider increased funding to enable new internal or managed entity capabilities such as coordinated access to care. This combined consolidation of current funding and effective grant management will enable a behavioral health system of the future.

Redesigned funding

A redesigned funding regime will focus on what works for Pinellas County and who does it best. The funding structure should enable a more streamlined governance of programs and providers and increase efficiencies in management of the behavioral health system. An effort should be made to ensure the strategy and use of funding within the control of the human services and other County agencies are aligned. When implemented, funding should be tied to performance of providers. The County budgeting apparatus should consider short- and long-term incentives for improved outcomes. In addition, contracts should have the right mechanisms to redirect funding solely based on performance.

1. **Evaluate what works** – The County needs to evaluate the programs and services that have been effective. A major conclusion of this report is that funding is disproportionately tied to crisis services. This practice is the inverse of leading global practices, which push most funding to preventative services. The County needs to ensure funding is directed to those services proven to be most effective.
2. **Evaluate which providers deliver** – The County should evaluate outcomes tied to current providers to evaluate which providers are most effective and what components of their delivery are responsible for that performance. The purpose is to develop contracts tied to these performance elements that could be aligned to the direction and purpose of funding.
3. **Develop proposals for Board of Commissioners** – County agencies working with partners should develop a coordinated and collaborative proposal to the BCC to redesign how funding is allocated across programs and providers. This should be submitted concurrently with a new strategy for behavioral health services.
4. **Align with governance & contracts** – Funding should be aligned with the new governance and contracting process recommended within this report and adopted concurrently with this recommendation by County agencies and the BCC.
5. **Seek additional funding** – The County should work with providers and the BCC to identify opportunities to fund new capabilities and enhancement of services recommended here.

Funding (continued)

Why consolidate funding?

Pinellas County as shown in the financial overview funds programs using a combination of federal, state, local and grant funding. These funds are allocated across a range of contractors and programs. This report outlines a path towards a refined performance evaluation program to determine the effectiveness of these programs. When that is complete the County has an opportunity to redesign what it funds and why it is funded. The consolidation of funds will be a powerful tool to simplify programmatic management.

Behavioral health entities across the country are consolidating to drive efficiencies, increase effectiveness and save money. The private industry and providers are leading these changes nationwide. Governments are following to ensure that funding is tied to a unified strategy. The core to those strategies involve holistic wraparound care of patients. The leading practitioners have realized that funding silos result in operational and programmatic silos—a situation in which Pinellas County is a case study.

In order to deliver world class service aligned with leading practices providers and government entities are using consolidated funding tied to strategic holistic care, which includes coordination and case management. To achieve this the County should consider consolidating its services into fewer contracts to align its vision for patients with the practical tools for programmatic and performance management. These steps taken together have been proven to deliver better outcomes.

An implementation pathway

The County will need to take several critical steps to determine how best to consolidate its funding into practical contracts. There are two practical considerations:

Funding Source

— **Unrestricted funds** – The County should determine which funding is unrestricted for the purposes of treatment and programs. These funds would begin with the County general funds and include a thorough evaluation of its grant funding. Barriers could include:

— Limitations to the governance of funding

— Limitations to the use of funding to specific programs

— **Restricted funds** – The County has determined which funding sources are restricted. The County should take the additional step to lobby its funding providers at the state and federal level to have greater flexibility with funds received to bundle holistic care for patients. Advocacy for pilot programs should be of high priority in being able to show results to funding providers.

Provider Model

— **Provider driven** – The County should consider creating a new request for proposal for holistic care programs delivered under fewer contracts that would be delivered by a lead service provider. This could be a managed entity or a prime contractor with several sub-contractors.

— **Program driven** – The County should evaluate what programs are currently effective and move forward with a strategy to deliver new services (case management and coordination of care) tied to the most effective programs currently in the County. The County should issue new RFPs to consolidate funding into these programmatic areas delivered by a lead service provider.

KPMG

Section 4.4: Coordinated access of model care

Coordinated access model of care

Ambulatory services

The challenge

In the current behavioral health system, **consumers are primarily entering into behavioral health services through crisis services**, there are persistent **silos of functions with minimal coordinated systems of care**, and **the unique topography is limiting the practicality of having one central coordinated model**. Based on these factors, Pinellas County should focus on improving access and coordination of its behavioral health services to connect consumers, family members, caregivers, and providers to the most appropriate level of care.

Why is this a problem?

1. **Consumers don't know where to go:** to access services until they get to the point of crisis and seek expensive, subacute and acute care. Delay in care impacts their quality of life, work function, and takes longer to get back to regular function.
2. **Growing demand:** for services among the population is not being met due to an inconsistent standardization of screening, triage, and transitioning clients to the appropriate level of care.
3. **Families feel overwhelmed by the system:** and are often unsure of where to seek help and support for their loved ones and themselves.
4. **A siloed system:** where care providers are providing similar and sometimes duplicative services without central coordination, and yet clients are seeking care through Crisis Services.

Recommendation

1. Pinellas County should establish a **Patient-Centered Coordinated Access Model** for behavioral health **ambulatory services**, supported by a standardized screening and triage tool for consumers, families, caregivers, and service providers seeking services, that streamlines care and ensures that clients receive the right care, at the right place, by the right provider, at the right time.

What is a Coordinated Access Model for Ambulatory Services?

The Coordinated Access Model is a hub-and-spoke model with one all-encompassing hub and numerous spokes dispersed throughout the County that correspond with the funded behavioral health service provider organizations in Pinellas County.

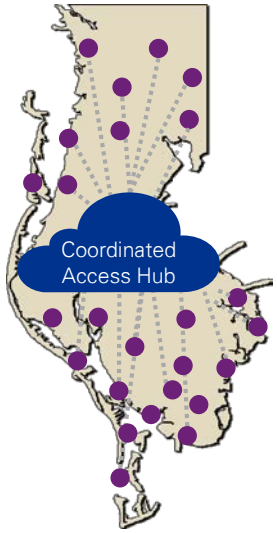
At a high level, the strategic responsibilities of the Hub, include:

- Data collection and performance management
- Standardization of access protocols and referral pathways for the County
- System planning and strategy development with other funders.

At a high level, the strategic responsibilities of the spokes, include:

- Acting as a point of entry to the model for consumers, families and caregivers that "walk in" to the system
- Submitting consumer e-Referrals to the hub and conducting warm handovers, where appropriate
- Providing support to consumers, family members, and caregivers on waitlists.

Hub and spoke model design



Note: This diagram has been developed for illustrative purposes only. The hub and spoke graphics do not represent actual proposed geographic locations for the future state model.

Coordinated access model of care (continued)

Ambulatory services

Examples of key elements of the model

The model can be accessed through **multiple access channels (including a 1-800 phone number)** and supports **multiple languages** (namely County priority languages).

The model provides access to **crisis services** and supports access **24/7/365.**

The **"no wrong door" approach** is used to access services wherein consumers, families, caregivers, and Peer and Family Support navigators are given choice to either continue to access services through local Behavioral Health providers if desired but where all referrals and walk-ins are managed through standardized processes, protocols, tools and using an integrated information technology platform.

The Coordinated Behavioral Health Access Model incorporates access to **peer and family supports** throughout the intake journey.

The Coordinated Behavioral Health Access Model spans the **full lifespan** (supports all age groups) and includes all organizations providing mental health and addictions services regardless of funding source.

Objectives & impacts

A Pinellas County Coordinated Behavioral Health Access Model for ambulatory services puts consumers, families, and caregivers at the center and should aim to ensure that both consumers and referrers are able to consistently access the right services in a timely manner leading to better outcomes. The model aims to do this by:

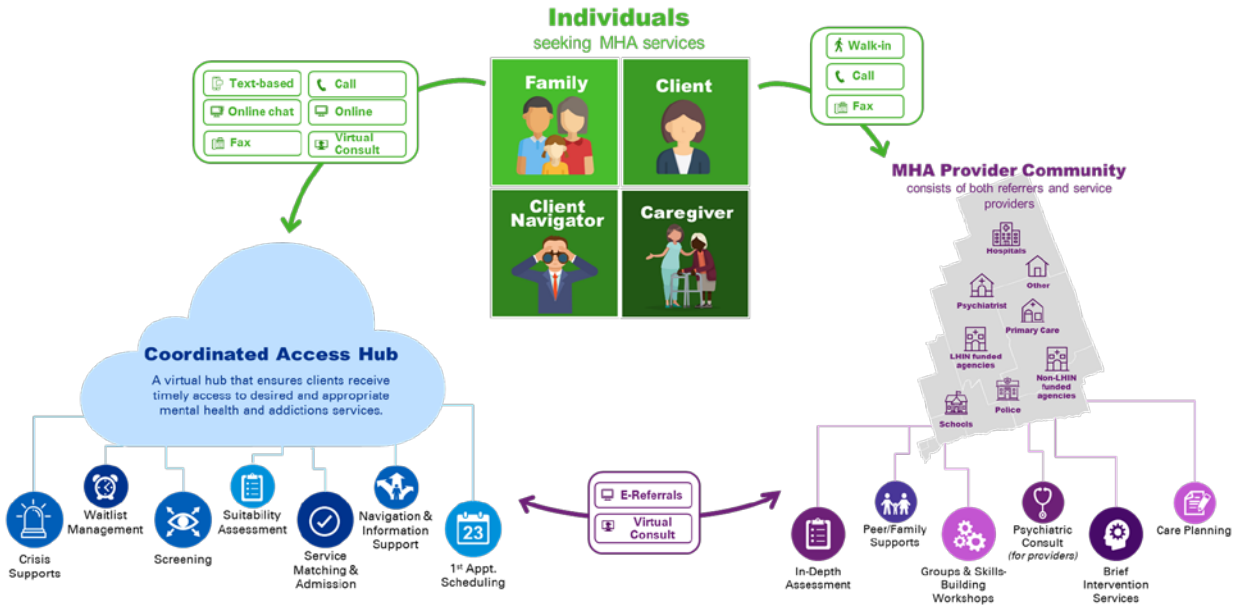
1. **Improving transparency**, so that consumers, families, caregivers, and service providers know where to go when they are seeking Behavioral Health support and treatment, particularly those unfamiliar with the complex system.
2. **Improving access**, the proposed future model will provide consumers, families, caregivers, and service providers with more choices for both access and care, incorporating wait time for services and location for service preference.
3. **Improving management of demand**, as the Coordinated Behavioral Health Access Model will have the ability to oversee regional service capacity and understand pressure points for assessments and treatment. This information can be used to conduct Just-in-Time and annual service planning.
4. **Improving consistency and minimizing duplication**, consolidating referral forms and utilizing consistent screening tools standardizes practices to facilitate that the right information is collected for screening, triage, and disposition, and to determine population health needs.

Coordinated access model of care (continued)

Ambulatory Services

Examples of key elements of the model

The key players in the model, channels for communication/interaction, and intake roles and responsibilities are depicted here. This diagram provides a high-level view of the potential future-state model.



Coordinated access model of care (continued)

Ambulatory services

Example of coordinated access hub functions

The vision for a Behavioral Health Coordinated Access Hub can be a virtual service available in Pinellas County that provides consumers, families, caregivers, and service providers with timely access to desired and appropriate mental health and addictions services for the County.

1. **Intake and triage** – Intake and triage to determine if consumer is appropriate for screening/assessment or require crisis support/intervention first
2. **Screening** – Staff will be responsible for conducting standardized mental health and addictions screening for all consumers that have provided consent and are seeking mental health and addictions services
3. **Suitability assessment** – Staff will conduct a high-level assessment to determine the calls overall needs, i.e., mental health services, addiction services, co-occurring services, housing, etc., in addition to acuity and suitability for services
4. **Program/service admission** – In enhanced models, staff make binding program/service admission decisions on behalf of the receiving mental health and addictions service providers
5. **Scheduling of first service appointment** – In enhanced models, staff schedules the initial client visit on behalf of the receiving mental health and addictions service provider. This ensures that clients do not "fall through the cracks" between screening and appointment
6. **Intervention** – Staff are highly educated and skilled personnel, trained to provide appropriate intervention based on consumer, family, caregiver and Peer and Family Navigators presenting needs
7. **Monitoring client response** – In this model, staff are responsible for monitoring consumers responses to specific services ensuring that the program was suitability to their needs

Case studies

Examples of ambulatory, subacute and acute behavioral health coordinated access models are common in high-functioning systems and are frequently identified as leading practices in system-level care coordination. Below are two case studies which demonstrate the role of a coordinated access model for behavioral health in practice.

Case study: Georgia Crisis and Access Line (GCAL)[1]

GCAL is the 24/7 hotline for accessing behavioral health services in Georgia. The call center has capabilities including language assistance, "warm transfers" for individuals determined to be in immediate danger, crisis assistance & post crisis follow-up, and routine service access for consumers with less intense needs.

Language assistance – Telephone interpreting services are provided to callers with limited English proficiency.

Emergencies – Individuals determined to be in immediate danger are "warm transferred" to the local 911 service in the area where the consumer is located. Call center staff do not leave the call until they have confirmation that 911 responders are on site with the caller.

Crisis assistance – Individuals in need of crisis management will receive 24/7 mobile response to assess the situation, de-escalate the crisis, consult and refer with post crisis follow-up to assure linkage with recommended services.

Routine service access – For consumers with less intense needs, the call center staff are able to offer consumers choice of providers and to schedule appointments for services.

Case study: Massachusetts Child Psychiatry Access Program[2]

MCPAP provides quick access to psychiatric consultation and facilitates referrals for accessing ongoing behavioral health care. MCPAP is available for all children and families through their primary care providers, regardless of insurance. MCPAP is free to all PCPs and seeks to improve access to treatment and integrate resources for behavioral health into everyday practice.

Ambulatory and acute care coordination – Run through the Children's Behavioral health initiative, virtual coordination of services for youth

Mobile crisis interventions – MCI provides children and families with an immediate 247/365 crisis assessment, intervention, and short-term stabilization. As an alternative to the emergency room, clients can receive services remotely where they are.

Residential sub-acute – Services vary from short-term acute programs designed to stabilize crisis to longer-term therapeutic environments that replicate a home-like environment.

Provider resources – Telephone consultations with primary care providers and referrals to child and adolescent physiatrists. Additional practice-focused training and education through regional teams provided by MCPAP.

Coordinated access model of care (continued)

Ambulatory services

Success factors for coordinated access: Peer support

Peer support is an evidence-based practice for individuals with mental health and/or addiction conditions or challenges. In behavioral health, a peer is usually used to refer to someone who shares the experience of living with a psychiatric disorder and/or addiction. Peer support is defined as the "process of giving and receiving encouragement and assistance to achieve long-term recovery… where peer supporters offer emotional support, share knowledge, teach skills provide practical assistance, and connect people with resources, opportunities, communities of support and other people.[4] Peer support has been increasingly linked to leading-practice behavioral health systems given their significant relationship to improved outcomes and low-cost implementation considerations.[5] Peer support can also play a critical role in coordinated access, acting as both a champion and facilitator of support when seeking care, enabling warm handoffs to institutions at the crisis level, and at the ambulatory level when seeking outpatient services.

The impacts of peer support[5]

According to research conducted by Mental Health America, peer support has demonstrated both quantitative and qualitative evidence that it lowers the overall cost of mental health services and improves quality of life for clients. Evidence on peer support indicates a reduction in rehospitalization rates and days spent in in-patient services, and increases and improves engagement with outpatient services, increasing whole health and self-management—two key drivers of positive outcomes in behavioral health.

Reduced re-hospitalization rates

- Pierce County Washington reduced hospitalization by 32% as a result of their peer support program, leading to a $1.99M savings in just one year.
- Recovery innovations grounded on peer support in Arizona saw a 56% reduction in hospital readmission rates.

Reduced days inpatient

- Tennessee Peer Link program showed a significant decrease of 90% in the average number of acute inpatient days per month.
- Wisconsin PeerLink program showed 71% decrease in number of acute inpatient days per month.

Lower overall cost of services

- An FQHC that implemented a peer support program had an ROI of $2.28 for every $1 spent on peer support.

Individual quality of life outcomes

- Meta-analysis by Pfieffer and Heisler identified that peer-support interventions can be superior to usual care in reducing depressive episodes.
- Buffalo, New York's Peer Connection Life Coaches helped 53% of individuals with employment goals to successfully return to work.

Increased engagement rates

- Peer support leads to improved relationships with providers and social supports, increasing satisfaction with treatment experience overall and reducing rates of relapse.

Increased whole health

- Preliminary study of the Peer Support Whole Health and Resiliency program RCT found 100% of individuals self-reported reaching their whole health goals (e.g., eating five healthy meals a week, exercising, etc.).
- Individuals receiving peer support show a significant decrease in substance abuse.

Coordinated access model of care (continued)

Ambulatory services

Peer support in Florida

Peer support usage in behavioral health systems is increasing internationally, nationally, and locally in the State of Florida. In a 2018 paper by the International Journal of Mental Health Systems, Casellanos et al studied the relationship of peer specialists to mental health outcomes in South Florida.[6] The results found that individuals in the treatment group receiving support from a peer support specialist, utilized more ambulatory/lower levels of care services; however they also had more frequent crisis stabilization unit admissions, likely not from peer supporters creating more crisis situations, but rather by identifying situations that otherwise would not have been caught.

In Pinellas County, peer support is being used in a variety of different ways including peer support groups such as the Pinellas County Anxiety and Depression Peer Support Group as well as the National Alliance on Mental Illness Peer-to-Peer Program, which provides educational programs for adults with mental health conditions looking to better understand themselves and their recovery efforts.

Diving deeper into other resources provided by the National Alliance on Mental Illness (NAMI) Pinellas County, programs such as NAMI On Campus, NAMI Homefront, and NAMI FaithNet utilize peer-based resources effectively to target populations most in need of support. Grounding this approach in their Peers in Recovery Mentorship Training Program, building capacity for peer support in the County, is a good step towards utilizing peer support resources at scale.

National Certified Peer Support Specialist (NCPS)[7]

Peer support specialist is an advanced credential recognizing peers who have extensive experience and a large knowledge base that sets them apart. Becoming an NCPS demonstrates that an individual is at the top of their field and requires a higher level of skills, knowledge, and experience than other certifications. Given the increasing demand for peer support specialists, Mental Health America (MHA) and the Florida Certification Board created the first national, advanced peer specialist certification of its kind, requiring 3,000 hours of supervised work/volunteer experience providing peer-to-peer recovery support services and a minimum of 40 hours of training.

By credentialing this role, the NCPS aims to drive more participation and certifications in peer support and drive organizations that could benefit greatly from investing in these programs. Additionally, this credential provides an opportunity to transition those who were clients of the system, or continue to be clients of a behavioral health system into a formal advocate and professional working within the system, supporting peers in attaining better wages and more job opportunities. Certifying all Peer Support Specialist to legitimize their role is imperative.

Opportunities to leverage peer support in Pinellas County

Currently, there are many organizations that are delivering peer-support services in Pinellas County, including NAMI Pinellas County and the Peer Support Coalition of Florida. All of these organizations operate as not-for-profits or social enterprises, relying primarily on grants and funding from governments. Given the best practice on the impacts of peer support, KPMG has identified four potential opportunities for Pinellas County to leverage peer support going forward.

1. **Link peer support to coordinates access** – One of the fundamental challenges of small not-for-profits providing referrals, is that they have limited insight into the availability of services for clients, as such support more as a directory than actually driving access. Peer supporters can be a valuable tool to assist in supporting homeless populations in particular with maintaining a regular schedule of treatment.
2. **Identify ways to scale peer support in Pinellas** – Leading practice organizations have found opportunities to embed peer support across the continuum of behavioral healthcare. Pinellas County may wish to invest in peer support services and scale the highest performing programs that are currently operating.
3. **Leverage peer support in both behavioral health and addiction treatment** – Right now, it appears that many programs in Pinellas have either a behavioral health or an addictions treatment lens. Consider opportunities to leverage best practice in both spaces, and supporting clients who have a co-occurring disorder.

Coordinated access model of care (continued)

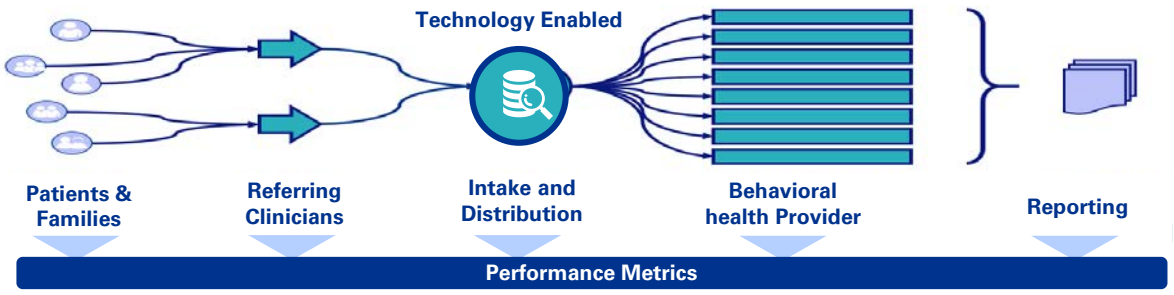
Subacute and acute services

Sub-acute and acute services

In addition to performing coordinated access to ambulatory services, Pinellas County should consider the development and implementation of technology that enables and supports a transparent process of admissions and transfers to the most suitable treatment subacute and acute facility. This will provide the County with a clear view of vacancies, acceptance rate through an electronic display, and eliminate skilled nursing staff calling multiple providers to determine if they have any vacancies. It will also give providers awareness of the admitted consumers who are awaiting for a facility to accept them and the length of time they have been waiting.

From an implementation standpoint, a subacute/acute coordinated model requires collaboration among providers in order to achieve success. In particular, this requires all providers to agree to a coordinated access model in which they provide real-time vacancy rates or frequent updates of vacancies and upcoming discharges. The development of the coordinated model and the change management of the implementation of the model will require significant stakeholder engagement in order for a successful process to be developed between providers, the receiving facility, and consumers. The success of the model provides a transparent process among providers and allows skilled staff to focus on consumer needs versus administrative duties that are best dealt with through the advancement of technology.

Sample intake process for coordinated services



Implementation considerations for coordinated access (ambulatory, subacute and acute services)

Physical infrastructure

— Although the Coordinated Access model (Ambulatory, subacute/acute) will only be accessible to clients and service providers through virtual channels (e.g., web-based access, phone, etc.), an infrastructure may need to be established to accommodate a staff/management team, as well as technology infrastructure to provide updates to organizations regarding clients. In some systems, this is done virtually versus a physical building or as part of the current infrastructure.

Staffing considerations

— All staff conducting intake functions will require training to provide consistent and standardized delivery of client triage, screening, and assessment. This promotes confidence among the coordinated access team and the providers.

Technology backbone

— Electronic referral processing management between the Coordinated Access and service providers

— For Ambulatory care, scheduling, and waitlist management functionality providing visibility into service provider calendars and therein allowing Coordinated Access staff to schedule the client's first service appointment

Performance management functions

— The Coordinated Access team tracks and reports on system-level access KPIs and provide public visibility into performance levels associated with these metrics.

Coordinated access model of care (continued)

Ambulatory services

Implementation framework

In order to design a Behavioral Health Coordinated Access Model, there are several implementation considerations that need to be addressed—especially in a complex system such as Pinellas County, where there are multiple funders and providers within a complex system.

Governance	People & organization	Process & standards	Performance management	Technology infrastructure
Define the management, roles, and oversight of the Behavioral Health Coordinated Access Model and provide clear governance to steer the model.	Identify the resourcing model required to ensure qualified and highly skilled individuals are hired and develop the training and communication materials.	Develop and manage standards for processes, protocols, and tools at all access points and ensure a streamlined consumer intake process.	Identify key performance metrics to be collected, and develop a data collection/reporting approach with an accompanying performance dashboard.	Conduct a current assessment of IT infrastructure in the County and oversee the development of an IT platform to enable the future Behavioral Health Coordinated Model.

Implementation considerations for Pinellas County

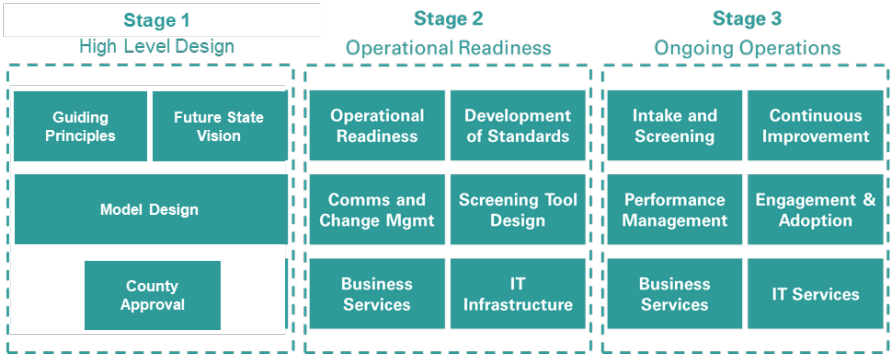
1. Identify the role (if any) that ***211 Tampa Bay Cares***[3] should play in the coordinated access model, eliminate duplication where possible.

2. Consider **integration of the proposed coordinated access model with the crisis stabilization center** such that standardized access and crisis services are linked.

3. Ensure the "**no-wrong-door approach"** considers the implications of the ***Baker Act*** and the ***Marchman Act*** such that families can do what is best for those they care for.

Implementation phases/stages

While much can be learned from functioning coordinated access models in other jurisdictions, there are several core activities/stages that must be completed before implementing a functioning coordinated access model. To assist the County in understanding the work process, complexity, and the steps required, we have broken down the activities required into three stages of work. The stages are listed in the diagram below.



Coordinated access model of care (continued)

Ambulatory services

Key-takeaways or coordinated access models

Based on our review of the evidence, it is clear that when done correctly, coordinated access models can drive substantial benefits to the health system that align with the Pinellas County vision and guiding principles for Behavioral health. Further, these benefits can be optimized by leveraging peer support throughout the access journey. Based on a jurisdictional analysis and leading practice literature, the following take always have been identified as the key lessons learned from implementing coordinated access models.

Patient centered	**Coordinated access can enable person-centered service delivery in collaboration with service delivery partners** — Responsive to clients/families and caregivers' needs and driven by them — Ensure services are tailored to meet the client needs and preferences and are culturally appropriate/grounded — Ensures that clients have supports in place during transition and waiting periods — Transparent to clients and providers about all steps in their future care journey
System-level quality outcomes	**Coordinated access can support the provision of high-quality clinical outcomes** — Do things the right way the first time — Have high-quality customer service and client experience and strive for clinical excellence — Ensure client safety, and seek the best client outcomes through consistency of support and standardization of care — Dynamic model to allow for continuous quality improvement
Proactive knowledge & empowerment	**Coordinated access can empower all clients, Coordinated Access Hub staff and health service providers, to:** — Have clarity on how to make decisions and be transparent to support self-management and self-advocacy — Understand service options, processes, and clinical tools to empower clients/families/caregivers to make their own choices — Be respected for their role in the client, family, and caregiver service journey — Be used to their fullest capacity to support access and service delivery.
Effective, efficient & adaptable	**Coordinated access must be effective, efficient, and adaptable to accommodate changes in:** — Governance, policy, and funding — Service delivery and client needs to provide more customized care — Emerging trends — Demographics (age, cultural group, geography, and other social determinants of health).
Results driven	**Coordinated access must hold itself and others accountable, through:** — Strong governance processes — A common set of performance indicators and transparent reporting mechanisms — An emphasis on value for money — Limiting exclusion criteria and making them transparent when necessary—no wrong door.
Equitable	**Coordinated access must provide equitable access to services** — Equitable access to services, regardless of race, color, religion, culture, creed, sexual orientation, gender identity, national origin, ancestry, age, geography, and other social determinants of health — Uphold principles of health equity in the design and operations of the Coordinated Access Model — Responsive to identified inequities and able to respond appropriately

[1] **Georgia Crisis and Access Line** https://www.georgiacollaborative.com/providers/georgia-crisis-and-access-line-gcal/
[2] **Massachusetts Child Psychiatry Access Program** https://www.mcpap.com/
[3] **211 Tampa Cares** http://211tampabay.org/
[5] **Mental Health America, The Case for Peer Support (2018) –** https://www.mhanational.org/sites/default/files/Evidence%20for%20Peer%20Support%20May%202018.pdf
[6] **Castellanos, Capo et al, (2018)** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6195727/
[7] **Florida Certification Board, National Certified Peer Specialist (NCPS)** https://flcertificationboard.org/certifications/mental-health-america-national-certified-peer-specialist/

Coordinated access model of care (continued)

Care pathways

Care pathways

Population groups were identified through stakeholder interviews with a focus on the "in-betweeners": populations that do are not yet entrenched in the cyclical use of emergency rooms, crisis psychiatric facilities, and jails (i.e., "super-utilizers'), but are at risk.

Population group 1

This population group represents those who have co-occurring behavioral health disorders. These individuals have stable housing, employment, and access to transportation but lack social support and also may have previous interactions with law enforcement for minor misdemeanors (e.g., drug-related charges).

Risk factors:

- Criminal justice involvement
- Co-occurring disorders
- Lack of social support

Protective factors:

- Stable housing
- Stable employment
- Access to transportation
- Insured

Population group 2

This population group represents those who have a behavioral health disorder. These individuals have stable housing and social support but face economic hardships, transportation barriers (e.g., long commuting duration) and also may be involved in the justice system (e.g., dependency courts).

Risk factors:

- Criminal Justice involvement
- Economic hardship
- Transportation barriers
- Uninsured

Protective factors:

- Stable housing
- Social support

Population group 3

This population group represents those who have co-occurring behavioral health disorders and additional chronic physical conditions (e.g., diabetes). These individuals have stable housing, employment, social support, and access to transportation, but may face cultural and language barriers.

Risk factors:

- Chronic physical conditions
- Co-occurring disorders
- Cultural/language barriers

Protective factors:

- Stable housing
- Stable employment
- Access to transportation
- Insured
- Social support

Coordinated access model of care (continued)

Care pathways

Pathway development

Population groups were identified through stakeholder interviews with a focus on the "in-betweeners": populations that are not yet entrenched in the cyclical use of emergency rooms, crisis psychiatric facilities and jails (i.e., "super-utilizers"), but are at risk.

Population group 1

This population group represents those who have co-occurring behavioral health disorders. These individuals have stable housing, employment, and access to transportation but lack social support and also may have previous interactions with law enforcement for minor misdemeanors (e.g., drug-related charges).

Risk factors:

- Criminal justice involvement
- Co-occurring disorders
- Lack of social support

Protective factors:

- Stable housing
- Stable employment
- Access to transportation
- Insured

Client history

Michael had been trying to secure an appointment to see a psychiatrist for three months before he relapsed and escalated into a subacute state. He voluntarily committed himself to a Baker Act receiving facility to receive co-occurring (i.e. mental health and substance use) intervention services. Once determined by the agency that he was not a danger to himself or others, he was able to receive referrals to community outpatient providers. However, throughout receiving outpatient care, he saw multiple different psychiatrists who did not communicate or coordinate with each other on his case, and received inconsistent diagnoses and medication prescriptions as a result.

Current state

Client is accessing care through crisis services; however, even through crisis intervention, he was not able to receive consistent psychiatric care and medication. Although the client was aware of his behavioral health conditions and was willing and able to seek treatment, he was unable to receive care outside of crisis services leading to a cycle of readmissions to crisis services.

Future state

(1) Client independently seeks services

(2) Police officer/mobile crisis team/navigate care pathway

(3) Crisis staff call to initiate access on behalf of client

Regardless of which of the three options is initiated, the client is screened by a Coordinated Access worker through a standardized screening tool to determine disposition to the right level of care.

Client is provided with a few appointment options based on provider wait times and location preference. Client is also connected to a Peer Support Worker, when deemed appropriate, as an interim until client is seen by the clinical team at his first appointment. Peer Support Worker provides client with the Peer Support line and contacts them daily until appointment date.

For high-risk clients and to support the transition from crisis to outpatient appointment, Peer Support Worker attends the Crisis center and does a warm handover from the crisis team, support client (via phone or in person) in the transition, and escorts/meets client at the facility for their outpatient appointment. This promotes early engagement, and intervention as seen as appropriate and focused on building a supportive and therapeutic relationship between client and program.

Coordinated access model of care (continued)

Care pathways

Pathway development

Population groups were identified through stakeholder interviews with a focus on the "in-betweeners": populations that are not yet entrenched in the cyclical use of emergency rooms, crisis psychiatric facilities and jails (i.e., 'super-utilizers'), but are at risk.

Population group 2

This population group represents those who have a behavioral health disorder. These individuals have stable housing and social support but face economic hardships, transportation barriers (e.g., long commuting duration) and also may be involved in the justice system (e.g., dependency courts).

Risk factors:

- Criminal justice involvement
- Economic hardship
- Transportation barriers
- Uninsured

Protective factors:

- Stable housing
- Social support

Client history

Jane was trying to regain custody of her child from court supervision, after giving permission to dependency case managers and her parents to support her in seeking treatment. However, her mental health rapidly deteriorated after running out of medication over the weekend and not being able to secure a prescription refill in time. Her parents contacted law enforcement to transport her to a Baker Act receiving facility, where she received the appropriate medication and was provided a short-term refill until a psychiatrist is able to see her. Jane became anxious about running out of medication again due to long wait times to see a psychiatrist for regular appointments and ongoing prescriptions. The case managers and her parents were also unable to collect Jane's comprehensive medical health records across the various providers that were involved in her care, which delayed court proceedings.

Current state

Appointment wait times impacted whether client was able to receive treatment and medication early enough to meet court requirements for regaining child custody. Due to the lack of information sharing between agencies that serve the same individual, the courts become de facto case managers to ensure necessary patient information is collected in time for frequent court hearings. Otherwise, there was a disconnect between what patients and court system need from providers, and provider understanding of the urgency for accurate and timely release of information.

Future state

The courts contact the Coordinated Access Centre (the Centre) for support and with appropriate permission by the client. The Centre has access to the provider system and is aware of which services have previously supported Jane. The Centre navigates the system on behalf of the client/courts and access the documentation required to support Jane in receiving a full review in order to get custody of her child back. Based on access to the treatment history, the Centre is able to determine which provider initially assessed and treated Jane. The Centre is able to determine if the provider has rapid access to an appointment/follow-up or contacts the providers Intake Worker to negotiate a faster appointment time on behalf of Jane. The Centre also has access to other provider wait times within the area and may seek other providers on behave of Tamika, transferring assessment documentation to facilitate rapid access to treatment/medication/long-term injectable.

The Centre will seek a transitional Case Manager to support Jane and her parents through the process (e.g., can be provided by Community Health Centers of Pinellas). In addition, a referral to a Day Treatment Program is made to provide Jane with an appropriate level of support, avoiding further deconditioning that could result in a crisis visit or an admission to a psychiatric facility.

Clients are triaged based on their needs and not based on "who is next on the list," accounting for client's location preference and provider's availability.

Coordinated access model of care (continued)

Care pathways

Pathway development

Population groups were identified through stakeholder interviews with a focus on the "in-betweeners": populations that are not yet entrenched in the cyclical use of emergency rooms, crisis psychiatric facilities and jails (i.e., "super-utilizers"), but are at risk.

Population group 3

This population group represents those who have co-occurring behavioral health disorders and additional chronic physical conditions (e.g., diabetes). These individuals have stable housing, employment, social support, and access to transportation, but may face cultural and language barriers.

Risk factors:

- Chronic physical conditions
- Co-occurring disorders
- Cultural/language barriers

Protective factors:

- Stable housing
- Stable employment
- Access to transportation
- Insured
- Social support

Client history

Ted was injured in a serious accident over a year ago, which required multiple surgeries and an opioid prescription to control the pain. Due to the injuries, Ted was unable to return to work, and would spend most days in bed and refusing to engage with family members. Ted also started taking his medication off prescription by increasing his dosage in an attempt to make himself feel better. He returned often to his family physician for additional prescriptions; however, by the third time, his physician refused as she recognized that Ted may be abusing his prescription. She was unsure what to do with Ted as he did not fit the profile of a "typical drug abuser", and counseled him to "take it easy" and take his medication as prescribed. Ted told his physician that he would do so, but turned to alcohol with opioids to help cope with his pain and depression. Ted's wife wanted to support him but was unsure what to do or where to go to get him the help that he needed.

Current state

The client's family physician and wife were both unsure how to access behavioral health resources and supports and whether he needed further professional help. Mental health and substance abuse are also taboo subjects within the cultural context of the client and his wife, leading to delayed recognition of the seriousness of his condition. At this point, the client is on a bad path towards decompensation of his co-occurring disorder, which was missed by his physician.

Future state

Ted's physician, who practices at one of the Medical Homes, seeks the interdisciplinary team to support Ted with his symptoms of depression and to stabilize his diabetes.

The Medical Home interdisciplinary team is well equipped to care for Ted based on an established consultation model. A nurse and social worker are assigned to work with Ted with a focus on psychoeducation, evidence-based treatment, and stabilization of his co-occurring disorder and diabetes. The Medical Home team seeks a Psychiatric Consultation through the Coordinated Access Model via telepsychiatry.

Ted's primary care doctor is comfortable in continuing to care for Ted with the support of the Psychiatrist as required. Ted's wife is accessing a support group through the Medical Home and feels well supported by the Medical Home team. This intervention has effectively provided the care Ted needed before subacute or acute care was required.

KPMG

Section 4.5: Prevention and early intervention

Prevention and early intervention

The challenge

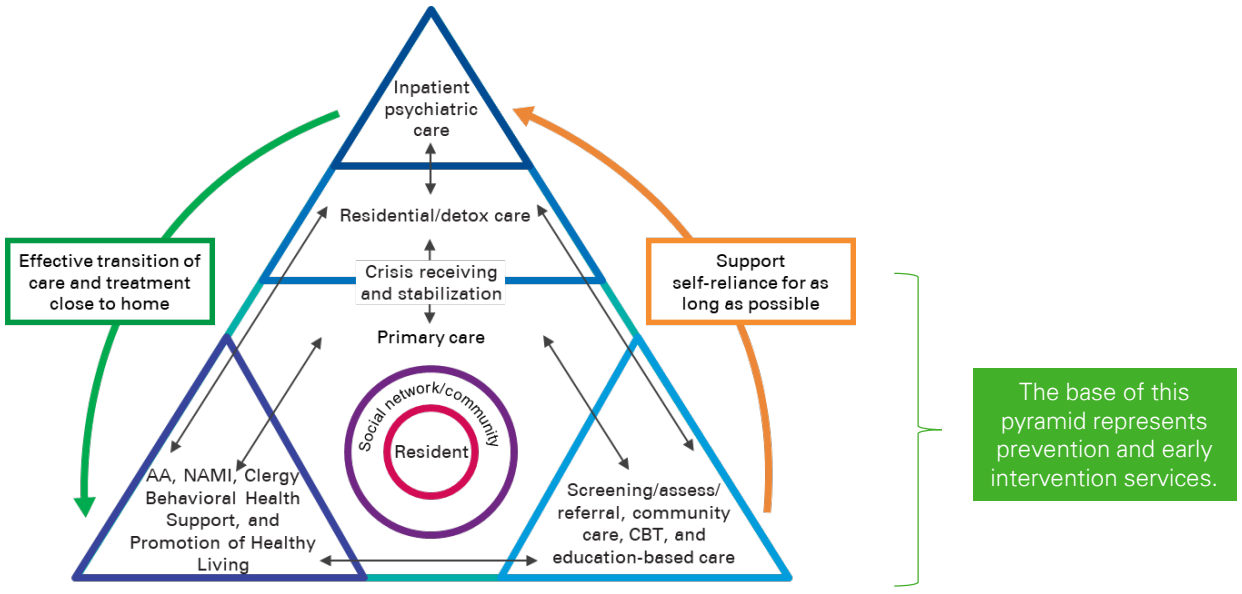
In Pinellas County, stakeholders who engaged in this initiative reported that the primary entry into behavioral health services is through crisis services (e.g., emergency department, crisis stabilization center, or even jail). This reliance on the crisis system poses a challenge for the residents of Pinellas County in delayed treatment, which may result in longer and more costly services in the long run. Emphasis on evidence-based prevention and early intervention may provide better results, driving clients away from crisis services and towards community-based services.

Why is this a Problem?

1. **Lack of transparency:** Clients need clear and defined guidance for engaging with the behavioral health system in order to effectively navigate the system.
2. **Suicide rates:** Pinellas County's higher rates of suicide (19.7 per 100K) versus State (15.3 per 100k) may be best addressed through early intervention and prevention care.
3. **Burden on crisis services:** Stakeholders have indicated that there are sufficient services in place; however, access to care is seen primarily through Crisis Services.
4. **Opioid crisis has high mortality rates:** High mortality rates (22.1 per 100K) may be better impacted through coordinated, evidence-based early intervention and prevention community care.

Suicide rates based on 2019 numbers published by the CDC

Future state of behavioral health system



Importance of having an effective early intervention and prevention system

Evidence increasingly shows that preventing and intervening early for clients with mental health and substance use/ abuse issues, particularly depression, anxiety, co-occurring and first onset psychosis, can dramatically improve immediate and long-term outcomes. The focus of prevention and early intervention activities is broad and can cover the full range of ages, from childhood to old age, and the full spectrum of intervention opportunities, where there is evidence for their effectiveness, from prevention to long-term care. Pinellas County should build on its knowledge of services focusing on understanding the effectiveness and accessibility of the services currently offered and take careful consideration of how increased efforts to bolster prevention and early intervention activities can benefit the behavioral health system.

Prevention and early intervention (continued)

Prevention in mental health

In the context of behavioral health, the World Health Organization defines prevention as interventions that occur before the onset of a mental disorder. The focus is on targeting relevant population groups and reducing the incidence of a mental illness or disorder by interventions that reduce and modify the risk factors associated with the illness and enhancing protective factors. Strategies for prevention in mental health can be classified into universal, selective, or indicated.

1. **Universal interventions** target the general public or whole population groups, such as youth, pregnant women, or parents.
2. **Selective interventions** target population groups whose risk of developing a particular disorder is significantly higher than average; for example, adolescents with hazardous substance use, children whose parents have a mental illness, or Veterans.
3. **Indicated interventions** focus on high-risk individuals who have been identified as having minimal but detectable signs or symptoms foreshadowing a mental disorder, or biological markers showing predisposition for metal disorder, but who do not meet diagnostic levels at the current time.

Early intervention in mental health

Early intervention refers to intervening at the earliest possible phase of an illness. Early intervention is recommended where there is evidence to show that:

1. Intervening early will have a **positive impact** on health outcomes.
2. There is an **effective and an available "mechanism"** to direct an illness at an early phase. The mechanism can include screening or assessment tools and should minimize the risk of identifying people as having the illness who do not actually have it as well as the risk of not identifying people who do have the illness.
3. Effective treatment for the illness is **available**.
4. The effective treatment can be **accessed early by those who need it**.

Early intervention should occur when warning signs or early symptoms begin to manifest, not at the point where they reach crisis. For individuals at high risk, early intervention may occur as an indicated prevention strategy before the onset of any signs or symptoms that reach clinical significance. Interventions that occur later in the process of illness onset, when symptoms have reached an acute stage, are classified as case identification and treatment.

Early intervention case study: Early intervention psychosis

Early psychosis intervention (EPI) programs improve clinical and functional outcomes for people with first-episode psychosis. Results from studies show that people who used EPI had substantially lower rates of all-cause mortality in the two-year period after EPI program admission, with limited differences noted in self-harm and suicide. The program is executed by an interdisciplinary team based on Standards of Care, which is rooted in best practice. Overall, EPI services have been shown to produce better outcomes across several health system indicators.

American Journal of Psychiatry: https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2017.17050480

Prevention and early intervention (continued)

Evaluating Pinellas County prevention and early intervention models of care

While it is clear that **too many patients in Pinellas County are entering the behavioral health system at the crisis level**, KPMG did not perform an operational review of the individual providers, and as such, this report cannot speak to the effectiveness of the current provider network in achieving their mandate. At a high level, it appears that the County has multiple provider organizations that fulfill a service obligation that focuses on prevention and early intervention.

Moving forward, KPMG would recommend that an operational review be considered for these providers to optimize the existing resources to create the greatest capacity possible in the system, by leveraging existing prevention and early intervention models. In the event that this analysis is performed and it is found that the existing care provider network is already optimized to provide preventive services, it is rational for Pinellas County to grow and invest in additional providers, facilities, or programs dedicated to prevention and early intervention.

Prevention and early intervention recommendations

1. **Operational review** – Review existing prevention and early intervention modalities available in Pinellas, leveraging the performance management framework, and identify gaps and capacity challenges.
2. **Targeted Investment** – Invest in leading-practice prevention and early intervention models of care to address gaps identified in assessment and evaluation of existing operations.

Considered prevention and early intervention models of care

1. **Substance use, abuse, and co-occurring disorders leading practices** – There is considerable strain placed on the behavioral health system regarding substance abuse. Pinellas could look to optimize its efforts related to opioid abuse and relieve pressure on the larger behavioral health system.
2. **Case Management** – Evaluate, enhance, or expand current case management services. Focus on the individual's strengths, promote the use of informal supportive networks and collaboration in interdisciplinary teams, and utilize either transitional case management (up to three-months) or long-term case management to effectively bridge clients and assist in navigating the complex behavioral health system.
3. **Medical Home Model** – Evaluate, enhance, and/or expand the patient-centered medical home model and its core components of (1) normalizing behavioral health in medical practice, (2) integrating reimbursement, (3) performance measurement, (4) implementation mechanisms for populations with complex behavioral health needs, (5) creation/dissemination of screening/diagnostic/monitoring tools, and (6) taking a coordinated multidisciplinary approach to engage, educate and support patients.
4. **Federally Qualified Health Center (FQHC)** – Evaluate, enhance, and/or expand primary care and behavioral health care integration models, including coordinated care, co-located care, and integrated care supported by shared treatment/care plans, prescription with psychiatric consultation, universal screening, etc.
5. **Certified Community Behavioral Health Clinic (CCBHC)** – Evaluate and implement a CCBHC for the provision of comprehensive 24/7 access to community-based mental and substance use disorder services, treatment of co-occurring disorders, and physical healthcare in one single location.
6. **Virtual Care** – Explore technologies that have the potential to bring more objectivity and reliability to the processes of assessment, diagnosis, and monitoring.

Prevention and early intervention (continued)

Substance use, abuse, and co-occurring disorders

Substance use/abuse has become an increasingly challenging concern for health systems across the globe. Specifically, the consumption of opioids has reached the stage of a global epidemic with estimates of more than 2 million Americans currently addicted to opioids with approximately 142 Americans dying every day from opioid overdoses[1]. In the United States, the CDC estimates that in 2018 there were 67,367 drug overdose deaths in the United States or an age-adjusted rate of drug overdose deaths of 20.7 per 100,000 people. In Florida, the problem is heightened, with above national-average rates of age-adjusted drug overdose deaths at 22.8 per 100,000 people. On a positive note, the overdose death rate is declining from 25.1 per 100,000 for the State of Florida (-9.16% change in rate) and 21.7 nationally in 2017.[1]

For Pinellas County, the challenges appear to be more acute, with the Florida Department of Health's recent community health assessment identifying "addiction" as a top health problem of concern and "alcohol and drug abuse" as the leading behavior of concern within the County.[2] According to this report, the three leading causes of opioid overdose in Pinellas were synthetic opioids, heroin, and prescription opioids. Opioids are effecting every demographic community across Pinellas County, with white men appearing to have the largest subset.[2]

Statistics on co-occurring disorders show that ~11% of individuals with mood and anxiety disorders have a high prevalence of drug abuse and dependence.[3] "Recent epidemiological studies suggest it is estimated that as many as half of all veterans diagnosed with PTSD also have a co-occurring substance use disorder (SUD)." An estimated 45% of offenders in State, local prisons, and jails have a mental health problem comorbid with substance abuse or addiction. However, adequate treatment services for both drug use disorders and other mental illnesses are greatly lacking within these settings. Treatment of comorbid disorders can reduce not only associated medical complications, but also negative social outcomes by mitigating against a return to criminal behavior and incarceration.[3] In the United States, different treatment systems address drug use disorders and other mental illnesses separately. Physicians are most often the front line of treatment for mental disorders, whereas drug abuse treatment is provided in assorted venues by a mix of health care professionals with different backgrounds. Thus, neither system may have sufficiently broad expertise to address the full range of problems presented by patients.[3]

Response to Opioid crisis in Pinellas County

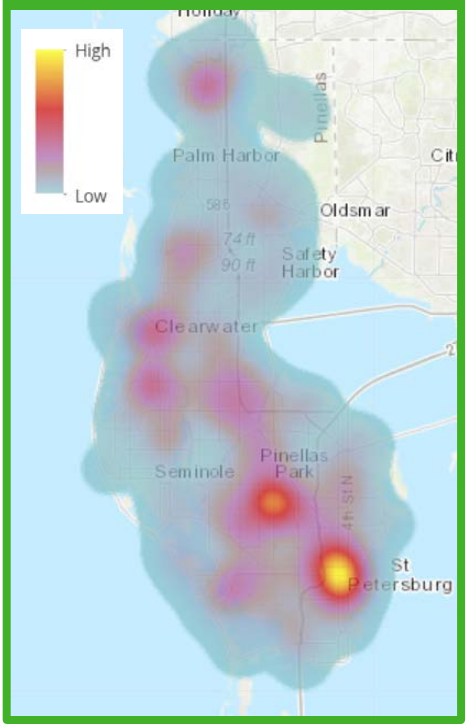
As a response to the significant increase in historical overdoses, In 2017, the ***Pinellas County Opioid Task Force*** released a strategic plan for 2017–2019 outlining a series of investment requests, tactical actions, and implementation roadmaps that aim to address the ongoing opioid crisis.

The pillars of this strategic plan are as follows:

1. **Increase education and awareness:** Detailed strategies included increasing the frequency and modality of information shared, targeting youth through schools and specialized groups as well as training for physicians.
2. **Reduce opioid related deaths:** Detailed strategies included increasing availability of overdose kits and training first responders.
3. **Connect to effective treatment:** Focus on increasing the availability of treatment, establishing meaningful connections, and increasing funding for opioid services.
4. **Decrease the supply of opioids:** Focus on strategies to work with law enforcement agencies and regulators to limit supply.
5. **Integrate and collaborate data sources:** Focus on standardized data collection and developing and assigning clear leadership.

The pillars of the strategic plan closely map against and support the recommendations made in this report. Pinellas should work to integrate the behavioral health efforts (mental health and addictions) to achieve greater outcomes. Leading practice shows that treatment of co-occurring disorders demonstrate best outcomes then treatment conducted in silo.

2018 Pinellas County Overdose Deaths



[1] **Centre for Disease Control (2019)** https://www.cdc.gov/nchs/products/databriefs/db356.htm
[2] **Florida Department of Health in Pinellas County (2018)** http://pinellas.floridahealth.gov/programs-and-services/community-health-planning-and-statistics/data-and-reports/_
[3] **National Institute of Drug Abuse (2008)** https://www.drugabuse.gov/sites/default/files/rrcomorbidity.pdf
[4] **Pinellas County Opioid Task Force (2017)** https://www.arcgis.com/apps/Cascade/index.html?appid=8c02b926f02c4498b1dda55f00e4a1aa

Prevention and early intervention (continued)

Continuum of Care for Addiction Services

A review of leading practice of addiction services demonstrate 5 levels of intervention through the continuum of care that should be available by any County servicing a population that seeks substance use/ abuse treatment. These levels of care should be offered to its citizens to facilitate appropriate intervention based on consumer needs. It also mitigates consumers entering care at the Crisis or Emergency level in order to access care when lower levels of services, such as Early Intervention or outpatient services etc. would have been more appropriate.

"Continuum of care refers to a treatment system in which clients enter treatment at a level appropriate to their needs and then step up to more intense treatment or down to less intense treatment as needed." A successful continuum of care facilitates clients moving between levels of care of similar philosophy, i.e., harm reduction versus abstinence with a efficient process to transfers both clients and records between programs/providers. The American Society of Addiction Medicine (ASAM) has outlined five main levels in the continuum of care:

Level 0.5: Early intervention services. Substance Use Disorders typically emerge during adolescence and may progress in severity and complexity with continued substance misuse. www.ncbi.nlm.nih.gov/books/NBK424859. It is important that early intervention services target this population through a variety of settings, such as primary care, public health, educational facilities and behavioral health services.

Level I: Outpatient services, which can be broken down into four stages that clients work through, regardless of the level of care at which they enter treatment:

Stage 1: Treatment engagement

Stage 2: Early recovery

Stage 3: Maintenance

Stage 4: Community support

It is important to note that referrals across services providers should have the same types of treatment models and philosophy, e.g., 12-Step, cognitive-behavioral or a combination to assist the client in the transition between providers. Clients typically struggle if they are confronted with significantly different treatment goals, approaches, and philosophies during the transition period and between providers.

Level II: Intensive outpatient/partial hospitalization services (IOT). A client may access this level of care through the following two scenarios;

A step-down model: Once a client has been stabilized in a residential treatment setting (level III), they can 'step-down' to an IOT program. This is an effective transition plan to support the client's ongoing care needs through continuing to work through their treatment goals.

A step-up model: The same can be applied for clients who require a step-up in intensity of treatment from unsuccessful outpatient care. This can prevent further relapse that may lead to Level III care.

It is important for both the clinician and the client to recognize and prepare for the transition to a lower level of care, as this is often when clients disengage from treatment.

Level III: Residential Services- This setting can be categories as nonmedical or social detoxification setting. This level emphasizes peer and social support and is intended for patients whose intoxication and/or withdrawal is sufficient to warrant 24hour support.

Level IV: Medically managed intensive inpatient services - is an inpatient detoxification service that provides 24hour medical supervision, observation, and support for patients who are intoxicated or experiencing withdrawal.

These levels of care are not discrete but rather as points in a continuum of treatment services. Programming, however, will differ based on populations and communities they serve. For example, a rural residential program treating women who are alcohol dependent will differ from an urban residential program treating men dependent on stimulants or adolescent requiring residential programming. Programs typically do not mix age populations as the needs of a middle age woman will differ from adolescents and again for the geriatric populations.

Through stakeholder engagement, it was reported that Pinellas County has an effective continuum of care to service its citizens. As there is very limited to no information on wait times and client outcomes, it is unclear what the gap is from the full continuum of care that is reported offered versus the high percentage of clients that are seeking services through crisis services. By implementing a Coordinated Access Model and Performance Management, the County, along with their partners will be able to better understand where the potential gaps are, target interventions and measure outcomes before consideration of additional funding is sought.

NCBI (2015) https://www.ncbi.nlm.nih.gov/books/NBK64088/
SAMHSA (2015) https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf
NCBI (2016) https://www.ncbi.nlm.nih.gov/books/NBK424859

Prevention and early intervention (continued)

At a glance: National trends in Opioid crisis prevention and early intervention

It is important to note that KPMG did not conduct a detailed operational scan of interventions currently in place by Pinellas providers. We have, however, pulled a few localized initiatives that have shown promise for consideration.

Physician Training: A good example of using non-opioid treatments is St. Joseph's Hospital in New Jersey, which banned opioid painkillers as the first line of treatment. St. Joseph's Regional Medical Center launched the Alternatives to Opiates (ALTO) Program to reduce the use of opiates in the emergency department of the hospital.[4] The program trains physicians to use a variety of non-opioid treatments to meet the pain management needs of their patients while avoiding the addictive risks inherent in opioids. *Result:* A reduction of opioid use by 38% in a five-month period.

Peer Support: The AnchorED program in Rhode Island has become a leading example of how peer recovery services can be an effective tool in combating opioid addiction.[5] The program places peer recovery coaches in the hospital who connect with individuals in the emergency department who have experienced nonfatal opioid overdoses. Peer recovery coaches build relationships with patients based on shared experience and connect patients to treatment and recovery resources, while providing education and mentoring. In the first 29 months of the program, 1,400 patients met with a peer recovery coach and 80% engaged in recovery support services upon discharge from the emergency department.

Data and Analytics: Governments have leveraged data and analytics at increasing rates for harm reduction to both understand the current state of the opioid problem to inform strategy and monitor changes so that trends can be identified. Forty-nine states, the District of Columbia, and Guam have enacted legislation authorizing the creation and operation of a prescription drug monitoring program (PDMP), and almost all are currently collecting data and reporting on it to authorized users. While not a full data analytics solution, agencies do have the option to expand the use of their PDMPs as a first step to creating a more comprehensive surveillance solution in addition to providing point-of-care support. Currently, prescribers in 29 states are required to check PDMP databases before prescribing certain controlled substances.

At a glance: Global trends in Opioid crisis prevention and early intervention

Australia[7]: The country is focused on expanding treatment for heroin users and people dependent on other opioids, providing heroin prescription treatment for select heavy users, providing **supervised injection centers** in areas with large numbers of drug overdoses, and expanding the distribution of Naloxone, which can reverse the effects of an opioid overdose in emergency situations. In addition, the rollout of a **national real-time monitoring system** that will alert pharmacists and doctors if patients attempt to obtain multiple supplies of prescription drugs, directing frontline pharmacists to take preventative measures.

Portugal[8]: With the lowest number of deaths globally, Portugal has taken a radical approach to combating opioid use. In the 1980s, drug use was a serious social and health issue and, as such, the Portuguese government increased investment in prosecution and administered severe punishments. As time went on, it became clear that the approach only exacerbated the crisis; by the end of the 1990s, 1% of the entire population (100,000 people) was addicted to heroin. In 2001, Portuguese leaders implemented a paradigm shift and **decriminalized the personal use of illegal drugs**; however, the distribution of drugs remains illegal in Portugal. Serious drug use in Portugal is down by half since the introduction of these changes and drug mortality is the lowest in Western Europe. It was reported that the proportion of 15 to 24-year-olds who said that they had used drugs in the last month had decreased by almost 50% since decriminalization in 2001. **Targeted education** and **community support** have promoted an open dialogue about drug use and its associated harm, with the conversation focused on helping those at risk avoid negative health and social consequences.

[4] **Microsoft Service Network (2017)** ttp://www.msn.com/en-us/video/news/the-opioid-epidemic-about-142-americans-die-everyday/vp-AApE8Wr.
[5] **The Providence Centre (2020)** https://providencecenter.org/services/crisis-emergency-care/anchored
[6] **Mattie Quinn (2017)** http://www.governing.com/topics/health-human-services/gov-opioid-lawsuits-companies-States-cities.html.
[7] **Melissa Davey (2016)** https://www.theguardian.com/science/2016/feb/03/painkiller-use-quadruples-in-australia-as-codeine-and-other-opioids-abused.
[8] **Nihcolas Krisotof (2017)** https://www.nytimes.com/2017/09/22/opinion/sunday/portugal-drug-decriminalization.html

Case study: Erie County and New York State Department of Health

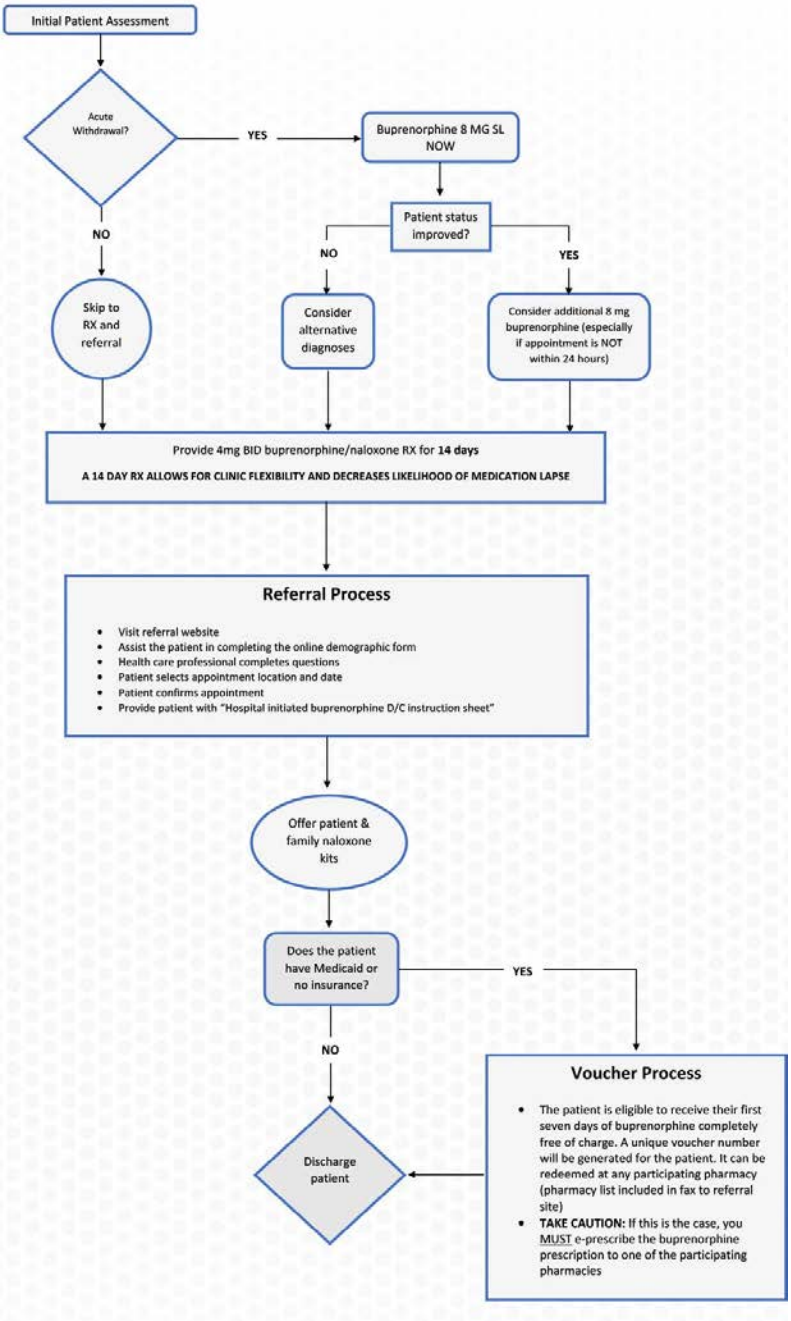
Fighting the battle on opioid use disorder in Western New York

Buffalo MATTERS is a program designed to aid healthcare providers in the treatment of patients with opioid use disorder. Developed by the University at Buffalo, emergency medicine physicians expedite a patient's access to comprehensive and effective opioid use disorder treatment. The model for Emergency Department Initiated Buprenorphine Programs, in addition to providing rapid, reliable referrals to community-based clinics for patients upon discharge, facilitates a comprehensive continuum of care needed to support this population.

The standardized care pathway, which aligns to leading practices, triages patients upon entry to the emergency departments. The clinician follows the algorithm (see adjacent figure) to determine next steps in both referral process, medication, and dosage. The success of this model is based on a population health approach, collaboration across the state that incorporates hospitals, clinics, and pharmacies, and follows a standardized care pathway across the system.

Outcomes:

1. From 2015 to 2018, the emergency departments of the major academic health centers in Buffalo saw a >50% decline in opioid prescribing.
2. Understanding that rapid, reliable referrals were necessary for success, initially, patients were referred from one hospital to three clinics to ensure proof of concept. Over the course of 2018, the network grew to 13 hospitals that refer to 27 separate substance abuse treatment clinics. As of the fall of 2018, over 60 weekly appointments are offered to patients referred through this network.



Buffalo Matters: https://buffalomatters.org/wp-content/uploads/2018/11/Buffalo-Matters-Overview.pdf

Prevention and early intervention (continued)

Case study: Allegheny County and their Opioid Response Team

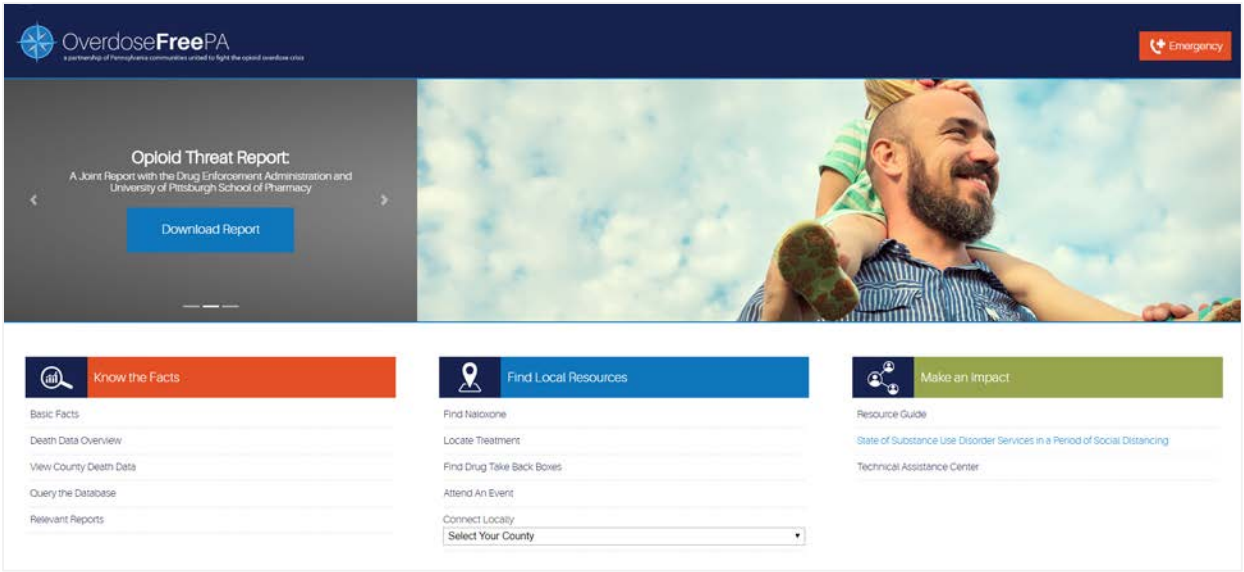
Allegheny County's Opioid Response Team was able to report a 41% reduction in accidental overdoses from 737 in 2017 to 432 in 2018– representing their lowest figure during the past three years. Their internal Opioid Response Team consists of the Medical Examiner's Office, County Police, the Health Department, Emergency Services, Human Services and the Jail with guidance and support from the Manager's Office and CountyStat.

The team credited this sharp decline to increased availability in naloxone, collaboration between various County agencies and availability of accurate and up-to-date data on the opioid crisis through their unique OverdoseFreePA website, developed by the University of Pittsburgh School of pharmacy's Program Evaluation and Research Unit (PERU). As seen in the following figure, the website provide a centralized, evidence-based resource to support multi-disciplinary efforts within participating counties to reduce overdoses and overdose-related deaths.

Other notable efforts taken by Allegheny County's team members include:

1. **Strengthening Surveillance Systems:** The County's Office of the Medical Examiner brings public health (e.g. epidemiologic surveillance methods) and public safety (e.g. law enforcement) together to provide and act on large-scale and real-time drug overdose data and analysis of emergency of new drugs within the County– which is shared with law enforcement, emergency medical services, emergency departments, and treatment providers.

2. **Project Safe Landing Initiative:** The Overdose Prevention Coalition developed an initiative to improve the identification of patients who are overdosing are at increased risk for overdosing, and then providing access to treatment and support services. The evidence-based approach of Screening, Brief Intervention and Referral (SBIRT) is used for this identification in collaboration with local Medicaid and commercial players through the use of data from adjudicated hospital claims and local behavioral health encounter data.



OverdoseFreePA https://www.overdosefreepa.pitt.edu
University of Pittsburg Institute of Politics (2016) http://d-scholarship.pitt.edu/29950/1/IOPOpioidReport2016.pdf
Allegheny County (2019) https://www.alleghenyCounty.us/News/2019/6442468032.aspx

Prevention and early intervention (continued)

Opportunities for Pinellas to focus on substance abuse prevention and early intervention

It is imperative that early intervention and prevention services are accessible and effective prior to any consideration being given to a stand-alone facility, as without the foundation of services in place, continuum of care will continue to be impacted. We have identified four opportunities for Pinellas County to consider when it comes to improving their substance abuse prevention and early intervention efforts.

1. **Collaborate with providers** including medical homes and FQHC in tackling early intervention and prevention for mental health, addictions, and co-occurring disorders through alignment with leading practice.
2. **Enhance peer-support engagement** into the behavioral health model, leveraging and accelerating existing initiatives.
3. **Integrate the Minimum Data Sets (MDS) developed through the performance management recommendations, to include data collected by the Pinellas County Opioid Task Force** through their *"Integrate and collaborate data sources"* initiative such that decision makers are leveraging data across the mental health and addictions continuum, able to identify gaps and performance issues in order to inform investment decisions.
4. **Promote a patient-centered view of treatment**, taking into account co-occurring disorders and co-morbidities, shifting away from an addiction-focused approach, and instead treating the whole person.

What is case management?

Case management is a collaborative, client-driven process that supports the clients in achieving safe, realistic, and reasonable goals within a complex health, social, and fiscal environment.

Based on the increased rates of homelessness seen through Crisis Services within Pinellas County, case management is and integral solution to meet the complex co-morbid needs of individuals experiencing homelessness. There have been several documented positive effects of case management interventions on individuals experiencing homelessness, including increased housing stability; increased engagement in medical and nonmedical services; reduced use of high-cost health system services; improved mental health status; reduced use of drug and alcohol; and improved quality of life.[1] Case management can be executed through providers or as a part of the coordinated access model.

[1] De Vet T, Van Luijtellar et Al, Effectiveness of Case Management for Homeless Persons: https://www.ncbi.nlm.nih.gov/pubmed/23947309

Types of case management

Clients are first assessed to determine whether they are better suited for transitional case management or intensive (long-term) case management services.

1. **Transitional Case Management** – Clients with short-term needs and/or with access to other supports may benefit from transitional case management services, which typically can last up to three months. Transitional case management clients often require short-term navigation and linkage support and have a lower severity diagnosis.

2. **Intensive Case Management (ICM)** – Clients with complex needs requiring more intensive support are better served through intensive case management. ICM provides assertive outreach and counseling services, including skills-building, family consultations and crisis intervention. The direct involvement of the consumer and the development of a caring, supportive relationship with the case manager are integral components. This service is a step up from Transitional Case Management and a step down from Florida Assertive Community Teams. It is common that Case Managers see clients multiple times a week.

Prevention and early intervention (continued)

Case study: Beacon Health

Using ongoing analysis of program data and outcomes, Beacon Health's informatics team informs and guides the overall admission and referral criteria. Using aggregate individual case risk weighting, they target the individuals that will be most impacted by program participation. This centralized referral criteria has also been provided to all Engagement Centers that work with Beacon Health in order to implement these criteria in the communities, determining how to maximize resources, workforce capacity, and prioritize referrals.

In addition, Beacon screening tools have been implemented by clinicians to determine the initial level of care.

- If categorized as "mild-moderate" needs, Beacon offers three local referrals or can help make an appointment.
- If categorized as "moderate-severe" needs, the screening tool is faxed to County MH programs.

By integrating with GPs, Beacon allows them to get care coordination support earlier for clients and looks to make referrals for assistance with Beacon's network, where appropriate.

Since screening and referral often begins in the primary care setting, Beacon Health has used data informatics and screening tools to support primary care physicians in linking clients to care earlier through strong identification systems, active outreach and appropriate matching of services based on needs before deterioration.

Beacon Health https://www.beaconhealthoptions.com/pdf/clinical/2-501.pdf

Integrating mental health into primary care: The medical home model

A Medical Home is primary care medical center that is accountable for meeting the large majority of each patient's physical and behavioral health needs including, but not limited to, prevention and early intervention and chronic care. Providing care in a medical home means that team-based care is used to treat the patient holistically. The core elements of a medical home are:

1. **Comprehensive Care:** responsible for serving a wide variety of care conditions
2. **Patient- Centered Care:** provides healthcare that is relationship-based with an orientation towards the whole person, partnering with patients and families
3. **Coordinated Care:** coordinates care across all elements of the broader health system, including specialty, hospital, home and community services and supports
4. **Accessible Care:** delivers accessible services with shorter wait times for urgent needs, enhanced in-person hours, and around-the-clock virtual care
5. **Quality and Safety:** demonstrates a commitment to quality and quality improvement through ongoing engagement with evidence-based medicine and clinical decision support-tools

U.S. Department of Health and Human Resources, Agency for Healthcare Research and Quality: https://pcmh.ahrq.gov/page/defining-pcmh

Medical home model in Pinellas County

A partnership between the Pinellas County Human Services Department, the Pinellas County Department of Health, and the Turley Family Health Center provides prevention-focused health services through the use of medical homes. The Pinellas County health program provides services for a wide variety of conditions and treatment needs including mental health and substance abuse services, case management services for those dealing with disability, psychological concerns, and addictive behaviors as well as a wide variety of tests and referral services.

The availability of these services in Pinellas County is a great start. The accessibility and effectiveness of the services could be examined to determine if the program/services are meeting consumers/community needs and being optimized for the services it offers.

Prevention and early intervention (continued)

Case study: Primary care mental health integration

"Roughly 80% of mental health care is delivered by nonspecialists in mental health integration clinics"[1]

Based out of Utah and Idaho, Intermountain Healthcare is a non-profit health system operating 22 hospitals, a medical group with 185 primary care clinics and an affiliated health insurance company.

In the early 2000s, Intermountain Healthcare developed the mental health integration program, which enables primary care practitioners to take on a greater role in the delivery of mental health services.

A multidisciplinary team is embedded in primary care, which is delivered in a stepped manner based on an algorithmic assessment of patient need:

- Mild complexity: managed primarily by the primary care physician with support from a case manager
- Moderate complexity: includes those with a physical co-morbidity and those living in an isolated or chaotic social environment and is managed with collaborative care from the MHI team
- High complexity: managed by mental health specialists, either working in primary care settings or with a referral to secondary care.

By integrating with GPs, Beacon allows them to get care coordination support earlier for clients and looks to make referrals for assistance with Beacon's network, where appropriate.

Since screening and referral often begins in the primary care setting, Beacon Health has used data informatics and screening tools to support primary care physicians in linking clients to care earlier through strong identification systems, active outreach and appropriate matching of services based on needs before deterioration.

Outcomes

A key success factor for Intermountain was the significant investment made in their change management processes, including consistent messaging from leadership regarding the need to address both mental and physical health in the primary care setting. Intermountain saw a variety of key quality and financial improvement outcomes following the implementation:

⬆	Patient satisfaction
⬆ 5x	Financial return on investment due to improved physical health and efficiencies gained in other areas of the system
⬇ 48%	Medical costs per patient in the 12 months following diagnosis of depression
⬇ 54%	Patients with depression were less likely to visit the emergency department
⬇	Hospital admissions for ambulatory care sensitive conditions for those accessing MIH mental health services
⬆	Diabetes control among those with diabetes and depression

Intermountain healthcare https://intermountainhealthcare.org/news/2016/08/new-jama-study-shows-that-integrating-mental-and-physical-health/

Case study: Collaborative care models in mental health

The Advancing Integrated Mental Health Solutions (AIMS) Centre at the University of Washington has developed an evidence-based approach to integrated care delivery. This model has been shown to be more effective than the standard care model in over 80 randomized controlled trials and meta-analyses. Specifically focused on chronic mental health conditions such as depression, anxiety, and alcohol or substance abuse that persist over clients' lifetimes, the model aims to deliver care to this population in an effective and efficient manner.

Teams consist of a primary care provider, a care manager (nurse, clinical social worker or psychologist), and a psychiatric consultant.

- Psychiatric consultations are generally conducted by phone with the care manager, along with the primary care provider if appropriate.
- Direct patient-psychiatrist interaction, conducted face-to-face or by video link, is reserved for higher-complexity cases and for patients who are not progressing as expected.

Advanced Integrated Mental Health Solutions: University of Washington Psychiatry and Behavioral Sciences: https://aims.uw.edu//

Prevention and early intervention (continued)

Collaborative care models (continued)

Foundational to the Collaborative Care model are the following five features; if anyone is missing, the AIMS Centre does not consider it too be effective Collaborative Care.

1	Patient-Centered Care Team	Mental health and primary care providers develop shared care plans, which include client goals, for a caseload of primary care patients.
2	Population-Based Care	Care teams share a defined group of clients, all of whom are tracked in a centralized registry so no one falls through the cracks. Clients who are not improving are flagged for a targeted reach out.
3	Measurement-Based Treatment to Target	Treatment plans articulate clients' goals and progress is measured against standardized tools such as the PHQ-9 depression scale. If patients are not progressing as expected, the treatment plan is adjusted.
4	Evidence-Based Care	Treatments adhere to clinical standards and include medications, Cognitive Behavioral Therapy, and Behavioral Activation
5	Accountable Care	Care providers are paid for performance—the quality of care and clinical outcomes achieved—as well as service volumes.

Federally qualified health centers

Federally Qualified Health Centers (FQHCs) are organizations that deliver primary healthcare services designated by the Bureau of Primary Healthcare and the Centre for Medicare and Medicaid Services to underserved populations and communities. They are grant-supported organizations that can operate as both public and private nonprofit health care organizations. FQHCs can operate under a variety of different models of care including:

1. **Community health centers**
2. **Migrant health centers**
3. **Healthcare for the homeless programs**
4. **Public housing primary care programs**

National Council for Community Behavioral Health: https://www.integration.samhsa.gov/integrated-care-models/October_27th_Webinar_Fact_Sheet.pdf

Case study: New Jersey FQHC and behavioral health

FQHCs can provide important support for marginalized communities, serving patients who experience increased life stress and barriers to care. Additionally, these communities have a significantly higher likelihood of experiencing behavioral health or addictions challenges and as such integration between FQHCs has shown significant promise in supporting these communities. Given Pinellas County has a high homeless population, they could benefit from this approach. A pilot project in New Jersey studying to FQHCs were granted funding by a private foundation to explore the integration of behavioral health services with FQHCs. The services offered through this integration included behavioral health care, chronic disease management, and computerized cognitive-behavioral therapy. Many changes were required to the health center structure. The FQHCs foundation allowed for implementation progress towards integrated care in just one year. The two sites, in Trenton and Lakewood New Jersey, both served diverse populations and made significant strides of integrating BHC into standard care models, including participation in morning primary care team huddles, and saw significantly increased response times, where patients screened in the huddles were seen by BHC on the same day.

Lesson's learned – The study identified several key lessons about the integration of behavioral health and primary care at a FQHC. These lessons include:

1. **Fundamental changes need to be made** – It is not simply enough to say that integrated care models need to be adopted in FQHCs—fundamental change-management to staffing, hiring, training, infrastructure, and physical space need to be considered to integrate care.
2. **Integrated care is better care** – Care integration serving marginalized populations allows people to access all the services they need through a single visit or health team.

Buddle, Friedman et Al (2017): https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201700240

Prevention and early intervention (continued)

Certified community behavioral health centers

Certified Community Behavioral Health Clinics (CCBHCs) were created through Section 223 of the Protecting Access to Medicare Act (PAMA), which established a program known as the **Excellence in Mental Health Act**. Currently, 113 CCBBHCs are operating in 21 States, CCBHCs are considered the gold standard by many in the behavioral health community. CCBHCs, as defined in the Excellence in Mental Health Act, are required to delivery nine types of services:

1. **Crisis mental health services**
2. **Screening, assessment and diagnosis, including risk assessment**
3. **Patient-centered treatment planning**
4. **Outpatient mental health and substance abuse services**
5. **Primary care screening and monitoring of key health indicators/health risk**
6. **Targeted case management**
7. **Psychiatric rehabilitation services**
8. **Peer support and family supports**
9. **Intensive, community-based mental health care for members of the armed forces and veterans.**

National Council for Behavioral Health: CCBHC https://www.thenationalcouncil.org/topics/certified-community-behavioral-health-clinics/

CCBHC case studies

In the event that an operational review proves that there is insufficient behavioral health capacity to meet the complex needs of the homeless population, and those with complex co-occurring needs within the community, a CCBHC could be effective at driving gaps in:

1. **Filling the Gaps and Making Care Available** – Prior to becoming a CCBHC, Bikur Cholim in New York had a waitlist of 140 patients. By adopting the CCBHC model and implementing rapid access protocols, Bikur Cholim has completely eliminated its waitlist while simultaneously expanding its patient caseload.

2. **Improving Coordination with Law Enforcement** – In partnership with a local jail, the Klamath Basin Behavioral Health center in Oregon provides on-site services, beginning with daily copies of booking reports and following up to determine treatment history using check-ins. Klamath County has pointed to this program as a significant driver in making it have the lowest recidivism rate in southern Oregon, saving an estimated $2.5M.

3. **Reducing Hospitalization and Emergency Department Visits** – Cascadia behavioral health in Oregon used a data-driven effort to identify and intervene for patients with a high risk of ED utilization. They found that 16% of their patients accounted for 54% of all hospital costs, largely driven by alcohol use, chronic pain, and hypertension. By implementing a preventative effort, Cascadia achieved an 18% reduction in ED visits and a 20% reduction in hospital admissions, saving an estimated $1.65M

4. **Addressing the Suicide Crisis** – Comprehensive MH Services in Missouri have used screening of clients who come for therapy or medication services and the addition of a suicide prevention liaison role to reduce psychiatric hospitalizations and make progress towards their goal of zero suicides.

5. **Addressing the Opioid Epidemic** – After becoming a CCBHC, Spectrum Human Services in New York developed a plan to incorporate MAT into its services and redesigned their intake process to address "no-shows." As a result, 77% of clients with substance use disorders began treatment within 14 days of diagnosis.

National Council for Behavioral Health: CCBHC https://www.thenationalcouncil.org/topics/certified-community-behavioral-health-clinics/

Prevention and early intervention (continued)

Virtual care

Increasingly, innovative technologies are being deployed as a measure to provide care or support in line with prevention and early intervention best practices. Especially due to the recent circumstances around COVID-19, the adoption of virtual care will be more relevant than ever for crises, as well as ongoing care. As digital tools continue to disrupt medical technology with respect to physical health, there are many good examples of the behavioral health space being disrupted as well with app-based peer support and patient experience systems being put in place to provide care where patients are at the right time and in the right format.

Approaches to virtual care

Virtual care can be categorized into the following three primary areas. This categorization are inclusive of different ways that care can be delivered virtually (source: World Health Organization).

Telemedicine	Telemedicine includes any use of information and communication technologies, regardless of location of either parties, to facilitate bidirectional health care interaction and sharing of information in the interest of improving health outcomes. Examples include eConsult (asynchronous or synchronous) between care providers, referral, and virtual visits.
Remote Patient Monitoring	This includes the use of various point-of-care technologies to remotely monitor a patient's physiological status and health condition in real time. Remote patient monitoring typically involves data collection at point of care, data transmission to integrated information systems (e.g., Clinical Information System or Electronic Medical Record), automated evaluation (through predictive analytics and algorithms, and notification and intervention (as necessary).
Consumer Engagement	Consumer engagement involves information and communication technologies designed to empower individuals to take action to improve their health, make informed decisions, and engage effectively and efficiently with the health care system. Examples include online resources, mobile applications, and personal health/wearable devices.

Case study: A4i (App4Independence)

App4Independence (A4i) addresses the complexity of support, isolation, and relapse risk along the schizophrenia care continuum. A4i is an evidence-based digital therapeutic intervention with a regulatory pathway, patient features, and early publications. The value of A4i is that it provides significant improvements in several symptom domains and uses early digital biomarkers identified related to risk of relapse and readmission. Features include an audio hallucination detection feature and life-skills education that will assist clients in performing daily tasks. It also engages the Case Manager most responsible for the client in providing updates on client activities and alerts of concerning activity, such as frequency of application engagement.
Source: A4i. www.a4i.me

Conclusion: Prevention and early intervention in Pinellas

Prevention and early intervention programs are foundational to all behavioral health systems. For Pinellas County, it is clear that too many people are accessing services in crisis, meaning that prevention and early intervention programs are either not easily accessible, are over-capacity and unable to meet demand, or underperforming at the level they should be.

Evaluation of the current system is required to determine if access, effectiveness, and resource optimization is meeting the needs of the community. Standards of care aligning with leading practices should be examined at each of the current prevention and early intervention programs. Having the services in the community is simply not sufficient, and adding additional services that are not aligned with leading practice is not an effective use of funds.

Therefore, without a comprehensive prevention and early intervention suite of programs, it is likely that consumers will continue to seek care at the crisis level. Pinellas County should not consider additional resources such as programs or a new facility without a thorough examination and evaluation of current programming and performance.

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Section 4.6: Receiving and diversion

Receiving and diversion

The challenge

The County currently engages residents in crisis through several doors: emergency rooms, jails, Marchman facilities, and Baker Act facilities are a few examples. These facilities are public and private in addition to being siloed in both treatment, assessment, intervention services. In addition for the need for some additional capacity identified by the community, the current system appears misaligned with leading practices and needs.

Why is this a Problem?

1. **Siloed Services:** There are 6 primary receiving facilities for those in crisis within Pinellas County. The facilities have differing capabilities in their ability to treat ambulatory, acute and subacute patients in crisis.
2. **Capacity:** It was identified in stakeholder interviews that the public receiving facility at times faces acute issues with capacity.
3. **A lack of integrated care:** The system lacks coordinated care and/or visibility of service availability and or bed space between facilities.
4. **Patients walk through the wrong door:** It was identified in stakeholder interviews that patients often are denied service where it does not exist and redirected to alternative facilities.

Recommendations/options

1. **Enhanced public receiving services** – The County could enhance the services and/or resources at its current public receiving facility. Allowing for a broader range of service in the ambulatory to sub-acute range with additional enhancements to screening, assessments and coordination of care will positively impact resident outcomes.
2. **Standardized public private receiving model** – The County could utilize its contracts across public and private entities to standardize screening, assessment and treatment options across the County. This combined with enhanced coordinated care ensures that no door is the wrong door for services in the ambulatory-subacute range.
3. **Enhanced public receiving capacity** – The County could develop additional capacity for residents in crisis who with substance abuse and/or mental health issues in situations where they pose a danger to themselves or others. This capacity could be in the form of a new facility; expansion of current facilities; contracted beds at private facilities.

Enhanced receiving and diversion capability & capacity

The County should take a range of steps to ensure that the guiding principles of its behavioral health department are aligned to the treatment of residents. The focus in a new receiving and diversion model should center around holistic treatment (enhanced services) and capability to provide treatment in the ambulatory-subacute range at all facilities. The following steps would be needed:

1. **Optimize current facilities** – Ensure that utilization of current facilities are maximized and optimized before making decisions on new capacity. Coordinated access to care and integrated technology will be key to optimization.
2. **Standardize** – Where possible, the County should utilize its contracts to standardize processes. This is particularly important for screening and assessment at all facilities. Currently, forms, systems, and validated tools are different at the facilities. This is leading to a misalignment in reporting, tracking, and referring patients.
3. **Expand Services** – Ensure that public and private receiving facilities for individuals in crisis for substance abuse and mental health services are aligned with services being provided. This will ensure that no door is the wrong door for initial treatment. This, combined with coordination of care, will improve outcomes. Providers would need to develop the necessary capabilities to expand services, this could include technology and skill sets.
4. **Seek additional investment** – The County funds services from a variety of sources. The expansion of services and increase in capacity may require further investment. This may be directly or indirectly through the creation of new requirements under existing contracts such as standardized screening.
5. **Optimize current facilities –** The County cannot do this alone! Alignment with the State and service providers will be needed to improve, expand and enhance service to residents in crisis.

Receiving and diversion - The case for change

A complete and connected behavioral health system

The County is currently suffering from an acute uptick in key outcomes for those suffering with behavioral health issues. Those outcomes include increases in suicide and substance abuse related deaths. As outlined in this report, the County has additional gaps that need to be filled. This includes more robust and consistent delivery of services across the behavioral health system. The counties with the most innovation have seen the County government get involved in the delivery of care and the expansion of services. Their expanded involvement has often come at a time where their communities were experiencing acute periods of poor outcomes for patients.

The County can improve its capacity and capability in the portion of the system where residents are in crisis. Facilities that redirect or divert residents in crisis to screening, assessment, stabilization, and coordinated outpatient treatment have been proven to result in positive outcomes. The County funds many of these services through their providers, but the public and private facilities do not offer a consistent menu of services nor are the underlying processes standardized allowing for strategic system performance management and case management of providers.

Case studies

1. **San Diego County, CA Behavioral Health Clinics** – San Diego County has authorized and is implementing a plan to expand behavioral health clinics across the County. The goal is to move services provided by unreliable state psychiatric hospitals to regional County hubs that allow for treatment in the County.
2. **Harris County, Texas** – In 2018, the County opened a new public mental health diversion facility. The facility provides additional capacity for the County and a range of services to patients in crisis. This has created an optimal diversion alternative to jail.
3. **Indianapolis County, IN** – In fall 2020, Indianapolis County will open a new facility run by the university hospital system that will act as an assessment and intervention center. This receiving and diversion capability will provide the County with the ability to stabilize residents in crisis and provide a case management function for additional treatment.

Implementing change

The County will need to consider a range of options to build more capability and capacity to handle individuals in crisis. Some counties have chosen to build capacity and capability in the form of programs and physical assets. Those assets have been run by the County and in some cases by private entities. Pinellas County can tailor its options based on its system of care. These are the operational steps needed to move forward.

1. **Decide on capacity** – This report was not a utilization study. As a result, the County needs to conduct a more systematic study to evaluate the County's needs for beds aligned with its strategic vision for their receiving model and diversion based treatment.
2. **Decide on capability** – The County needs to crosswalk its behavioral health needs assessment with the services provided and identify gaps in service delivery across the public and private receiving facilities.
3. **Contract for new capability** – The County does not intend to be the provider of services, thus the County will need to develop new contracts for capacity and capability.
4. **Build internal capacity** – The County or its managed entity needs to build or deliver the internal capacity for non-treatment gaps in the behavioral health receiving and diversion spectrum. This includes case management, performance management, and funding.
5. **Redesign system performance measures** – The County cannot do this alone! Alignment with the State and service providers will be needed to improve, expand, and enhance service to residents in crisis.

Receiving and diversion - A new facility?

Does Pinellas County need a new facility?

Stakeholders in Pinellas County, like other counties, has questioned whether a new facility is needed to address the needs of behavioral health patients. The answer to this question is not simple, and currently it is not clear if the County has the ability to answer this question. At first glance, it appears the uptick in suicides and substance abuse related deaths may indicate that the current system is not managing the problem well and a new public receiving facility might be needed. The County cannot answer questions in the current performance management framework as to why outcomes are moving in a negative direction.

The County needs to grapple with several additional questions, which today do not have answers:

- What is the facility for?
- Who will it service?
- How much capacity is needed?
- Is the current capacity fully utilized?
- Can the County acquire new capacity without building facility

The case against building a new facility

The County should not build a new facility for the following two reasons: The County does not know if it needs one; and if the facility relates to the need for additional Marchman beds, this type of treatment is not in line with leading practices.

1. **Lack of understanding** – The Pinellas County Behavioral Health System does not know if the need for additional capacity exist. There are few indicators that lead to the conclusion that a new facility is needed, and the current system is unable to manage the community need.
2. **Counter to leading practices** – The evidence for forced treatment in cases of substance abuse is lacking. The best practices align to treatment when the patient is voluntarily ready to receive treatment. The Marchman Act remains a tool available to the County, but further investment in this tool as opposed to prevention would appear to be counter to the leading practices in treatment of substance abuse disorders.

The alternatives for capacity

The County should consider thinking about its needs in terms of capacity, not a new facility. These types of facilities require specific licensure because of their need to be secured. Facilities would need to be modified to meet specific requirements by law. The County has two options to develop the most optimized system with enhanced capacity.

1. The County should optimize the utilization of its current bed capacity. We have found that systems can find additional capacity within its existing infrastructure. We know that effective usage of coordination of care and case management could decrease usage or reliance of beds.

2. The County should contract for additional flex beds within its current provider network. The building of a new facility for the purposes of treatment should be considered as a last resort considering the investment. In addition, current receiving facilities can be optimized to deliver standardized screening and assessments that lead to coordinated care.

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Section 5: Implementation pathways

Overview of implementation pathways

The five pathways below integrate the strategic options into logical groups based on the interdependencies and represent significant multiyear efforts. For instance, consolidated funding being predicated on performance-based contract governance and a system wide Minimum Data Set. Similarly, investment in expanded public receiving capacity should be predicated on residual needs once Coordinated Access Models and enhanced prevention services are in place. Implementation pathways include:

Pathway 1 **System wide**	Pathway 2 **County-focused comprehensive**	Pathway 3 **Focus on prevention**	Pathway 4 **Enhanced**	Pathway 5 **Enhanced plus new capacity**
This implementation pathway emphasizes system wide collaboration between County and State funders and providers for performance management and the coordinated access model of care. A hybrid approach is taken to contracting, funding, and receiving and diversion.	This implementation pathway focuses on what the County can independently influence, including a consolidated approach to contracting, funding and performance management, and further investment in receiving and diversion, coordination, and prevention and early intervention.	This implementation pathway focuses on investing further in prevention and early intervention services, while enhancing performance-based contracting and the existing public receiving facility.	This implementation pathway focuses on enhancing existing contractual frameworks and their public receiving facility, and developing a County Minimum Data Set requirement for all providers.	This implementation pathway focuses on creating net new capacity across diversion programs and receiving facilities, while enhancing critical components in contracting and funding.
PM-2 Develop System wide Minimum Data Set	**PM-3** Integrate County Minimum Data Set with Funding	**G-1** Enable Performance-Based Contracting at County Level	**PM-1** Develop County Minimum Data Set	**PM-1** Develop County Minimum Data Set
+	+	+	+	+
G-2 Engage a Managed Entity at County Level and/or State	**G-2** Engage a Managed Entity at County Level and/or State	**F-2** Hybridize Funding Across County & State Sources	**G-1** Enable Performance-Based Contracting at County Level	**G-1** Enable Performance-Based Contracting at County Level
+	+	+	+	+
F-2 Hybridize Funding Across County & State Sources	**F-1** Consolidate Funding Across County & State Sources	**PE-1** Enhance Existing Prevention & Early Intervention Services	**D-3** Enhance Existing Public Receiving Capacity	**D-1** Enhance Existing Public Receiving Service Capability
+	+	+		
C-2 Coordinated Access Model – Managed Entity & Provider Managed	**C-1** Coordinated Access Model – County & Provider Managed	**D-1** Enhance Existing Public Receiving Service Capability		
+	+			
D-2 Standardize Across Public & Private Receiving Model	**PE-1** Enhance Existing Prevention & Early Intervention Services			
	+			
	D-2 Standardize Across Public & Private Receiving Model			

- Performance Management
- Governance
- Funding
- Coordination
- Prevention & Early Intervention
- Receiving & Diversion

Implementation steps for pathway 1

Pathway 1 **System wide**	**Implementation steps**
This implementation pathway emphasizes system wide collaboration between County and State funders and providers for performance management and the coordinated access model of care. A hybrid approach is taken to contracting, funding, and receiving and diversion. **PM-2** Develop System wide Minimum Data Set + **G-2** Engage a Managed Entity at County Level and/or State + **F-2** Hybridize Funding Across County & State Sources + **C-2** Coordinated Access Model – Managed Entity & Provider Managed + **D-2** Standardize Across Public & Private Receiving Model	1) **PM-2:** Collaborate with key funders and service providers to develop a robust Minimum Data Set that aligns with leading practice. This will support the understanding of whether clients are accessing the right services in a timely manner, and whether services provided are effective and clinicians' utilization is being optimized, to name just a few. 2) **G-2:** The County should engage a managed entity to manage its service provider contracts and deliver new services for the County such as coordinated access to care and case management. 3) **F-2:** The County should consolidate funding where possible to streamline its contracts and utilize a managed entity to do so, in addition to providing new capabilities for the County that will require an additional investment. 4) **C-2:** Develop a Coordinated Access Model that allows for clear transparency in how clients, families, caregivers, and professionals can access the right services within the system. Embed a transparent view on wait times for both Assessment and Treatment by region. This model can be managed by a third party or through a provider. KPIs such as wait time data is collected and reported on a regular, i.e., monthly, basis. 5) **D-2:** The County should work with its providers to standardize care across its network at public and private receiving facilities. The County should ensure that screening, assessments and ambulatory-subacute services are available at all receiving facilities for stabilization of patients in need of care.

Implementation steps for pathway 2

Pathway 2
County-focused comprehensive

This implementation pathway focuses on what the County can independently influence, including a consolidated approach to contracting, funding and performance management, and further investment in receiving and diversion, coordination, and prevention and early intervention.

PM-3 Integrate County Minimum Data Set with Funding

+

G-2 Engage a Managed Entity at County Level and/or State

+

F-1 Consolidate Funding Across County & State Sources

+

C-1 Coordinated Access Model – County & Provider Managed

+

PE-1 Enhance Existing Prevention & Early Intervention Services

+

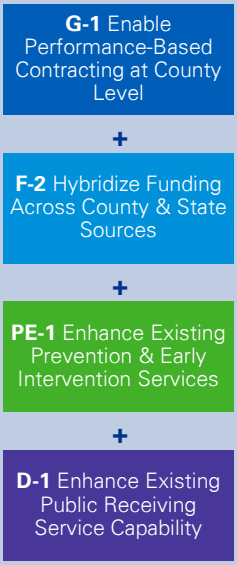
D-2 Standardize Across Public & Private Receiving Model

Implementation steps

1) **PM-3:** Collaborate with key funders and service providers to develop a robust Minimum Data Set that aligns with leading practice. This will provide an understanding of whether clients are accessing the right services in a timely manner; are services provided effective; and are clinicians utilization being optimized, to name just a few. Funding for the provider is tied into meeting performance targets and as such are clearly stated in their contracts. For providers who are not meeting performance targets, funding is allocated to other providers who are able to achieve or exceed performance targets.
2) **G-2:** The County should engage a managed entity to manage its service provider contracts and deliver new services for the County such as coordinated access to care and case management.
3) **F-1:** The County should consolidate the funding of services. Today, the funds for services are spread across many providers and contracts. A new regime of funding tied to performance and optimized service delivery under larger contracts will allow for the execution of many of the recommendations noted in this report.
4) **C-1:** The County, in collaboration with the providers, develop and manage a Coordinated Access Model that allows for clear transparency in how clients, families, caregivers, and professionals can access the right services within the system. This will potentially consist of a 1-800 number, standardized screening, triage, and scheduling practices. Embed a transparent view on wait times for both Assessment and Treatment by region. This model can be managed by the County or through a provider. KPIs such as wait time data is collected and reported on a regular, i.e., monthly, basis.
5) **PE-1:** The County should map all prevention and early intervention services across the County in order to understand access to care pathways and services offered by sub region. In addition, evaluate access to care and the effectiveness of the services offered based on leading practices standards of care. Understanding gaps within the system will be the first step in addressing and building a strong base for Behavioral Health services. Enhance integrated care models with Behavioral Health partners to bolster early intervention and prevention programs. Evaluation of programs is required in order to understand effectiveness.
6) **D-2:** The County should work with its providers to standardize care across its network at public and private receiving facilities. The County should ensure that screening, assessments, and ambulatory-subacute services are available at all receiving facilities for stabilization of patients in need of care.

Implementation steps for pathway 3

Pathway 3 **Focus on prevention**	**Implementation steps**
This implementation pathway focuses on investing further in prevention and early intervention services, while enhancing performance-based contracting and the existing public receiving facility.	1) **G-1:** The County should revamp its contracting process to be performance based with appropriate incentives. 2) **F-2:** The County should consolidate funding where possible to streamline its contracts and utilize a managed entity to do so, in addition to providing new capabilities for the County that will require an additional investment. 3) **PE-1:** The County should map all prevention and early intervention services across the County in order to understand access to care pathways and services offered by sub region. In addition, evaluate access to care and the effectiveness of the services offered based on leading practices standards of care. Understanding gaps within the system will be the first step in addressing and building a strong base for Behavioral Health services. Enhance integrated care models with Behavioral Health partners to bolster early intervention and prevention programs. Evaluation of programs is required in order to understand effectiveness. 4) **D-1:** The County should consider expansion of services at its only public receiving facility. Today, that facility acts as largely a facility for Baker Act patients and could offer a broader set of screening, assessment, and treatment for patients across the behavioral health needs spectrum.



Implementation steps for pathway 4

Pathway 4 **Enhanced**	**Implementation steps**
This implementation pathway focuses on enhancing existing contractual frameworks and their public receiving facility, and developing a County Minimum Data Set requirement for all providers. **PM-1** Develop County Minimum Data Set + **G-1** Enable Performance-Based Contracting at County Level + **D-3** Enhance Existing Public Receiving Capacity	1) **PM-1:** Collaborate with service providers to develop a robust Minimum Data Set that aligns with leading practice. This will provide an understanding of County funded programs (25% of current providers). To name a few: (1) Are clients accessing the right services in a timely manner? (2) Are services provided effective based on leading practices? and (3) Are clinicians utilization being optimized? 2) **G-1:** The County should revamp its contracting process to be performance based with appropriate incentives. 3) **D-3:** The County should consider building more capacity (beds) for patients in crisis in the behavioral health spectrum. Stakeholders today believe that need is for additional Marchman beds. A utilization study should be conducted to validate this need. Public beds could be acquired via additional contracts within the service provider network or externally.

Implementation steps for pathway 5

Pathway 5 **Enhanced plus new capacity**	**Implementation steps**
This implementation pathway focuses on creating net new capacity across diversion programs and receiving facilities, while enhancing critical components in contracting and funding. **PM-1** Develop County Minimum Data Set + **G-1** Enable Performance-Based Contracting at County Level + **D-1** Enhance Existing Public Receiving Service Capability	1) **PM-1:** Collaborate with service providers to develop a robust Minimum Data Set that aligns with leading practice. This will provide an understanding of County funded programs (25% of current providers). To name a few: (1) Are clients accessing the right services in a timely manner? (2) Are services provided effective based on leading practices? and (3) Are clinicians utilization being optimized, to name just a few? 2) **G-1:** The County should revamp its contracting process to be performance based with appropriate incentives. 3) **D-1:** The County should consider expansion of services at its only public receiving facility. Today that facility acts as largely a facility for Baker Act patients and could offer a broader set of screening, assessment, and treatment for patients across the behavioral health needs spectrum.

Comparison of implementation pathways

Implementation pathway summaries

Long-term pursuits

- **Pathway #1: System wide** – The system-wide change program comes with a high level of impact because of the fundamental changes to performance and governance. The addition of new services via a managed entity will enhance the counties capabilities. This comes with a significant level of effort to almost totally redesign the system you have in place, including the creation of new contracts and redesigning the old ones. This is estimated to take 3-5 years to accomplish and will cost year over year and additional $2-$3 million dollars.
- **Pathway #2: County-focused comprehensive** – This pathway while internally focused will deliver a high level of impact but puts the burden on the County to revamp and introduce new systems, capabilities and services to citizens. This could be accomplished within 2 to 4 years with a focused implementation plan. The efforts will be on contracting for new services and revamping the performance management structure which will be tied to funding and redesign of contracts. The additional cost year over year is estimated at $2–$3 million.

Short-term pursuits

- **Pathway #3: focus on prevention** – Prevention has been proven to be a leading practice to deliver the largest return on investment over time in behavioral health services. This pathway is expected to cost the least, and since there is no need to create new services, the level of effort remains low. Your long-term impact from this pathway would be good but would not deliver the types of fundamental change across the full spectrum of services that the County delivers.
- **Pathway #4: Enhanced** – Pathway 4 represents the most incremental change. This low-impact work stream would see the County tinker to process and program management to improve contracting and enhance services. The cost of the program is correspondingly low and the County would be able to achieve these changes within two years. This pathway allows the County to achieve some quick wins while setting itself up to make more fundamental changes later.

Building capacity

- **Pathway #5: Enhanced plus new capacity** – This pathway is focused on building new capacity (beds) for the County and comes with several different possibilities. If the County moves to build a new facility to get additional beds, this work stream would have the most effort with a significant procurement period. The impact of in-patient crisis services has also not been proven to be a leading long-term practice for treating patients. The cost is also estimated to be the highest of all the options as building a new facility would represent a significant up-front capital investment.

	Pathway 1 **Systemwide**	Pathway 2 **County-focused Comprehensive**	Pathway 3 **Focus on prevention**	Pathway 4 **Enhanced**	Pathway 5 **Enhanced plus new capacity**
Level of Impact	High	High	Medium	Low	Low
Level of Effort	High	Medium	Low	Low	High
Level of Investment	$2–3M (>20% current budget)	$2–3M (>20% of current budget)	$500–1M (>10% current budget)	$500K to $1M (<10% current budget)	$3–10 M (>30% current budget)

Comparison of implementation pathways (continued)

Making sense of the implementation pathways

The implementation pathways give the County the ability to set itself on a trajectory for more effective and efficient services, but how do you evaluate the practicality of each implementation pathway? KPMG has provided a simple visual on page 79 that engages the County to ask several critical questions:

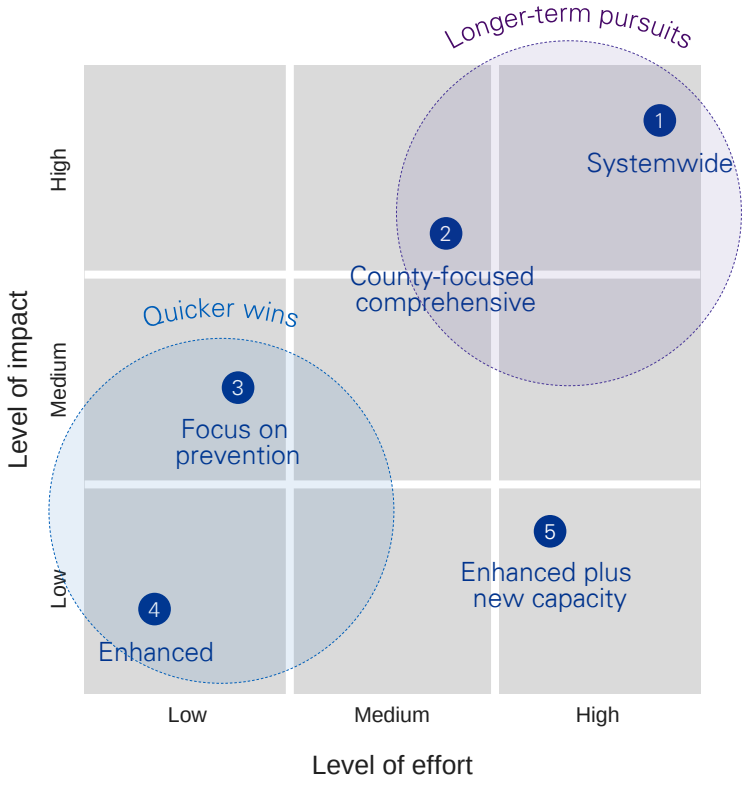
- **How much change does the County need?** If the County believes significant change is needed to achieve its expected outcomes, the County must consider pathways 1 and 2. Pathways 3 and 4 would be the best fit if the County is seeking more incremental change.
- **What level of impact does the County expect?** Pathways 1, 2, and 3 would provide the highest impact to the County. The changes would drive fundamental changes to treatment delivery and strategic performance management.
- **What level of investment is available?** Pathways 3 and 4 come at the lowest cost, with pathways 1 and 2 representing about an equal level of additional investment in new and enhanced services. Pathway 5 has the possibility to be the highest cost.
- **What will the level of effort be?** Pathway 1 represents a high level of effort due to its implied systematic changes. Pathway 2 falls in the middle, and 3 and 4 are low effort options that still can provide great benefits to the County. Pathway 5 could represent significant effort if the County goes down the path to build a new facility.

The pathways are not prioritized nor does the adoption of one pathway mean that another could not be adopted in the future. Nonetheless, it is noteworthy that every pathway represents a multiyear effort that will require a coordinated effort by the County and its stakeholders.

The position of the implementation pathways in the adjacent impact and effort matrix presents considerations for the implementation:

Quicker wins: These pathways deliver high value and are relatively low in their effort and complexity to implement. These should be considered for early deployment.

Longer-term pursuits: These pathways are the highest in value to Pinellas County, but also the highest in effort and complexity. These should be prioritized for implementation as long as appropriate prerequisites are met, such as resources, funding, executive support, etc.



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Appendix

Section A: Stakeholder engagement

List of stakeholders/organizations engaged			
1	211 Tampa Bay Cares	26	HCA Largo Medical Center
2	Agency for Community Treatment	27	Homeless Empowerment Program
3	ALPHA House of Pinellas County	28	Homeless Leadership Alliance
4	Bay Pines Veterans Affairs	29	Judiciary
5	Baycare Behavioral Health	30	Juvenile Welfare Board
6	Board of County Commissioners	31	Local and Statewide Baker Act Experts
7	Boley Centers	32	Magistrates
8	Catholic Charities of the Diocese of St. Petersburg	33	Manatee County
9	Central Florida Behavioral Health Network (CFBHN)	34	Medical Examiner's Office
10	Circuit Court Judges	35	NAMI Pinellas
11	City of St. Petersburg	36	Northside Hospital
12	Clearwater Police Department	37	Operation PAR
13	Community Action Stops Abuse (CASA)	38	PCSO Jail Health Services
14	Community Health Centers of Pinellas	39	PCSO Safe Harbor
15	County Administration	40	Personal Enrichment Through Mental Health Services (PEMHS)
16	Daystar Life Center	41	Pinellas County Schools
17	Directions for Living	42	Pinellas County Sheriff's Office (PSCO)
18	Eckerd Connects	43	Pinellas Integrated Care Alliance (PICA) Team
19	Emergency Medical Services	44	Pinellas Public Defender
20	Faith and Action for Strength Together (FAST)	45	Religious Community Services
21	Family Resources	46	Society of Saint Vincent De Paul
22	Florida Department of Children and Families	47	Suncoast Center
23	Florida Department of Health	48	Vincent House
24	Foundation for Healthy St. Petersburg	49	Westcare-Gulfcoast of Florida
25	Gulf coast Jewish Family Services	50	Windmoor Healthcare

Section B: Data requests

#	Chapter Title	Folder	Item
1.1	Introduction to Pinellas County	Human Services Overview	Human Services Overview (budget book and table of organization)
1.2	Introduction to Pinellas County	Human Services Points of Contact	Human Services Project POC
1.3	Introduction to Pinellas County	Demographic-Population	Demographic/Population
1.4	Introduction to Pinellas County	Juvenile Welfare Board Overview	Juvenile Welfare Board (JWB) Overview
1.5	Introduction to Pinellas County	Foundation for a Healthy St. Petersburg (FHSP)	Foundation for a Healthy St. Petersburg (FHSP)
1.5	Introduction to Pinellas County	Foundation for a Healthy St. Petersburg (FHSP)	FHSP - Equity Scan Report
1.5	Introduction to Pinellas County	Foundation for a Healthy St. Petersburg (FHSP)	FHSP - Nonprofit Scan 2018
1.5	Introduction to Pinellas County	Foundation for a Healthy St. Petersburg (FHSP)	FHSP - Pathway to Health Equity Through Housing 2018
1.6	Introduction to Pinellas County	Overdoses and Accidental Substance Deaths	Overdoses FY14 through FY19
1.6	Introduction to Pinellas County	Overdoses and Accidental Substance Deaths	Drug Related Accidental Deaths 2009-2018
1.6	Introduction to Pinellas County	Overdoses and Accidental Substance Deaths	Narcan Administrations for Overdose
1.6	Introduction to Pinellas County	Overdoses and Accidental Substance Deaths	Pinellas Overdose Calls 2017-19
1.7	Introduction to Pinellas County	Suicides in Pinellas County	2010 - 2018 Suicides by Age Group
2.1	State of Florida Laws/Reports	Agency for Health Care Administration (AHCA) Overview	AHCA Overview
2.2	State of Florida Laws/Reports	Marchman Act	Marchman Statute
2.3	State of Florida Laws/Reports	Baker Act	Baker Act Statute
2.3	State of Florida Laws/Reports	Baker Act	Annual Baker Act Report 2017-18
2.3	State of Florida Laws/Reports	Baker Act	Annual Baker Act Report 2016-17
2.4	State of Florida Laws/Reports	Governor's Executive Order for Behavioral Health	Governor's Executive Order Report 2016
2.4	State of Florida Laws/Reports	Governor's Executive Order for Behavioral Health	USF Executive Summary Data Report 7/2016
2.4	State of Florida Laws/Reports	Governor's Executive Order for Behavioral Health	USF Final Case File Report 6/2016
2.4	State of Florida Laws/Reports	Governor's Executive Order for Behavioral Health	Summary of Pinellas Executive Order Findings
3.1	Overview of the BH System	Homeless Infographics	Pinellas County Homeless Infographic
3.1	Overview of the BH System	Homeless Infographics	Pinellas County Homeless Crisis Response System Infographic
3.11	Overview of the BH System	Arnold Foundation High Utilizer Review	Email - CUNY Invite and 10 Jurisdictions
3.11	Overview of the BH System	Arnold Foundation High Utilizer Review	ISLG Pinellas County Frequent Utilizers Profile 4/2018

Section B: Data requests (continued)

#	Chapter Title	Folder	Item
3.2	Overview of the BH System	Key Contacts and Website Links	BH Provider Info/Websites
3.2	Overview of the BH System	Key Contacts and Website Links	Key Stakeholders/CEOs
3.3	Overview of the BH System	Pinellas Behavioral Health Plans	Pinellas BH Receiving System Plan
3.4	Overview of the BH System	Behavioral Health System Overview	2019 BH System overview to BCC
3.5	Overview of the BH System	Suicide Prevention	Zero Suicide Initiative
3.5	Overview of the BH System	Suicide Prevention	Baycare Suicide Study
3.6	Overview of the BH System	EMS and HS Data Sharing	EMS Transport Data and EMS/HS sharing
3.7	Overview of the BH System	Community Health Assessment	Community Health Assessment
3.7	Overview of the BH System	Community Health Assessment	Community Health Assessment Collaborative Lab
3.8	Overview of the BH System	Marchman Act Projects	Marchman Utilization
3.8	Overview of the BH System	Marchman Act Projects	Current Marchman Pilot Information
3.9	Overview of the BH System	Intercept Maps	2016 Adult Intercept Map
3.9	Overview of the BH System	Intercept Maps	2012 Juvenile Intercept Map
3.9	Overview of the BH System	Intercept Maps	2010 Adult Provider Intercept Map
3.9	Overview of the BH System	Intercept Maps	Intercept Mapping - Manatee
3.10	Overview of the BH System	Adult and Juvenile Justice Collaborative Lab Reports	Adult Collaborative Lab
3.10	Overview of the BH System	Adult and Juvenile Justice Collaborative Lab Reports	Juvenile Collaborative Lab
3.11	Overview of the BH System	Arnold Foundation High Utilizer Review	Pinellas County-CUNY-CFBHN Data Agreement
3.12	Overview of the BH System	Opioid Task Force	Opioid Task Force (Strategic Plan)
3.12	Overview of the BH System	Opioid Task Force	Opioid Task Force Data
3.13	Overview of the BH System	Fusion Group	Fusion Group Agenda and Reports
3.14	Overview of the BH System	State MH Facility Utilization	DCF Forensic Mental Health Treatment Facilities Utilization
3.15	Overview of the BH System	Data Collaborative Cross System Report Example	Data Collaborative Report Example- Individuals Crossing Systems
3.3.	Overview of the BH System	Pinellas Behavioral Health Plans	Pinellas Transportation Plan
4.1	Pinellas County HS Funded Programs	Human Services Contracts	Contracts
4.10	Pinellas County HS Funded Programs	Personal Enrichment through Mental Health Services - Crisis Stabilization Unit (PEMHS-CSU)	PEMHS Adult CSU Q3 Survey 3/2019
4.10	Pinellas County HS Funded Programs	Personal Enrichment through Mental Health Services - Crisis Stabilization Unit (PEMHS-CSU)	PEMHS Emergency Services Report 2017-18
4.10	Pinellas County HS Funded Programs	Personal Enrichment through Mental Health Services - Crisis Stabilization Unit (PEMHS-CSU)	PEMHS Baker Act Discharge Data 2018-19
4.10	Pinellas County HS Funded Programs	Personal Enrichment through Mental Health Services - Crisis Stabilization Unit (PEMHS-CSU)	PEMHS Emergency Services Report 2018-19
4.10	Pinellas County HS Funded Programs	Personal Enrichment through Mental Health Services - Crisis Stabilization Unit (PEMHS-CSU)	PEMHS CSU FY19 Q2 Report 3/2018
4.10	Pinellas County HS Funded Programs	Personal Enrichment through Mental Health Services - Crisis Stabilization Unit (PEMHS-CSU)	PEMHS Recovery Room Overview
4.10	Pinellas County HS Funded Programs	Personal Enrichment through Mental Health Services - Crisis Stabilization Unit (PEMHS-CSU)	PEMHS Recovery Room Model

Section B: Data requests (continued)

#	Chapter Title	Folder	Item
4.10	Pinellas County HS Funded Programs	Personal Enrichment through Mental Health Services - Crisis Stabilization Unit (PEMHS-CSU)	PEMHS Recovery Room 7/2019
4.11	Pinellas County HS Funded Programs	Pinellas Drug Court Reports and Outcomes	Pinellas Drug Court Reports
4.11	Pinellas County HS Funded Programs	Pinellas Drug Court Reports and Outcomes	Exit Cohort Report FY18
4.11	Pinellas County HS Funded Programs	Pinellas Drug Court Reports and Outcomes	Pinellas County Adult Drug Court Policies & Procedures
4.12	Pinellas County HS Funded Programs	Co-Occurring, Assistance, Recovery, and Empowerment Team (CARE Team)	Care Team Blue Card Behavioral Health Flow 2/2019
4.12	Pinellas County HS Funded Programs	Co-Occurring, Assistance, Recovery, and Empowerment Team (CARE Team)	Care Team HCH Info
4.13	Pinellas County HS Funded Programs	PCET and PICA System Issues	PCET and PICA System Issues 9/2019
4.14	Pinellas County HS Funded Programs	Pinellas County Public Defender Jail Diversion	Pinellas County Jail Diversion Summary and Stats 10/2019
4.15	Pinellas County HS Funded Programs	Pinellas County Homeless Memo and Presentation	Homeless Services Funded by Pinellas HS
4.16	Pinellas County HS Funded Programs	Pinellas County Substance Abuse Grant Award Examples	Pinellas Grants - Opioid Planning Diagram
4.16	Pinellas County HS Funded Programs	Pinellas County Substance Abuse Grant Award Examples	Pinellas Grants - Opioid Data Phases Planning
4.16	Pinellas County HS Funded Programs	Pinellas County Substance Abuse Grant Award Examples	Pinellas Grants - Opioid Site Based Program Narrative
4.16	Pinellas County HS Funded Programs	Pinellas County Substance Abuse Grant Award Examples	Pinellas Grants - Veterans Treatment Program Narrative
4.16	Pinellas County HS Funded Programs	Pinellas County Substance Abuse Grant Award Examples	Pinellas Grants - Aiding Drug Impacted Children
4.16	Pinellas County HS Funded Programs	Pinellas County Substance Abuse Grant Award Examples	Pinellas Grants - Aiding Drug Impacted Children Prog. Narrative
4.16	Pinellas County HS Funded Programs	Pinellas County Substance Abuse Grant Award Examples	Pinellas Grants - Aiding Drug Impacted Children Logic Model
4.16	Pinellas County HS Funded Programs	Pinellas County Substance Abuse Grant Award Examples	Pinellas County Substance Abuse Grants for 2019
4.17	Pinellas County HS Funded Programs	SAMHSA Best Practice Project Mtg, featuring PCET	SAMHSA BPIA 4/2018 Agenda
4.17	Pinellas County HS Funded Programs	SAMHSA Best Practice Project Mtg, featuring PCET	SAMHSA BPIA Site Visit 3/2018 Agenda
4.17	Pinellas County HS Funded Programs	SAMHSA Best Practice Project Mtg, featuring PCET	SAMHSA BPIA - PCET Presentation
4.2	Pinellas County HS Funded Programs	Pinellas Integrated Care Alliance (PICA)	PICA (steering committee, PIC Team Reports, USF report)
4.3	Pinellas County HS Funded Programs	Coop Agreement to Benefit Homeless (CABHI)	CABHI (program information, Collaborative Lab)
4.4	Pinellas County HS Funded Programs	Assisted Outpatient Treatment (AOT)	AOT (program information/overview)
4.5	Pinellas County HS Funded Programs	HCH and PCHP BH and SUD	HCH/PCHP *BH, SUD
4.6	Pinellas County HS Funded Programs	Dashboards and Performance	Dashboards/Logic Models

Section B: Data requests (continued)

#	Chapter Title	Folder	Item
4.7	Pinellas County HS Funded Programs	Pinellas County Empowerment Team Project (PCET)	PCET (USF report, lessons learned, client reports, system issues)
4.7	Pinellas County HS Funded Programs	Pinellas County Empowerment Team Project (PCET)	Behavioral Health High Utilizers Pilot
4.7	Pinellas County HS Funded Programs	Pinellas County Empowerment Team Project (PCET)	PCET Presentation 5/2019 to Public Safety Coordinating Council
4.7	Pinellas County HS Funded Programs	Pinellas County Empowerment Team Project (PCET)	Empowerment Team Year 1 Analysis
4.8	Pinellas County HS Funded Programs	White House Data Driven Justice Initiative	White House Initiative Fact Sheet
4.8	Pinellas County HS Funded Programs	White House Data Driven Justice Initiative	Data Driven Justice Initiative Playbook Draft
4.8	Pinellas County HS Funded Programs	White House Data Driven Justice Initiative	Data Driven Justice Initiative Innovative Communities
4.8	Pinellas County HS Funded Programs	White House Data Driven Justice Initiative	Data Driven Justice Initiative Data and Service Mapping
4.8	Pinellas County HS Funded Programs	White House Data Driven Justice Initiative	Data Driven Justice Initiative - PCET Case Study 2018 Final
4.8	Pinellas County HS Funded Programs	White House Data Driven Justice Initiative	Data Driven Justice Initiative Toolkit Chart Responses
4.8	Pinellas County HS Funded Programs	White House Data Driven Justice Initiative	Data Driven Justice Initiative Worksheet for Communities
4.9	Pinellas County HS Funded Programs	Pinellas County Behavioral Health Memo and info	BH Memo
4.9	Pinellas County HS Funded Programs	Pinellas County Behavioral Health Memo and info	Pinellas County Behavioral Health Funded Programs
5.1	Central Florida Behavioral Health Network (CFBHN)	Pinellas Managing Entity Funding	CFBHN Funding in Pinellas 5/2019
5.2	Central Florida Behavioral Health Network (CFBHN)	Managing Entity Statute	Managing Entity - Statute
5.3	Central Florida Behavioral Health Network (CFBHN)	Managing Entity Reports and Measures - Various	CFBHN June 2017 Data Alliance Report
5.3	Central Florida Behavioral Health Network (CFBHN)	Managing Entity Reports and Measures - Various	CFBHN June 2018 Data Alliance Report
5.3	Central Florida Behavioral Health Network (CFBHN)	Managing Entity Reports and Measures - Various	CFBHN June 2019 Data Alliance Report
5.3	Central Florida Behavioral Health Network (CFBHN)	Managing Entity Reports and Measures - Various	CFBHN Region Wide Primary Drug of Choice - Multiple Years
5.3	Central Florida Behavioral Health Network (CFBHN)	Managing Entity Reports and Measures - Various	CFBHN Pinellas County Contracted Dollars by Cost Center 3/2017
5.3	Central Florida Behavioral Health Network (CFBHN)	Managing Entity Reports and Measures - Various	CFBHN Pinellas County Contracted Funding 5/2019
5.3	Central Florida Behavioral Health Network (CFBHN)	Managing Entity Reports and Measures - Various	CFBHN Pinellas County Contracted Rates by Provider and Program 2019-20
5.3	Central Florida Behavioral Health Network (CFBHN)	Managing Entity Reports and Measures - Various	CFBHN 2016-17 CAFE Dollars Raw Data
5.3	Central Florida Behavioral Health Network (CFBHN)	Managing Entity Reports and Measures - Various	CFBHN Funding by Agency and Program 2016-17
5.3	Central Florida Behavioral Health Network (CFBHN)	Managing Entity Reports and Measures - Various	CFBHN Funding by Program and Cost Center 2016-17

Section B: Data requests (continued)

#	Chapter Title	Folder	Item
5.3	Central Florida Behavioral Health Network (CFBHN)	Managing Entity Reports and Measures - Various	CFBHN Funding by Provider Cost Center and OCA Title 2016-17
5.3	Central Florida Behavioral Health Network (CFBHN)	Managing Entity Reports and Measures - Various	CFBHN Funding by Provider Program and Cost Center 2016-17
5.3	Central Florida Behavioral Health Network (CFBHN)	Managing Entity Reports and Measures - Various	CFBHN Minimum Performance Measures - Exhibit E
5.3	Central Florida Behavioral Health Network (CFBHN)	Managing Entity Reports and Measures - Various	CFBHN December 2018 Agency Performance Outcomes
5.3	Central Florida Behavioral Health Network (CFBHN)	Managing Entity Reports and Measures - Various	CFBHN AMH CSU 30 Day Readmissions
5.3	Central Florida Behavioral Health Network (CFBHN)	Managing Entity Reports and Measures - Various	CFBHN AMH CSO 90 Day Readmissions
5.3	Central Florida Behavioral Health Network (CFBHN)	Managing Entity Reports and Measures - Various	CFBHN AMH Detox 30 Day Readmissions
5.3	Central Florida Behavioral Health Network (CFBHN)	Managing Entity Reports and Measures - Various	CFBHN AMH Detox 90 Day Readmissions
5.3	Central Florida Behavioral Health Network (CFBHN)	Managing Entity Reports and Measures - Various	CFBHN Opioid Summary for State Opioid and State Targeted Response Grants
5.4	Central Florida Behavioral Health Network (CFBHN)	BAA with HS and Managing Entity	CFBHN-Pinellas County BAA
6.1	Overview of Homeless System	Homeless System Programs	Coordinated Entry
6.1	Overview of Homeless System	Homeless System Programs	Permanent Supportive Housing
6.1	Overview of Homeless System	Homeless System Programs	Rapid Re-Housing Programs
7.1	Overview of Justice System	Justice System Process Study	Justice System Process Study Final
7.2	Overview of Justice System	Public Safety Coordinating Council (PSCC)	PSCC 5/6/19 Agenda
7.2	Overview of Justice System	Public Safety Coordinating Council (PSCC)	PSCC 8/12/19 Agenda
7.2	Overview of Justice System	Public Safety Coordinating Council (PSCC)	PSCC Minutes 2/4/2019
7.2	Overview of Justice System	Public Safety Coordinating Council (PSCC)	PSCC Minutes 5/6/2019
7.2	Overview of Justice System	Public Safety Coordinating Council (PSCC)	Florida County Detention Facilities AIP 1/2019
7.2	Overview of Justice System	Public Safety Coordinating Council (PSCC)	Florida County Detention Facilities AIP 3/2019
7.2	Overview of Justice System	Public Safety Coordinating Council (PSCC)	PSCC Indicators Report 5/2019
7.2	Overview of Justice System	Public Safety Coordinating Council (PSCC)	PSCC Indicators Report 8/2019
7.2	Overview of Justice System	Public Safety Coordinating Council (PSCC)	PSCC Designated Membership List 5/2018
7.2	Overview of Justice System	Public Safety Coordinating Council (PSCC)	PSCC Membership 8/2018
7.3	Overview of Justice System	Pinellas County Safe Harbor	Pinellas Safe Harbor 2018 Q4 report
7.4	Overview of Justice System	Court Performance Report 2018	2018 Sixth Judicial Circuit Performance Report
7.5	Overview of Justice System	Jail Medical Services Overview	PCSO Jail Health Services
8.1	Overview of Veterans Services	Pinellas County Veteran Services	Veterans Behavioral Health Services
9.1	Other	Tarzana Treatment Center	Tarzana Treatment Center Webinar and Notes from Conference call
9.2	Other	Crisis Assessment Center - Brown County Wisconsin	Brown County Wisconsin Crisis Assessment Center

Section B: Data requests (continued)

#	Chapter Title	Folder	Item
9.3	Other	Health and Human Services Coordinating Council (HHSCC)	HHSCC Issue and Funding Meeting 8/2009
9.4	Other	Revolution in Healthcare Mtg	Revolution in Healthcare Meeting 10/2019
9.5	Other	Wellness for Life	The Well for Life
9.6	Other	Dental Services in PCHP	Dental Bullet Points and Numbers
9.7	Other	Behavioral Health Provider Presentation 2013	Behavioral Health Provider BCC Presentation 12/2013
9.8	Other	Data MAP	Data Map

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