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Enhanced Outpatient Treatment Pilot

Fiscal Year 2020

Massachusetts Department of Mental Health

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Overview:

The Department of Mental Health's (DMH) Enhanced Outpatient Treatment (EOT) program has been providing services to an under-served population in the Metro North area to increase access and engagement in behavioral health services. The EOT program, located at Eliot's Everett Outpatient Clinic, provides intensive services to individuals who demonstrate a high need of behavioral health services yet do not maintain a consistent connection with outpatient services. Since the implementation of Accountable Care Organizations (ACOs) and Behavioral Health Community Partners (BH CPs), EOT has played a critical role in providing ACO members and BH CP members with increased access to behavioral health services while reducing a reliance on emergency and acute care services. Eliot and DMH have focused on process improvements over this past year to focus on utilization management to increase EOT's referral base. As a result, EOT has become more entrenched in our local communities providing increased access to services to individuals in acute need. Our EOT is making more referrals to ACOs, BH CP, and assisting individuals in applying for OneCare services. Eliot's EOT Team has remained nimble and continues to focus on swift engagement of individuals that could benefit from additional services including those with:

- Acute Mental Health Disorder;
- Lack of or inability to follow up with mental health providers and referrals;
- Cycle of connection and disconnection with outpatient services;
- Dual Diagnosis including mental illness and substance use disorder;
- Current or past involvement with the criminal justice system;
- Frequent use of emergency services or other urgent/emergency care services for medical or mental health needs; and
- Life instability such as frequent homelessness and joblessness.

Service Population:

The targeted population experiences poor quality of life, a high utilization of urgent and emergency services in response to crises, and demonstrates an inability to consistently use traditional treatment options offered in the community. With the implementation of ACOs and BH CPs we have seen that this population also struggles to engage with newly identified care coordination teams and struggles to maintain appointments with their Primary Care Physicians (PCPs). In addition to the ACO/BH CP population, EOT has increased our partnerships with Commonwealth Care Alliance. While these populations struggle to engage with traditional behavioral health services, they instead rely on acute services, often utilizing high cost services such as hospital emergency rooms, psychiatric hospitals, medical facilities, the criminal justice system, and first responders. Many of these individuals have compounding life difficulties and illnesses such as substance use disorders, undertreated medical illnesses, or oppressive socioeconomic conditions which result in increased symptoms and amplify the need for specialized services.

This target population demonstrates a great need of services yet paradoxically is unable to engage in preventive services and supports that would reduce stress, experience of symptoms and reliance on

emergency based services. Often this population needs immediate access to services and is frustrated with future scheduling of medication treatment, therapy, substance abuse treatment and medical care. As a result, they often experience homelessness, incarceration, suicidality, health problems, mental health crises, and overall life instability. EOT has a proven ability to engage this population and assist them with immediate access to services and supporting problem solving of a myriad of complicated health and life difficulties.

Volume and Key Statistics Since Program Inception (2015)

Total Served:	167
Total Referrals:	195
Engagement Rate:	86%

ACO and BH CP Information:

Current Individuals Served with ACO/One Care: 65%
Current Individuals Served with BH CP: 42%

Referral Sources:

Treatment Provider:	65%
Community HUBs:	20%
Police Department:	10%
Providers (DMH/ACO/BHCP/CCA):	5%

Discharged Individuals: 89

68% of the discharges are considered successful discharges where the individual's recovery was sustained and services were no longer necessary; or the individual was successfully transitioned to another service/treatment provider.

32% of the individuals chose to terminate services.

Demographics of the Service Population:

Male:	54%
Female:	46%

Diagnostic Information:

Primary Diagnosis:

81%	Mood disorder (Major Depression, Bipolar Disorder)
13%	Substance Use
2%	Other (PTSD, Anxiety Disorder, Psychotic Disorder etc.)

Co-Existing Illness:

85%	Substance Use Disorder
68%	Significant Physical Health and/or Medical Issues

Risk, Safety and Protective Factors:

Need Stable Housing	75%
Legal Issues	47%
Custodial Issues with minor children	11%
Suicide/self- harm	85%
Unemployment	90%
Psychiatric Hospitalizations	96%
Lack of Engagement in Treatment	100%
Domestic Violence Victim	13%

Services:

A clinical team comprised of a Clinician, Nurse, Peer Specialist, Recovery Coach and Psychiatric Nurse Practitioner provide a person centered approach that encompasses both the traditional modes of assessment, medication treatment, care coordination, symptom management, medical and housing supports as well as more tailored strategies such as peer support, clinical outreach, medication outreach, and harm reduction. The team uses a dynamic approach to ensure that real time assessments of needs and interventions will happen within a community context.

The Enhanced Outpatient Program provides a single point of accountability including a multidisciplinary team with 24/7 services and operations beyond the walls of the clinic setting. The team outreaches and engages clients in the community, at their homes, or wherever they are to ensure services are provided. Engagement is the core strategy to deliver services so that we are constantly building and refining a sustained treatment relationship, including the appropriate intensity of intervention to meet the needs and acuity of each individual.

Current Engagement and Services:

100% Actively engaged in EOT
84% Actively engaged in treatment (therapy and/or substance use treatment)
83% Weekly face to face contact
95% Weekly phone contact (average of 3 contacts per week per client)
80% Engaged in peer and recovery supports

Current Outcomes:

Need Area	Current Outcomes
Need Stable Housing	70% Decrease
Legal Issues	91% Decrease
Custodial Issues with minor children	85% Decrease
Suicide/self- harm	83% Decrease
Psychiatric Hospitalizations	87% Decrease
Lack of Engagement in Treatment	100% Decrease