

Opening the Door to Behavioral Health Open Access in Massachusetts: Four Case Studies

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TABLE OF CONTENTS

Introduction.....	1
Methodology.....	1
Case Study 1. Community Counseling of Bristol County	2
Organizational Background.....	2
Open Access Model Description.....	3
Open Access Implementation	4
Successes and Challenges of Open Access	4
Operations During COVID-19.....	5
Case Study 2. Gándara Mental Health Center.....	6
Organizational Background.....	6
Open Access Model Description.....	6
Successes and Challenges of Open Access	7
Operations During COVID-19.....	8
Case Study 3. High Point Treatment Center.....	8
Organizational Background.....	8
Open Access Model Description.....	9
Open Access Implementation	10
Successes and Challenges of Open Access	10
Operations During COVID-19.....	10
Case Study 4. East Boston Neighborhood Health Center	11
Organizational Background.....	11
Open Access Model Description.....	11
Open Access Implementation	12
Successes and Challenges of Open Access Through Integrated Primary Care	13
Operations During COVID-19.....	13
Conclusion.....	14
Endnotes.....	15

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INTRODUCTION

Open access, also known as same-day or walk-in behavioral health¹ services, is a model of care in which patients receive behavioral health intakes and assessments and initial appointments for treatment services on a walk-in basis or on the same day as requested. The open access model has been shown to reduce patient no-shows and improve timely access to care, leading to greater patient satisfaction and treatment engagement.² The model has also demonstrated financial benefits for provider organizations when reduced no-show rates translate into increased patient volume and provider productivity.³

Open access holds promise for improving timely access to behavioral health care services, and though behavioral health provider organizations across Massachusetts have implemented this model over the past 10 years, no study has yet documented their experiences using the model.

The Blue Cross Blue Shield of Massachusetts Foundation engaged the Commonwealth Medicine division of the University of Massachusetts Medical School to study the open access model and fill this knowledge gap by identifying organizations currently operating on an open access basis, describing the open access models in use, and highlighting the most successful approaches. The study also pinpoints keys to success for organizations to consider in adopting an open access model and offers policy recommendations to promote the broader adoption of open access in the Massachusetts behavioral health care system.

Two reports are products of this study: This report is a case study presentation that describes the open access model practiced within four Massachusetts behavioral health organizations and community health centers. A companion [report](#) details the study methodology, key factors critical to successful implementation of an open access model, challenges to implementation, and potential policy solutions necessary to address barriers to and support adoption of an open access model.

The four case studies included in this report document the range of clinic settings in which open access has been successful and the variety of service delivery practices clinics employ to operationalize the model. The case study subjects are the following organizations:⁴

- **Community Counseling of Bristol County**—an early adopter of open access services serving the southeastern urban and suburban communities in Bristol County.
- **Gándara Mental Health Center**—a midsize behavioral health organization serving an urban area in Western Massachusetts and focusing on Hispanic, African American, and culturally diverse populations.
- **High Point Treatment Center**—a recent open access adopter, serving individuals with substance use disorders (SUD), as well as individuals with mental health conditions.
- **East Boston Neighborhood Health Center**—a community health center practicing an integrated primary and behavioral health care approach that includes open access.

METHODOLOGY

In a brief survey of Massachusetts behavioral health provider organizations,⁵ 20 organizations indicated they currently or previously provided open access to behavioral health services and were willing to participate in a follow-up interview. Nine organizations were interviewed. These organizations reflected a range of sizes and types located in rural, suburban, and urban settings across the state and provide services to communities of color, culturally and linguistically marginalized communities, and specialty populations such as children and families. Each provider organization participated in a two-hour interview that followed a semi-structured interview guide. Interviews were conducted with senior leadership between January and March 2020.

From these nine organizations, four representing different provider types were selected to participate in more in-depth interviews used to inform the development of the case studies. Additional agency staff and leaders from these organizations participated in follow-up interviews between March and May 2020 to provide further information on their open access operations. The organizations selected to participate in the case studies had different approaches to implementing open access services and to serving diverse populations. This is reflected in the case studies below.

CASE STUDY 1. COMMUNITY COUNSELING OF BRISTOL COUNTY

ORGANIZATIONAL BACKGROUND

Established 50 years ago to serve the municipalities of Taunton and Attleboro and surrounding communities in southeastern Massachusetts, Community Counseling of Bristol County (CCBC) provides comprehensive outpatient behavioral health care services for adults with serious mental illness and children and adolescents with serious emotional disturbance. CCBC describes the demographic profile of its patient population as majority White and reflecting the demographics of the geographic area in which it is situated. Its payer mix is approximately 80 percent Medicaid and 20 percent commercial insurance.⁶

CCBC described various motivations for the change to open access. Before it implemented open access, CCBC's adult outpatient program was operating at a "manageable loss" and leadership believed that open access would improve the financial sustainability of the adult outpatient program by decreasing the no-show rate. They also saw open access as a way to provide care more quickly by severely reducing or eliminating wait times for initial appointments.

CCBC's outpatient clinics in Taunton and Attleboro provide a similar range of services. The Taunton site is CCBC's largest outpatient clinic and serves more children and adolescents in clinic, school, and home-based settings. The Attleboro site is a smaller satellite clinic. Most of CCBC's services for school based care are in the Taunton and New Bedford Public schools. In recent years, CCBC has developed specialized services to meet the needs of the LGBTQ population in the region.

At both clinics, CCBC offers a full range of community mental health center services including individual,⁷ group,⁸ and family therapy;⁹ psychiatric medication management;¹⁰ an Emergency Services Program;¹¹ Assertive Community Treatment;¹² and a Community Support Program.¹³ The organization also serves as a Community Partner¹⁴ for the service area, providing care coordination to members of MassHealth, Massachusetts' Medicaid program, who are enrolled in Accountable Care Organizations and who have mental health and substance use disorders.

The Substance Abuse and Mental Health Services Administration has awarded CCBC several Certified Community Behavioral Health Clinic

WHAT IS A CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC (CCBHC)? WHAT IS A COMMUNITY BEHAVIORAL HEALTH CENTER (CBHC)?

Certified Community Behavioral Health Clinics (CCBHCs) are organizations that have been awarded federal funding for the purpose of increasing access to and improving the quality of community mental health and substance use disorder treatment services. Per the parameters of these grants, CCBHCs must provide person- and family-centered integrated services. Organizations with CCBHC expansion grants must provide access to services including 24/7 crisis intervention services for individuals with serious mental illness or SUDs, including opioid use disorders; must provide services for children and adolescents with serious emotional disturbance; and must provide services for individuals with co-occurring mental health and substance use disorders. CCBHCs are also expected to provide comprehensive 24/7 access to community-based mental health and substance use disorder services.

Community Behavioral Health Centers (CBHCs) will be organizations in Massachusetts newly designated as such entities as part of the state's *Roadmap for Behavioral Health Reform*. These organizations are intended to serve as community-based locations that can serve as an entry point for timely assessment and connection to behavioral health care treatment. Initial information suggests they may be required to meet similar, but not exactly the same, requirements as federal CCBHCs. More information on state CBHCs will be forthcoming once a procurement for these organizations is initiated by the Commonwealth.

Sources: <https://www.samhsa.gov/grants/grant-announcements/sm-21-013>; <https://www.mass.gov/service-details/roadmap-for-behavioral-health-reform>.

(CCBHC) expansion grants, with the current two-year grant having started in 2020. These grants have enabled CCBC to build its capacity to meet the mental health, substance use treatment, and care coordination needs of adults, children, and adolescents with complex and co-occurring mental health, substance use, and medical conditions. As a CCBHC, the organization has developed an integrated approach to assessing patient needs and providing appropriate services in coordination with primary care and other community providers. Patients can have a primary diagnosis of a mental health disorder, an SUD, or co-occurring mental health and SUD conditions. Most patients receive psychotherapy services or a combination of psychotherapy and psychiatric medication prescribing. Few patients receive medication-only services. Plans are underway to develop a medication-assisted treatment (MAT)¹⁵ clinic to treat opiate addictions.

CCBC's outpatient program employs approximately 75 full- and part-time clinicians, reflecting a mix of licensed clinicians and master's-level unlicensed clinicians. The clinicians also aid in the professional development of bachelor's-level interns, who assist with clinical care under the supervision of a licensed clinical therapist. Licensed clinicians represent approximately 25 percent of clinician staffing and generally serve patients whose insurance carriers require a license (e.g., some commercial carriers and Medicare).¹⁶ They also serve as clinical supervisors. In addition, the clinics employ certified peer specialists, social workers, and nonclinical mental health counselors.

Most of the clinical staff are salaried employees, although several work on a part-time, fee-for-service basis. Currently, CCBC employs 2.75 full-time-equivalent (FTE) psychiatrists (serving adult patients) and six FTE nurse practitioners.¹⁷ A child psychiatrist was recently recruited.

OPEN ACCESS MODEL DESCRIPTION

CCBC calls its open access model Rapid Access and initiated the model in 2014 as a member of the first cohort of organizations sponsored by the Association for Behavioral Healthcare (ABH) to receive consultation and training in open access. The consultation was provided by MTM Services, a national consulting firm that developed an open access model to help behavioral health organizations increase patient access to services while simultaneously improving operational and financial performance.

Under Rapid Access, when individuals call for an intake appointment, they are told to "just come in" when they are ready to receive care. Intake appointments are scheduled for patients who are directly referred by hospitals, schools, and other institutions. An intake may also be scheduled if the patient's insurer requires a licensed clinician or if the patient needs an evening appointment. Diagnostic evaluations that do not require licensed personnel are conducted by unlicensed master's-level clinicians.

Prior to operational restrictions caused by the COVID-19 public health emergency, all new patient intakes were walk-ins that occurred between the hours of 9 a.m. and 4 p.m. Monday through Thursday and 9 a.m. to 3 p.m. on Friday. The intake process includes a registration component with insurance verification (to determine whether an individual has insurance and what type, though people are not turned away based on this information) conducted by administrative personnel. The intake also includes a psychiatric diagnostic evaluation, or assessment, conducted by a clinician.

CCBC uses a staff rotation system for scheduling all clinicians to conduct intakes and diagnostic evaluations, rather than dedicating clinicians to one of these tasks exclusively. Throughout the week, clinicians have blocks of two to four hours in their schedules for intakes. CCBC generally has two employees in a Rapid Access role on any given shift,

MTM SERVICES OPEN ACCESS MODEL

MTM's model of open access includes the following elements:

- Open access intake and assessment are available during most or all hours of clinic operations.
- All intakes are conducted as a walk-in or same-day telehealth appointment; no intake appointments are prescheduled.
- The initial walk-in appointment includes a diagnostic assessment and completion of at least one treatment plan goal.
- The first appointment for ongoing clinical care is scheduled at the first intake and assessment for within seven days.
- If the initial assessment identifies the need for a psychiatric evaluation, an appointment with a psychiatrist or psychiatric nurse specialist is scheduled to occur within three to five days.

one responsible for completing diagnostic evaluations and the other engaging walk-in patients, getting basic intake information, and describing to them the process and services available at CCBC. Clinical therapists from either the adult or child outpatient departments may be called upon to complete evaluations if their schedules allow.

The implementation of open access significantly reduced wait time for care. Prior to the public health emergency,¹⁸ all initial diagnostic evaluations were provided on a walk-in basis, and ongoing treatment could usually be scheduled within seven days after the initial diagnostic evaluation. Psychiatry is typically scheduled within 14 days of receiving a referral from an outpatient therapist. Generally, psychiatric referrals are made following a minimum of three sessions with the outpatient therapist, allowing the clinician to further assess need and ensuring that engagement with treatment can be established. Access to psychiatry can be expedited based on need, particularly after a recent hospital discharge. Children and adolescents typically had longer wait times between their initial assessment and first session, especially if the family required services in the evening or from a licensed clinician.

OPEN ACCESS IMPLEMENTATION

CCBC implemented Rapid Access over 12 months in 2014, fundamentally transforming nearly all clinic operations. Other changes to CCBC's behavioral health practice took place in tandem with the Rapid Access implementation, with the goals of improving staff productivity and providing timely access to care. The clinical treatment model shifted to shorter-term outcomes-focused care, using motivational interviewing, cognitive behavioral therapy (CBT),¹⁹ and other evidence-based practices to provide solution-based care. In addition, the clinician productivity measure was reduced to 25 hours of billable services per week in order to accommodate the open access system. Clinicians who exceed that standard receive incentive payments contingent on positive patient outcomes and completed clinical documentation. These changes, along with closing the cases of patients who are not engaged in care and who frequently miss appointments, has allowed for increased availability for new patients and reduced wait times.

The shift in treatment modality required significant staff training. Training was aimed at encouraging staff to use a holistic approach and view patients as customers, with an emphasis on providing outstanding customer service.

Clinicians were trained to use concurrent documentation (to complete treatment plans and notes during the session), increasing the patient's involvement in the treatment process. This method has been found to improve patient satisfaction, as it helps both the therapist and patient focus on the clinical goals of treatment and increases productivity by reducing nonbillable administrative time.²⁰

Administrative staff were trained to use a centralized scheduling system²¹ to implement Rapid Access throughout the organization. Many clinicians were accustomed to managing their own schedules, and some were concerned that the centralized system would entail a loss of autonomy, which they valued as part of their work life. CCBC reports that most clinicians who initially resisted moving to centralized scheduling embraced the change over time, as their productivity increased and as they experienced improvements in patient engagement and retention. Those who did not embrace centralized scheduling and related changes chose to leave the organization.

SUCCESSSES AND CHALLENGES OF OPEN ACCESS

Making such a significant change in clinic practice required sustained support from CCBC's leadership team. During implementation and to encourage a smooth transition to the new model, leadership helped staff adjust to the transition by addressing concerns, troubleshooting operational issues, and reassuring them of the value of the new clinical approach. This foundational change addressed CCBC's financial challenges. Within two years, the organization eliminated a deficit of \$600,000 in its outpatient programs.

CCBC cited several key factors for the successful implementation of Rapid Access and associated service delivery practices, starting with staff training on centralized scheduling and billing. Centralized scheduling allows administrative staff to view clinician schedules and insert patients into clinician schedules as they come in. Centralized scheduling

requires dedicated, well-trained front desk personnel to manage clinician schedules, conduct the nonclinical portions of each intake, and schedule ongoing appointments. Front desk staff are in charge of the central scheduling system, requiring them to maintain good working relationships with the clinicians they support. Centralized scheduling streamlines preregistration, helps to keep clinicians' schedules full, and therefore improves access. Additionally, CCBC emphasizes the importance of having administrative staff trained in best billing practices, to ensure that staff utilize reimbursement codes that maximize revenue while remaining compliant with payer rules.

Another key to success for CCBC is providing managers with relevant, timely data and training them to use the data to drive decision-making. For example, real-time information can help managers understand the typical peaks and valleys of intake volume and schedule staff to minimize wait times, as well as develop backup plans for those times when the waiting room is getting full. It takes ongoing management oversight and analysis of reliable data to enable the organization to continuously improve.

Implementation of the new model did not come without challenges. CCBC cited the upfront costs incurred as its greatest challenge. Costs included hiring additional staff, consultation and training costs, and investment in a new electronic health record (EHR) system to facilitate centralized scheduling. Moreover, as CCBC hired additional unlicensed clinicians to serve walk-in patients, supervisors saw an increase in the staff's administrative time and a reduction in their billable clinical services hours. CCBC continues to budget for ongoing staff training, which entails both a direct training cost and the cost of reduced productivity. Yet, once implemented, the open access strategy more than paid for itself by increasing patient volume and staff productivity and reducing no-show rates.

Since training is costly, maintaining staff stability is key to implementation but also a challenge for the organization, particularly among clinicians. CCBC has found that most clinicians want to experience a broad range of clinical work and do not want to dedicate a significant portion of their availability to providing intake sessions. The rotation system, used to staff intake sessions and filling vacant clinical positions on a timely basis, is important to maintaining patient access and limiting the number of "time blocks" clinicians spend conducting intakes.

OPERATIONS DURING COVID-19

Adapting to the provision of telehealth outpatient services during the COVID-19 pandemic entailed a radical shift in clinic operations, affecting all processes, from the ability to conduct walk-in intakes to providing traditional face-to-face services. Prior to the public health emergency, CCBC conducted approximately 160 intakes (100 adult and 60 child and adolescent intakes) per month, which were completed as in-person visits. The volume of intakes dropped significantly at the start of the public health emergency but gradually increased to an average of 111 telehealth intakes a month during the period of September 2020 through January 2021.

CCBC was able to implement telehealth services almost immediately, dedicating the open access phone line for prospective patients to call to enroll in outpatient services. Prospective patients could connect to available intake clinicians immediately if they called during open access hours (Monday through Thursday, 9 a.m. to 4 p.m. and Friday, 9 a.m. to 3 p.m.). The intake clinician completed the registration process and determined if the client was able to use videoconferencing technology, in which case the clinician scheduled to conduct the intake provided the client with a link to the clinic's platform. Otherwise, the patient was scheduled for a telephone intake with the clinician who would conduct the diagnostic evaluation.

Over time, the organization has adopted various HIPAA-compliant videoconferencing platforms, including Doxy.me, Zoom, and Google Virtual Office. For patients without access to videoconferencing technology at home, CCBC offers "Zoom Rooms" based at the clinic, in addition to the telephone option. The Zoom Rooms are private spaces equipped with computers and internet connectivity, and patients use them for virtual appointments with their clinicians who are working from home or in another clinic. Zoom Rooms must be scheduled in advance and as a COVID-19 precaution are disinfected after each appointment.

CASE STUDY 2. GÁNDARA MENTAL HEALTH CENTER

ORGANIZATIONAL BACKGROUND

Since its inception in Springfield in 1977, Gándara Center has specialized in providing culturally relevant behavioral health care and social services to Hispanic, African American, and other diverse communities in Western Massachusetts. The staff at Gándara reflects the populations it serves, and direct care and support staff communicate in patients' primary languages, including Spanish, Cape Verdean, and Portuguese, as well as English. While the organization focuses on serving communities that are racially, ethnically, and linguistically marginalized, its programs are open to and benefit the entire community.

Over time, the organization has expanded its programs beyond the state's western region and now provides children's mental health services and community support and prevention programs for justice-involved youth and adults statewide. Gándara offers peer recovery services in Plymouth, Brockton, and Hyannis and operates a small outpatient mental health clinic in Brockton. The organization provides a comprehensive set of behavioral health care services that address mental health, SUDs, and co-occurring conditions, providing all levels of care with the exception of acute inpatient treatment service for SUDs (i.e., detoxification) and psychiatric inpatient care.

The desire to implement open access at Gándara originated not from a business or financial imperative but from a focus on better meeting patient needs and ensuring that patients did not experience long wait times to access services. Gándara leaders express a commitment to build on the experience of the past few years and continue to improve its open access system to drive down wait times and no-show rates.

Gándara has two outpatient clinics in Springfield in close proximity to each other, and they operate as a single unit, with the facility at 2155 Main Street identified as the main campus and the site at 85 St. George Road licensed as a satellite clinic. While both sites offer the full range of services to the patient population, the Main Street clinic provides the majority of mental health services for children and youth, and the St. George clinic provides the majority of specialized treatment for adults referred from the criminal justice system. Intakes for new patients at both sites are provided through a centralized open access system.

The initial intake and assessment process is used to determine the level of care or specific program best suited to meet a patient's needs. Based on the clinical evaluation, the patient may be given a first appointment with an outpatient clinician or a referral directly to an appropriate program the agency operates. In addition to therapy services, the clinics provide medication-assisted treatment, using Suboxone and Vivitrol protocols. Psychotropic medication management is available, but the organization's philosophy de-emphasizes psychotropics—utilizing nonpharmaceutical approaches over a period of three to four sessions—before referring a patient to the clinic medical director or a nurse practitioner for a medication evaluation. A six- to eight-week wait is typical for a medication evaluation, although referral to psychiatry can be fast-tracked to occur within three to five days for at-risk patients who present with an urgent need for medication.

The Brockton satellite clinic offers a more limited range of outpatient therapy services than the Springfield clinics. This site does not use an open access system due to its small size, and so will not be a focus of this case study.

OPEN ACCESS MODEL DESCRIPTION

The Gándara open access model enables patients to walk in during normal clinic hours and receive same-day intake and assessment or counseling. Each new patient meets with an intake coordinator who obtains basic demographic and billing information and informs the patient of agency services and programs. The patient is assigned to a clinician who

initiates the clinical evaluation, normally on the same day. If the assessment cannot be completed that day, the intake coordinator schedules the patient for the next day or later in the same week.

Another feature of the open access model is that a patient may start treatment as soon as the same day or the next day following the intake and assessment, depending on clinician availability. Despite this goal, Gándara has a limited clinician capacity and typically schedules patients for their first appointment two weeks after the clinical evaluation.

Gándara employs a rotation system for scheduling clinicians to conduct intake assessments, assigning therapists intake time blocks. With the clinics located across the street from each other, Gándara has the flexibility to conduct an intake and assessment at either site, based on the availability of an intake coordinator and clinician. Gándara conducts an average of 100 intakes per month at the two locations combined. All patients, including those referred by courts and other organizations, are scheduled for intakes within the open access system.

While Gándara primarily uses open access for new patient intakes, an existing patient with an immediate need to see a therapist may also walk in and receive an open access appointment the same day with an available clinician. According to Gándara, even though its patients appreciate the availability of this access, they use it infrequently because most patients prefer to meet with their assigned clinician during scheduled appointments.

Clinical staffing for the two clinic sites includes 11 FTE therapists, three FTE nurse practitioners, and a 0.5 FTE psychiatrist, who also serves as the agency's medical director. As mentioned, all clinicians conduct intake assessments on a rotating basis, with either two or three clinicians scheduled in each time block, based on predicted or actual patient demand. In the event of unusually high volume, additional clinicians who have open slots are assigned to conduct intakes. Wait times vary during the course of each day as well as by day of the week—Gándara reports that Monday and Tuesday mornings, and often mid-afternoons, are typically the busiest periods. Intake volume tends to be lowest on Thursday and Friday.

Gándara expects its clinicians to fulfill 26 billable hours in a 40-hour workweek. It reduced its productivity expectation from a previous target of 28 hours per week in order to accommodate the open access system. Gándara uses a hybrid scheduling system in which front desk staff have access to each clinician's calendar and book appointments directly and clinicians also schedule appointments with patients at the end of therapy sessions.

SUCCESSSES AND CHALLENGES OF OPEN ACCESS

Since Gándara completed its open access implementation in 2015, patient surveys have reflected an overall high level of satisfaction with access to services. Patients state that they value the ability to receive services on the same day they decide they need them. The organization recognizes that maintaining patient satisfaction and engagement requires the wait time for the first therapy appointment to be as short as possible. The rate of no-show and canceled appointments climbs when patients wait more than one to two weeks for their first treatment session or between sessions.

The organization reports that open access has generally had a positive impact on financial performance but has also increased clinical and administrative costs. To realize success with open access, an agency must maintain enough intake coordinators to assign walk-ins to clinicians, complete the nonclinical portion of the intake, and have enough clinicians available to complete intakes on an ongoing basis.

Gándara is challenged to hire enough clinicians to meet the high demand for services. The organization reports that this challenge is due to both budget limitations and the difficulty in recruiting and retaining personnel, especially those who are bilingual in English and Spanish.

Gándara's leadership believes that scale matters in implementing the open access model. A clinic must employ enough clinicians to deploy them efficiently to provide both intakes and ongoing treatment. The agency has not implemented open access in its small Brockton clinic due to staffing limitations, although staff there work hard to maintain rapid

access to services. Gándara's leadership attributes the size and proximity of the two Springfield clinics to the efficiency and effectiveness of its open access program, inasmuch as these factors increase open access visit availability for patients.

While patients respond positively to the open access model, Gándara clinical staff hold mixed opinions about the system. One clinical leader stated, "I wouldn't say they hate it." The staffing model is intended to keep clinicians' schedules full, and because clinical evaluations involve a greater amount of documentation than routine therapy sessions, clinicians sometimes express frustration if they believe they are conducting too many intakes. The open access system can also be perceived as increasing the administrative burden on front desk staff, as well as on clinicians.

OPERATIONS DURING COVID-19

The organization found the initial months of the COVID-19 pandemic challenging. Gándara initially curtailed face-to-face appointments and offered appointments, when necessary, at the Main Street clinic only. Clinicians delivered most new patient intakes and ongoing care remotely by telephone. Gándara delivered services through videoconference to a few patients who were able to connect to their clinician in this way. By the fall of 2020, Gándara restored several small in-person treatment groups. A sex offender treatment program remained an in-person service throughout the public health emergency.

The volume of intakes and ongoing care significantly decreased early in the pandemic. Volume increased through a combination of video and telephone appointments throughout the summer, fall, and winter of 2020, as the need for behavioral health services remained strong.

Gándara has trained its staff in HIPAA-compliant video technology for conducting treatment services. Staff report, however, that most of their patients do not have smart phones or computers with videoconferencing technology or have limited or no internet connectivity at home. Some patients own smart phones with very limited data plans and are unwilling to use their minutes for therapy visits. Nonetheless, patients and staff have adapted to telephone therapy sessions that have been reimbursed by MassHealth and other payers, at least during the public health emergency.²² At the time of the interviews, leaders expressed hope that payers would approve telehealth on an ongoing basis to promote expanded access to services and continued improvements in the quality of patient care. The Commonwealth, in January 2021, passed legislation that made the telehealth changes implemented during the pandemic permanent.²³

At the time of this report, Gándara has put into effect a modified arrangement for conducting walk-in intakes and in-person care. There is now a room at the clinic where patients can participate in videoconference sessions for intake and follow-up services while clinicians work remotely. One clinician and one clinical supervisor are available on-site to meet immediate needs. Patients are also able to walk in, talk with a staff person at the front desk, and receive an appointment for a phone or videoconference assessment for the same or next day.

CASE STUDY 3. HIGH POINT TREATMENT CENTER

ORGANIZATIONAL BACKGROUND

High Point Treatment Center incorporated in 1996 as a nonprofit provider of mental health and SUD treatment services in southeastern Massachusetts. The organization has expanded from its original Plymouth location and today also offers services in Brockton, Taunton, and New Bedford. High Point provides outpatient, residential, and community-based services, serving individuals across the age spectrum.

High Point was motivated to implement open access in April 2019 to increase clinician productivity, reduce its no-show rate, and improve patient satisfaction. High Point has noted that while financial indicators do not yet reflect any

benefits of open access, this is largely due to the impact of the COVID-19 pandemic on clinic volumes and temporarily halting open access services. High Point hopes that a positive financial impact of open access will be realized by the end of fiscal year 2022.

High Point historically focused on serving adults with SUD and co-occurring mental health and substance use conditions but now also offers services to address a range of mental health conditions. Currently, the patient population is evenly divided between individuals with primary mental health diagnoses and those with primary substance use diagnoses. The demographic profile varies widely within the agency's service area: Brockton and New Bedford comprise diverse populations, with Brockton having a larger African American population and New Bedford a large Portuguese and Cape Verdean community. Plymouth and Taunton's populations are primarily White and English-speaking.

High Point operates four licensed outpatient clinics, serving approximately 2,100 patients at any given time, with each site serving between 380 to 730 patients. New Bedford is the largest of High Point's outpatient clinics. The organization employs psychiatrists and psychiatric nurse practitioners for prescribing and master's-level behavioral health clinicians at each outpatient clinic, with the number of staff varying by patient volume. A typical patient-to-staff ratio is one FTE staff member for every 60 to 65 patients.

At its New Bedford and Brockton locations, High Point's payer mix is approximately 90 percent Medicaid and 10 percent commercial insurance, while the Plymouth location serves a somewhat higher percentage of patients with commercial insurance. According to agency leadership, 40–60 percent of children and adolescents receiving behavioral health services at this site are commercially insured.

Each of High Point's service locations provides mental health and SUD outpatient services to children, adolescents, and adults. The range of services include individual and family counseling; psychiatric medication services; medication assisted treatment (MAT) including Suboxone, Vivitrol, and Naltrexone; and a Community Support Program. Services include certain specialty treatments, including court-mandated programs, anger management groups, Structured Outpatient Addiction Program,²⁴ and gambling addiction treatment. The Brockton clinic provides a mental health/SUD Intensive Outpatient Program (IOP).²⁵ Plans are underway to open a second IOP program at the New Bedford facility. High Point also provides Children's Behavioral Health Initiative (CBHI)²⁶ services at all outpatient sites.

High Point provides inpatient services for SUD (i.e., detoxification) and dual diagnosis treatment at locations in Plymouth, Brockton, and New Bedford. It also operates six residential facilities for adults recovering from substance use and co-occurring mental health disorders.

OPEN ACCESS MODEL DESCRIPTION

Several years before implementing its current model of open access in April 2019, High Point offered intake appointments with a small number of clinicians who were assigned exclusively to conduct these assessments. While the intent of this scheduling was to make more efficient use of the clinical schedule and to see patients as they decided to seek care, the limited number of intake clinicians meant that some patients were scheduled up to 10 days after their initial call to request services. This delay resulted in a no-show rate for scheduled intakes that ranged from 50 percent to 65 percent.

The organization adopted open access for all intakes to reduce the no-show rate, increase the number of billable hours for clinicians, and improve the financial performance of the outpatient clinics, which historically have not been self-sufficient. Additional goals included providing care to more patients and providing care at the time patients are ready to receive it, an objective considered crucial in meeting the needs of individuals with SUDs.

Open access is available in all five outpatient locations during most clinic hours, primarily for conducting new patient intakes but also for providing mental health services for existing patients who want to speak with a clinician that day.

All clinicians perform intakes, and if they have room in their caseload, they typically arrange to provide ongoing care for the patient. If their caseload is full, High Point will schedule the ongoing care with a different clinician.

High Point does not currently offer drop-in groups or open access for intake into its MAT program, but it is exploring both options.

OPEN ACCESS IMPLEMENTATION

High Point took two related actions to facilitate the full implementation of open access. First, the organization centralized its scheduling process so that the front desk administrative staff could directly schedule new and existing patients into clinician schedules. Second, High Point replaced its previous system—in which a few dedicated clinicians conducted assessments for walk-in patients—with a new process whereby front desk personnel scheduled new walk-in patients with any clinician who had an open time slot. Through centralized scheduling, staff were able to identify no-show and canceled appointments more quickly, filling them with walk-in patient visits throughout the day.

SUCCESSSES AND CHALLENGES OF OPEN ACCESS

Open access radically changed how new patients were admitted for services at High Point. Prior to its implementation, a new patient had to be scheduled days in advance. As a provider with a focus on substance use treatment, High Point found that a wait of even a few days could have serious detrimental effects on motivation and could even lead to the onset of a crisis or medical emergency, such as an overdose. With the implementation of open access, a patient experiences same-day access to a clinical assessment—usually within an hour—and is assigned to a treatment program or clinician. On an especially busy day, a patient may be asked to return the next morning, at which time they will be prioritized for an immediate appointment.

High Point encountered some clinician resistance and dissatisfaction as it transitioned to the central scheduling and open access systems. As with staff at other organizations interviewed for this study, High Point clinicians initially felt a loss of autonomy as they began to share patient scheduling responsibility with front desk personnel. They also feared the potential for double-booking, the practice of scheduling two patients for the same time slot.

High Point is currently using a hybrid approach to scheduling. The front desk staff can book, cancel, and reschedule appointments in clinician schedules, and clinicians themselves can also schedule patients. There are challenges to this hybrid model because there can be lags in the scheduling system: A patient may call the clinician directly to cancel or reschedule an appointment, requiring the clinician to notify the front desk team of the opening.

Productivity concerns also presented a challenge during the implementation of open access. Clinic productivity expectations of a minimum number of billable hours a week can reinforce the practice of providing long-term therapy, rather than solution-focused care, which tends to be shorter term. Clinicians who provide weekly long-term therapy to stable patients may more easily meet their productivity goals, but continuing to treat patients with less urgent needs for care reduces the time available for new patients with more urgent needs.

OPERATIONS DURING COVID-19

The COVID-19 pandemic has presented operational challenges for High Point, including its delivery of open access services. Data indicate that treatment volumes dropped across all five locations following the initiation of pandemic-related restrictions and the onset of remote service delivery in March 2020. Brockton's outpatient program, for example, had 41 intakes in the first quarter of 2020 (July through September 2020), compared with 382 intakes for the same period in 2019.

As of October 2020, High Point operated a hybrid model of in-person visits and remote appointments using a teleconferencing platform. Clinicians worked one to two days on site and two to three days at home. Four locations

initially halted open access walk-in intakes, although the Brockton clinic continued to offer them throughout the pandemic. By October 2020, all locations had resumed open access intakes.

The implementation of telebehavioral health services also highlighted the need for a scheduling system that would update clinician calendars in real time when there was a cancellation or other scheduling change. The current system operates with a lag, so that when clinicians update their schedules with a cancellation, front desk staff do not see the appointment vacancy until three to four hours later. This lag impedes the ability of the front desk staff to immediately schedule a telehealth intake or regular appointment to fill a newly opened slot. At the time of this study's publication, High Point was working with its EHR vendor to resolve this operational challenge. In the meantime, its clinicians communicate schedule changes directly with the front office staff to compensate for the EHR lag.

Despite challenges to open access implementation, High Point officials point to several notable successes. Clinicians have been meeting and, in many cases, exceeding their productivity targets, qualifying them for monthly bonuses. Clinicians' satisfaction has increased with the financial rewards and their growing level of comfort with the open access system. Open access has not yet produced overall financial success for the organization. However, High Point indicated that net revenue was trending in the right direction prior to the beginning of the COVID-19 pandemic. There is optimism that positive financial results will come over time, once normal service delivery resumes.

CASE STUDY 4. EAST BOSTON NEIGHBORHOOD HEALTH CENTER

ORGANIZATIONAL BACKGROUND

East Boston Neighborhood Health Center (EBNHC) is a large federally qualified health center (FQHC), celebrating 50 years of serving the communities of East Boston, Everett, Revere, Chelsea, and Winthrop. The health center has two sites in East Boston, at 10 Gove Street, its flagship location, and at 20 Maverick Square. A third site is located in Winthrop. Reflecting the demographics of its communities, EBNHC serves a largely Spanish-speaking Latino population. The organization recently merged with the South End Community Health Center, increasing its geographic reach in Boston and the breadth of its services. With the merger, the organization now sees approximately 100,000 patients per year and provides nearly 300,000 visits for all health services. The merger also doubled the organization's capacity to provide a complete continuum of brief to longer-term behavioral health services.

EBNHC originated as a relief station for Boston City Hospital, now Boston Medical Center, or BMC, and it retains its affiliation with the hospital. In addition to its FQHC certification, EBNHC is licensed as a BMC satellite site for the provision of emergency services. The health center offers primary care, including family medicine, pediatrics, and OB/GYN care; and specialty mental health and SUD services; and it runs a large Program of All-Inclusive Care for the Elderly (PACE) program.²⁷

OPEN ACCESS MODEL DESCRIPTION

EBNHC first used open access in 2009, when it embedded a behavioral health clinician in the primary care clinic to provide immediate access to behavioral health care from 8 a.m. to 5 p.m., Monday through Friday. The clinician provided brief behavioral health interventions and assessments but not continuing care, instead referring patients to behavioral health specialty services in the community.

To improve access to behavioral health services and respond to Massachusetts's 2012 health reform law, Chapter 224,²⁸ EBNHC fully integrated behavioral health care in its primary care clinics in 2014. Its integration model is based on the Cherokee Health System in Tennessee.²⁹ EBNHC formed a strong partnership with Cherokee, and EBNHC staff

received training in Cherokee's model of care at its Knoxville headquarters. Cherokee provided ongoing consultation after initial implementation of the model at EBNHC's primary care sites.

EBNHC strives to provide same-day access for both primary and behavioral health care services within its integrated care model. To staff this model, all clinics have set aside a certain number of same-day appointments for all services, including medical and behavioral. Behavioral health services are available during health center hours, and all services are available within 24 hours, and often on the same day, following a request from a patient or provider.

Typically, when patients come to the clinic for primary care services, their primary care clinician sees them first. If the patient presents with a behavioral health need, the clinician can offer them immediate access through a warm handoff to a behavioral health clinician, who provides an assessment and briefly treats the patient. While most initial behavioral health services are conducted this way, EBNHC provides open access to all its services; a patient can call and receive an appointment on the same day for primary, behavioral health, and specialty care.

The integrated care model provides intervention, assessment, brief treatment, and, when needed, referral to specialty behavioral health care. Typically, behavioral health treatment is brief and intervention-based following the initial warm handoff. At the discretion of the care team a full episode of care, regardless of length, can be provided as long as it is appropriate for the primary care setting. Services include mental health and substance use outpatient therapy, the prescribing of psychotropic medication (when not prescribed by the primary care clinician), and MAT, including Suboxone and Naltrexone.

EBNHC employs 32 to 35 FTE licensed clinicians to provide its integrated behavioral health services, including licensed social workers, licensed marriage and family therapists, licensed mental health counselors, and psychologists. Master's-level unlicensed clinicians are also hired if they previously served as interns at the center, but they are expected to obtain their license as soon as feasible. A full-time clinician typically sees eight to 10 patients each day, which amounts to approximately 32 hours of face-to-face care per week.

Scheduling of all appointments is centralized at the front desk; clinicians do not manage their own schedules. An operations coordinator at each site maintains an online in-basket of behavioral health service requests from both patients and primary care clinicians and is responsible for assigning clinicians to take warm handoffs within 15 minutes of the conclusion of the primary care visit. EBNHC facilitates communication and coordination of care between behavioral health clinicians and primary care clinicians through a secure chat feature in its EPIC health record system.

OPEN ACCESS IMPLEMENTATION

EBNHC began providing open access services in 2009. Having implemented the model twelve years ago, the study focuses on current operations rather than implementation challenges. EBNHC provides open access for all services, including primary care, specialty care, and behavioral health, under an integrated care model, which continues to evolve. Although the organization started its behavioral health integration efforts with a commitment to providing short-term (four to six appointments), targeted half-hour interventions, the service model is developing into a hybrid of brief treatment and more traditional longer-term therapy.

EBNHC encourages behavioral health clinicians to develop specialized expertise in evidence-based practices, such as Eye Movement Desensitization and Reprocessing,³⁰ and trauma-focused care. Clinical staff are interested in providing traditional longer-term therapy to gain expertise in that model of care. Some patients, especially those addressing complex trauma, also find that longer-term treatment better meets their needs. While the 30-minute, four- to six-session course of treatment remains the norm at EBNHC, clinicians increasingly provide 45- to 60-minute therapy sessions that exceed the typical four- to six-session target. Providing opportunities for EBNHC's behavioral health clinicians to conduct these longer-term interventions increases staff satisfaction and meets the needs of patients in the primary care setting, reducing the necessity to refer out to specialty behavioral health care.

A patient must be registered as a primary care patient to access behavioral health services at their integrated primary care clinic. EBNHC also provides same-day walk-in access to behavioral health services, including Suboxone treatment, at its emergency department (ED). Patients who present at the health center's ED are assigned a primary care physician for follow-up care if they do not already have one. The ED also offers immediate access to other behavioral health services through an on-call consultation service. Once seen at the ED, patients are scheduled for a same- or next-day primary care visit and behavioral health assessment at the clinic or are referred to their own primary care clinician not affiliated with EBNHC.

Even so, some patients have longer-term or more complex needs than can be appropriately met in the integrated care setting. EBNHC refers these patients to the specialty behavioral health clinic at South End Community Health Center, BMC, or another local community mental health center.

SUCCESSSES AND CHALLENGES OF OPEN ACCESS THROUGH INTEGRATED PRIMARY CARE

EBNHC officials believe that providing behavioral health care within an integrated service model reflects best practice and is the way most people want to receive their care. Warm handoffs greatly reduce no-show rates, for both initial and follow-up appointments. By reducing no-show rates, EBNHC officials report that implementing open access in the integrated care setting has benefited the health center financially and that its business model for providing integrated primary and behavioral health care services is sound.

In addition to the financial success, integrated behavioral health clinicians receive satisfaction from working as a member of the primary care team to improve patients' health in a holistic way. Nonetheless, some behavioral health clinicians have expressed the desire to provide more specialized care that better serves patients with complex behavioral health conditions. In response to this, EBNHC is making changes in the brief treatment model to support professional development of the clinical workforce as well as meet evolving patient needs.

The organization recognizes the need to continuously promote culturally appropriate care. This imperative informs its staff development program, recruitment efforts, and graduate education initiatives.

OPERATIONS DURING COVID-19

The COVID-19 pandemic has had a significant impact on EBNHC operations. Sixty percent of primary care clinician visits and 90 percent of behavioral health visits shifted from in-person to virtual, either over the phone or via the Doxy.me telehealth video platform. EBNHC reports that during the pandemic the number of requests for behavioral health services has increased.

EBNHC has preserved open access during this period. Primary care clinicians and behavioral health clinicians collaborate using the EHR's secure chat function. A member of the primary care team sees each patient via a virtual appointment within 24 hours and, if needed, provides a virtual warm handoff to the integrated behavioral health clinician. While this approach may lack the personal touch of a face-to-face warm handoff, patients appreciate being connected to the behavioral health clinician, usually on the same day.

CONCLUSION

The four case studies included in this report document the range of clinical settings and approaches in which open access has been successful, as well as the variety of specific service delivery practices clinics employ under this model. The case studies provide a detailed profile of organizations that have successfully operated open access over a number of years.

While there are differences in the approach taken by each site's open access model, the case studies reveal several commonalities that support successful implementation of open access. These common factors include:

- Having the support of leadership to implement this major organizational change
- Implementing open access using a specific open access model
- Organizing staffing to provide open access during most or all clinic hours
- Implementing an effective centralized scheduling system
- Providing timely access to care after the initial intake

Each of these factors is discussed in more detail in the companion [report](#), *Opening the Door to Behavioral Health Open Access in Massachusetts: A Look at the Experience and Opportunities to Support Implementation*. In addition, that report highlights key policy considerations to supporting the adoption of open access models for behavioral health care. As the Commonwealth focuses on reforming the behavioral health care system, supporting open access to behavioral health care is a key strategy that can improve the overall performance and stability of the behavioral health system in Massachusetts and, more importantly, can improve the lives of Massachusetts residents who need mental health and/or substance use disorder care.

ENDNOTES

- 1 For the purposes of this report, *behavioral health* is inclusive of mental health disorders, substance use disorders (SUDs), and co-occurring mental health disorders and SUDs.
- 2 Institute of Medicine. Transforming health care scheduling and access: getting to now. 2015. Accessed August 21, 2020. www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.
- 3 Measuring staff productivity: For many community mental health agencies, measuring staff productivity involves measuring therapists' billable patient contact hours. Productivity can be measured in percentages, hours, or minutes. Productivity standards are defined as performance measures that rate an employee's effectiveness and efficiency at work. Franco, GE. Productivity standards: do they result in less productive and satisfied therapists? *The Psychologist-Manager Journal*;19(2):91–106. <https://doi.org/10.1037/mgr0000041>.
- 4 When describing the population each organization serves, we rely upon the language each organization uses to describe the population it serves.
- 5 The Association for Behavioral Healthcare (ABH) sent a link to the survey to 95 ABH member organizations, and the authors sent an additional 10 surveys through Survey Monkey to 10 non-ABH behavioral health provider organizations. The authors received 28 complete responses (a response rate of 27%); 20 of these organizations indicated a willingness to participate in an interview and/or a site visit.
- 6 CCBC demographic profile is based on provider estimation, not on client self-report.
- 7 Individual therapy: a form of psychotherapy that focuses on the development of a one-to-one relationship with a therapist in which the patient is engaged in a process of reflection on their emotions and behaviors. Tomasulo D. Differences Between Individual, Group and Couples Therapy. *Psychology Today*, January, 2015. Accessed June 9, 2021. <https://psychologytoday.com/us/blog/the-healing-crowd/201501/differences-between-individual-group-and-couples-therapy>.
- 8 Group therapy: a form of psychotherapy in which a group of patients meets to describe and discuss their problems together under the supervision of a therapist. Piper, W. Group Therapy. In *The Corsini Encyclopedia of Psychology* (eds Weiner IB and Craighead WE). 2010. <https://doi.org/10.1002/9780470479216.corpsy0393>.
- 9 Family therapy: therapy focused on an entire family or several of its members. Mirsalimi H. Family Therapy. In *The Corsini Encyclopedia of Psychology* (eds Weiner IB and Craighead WE). 2010. <https://doi.org/10.1002/9780470479216.corpsy0348>.
- 10 Medication management: a treatment system to ensure that patients are receiving optimal therapeutic outcomes for the prescription medications they are taking. *Medication management* describes a range of activities including performing patient assessments or a comprehensive review of prescriptions, creating medication treatment plans, and ensuring compliance through patient education. Substance Abuse and Mental Health Services Administration. (2010). *Illness Management and Recovery Evidence-Based Practices (EBP) Kit*. 2010. Rockville, MD: Center for Mental Health Services, U.S. Department of Health and Human Services.
- 11 Emergency Services Program (ESP): a program that provides 24/7/365 crisis assessment, intervention, and stabilization services to individuals of all ages with mental health, substance use disorder, and/or co-occurring conditions. Massachusetts Emergency Service Program. Flyer. Beacon Health Options. Accessed April 15, 2021. www.masspartnership.com/pdf/ESPflyerprovidersandcollaterals.pdf.
- 12 Assertive Community Treatment Evidence-Based Practices kit. Accessed April 15, 2021. <https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4344>.
- 13 Community Support Programs (CSP): programs that provide an array of services delivered by mobile community-based paraprofessional staff, supported by a clinical supervisor, to individuals with psychiatric or SUD diagnoses and/or to individuals whose psychiatric or SUD diagnoses interfere with their ability to access essential medical services. Community Support Program. Massachusetts Behavioral Health Partnership. July 1, 2014. Accessed April 15, 2021. <https://www.masspartnership.com/pdf/CSPFINALJul2014.pdf>.
- 14 Community Partners (CPs): community-based entities that work with accountable care organizations (ACOs) and managed care organizations (MCOs) to provide care management and coordination to certain members identified by MassHealth, ACOs, and MCOs. Behavioral health CPs provide support to individuals with significant behavioral health needs, including serious mental illness and addiction. MassHealth Community Partners (CP) program: information for providers. Mass.gov. Accessed April 15, 2021. www.mass.gov/guides/masshealth-community-partners-cp-program-information-for-providers.
- 15 Medication-assisted treatment: the use of medication in combination with counseling and behavioral therapies to provide a whole-patient approach to the treatment of substance use disorders. Medication-Assisted Treatment (MAT). SAMHSA.gov. Accessed April 15, 2021. www.samhsa.gov/medication-assisted-treatment.

- 16 Licensed clinicians include licensed mental health counselors, licensed alcohol and drug counselors, licensed social workers, licensed independent social workers, and psychologists. Reimbursement is typically tied to clinician type. For all of these clinician types, there is a period between obtaining a degree in the field and licensure, after the clinician completes post-degree supervised clinical work. These new “pre-licensed” clinicians are a significant part of the workforce at behavioral health clinics, and they provide much of the workforce for open access services at provider organizations. But some insurers do not reimburse for their services.
- 17 All sites voiced concerns about the scarcity of psychiatrists.
- 18 A description of how CCBC continued to provide access to same-day services during the pandemic is given on page 5.
- 19 Cognitive behavioral therapy (CBT): a psychosocial intervention that focuses on challenging and changing cognitive thoughts and behaviors, improving emotional regulation, and developing coping strategies to solve current problems. What is cognitive behavioral therapy? American Psychological Association. July 2017. Accessed April 16, 2021. www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral.
- 20 Grantham D. Concurrent documentation wins trifecta: how one documentation project made clinicians, clients, and even accountants happy. 2010. Behavioral Healthcare;30(8):32+. Gale Academic OneFile. Accessed July 2, 2021. link.gale.com/apps/doc/A239820182/AONE?u=mlyn_oweb&sid=googleScholar&xid=a7922746.
- 21 Centralized scheduling: For the purposes of this report, *centralized scheduling* refers to computerized scheduling systems that administrative staff use to make patient appointments.
- 22 For more information, see Expanding Access to Behavioral Health Care Services in Massachusetts through Telehealth: Sustaining Progress Post Pandemic. Available at: www.bluecrossmafoundation.org/publication/expanding-access-behavioral-health-care-massachusetts-through-telehealth-sustaining.
- 23 An Act promoting a resilient health care system that puts patients first Fact Sheet. Accessed July 2, 2020. [https://mhalink.informz.net/mhalink/data/images/20-12-23ADVconference report.pdf?eType=EmailBlastContent&cId=48d7daec-a722-447b-8cff-680dbc6b6b40](https://mhalink.informz.net/mhalink/data/images/20-12-23ADVconference%20report.pdf?eType=EmailBlastContent&cId=48d7daec-a722-447b-8cff-680dbc6b6b40).
- 24 Structured Outpatient Addiction Program: consists of short-term, clinically intensive, structured, day and/or evening substance use disorder services. Structured Outpatient Addiction Program (SOAP). MDHP. July 1, 2014. Accessed April 16, 2021. <https://www.masspartnership.com/pdf/SOAPFINALJul2014.pdf>.
- 25 Intensive Outpatient Programs: provide time-limited multidisciplinary, multimodal structured treatment in an outpatient setting. Intensive Outpatient Program (IOP). Massachusetts Behavioral Health Partnership. July 1, 2014. Accessed April 16, 2021. www.masspartnership.com/pdf/IOPFINALjul2014.pdf.
- 26 Children’s Behavioral Health Initiative: offers MassHealth children and their families integrated behavioral health services and a comprehensive, community-based system of care. Services include outpatient and in-home therapy, therapeutic mentorship, family support, and substance-use services. MassHealth Services for Children & Youth. Brochure. Mass.gov. Revised March 2019. Accessed April 16, 2021. www.mass.gov/doc/cbhi-brochure-masshealth-services-for-children-and-youth/download.
- 27 Program of All-Inclusive Care for the Elderly (PACE): a managed care program for older adults that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. What is PACE? Mass.gov. Accessed April 17, 2021. www.mass.gov/service-details/what-is-pace.
- 28 Chapter 224: created the Behavioral Health Integration Task Force to study payment systems for behavioral and substance use disorders and integration with primary care. Blue Cross Blue Shield of Massachusetts Foundation. Summary of Chapter 224 of the Acts of 2012. September 28, 2012. Accessed April 15, 2021. www.bluecrossmafoundation.org/publication/summary-chapter-224-acts-2012.
- 29 Cherokee Health Systems: pioneer of an integrated care model based on the idea that the best approach to wellness involves treating both body and mind. At Cherokee, a team of primary care and behavioral health clinicians work with patients and families to provide patient-centered care. This care may address mental health and substance use conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, and stress-related physical symptoms. Services: Adult Primary and Behavioral Care. Cherokee Health Systems. Accessed January 10, 2021. www.cherokeehealth.com/patient-services/adult-primary-behavioral-care.
- 30 Eye Movement Desensitization and Reprocessing: a psychotherapy in which the person being treated is asked to recall distressing images; the therapist then directs the patient in one type of bilateral stimulation, such as side-to-side eye movements or hand tapping. The treatment involves standardized procedures that include focusing simultaneously on spontaneous associations of traumatic images, thoughts, emotions, and bodily sensations and bilateral stimulation that is most commonly in the form of repeated eye movements. Shapiro, F. and Solomon, R.M. Eye Movement Desensitization and Reprocessing. In The Corsini Encyclopedia of Psychology (eds I.B. Weiner and W.E. Craighead). 2010. <https://doi.org/10.1002/9780470479216.corpsy0337>.

