

Opening the Door to Behavioral Health Open Access in Massachusetts: A Look at the Experience and Opportunities to Support Implementation

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IMPROVING ACCESS TO BEHAVIORAL HEALTH CARE: THE ROLE OF OPEN ACCESS

Timely access to behavioral health¹ care is a critical and often unmet need for people in Massachusetts facing mental health and substance use disorder (SUD) challenges. Patients and caregivers often describe a struggle to find care during or after a crisis, particularly when seeking help for the first time.^{2,3} For individuals with SUDs, immediate access to SUD treatment is of critical importance, as typically a short window of opportunity exists when a person in need is ready and willing to engage in care.⁴ For people who are experiencing a mental health crisis or who have just been discharged from psychiatric hospitalization, quick access to an assessment for outpatient care, including psychopharmacology, may make the difference in preventing escalating crises.⁵

Despite the need, individuals and provider organizations report waits of multiple weeks for an initial intake appointment and even longer for a psychopharmacological evaluation.⁶ Studies conclude that the longer the duration between a crisis and access to services, the less likely it is that a patient will keep an appointment.⁷ While there are multiple reasons for no-shows,⁸ patients often report that they sought acute services at an emergency room (either because the delay in care exacerbated the crisis and made a higher level of care necessary or because it was the option of last resort), found services elsewhere, or no longer felt they were in crisis.

In the case of patients with SUDs, they may resume or continue their substance use to avoid withdrawal symptoms. Perceived societal stigma may also be a barrier for some families and patients who may delay seeking care until the situation is dire, further lengthening the time between crisis and initiation of services. The absence of a timely and simple pathway to care keeps individuals from receiving the behavioral health services they need.

Regardless of the reason, lack of timely access to care results in a greater likelihood that patients will not keep their first scheduled appointment. High no-show rates, which can exceed 50 percent, not only contribute to poor patient outcomes but also have a negative financial impact on provider organizations and individual clinicians.⁹ Addressing timely access to care through the adoption of open access methods supports the well-being of people with behavioral health conditions (a primary goal of behavioral health organizations), improves staff productivity, and increases financial stability. Prior research sponsored by the Blue Cross Blue Shield of Massachusetts Foundation has focused on the individual and family experience of seeking behavioral health care services;¹⁰ this research is approached from the perspective of providers of behavioral health services, specifically those providing services through an open access model.

“Open access” can refer to several different service models, including, for example, urgent care for people experiencing crises, drop-in support or psycho-education groups, and same-day induction for medication for addiction treatment. The organizations interviewed in this study used the term to refer to same-day access to intake services, after which the organization would identify and schedule the type of treatment a person needed. As a result, this study defines open access in behavioral health care as same-day appointments, available on a walk-in basis or by calling, for initial intake and diagnostic evaluation services. Providers may use an open access model to increase access to care and streamline the pathway to care;

KEY DEFINITIONS

Open access—In this report, open access refers to intake and diagnostic evaluation services for behavioral health available on the same day that someone requests them either through a phone call or on a walk-in basis.

Same-day access—In this report, the term is used for any service available on the day it is requested.

Intake—A behavioral health intake is the process through which a patient starts services. It includes information collected through an intake form or by front desk staff and the initial diagnostic assessment session with the behavioral health clinician.

Assessment—A diagnostic assessment, sometimes called a psychiatric evaluation or diagnostic evaluation, is conducted during the initial session with a clinician, who may be a master’s-level behavioral health clinician, psychiatrist, or behavioral health clinical nurse specialist. The assessment is used to form a diagnosis and develop a treatment plan and involves a series of questions and observations to complete the assessment. It is part of the intake process.

No-show—A no-show refers to a missed patient appointment wherein the patient was scheduled, did not appear for the appointment, and made no prior contact to cancel or reschedule the appointment with the clinic staff.

enhance provision of community-based services, which may reduce unnecessary emergency room visits; and eliminate no-shows for intake appointments, which improves a clinic's financial viability.

Broad implementation of open access by Massachusetts outpatient provider organizations has the potential to make it easier for individuals and families to get care and improve the patient experience and outcomes of care.

Improving access to behavioral health care in Massachusetts is a key concern for stakeholders including patients and their caregivers, state government leaders, and advocacy groups. When the Commonwealth conducted a series of community engagement listening sessions in 2019 as part of its ambulatory Behavioral Health Reform initiative, one of the most frequently mentioned needs was improved access to care. In response to these findings, leadership at the Executive Office of Health and Human Services (EOHHS) is focusing on improving access to outpatient behavioral health care, including open access to care, at newly designated Community Behavioral Health Centers, positioning these to be a key component of its Roadmap for Behavioral Health Reform.¹¹

Open access holds promise for improving timely access to behavioral health care services, but no study has previously documented the experience of provider organizations using this model in Massachusetts. The goal of this study is to fill that knowledge gap by identifying organizations that operate open access today, describing the open access models they use, and highlighting the approaches that have been most successful. The study also pinpoints keys to success for organizations to consider in adopting an open access model. Finally, this report offers policy recommendations to promote the broader adoption of open access in the Massachusetts behavioral health care system.

BACKGROUND

The report authors searched the academic literature for published articles on open access models for behavioral health and advanced access scheduling models, including same-day scheduling in the wider health care system. The available peer-reviewed literature on these topics comes from the field of operations management and focuses on scheduling systems for large medical organizations (i.e., for all medical services, not solely behavioral health care services). In addition to the academic literature, the authors reviewed materials on open access produced by MTM Services, a technical assistance firm associated with the National Council for Behavioral Health. MTM developed an open access model (described in more detail below) that mental health and SUD provider organizations across the country have widely adopted.

DEFINITIONS OF OPEN ACCESS

Open access to care is known by several names in medical settings, including advanced access model of patient scheduling, same-day access, and same-day scheduling.¹² Open access is an appointment-scheduling method that allows patients to seek and receive health care from their provider at the time of their choosing. Patients typically use either drop-in clinic hours or are offered an appointment on the day they call.¹³ Previous studies have found that same-day scheduling in health care clinics reduced wait times and no-show rates.¹⁴

BEHAVIORAL HEALTH SERVICES AVAILABLE THROUGH OPEN ACCESS

In behavioral health, open access typically applies to intake and initial diagnostic evaluation appointments only, with follow-up appointments and ongoing therapeutic work assigned and scheduled with the therapist, physician, or nurse specialist who provides the ongoing care.¹⁵ Some behavioral health provider organizations offer same-day access to other types of services, such as drop-in group therapy or urgent care visits, but there is less literature on same-day access to these other types of services, and since we did not conduct case studies on organizations that used those strategies, they are not a focus of this report.

Some medical clinics offer their full range of services through same-day scheduling or walk-in services. In these cases, whichever physician or nurse specialist is available sees the patient. Behavioral health clinics may use this practice less frequently, in part because therapeutic work depends upon continuity of care provided through an ongoing, aligned therapeutic relationship.

In 2013, the Massachusetts Behavioral Health Partnership (MBHP), in collaboration with the Association of Behavioral Healthcare (ABH), provided training and consulting from MTM through a quality initiative aimed at increasing the use of open access among Massachusetts behavioral health provider organizations. MTM's model of open access includes the following elements:¹⁶

- 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 pre-scheduled.
- The initial walk-in appointment includes the diagnostic assessment and completion of at least one treatment-plan goal, which promotes immediate patient engagement and motivates the patient to return for ongoing care.
- The first appointment for ongoing clinical care is scheduled at the first intake and assessment appointment and is intended to occur within seven days.
- If the initial assessment identifies the need for a psychiatric (including medication) evaluation, an appointment with a psychiatrist or psychiatric nurse specialist is scheduled to occur within three to five days.

MTM also promotes rapid access to psychiatric services through a scheduling method it calls Just-in-Time Psychiatry. In this practice of scheduling psychiatry appointments, psychiatrists and nurse specialists do not schedule their ongoing care more than a week in advance, leaving available a large number of appointment slots. Patients are instructed to call in the week that they need a medication refill or medication appointment. This method reduces the number of no-shows to psychiatry appointments and can free up psychiatrists to meet with people quickly to meet urgent needs.¹⁷

REASONS TO IMPLEMENT OPEN ACCESS FOR BEHAVIORAL HEALTH SERVICES

Behavioral health organizations choose to implement open access to address their patients' demonstrable and pressing need for timely access to care. Individuals often seek care when a situation becomes urgent, so providing open access is consistent with the organizations' mission to provide clinically appropriate services when and where people need them.

Organizations also implement open access to reduce no-show rates by engaging people in care when they are first seeking it or when they have an urgent need. As mentioned previously, the literature demonstrates that the longer patients wait for an initial or follow-up appointment, the higher the likelihood is that they will not show up for the appointment.^{18,19} For primary care clinics that have baseline no-show rates higher than 15 percent, moving to an open access model can significantly reduce no-show rates and improve the clinic's financial performance.²⁰

From the perspective of the provider organization, offering open access to services helps increase efficiency and financial stability. Several organizations interviewed for this study indicated that adoption of open access was the cornerstone of a fundamental transformation in their delivery of outpatient services. Provider organizations that successfully implemented open access experienced increased staff productivity and an overall positive reaction from staff over time. Additionally, offering open access gave organizations a competitive advantage. Publicizing that anyone with a need could drop by to start services helped to bring in new patients and expand outpatient clinics.

STUDY APPROACH

This study included three components: stakeholder interviews, a provider organization survey, and provider organization interviews. Follow-up interviews with four provider organizations resulted in detailed case studies that are presented in a companion report.

BACKGROUND STAKEHOLDER INTERVIEWS

The authors conducted stakeholder interviews with key informants at MassHealth's Office of Behavioral Health, MBHP, and ABH. Stakeholder interviews provided useful information on the current state of open access in Massachusetts and helped identify behavioral health provider organizations that are using best practices in providing open access to outpatient care. These interviews also made clear some concerns and questions regarding timely access to care that merited further exploration during the study.

PROVIDER ORGANIZATION SURVEY

The project included a short survey created in Survey Monkey. ABH sent the survey to its members (behavioral health provider organizations) through a link, along with a letter expressing support for this project and asking members to participate. Ten other large behavioral health provider organizations received the survey directly through Survey Monkey, bringing the total number of surveys sent to 105. Twenty-eight organizations completed the survey, representing a 27 percent response rate. The survey was directed to an organization's executive director or clinical director.

The goal of the survey was to learn which entities in Massachusetts are currently using or recently used an open access model, to catalog what behavioral health services are available through open access, and to identify provider organizations willing to participate in interviews for the project. The survey included 15 questions, which were a mix of multiple choice and yes/no questions, and one open response question. The survey asked organizations for the following information:

- Whether it provided open access or same-day access to services
- The services included
- The populations served
- Its clinic(s) size(s) and region(s) served
- Whether the respondent was willing to participate in interviews and case studies

A copy of the survey appears in Appendix A. A summary of survey results is included in Appendix B.

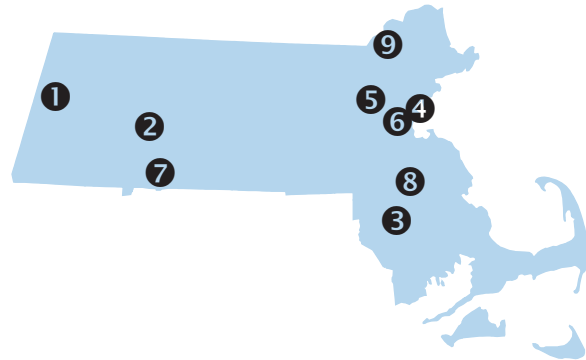
PROVIDER ORGANIZATION INTERVIEWS AND CASE STUDIES

The authors used the information gathered in the survey to select provider organizations to interview. Twenty organizations indicated in their survey responses that they currently or recently provided some form of open access for behavioral health services and were willing to participate in an interview.

Nine organizations were selected for interviews. They reflected a range of sizes and types, including mental health centers, community health centers (CHCs), and substance use treatment providers; rural, suburban, and urban settings across the state; and provider organizations that serve communities of color, culturally and linguistically marginalized individuals, or specific populations like children and families. One of the nine organizations interviewed had discontinued using open access but participated to provide information about barriers to implementing and maintaining an open access model.

The following organizations participated in interviews. Those with asterisks (*) participated in a second, more in-depth interview and are included as case studies.

- ❶ The Brien Center
- ❷ Clinical & Support Options
- ❸ Community Counseling of Bristol County*
- ❹ East Boston Neighborhood Health Center*
- ❺ Eliot Community Human Services
- ❻ Fenway Health
- ❼ Gándara Mental Health Center*
- ❽ High Point Treatment Center*
- ❾ Lahey Behavioral Health Services



These detailed case studies provided a more extensive profile of organizations that had successfully operated open access over several years. The selected organizations took somewhat different approaches to implementing open access services, represent different types of organizations, and collectively provide services to a diverse population of people:²¹

- Community Counseling of Bristol County—an early adopter of open access services utilizing the MTM model and serving the urban and suburban southeastern communities of Bristol County;
- Gándara Mental Health Center—a midsize behavioral health organization serving an urban area in Western Massachusetts and specializing in providing culturally relevant behavioral health care and social services to Hispanic, African American, and other culturally, racially, and ethnically diverse communities;
- High Point Treatment Center—a recent open access adopter serving individuals with primary SUD, as well as individuals with mental health conditions; and
- East Boston Neighborhood Health Center—a CHC practicing an integrated primary and behavioral health care approach that includes open access.

Detailed case studies of these organizations' experience in implementing the open access model is available in a companion [report](#), *Implementing Open Access to Behavioral Health Services: Four Case Studies*.

FINDINGS

KEY FACTORS FOR SUCCESSFUL IMPLEMENTATION OF OPEN ACCESS

Based on the interviews and case studies conducted for this report, the authors identified five key factors for successful implementation of an open access program: committed leadership; fidelity to an effective open access model; flexible staffing; effective scheduling systems; and timely access to ongoing care. These are discussed in more detail below.

Leadership Commitment to Open Access

Organizations that have been successful in implementing open access emphasize that achieving sustained and measurable results entails making significant changes in organizational practices and culture. Commitment and support from the chief executive officer and other senior managers are critical to success.

There are considerable upfront and ongoing costs, as well as transformations in administrative and clinical policies and procedures necessary to implement an open access model for behavioral health services. While reductions in wait times and no-show rates occur upon implementing open access, financial benefits do not immediately accrue. One organization in this study reported that a substantial deficit in its outpatient clinic budget was not erased until the end of the second year after it implemented open access. During that time, the organization's CEO was steadfast in his support for open access and championed the model's acceptance throughout the clinical and administrative staff. Other interviewees echoed the importance of support from the top and of exercising patience and taking a "long-range view" during implementation.

Fidelity to an Effective Open Access Model

Provider organizations are most successful in implementing open access when they use a proven method. Without a model to follow, some organizations implement open access in ways that lead to financial losses or fail to improve patient wait times. Many of the organizations interviewed received consultation and staff training during the implementation of open access and indicated that following a specific model helped them achieve success.²²

Open Access Models in Mental Health Centers

Mental health centers interviewed for this study used the MTM model described above, which provided a same-day or walk-in session for an initial behavioral health intake and assessment. After completing this initial assessment, these organizations scheduled a future appointment with an ongoing therapist or, if needed, with an intensive outpatient program. Most often, ongoing care was scheduled for within a week of the initial assessment.

The most successful open access clinics organized their staffing levels and staff schedules to create availability for drop-in intake and assessment appointments during most if not all clinic hours. Interviewees reported that most often, walk-in patients were seen in less than an hour from the time of their arrival, with a typical wait time of 20 minutes.

Of the organizations interviewed, those that departed from a full embrace of open access had less success with their open access programs. For example, one organization limited access to same-day intakes and assessments for patients referred through its Emergency Services Program (ESP). Individuals seeking care outside of the ESP were scheduled several weeks out.

Several organizations that abandoned open access had implemented drop-in intake slots for a limited number of hours per week. New patients who called for services were told they could either come in during the limited open access hours or schedule an appointment. Over time, these clinics found that there were insufficient walk-in patients to justify having the intake clinicians hold these time slots open. Insufficient patient volume resulted in lower productivity and financial losses.

Open Access Models in Primary Care

The integrated primary and behavioral health care model was reported to be successful in providing open access to behavioral health care. One CHC employs behavioral health clinicians who are embedded within the health clinic setting and serve as integral members of the primary care team. During a primary care visit when a behavioral health need is identified, the CHC uses a warm handoff approach, in which a primary care provider personally introduces a patient who may need behavioral health care services to a clinician during the patient's primary care visit.²³

This CHC has found success by following an evidence-based model—the integrated primary and behavioral health care model developed by the Cherokee Health System.²⁴ Using this model, the CHC arranges for the patient to receive treatment for up to six sessions, to be provided at the primary care site by the clinician who receives the warm handoff. The first visit is scheduled at the time of the warm handoff. Most patients who need or request more than six sessions are referred to a specialty behavioral health organization in the community, although some patients may continue to receive longer-term behavioral health care through their behavioral health clinician in the integrated primary care clinic.

Staffing Flexibility to Facilitate Open Access

Implementing open access requires provider organizations to adjust staff schedules and responsibilities so that access to service is available during all clinic hours. All interviewees agreed that adequate staffing is essential to successfully implementing and benefiting from open access. Provider organizations make use of several staffing models, depending on clinic size, to ensure that behavioral health clinicians are available to handle walk-in intakes and assessments during clinic hours, as well as to meet the demand for ongoing care.

Clinics with a larger number of clinicians appear to have more flexibility to schedule both same-day intakes and ongoing care. They also seem to experience a more predictable and consistent flow of patients than do smaller clinics. Smaller clinics tend to experience greater fluctuations, and possibly less predictability, in their number of weekly intakes, while having less staffing flexibility. Despite such limitations, interviewees representing several provider organizations with smaller clinics described scheduling strategies they have employed to creatively deploy their clinicians, including the use of clinical directors and/or supervisors to conduct intakes. Several of the smaller clinics also are nimble at identifying openings in clinician schedules caused by no-shows and cancellations and scheduling intake and assessment visits into those slots in real time.

Though open access clinics sometimes use clinicians whose sole function is to conduct intakes and assessments for new patients, most provider organizations interviewed now assign intakes and assessments to all clinicians on a rotating basis, so a staff member may be assigned to intakes only one morning or afternoon a week. These organizations believe that such an approach helps them maintain greater staffing flexibility than using dedicated intake clinicians. Additionally, organizations that had initially used dedicated intake clinicians found that those clinicians wanted to also provide ongoing therapy.

During a clinician's assigned intake times, if no walk-in patients arrive, the clinician uses the time to complete documentation, conduct care coordination, and carry out other administrative tasks. If more patients arrive than the scheduled intake clinician can handle, the clinic determines whether there are other clinicians who have availability due to no-shows or cancellations, or whether a clinical supervisor can conduct the intake. Occasionally, during high-volume periods, new walk-in patients may be asked to wait for a later available slot or asked to return the next day, at which time they would be prioritized for the first available opening.

A key concern for mental health centers using open access is achieving a budgeted level of clinician productivity. Staff productivity is measured in terms of number of clinician hours spent each week on direct, billable services. The productivity standard for mental health clinics interviewed for this study ranged from 22 to 26 hours in a 40-hour workweek. For an outpatient clinic to be financially viable, clinicians need to meet their productivity standards for number of billable hours on a regular basis.

Organizations that benefited from open access reported that the model increased overall staff productivity by increasing the volume of intakes and reducing waitlists and no-show or canceled appointments. Organizations that reported little or no benefit from open access experienced less predictable and insufficient use of walk-in time slots. In several cases, the use of dedicated full-time intake clinicians led to underutilization (i.e., lower productivity) during low-intake periods. In other cases, organizations limited walk-in intakes to several days a week or several hours a day. This practice seemed to result in underutilization of open access services or unpredictable walk-in volume.

Effective Scheduling Systems

One of the biggest administrative changes in open access is in the way the front desk and scheduling system operate. Provider organizations that successfully implemented open access reconfigured their administrative processes. Most importantly, they established centralized clinician scheduling by making use of integrated electronic health record (EHR) software. They also employed more administrative staff at the front desk. These organizations found that the added personnel and other costs were more than offset by increased revenue resulting from higher patient volume and clinician productivity.

It is common practice among open access organizations for front desk administrative staff to perform outpatient registration, benefits review, and other nonclinical functions prior to the clinical assessment portion of the intake. Administrative staff may also inform new patients of the various programs and services that the organization offers. This practice enables staff to complete necessary administrative tasks while the patient waits for an available intake clinician. It also maximizes clinician time by eliminating nonclinical activities in the intake process. For organizations that did not assign clinicians to conduct intake assessments during specific times, front desk staff used the EHR to view each clinician's schedule and fill vacant time slots with new patient intakes.

Most of the organizations interviewed stated that they did not use centralized scheduling prior to initiating open access. The organizations interviewed agreed that centralized scheduling is important to the success of open access and to behavioral health outpatient care generally.

Some provider organizations used a hybrid scheduling model in which both the front desk staff and clinicians could schedule appointments. Some organizations interviewed noted technology challenges with this approach, such as the inability of the electronic system to update the central schedule in real time so that front desk personnel could see when clinicians had scheduled their own appointments. Even in the absence of technology issues, organizations reported more challenges and conflicts around scheduling when they used a dual system that allowed both centralized and decentralized scheduling.

Managing staff expectations and concerns during such a major operational change can be challenging. Some clinicians do not readily embrace a centralized scheduling system, in which front desk staff schedule their appointments, possibly perceiving this as a reduction in autonomy. Organizations reported that some staff left when open access was implemented but that those who remained reported that centralized scheduling actually made their work lives easier by alleviating the burden of scheduling and tracking down patients.

Timely Access to Follow-Up Care

For open access to be meaningful, patients must have ready access to ongoing care after intake. Provider organizations that can offer timely access have enough clinicians to initiate ongoing treatment for new patients. Without access to ongoing care, the benefits of open access for intakes are limited. One standard open access model calls for an initial therapy appointment to be scheduled within seven days of intake, and a psychiatric evaluation, when required, to be scheduled within three to five days of intake.²⁵

During provider organization interviews, organizations indicated that successful implementation of open access for intakes and assessments did not always translate to ready access to ongoing care. Sometimes patients can receive an intake assessment on the day they ask for one but are then placed on a waitlist for ongoing therapy or medication

services. The limiting factor in offering access to ongoing care within the desired time frame is the availability of sufficient clinical and psychiatric staff. Most of the interviewed organizations stated that they are challenged to meet the demand for ongoing services on a timely basis because of budget constraints, vacant positions, or both. Most were typically able to schedule a new patient for a first therapy visit within seven to 14 days following the intake and assessment, though once demand for services grew in response to the COVID-19 pandemic, some provider organizations reported that the wait could extend beyond 14 days.

Open access organizations have employed several strategies to mitigate the impact of longer than desired delays in the onset of continuing care. Several clinics prioritize patients with urgent needs when filling open slots in clinician schedules caused by no-shows and canceled appointments. Others provide support during the waiting period by connecting new patients with peer specialists or recovery coaches. Despite the mitigation efforts, open access organizations noted that no-show rates increase when new patients have to wait more than two weeks to initiate ongoing care, reducing the benefit of open access to intakes for both the provider organization and patient.

Peer specialists and recovery coaches are people with lived experience of mental illness and/or substance use disorder, who provide support to others experiencing similar challenges. By being a role model, and sharing their story, peer specialists can help to engage people in treatment, and can help people in their recovery planning and in developing life skills and coping strategies.

– Adapted from Substance Abuse and Mental Health Services Administration

None of the interview respondents reported that they were able to meet the MTM standard for scheduling a psychiatric evaluation, when required, within three to five days of initial intake.²⁶ Several organizations were in various stages of recruiting for additional psychiatrist and nurse specialist time to address the need for better access to psychiatry. While lengthy wait times for psychiatry continue, most provider organizations reported using protocols to make psychiatry available for urgent appointments, such as an onset of acute symptoms, by either leaving slots open to meet this need or creating drop-in times for patients who had missed previous medication appointments.

While all provider organizations agreed that access to psychiatry is important, they varied in their processes and timing for determining the need for psychiatry. Several organizations indicated that except for patients with acute psychiatric symptoms, their normal treatment practice is to assess the potential need for psychiatry over a few therapy sessions to see if a patient's concerns resolve with a behavioral intervention alone before referring a patient for psychiatric and medication evaluation.

Other Practice Changes Related to Successful Open Access Implementation

Provider organizations instituted a variety of changes in clinic practices that accompanied and facilitated the successful implementation of open access. For the CHCs, these changes included a broad acceptance of fully integrated primary care and mental health and the adoption of brief, solution-focused interventions by their behavioral health clinicians for most patients receiving behavioral health care.

Provider organizations that incorporated evidence-based brief treatment models into their practices found that they were able to close more cases when their patients met treatment goals, thereby increasing the availability of clinicians to serve more new patients.

Another significant practice innovation is the concurrent or collaborative documentation model for documenting care in a patient's clinical record. In this practice, the clinician prepares progress notes, with patient input, during a session.²⁷ Organizations that use concurrent documentation report improvements in patient engagement in their care and subsequent reductions in no-show and canceled appointments.²⁸ This practice can also have a financial benefit by increasing clinician productivity while increasing access for new patients seeking care.

These changes in clinician roles did create some challenges for provider organizations, as some clinicians view traditional individual therapy as their preferred treatment modality and resist the adoption of other approaches such as brief, solution-focused therapy. Provider organizations that only practice a brief treatment model may not offer a suitable

treatment environment for these clinicians. One CHC that previously offered only brief therapy has increased the array of treatment modalities offered by its behavioral health clinicians to meet the needs of its patients and staff and increase staff satisfaction and retention.

Implementing Open Access During the Transition to Telehealth

The COVID-19 pandemic quickly changed the environment for providing behavioral health services in Massachusetts, as elsewhere. Most provider organizations halted face-to-face services, including walk-in intakes, due to public health restrictions and social distancing requirements implemented at the onset of the pandemic. Though they experienced a steep decline in demand for services during the early days of the pandemic, health care organizations, including behavioral health centers, quickly pivoted to telehealth, facilitated by increased flexibility in federal and state reimbursement requirements. As behavioral health concerns increased in the general population over the past year, most provider organizations interviewed reported that service levels had generally returned to pre-pandemic levels.

Some organizations struggled to maintain open access as their practices transformed into a telehealth model. While Massachusetts expanded access to behavioral health care through telehealth for MassHealth members in February 2019, remote technology was adopted only slowly until the official announcement of the public health emergency in March 2020 closed all clinics to in-person visits and created an immediate need to implement telehealth. Because most providers had little experience with telehealth prior to the pandemic and had envisioned their open access as walk-in services, many initially did not think about how to translate their open access model to a same-day telehealth appointment.

While some organizations stopped providing open access to services, others sought to maintain their ability to provide timely access to both intakes for new patients and ongoing care for existing patients using telehealth. Often displaying remarkable ingenuity and creativity, most of the organizations interviewed adapted their practices so that when an individual called to seek care, front desk staff collected necessary information and arranged for a clinician to call the patient on the same or the next day to conduct a telehealth assessment. Several organizations resumed walk-in services by providing rooms at their clinics for patients to connect by telehealth or videoconference with an intake clinician working remotely from home.

The Commonwealth has implemented policies to ensure that as the pandemic recedes or ends, telehealth will remain a standard method of care. It will be important for all provider organizations that seek to provide open access to incorporate telehealth into their processes for same-day access. This may require some additional technical assistance and training for providers and patients, as well as investments in increasing broadband at provider organizations. In addition, it may be necessary for providers to offer access to mobile hotspots for patients who may not have broadband or data plans that allow them to participate in telehealth, possibly through the grant awarded by the Federal Communications Commission to the Massachusetts Federally Qualified Health Center (FQHC) Telehealth Consortium in 2021.²⁹

Providers noted that many of their patients did not have access to computers, smart phones, or data plans that allowed them to access HIPAA-compliant video platforms.³⁰ Recent Massachusetts law allows telebehavioral health to be conducted by phone,³¹ but in the long term, some patients may benefit from expanded access to video telehealth technology.

KEY CONSIDERATIONS AND POLICIES TO ENCOURAGE OPEN ACCESS AND ACCESS TO BEHAVIORAL HEALTH SERVICES

Behavioral Health Workforce Capacity, Reimbursement Rates, and Types

While open access to first appointments is an important goal, having a robust workforce to maintain timely access to ongoing care is essential for that initial open access to lead to overall access to care. The underlying factor that must be

resolved to make behavioral health services broadly available when needed—through open access as well as other models of care delivery—is to increase the behavioral health workforce. Moreover, it’s imperative to enhance the diversity of the behavioral health workforce to ensure that culturally, racially, and ethnically diverse providers are available to meet the needs of all residents.

Generally speaking, there are a few different models for paying behavioral health clinicians in Massachusetts. Behavioral health clinicians may be employed by a health care or behavioral health care organization with their pay largely tied to insurance-based reimbursement for services provided, or they may practice independently and be paid through insurance-based reimbursements and/or through private pay (seeing patients who are willing to pay for services out of pocket).

Across these models, with the exception of private pay, a persistent challenge is the reimbursement rate for behavioral health services and the resulting compensation for clinicians. It was the consensus of the organizations interviewed that current outpatient reimbursement rates in MassHealth (Massachusetts’ Medicaid program) and commercial insurance plans are insufficient to attract and retain a salaried full-time clinical staff necessary to meet the demand for services. Additionally, several organizations noted that moving from traditional fee-for-service reimbursement to other payment methodologies, such as bundled payments, case rates, or prospective payment, could give staff the flexibility to provide both open access and ongoing care. It merits noting that among providers not accepting insurance, reimbursement rates are a key factor driving that decision.³² Addressing rates and types of payments for behavioral health services will be critical to enabling timely access to behavioral health services. In addition, policymakers may want to consider initiatives or regulations that strongly promote acceptance of insurance, including MassHealth, by clinicians in their private practices.

Payer Policies

In addition to the underlying workforce challenges highlighted above that are tied to rates and types of payment for behavioral health services, all interviewees also flagged a particular payer policy that hinders access to behavioral health services and an organization’s ability to leverage its staff as part of the open access model. To provide some context, many types of staff can provide behavioral health services, including, for example, licensed mental health counselors, licensed alcohol and drug counselors, licensed social workers, licensed independent social workers, and psychologists. Generally speaking, reimbursement is tied to clinician type. All of these clinician types spend a period between obtaining a master’s degree in the field and licensure, during which the clinician is required to take part in supervised clinician field experience and direct client contact.³³ MassHealth will reimburse for these services that clinicians provide before licensure if they do so at a clinic and under the supervision of a licensed clinician. However, some insurers do not reimburse for these services. These “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.

All interviewees agreed that payer policies that require the assessing or treating clinician be an independently licensed clinician, rather than a master’s-level clinician working under the supervision of a licensed clinician, limits the availability of open access for patients with these plans. To eliminate this barrier, all health plans could adopt a policy to cover services provided by a pre-licensed clinician under the supervision of a licensed clinician within a licensed health facility. Alternatively, a legislative mandate that required all payers to follow this policy would also eliminate this barrier.

Clinic Size

The size of a clinic, regardless of the size of the overall organization, appears to play a role in the successful implementation of open access models.

Clinics with larger clinical staff and greater administrative resources, including front desk personnel, can offer open access during all clinic hours of operation, generate consistent and predictable patient flow, and achieve administrative efficiencies and economies of scale. Smaller clinics tend to have more difficulty with open access, because with only a

few clinicians at a location and fewer potential new patients, they cannot guarantee that a clinician will be available at any time a walk-in client arrives.

Organizations with smaller clinics contemplating implementing open access should analyze the variation in the daily number of new patients, typical availability in their clinical staff's schedule, and the capacity of clinical supervisors to conduct intakes when needed. Some smaller clinics may find the projected number of intakes fits within their staff capacity, while others may find that operating an open access model will not be feasible without additional funding to cover the costs of an intake clinician and administrative support.

Payers may consider whether the goal of increasing access to behavioral health in all service settings would warrant additional funding that could make providing open access more feasible for smaller providers, or whether it makes sense to focus open access efforts on larger clinics where the economies of scale make the model more financially feasible for provider organizations.

CONCLUSION

During the interviews conducted for this project, many behavioral health providers expressed strong support for open access, as did policy and program officials and behavioral health advocacy organizations. Provider organizations that have embraced open access have found that implementing open access to behavioral health not only improves the clinical experience of their patients but also improves most organizations' financial stability.

This study highlights that while barriers to implementing open access remain, there are also state health policies under development that may help address them. For example, the EOHHS Roadmap for Behavioral Health Reform initiative includes the creation of a new type of provider called a Community Behavioral Health Center, which will be required to offer same-day access to services.³⁴ Additionally, MassHealth will provide increased payment to other behavioral health providers that offer rapid access and urgent care, and it will invest in the Bridge Clinic model, which delivers rapid, lower-barrier access to medication and therapy to treat SUD.³⁵ These are important steps toward supporting greater adoption of open access models for behavioral health care services and helping providers now using them to maintain them.

Without timely access to behavioral health care, individuals and families in Massachusetts struggle to find care, allowing untreated mental illness or substance use to escalate and ultimately resulting in crises and emergency room care. As the Commonwealth focuses on reforming the behavioral health care system, supporting open access to behavioral health care is a key component of providing access to care when people need it the most. Open access can also improve the long-term performance and stability of the behavioral health system in Massachusetts and, more importantly, the lives of Massachusetts residents who live with mental health and substance use disorders.

APPENDIX A: SURVEY TOOL

Survey Terms and Definitions

This survey uses the terms *same-day* and *walk-in* behavioral health services, to describe a variety of open access practices in outpatient settings. *Same-day* refers to the practice of regularly scheduling appointments on the same day that someone calls a clinic or other provider. *Walk-in* refers to the practice of having planned hours where people who walk into a clinic unannounced can receive services. The types of care in open access models vary and for purposes of the survey include any combination of intake and assessment, individual therapy or counseling, group therapy, medication management or medication groups, and other treatment services.

For purposes of the survey, *behavioral health* refers to mental health and/or substance use disorder services.

1. Organization Name:
2. Has your organization ever offered same-day or walk-in (i.e., open access) behavioral health services?
[Required Question: If answer is no, survey is complete]
 - ☐ Yes—Currently Offer
 - ☐ Yes—Previously Offered *[after comment, logic goes to contact information page]*
 - ☐ No—Never Offered *[End Survey]*

If you have stopped offering same-day or walk-in services, when did you provide these services, and why did you stop? *[100-character comment field]*

3. How many service locations offering behavioral health services does your organization have?
 - ☐ One
 - ☐ 2–5
 - ☐ 6–10
 - ☐ More than 10
4. How many locations in your organization offer same-day and/or walk-in behavioral health services?
 - ☐ One
 - ☐ Two
 - ☐ Three
 - ☐ Four
 - ☐ Five or more

5. Please tell us the size of the service locations that offer same-day and/or walk-in behavioral health services:

(Size is defined as the average number of TOTAL intake appointments a month, including both same-day and/or walk-in, as well as intakes through standard scheduled appointments, including telehealth and in-person)

Check all that apply if you have multiple locations offering same-day and/or walk-in behavioral health services.

- ☐ Small (0–25 Intakes a Month)
- ☐ Medium (26–75 Intakes a Month)
- ☐ Large (More than 75 Intakes a Month)

6. What types of disorders do you assess and/or treat through walk-in and/or same-day appointments?
(Check all that apply, selecting both if you assess/treat co-occurring disorders.)

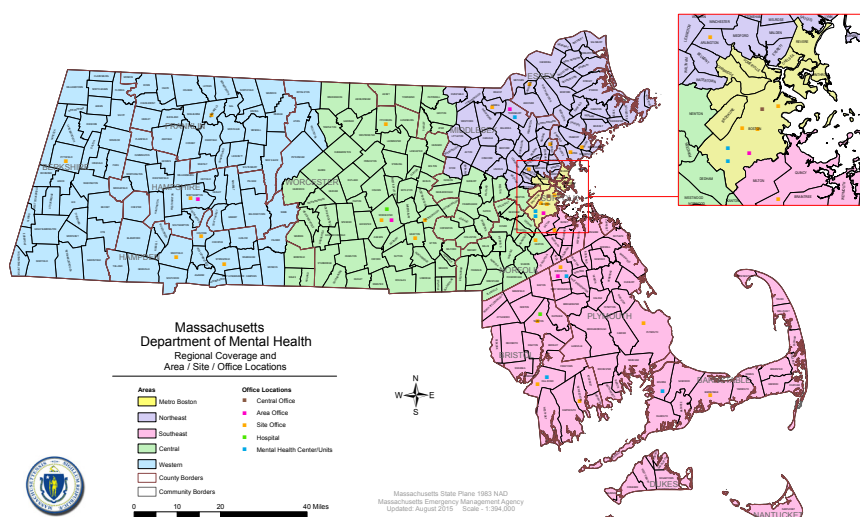
- ☐ Mental Health Disorders
- ☐ Substance Use Disorders

7. What types of same-day and/or walk-in services do you offer? (Check all that apply.)

- ☐ Intake/assessment
- ☐ Individual therapy/counseling
- ☐ Group therapy
- ☐ Individual medication management
- ☐ Medication groups
- ☐ Other: Specify

8. In which Department of Mental Health regions do you offer same-day and/or walk-in services?
(Check all that apply.)

- ☐ Metro Boston
- ☐ Northeast
- ☐ Southeast
- ☐ Central
- ☐ West



9. For which age groups do you offer same-day and/or walk-in services? (Check all that apply.)

- ☐ Children (0–12)
- ☐ Adolescents (13–17)
- ☐ Transition Age (16–25)
- ☐ Adults (18–64)
- ☐ Seniors (65+)

10. Does your clinic have a specialty focus on any specific populations?

- ☐ No
- ☐ Yes

If yes, please describe: _____

11. Can you roughly estimate the percent of your patient caseload that is Commercial Insurance/Medicaid/MassHealth/Medicare/Private/Self-Pay?

- ☐ Yes—see estimates below
- ☐ Data is not immediately available, skip question 12

12. Please provide a rough estimate of the payer mix of patient caseload:

___ % Commercial

___ % Medicaid/MassHealth

___ % Medicare

___ % Private/Self pay

13. Are you willing to participate in a phone interview to discuss your same-day and/or walk-in behavioral health services for a Blue Cross Blue Shield of Massachusetts Foundation report on this subject?

☐ Yes

☐ No

14. One goal of the study is to produce a series of case studies that document the experiences of organizations providing same-day and/or walk-in behavioral health services. Would you consider having your organization participate in an in-depth case study for this report?

☐ Yes

☐ No

☐ Not sure—need more information

15. Please provide contact information

Name:

Phone Number:

E-mail:

APPENDIX B: SURVEY RESULTS

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.

A high proportion of survey respondents offer or previously offered open access to services:

- 61% (17) currently offer same-day access (one of these did not answer other survey questions).
- 29% (8) indicated that they had previously offered same-day access.
 - Of these, 50% (4) stopped doing so due to the pandemic.
- 11% (3) indicated that they had never offered open access.

The provider organizations that reported currently offering open access to services represent a mix of those with a single open access clinic site and those that offer open access at multiple site locations:

- 44% (7) offer open access services at one service location.
- 31% (5) offer open access services at between two to four service locations.
- 25% (4) offer open access services at five or more service locations.

Respondents represent a range of organizational sizes. Among respondents who currently offer same-day access:

- 50% (8) offer services in small clinics (defined as fewer than 25 intakes per month).
- 44% (7) offer services in medium clinics (26–75 intakes per month).
- 19% (3) offer services in large clinics (more than 75 intakes per month).

(The total exceeds 100%, reflecting that several respondents operate multiple clinics of different sizes.)

The most frequently cited services available through same-day access were intake and assessment. Both substance use disorder services and mental health treatment are available at the provider organizations offering open access: Fourteen of the 16 respondents currently offering open access provide both mental health and substance use services through their open access service locations. The other two provide only mental health services through open access. Respondents that provide same-day access to services represent all regions of the Commonwealth.

The provider organizations that had previously offered open access indicated these reasons for discontinuing the practice:

- Four indicated they stopped due to COVID-19 restrictions and the move to telehealth.
- Three reported that there was insufficient patient volume during their open access hours to support the staffing level necessary.
- One indicated that open access intakes did not reduce its waitlists.

APPENDIX C: SEMI-STRUCTURED INTERVIEW GUIDE

INTERVIEW QUESTIONS

Background

1. Give us some background on your organization: a brief history, service area, corporate affiliations, if any, etc.
Probe: particular populations of focus or programs that are particularly prominent, key focuses, or sources of pride for them?

Operations

1. Please describe each location/setting in which you provide open access. For each location that is included in this interview:
 - a. How long has open access been practiced at this location?
 - b. Who is the target population? (Provide a general profile of those served in terms of gender, age, language spoken, ethnic or racial makeup, socioeconomic status indicators, such as insurance type of clientele, and any other relevant population characteristic).
 - c. What is the size of your clinic location? (Note: We want “best guess” estimates at the time of the interview. We will follow up for specific data with clinics that will be the subject of case studies).
 - i) Average monthly intakes [For BH—if integrated site for all these questions]
 - ii) Estimated active number of clients
 - iii) Estimated number of clients served in one year
 - iv) Estimated Number of FTE prescribers (MD, PA, and NP)
 - v) Estimated Number of FTE therapists
 - vi) Estimated Number of FTE nurses (RN and LPN)
 - a. What services are provided at this clinic location? For example,
 - i) Mental health outpatient (individual, couples, family) therapy
 - ii) Substance use outpatient (individual, couples, family) therapy
 - iii) Co-occurring MH/SUD (individual, couples, family) therapy
 - iv) Intensive outpatient (MH and/or SUD)
 - v) Specialized modalities such as DBT, art therapy, yoga, etc.
 - vi) Psychotropic medication prescribing (including medication groups)
 - vii) Medication-assisted treatments (e.g., Suboxone, Naltrexone) (including groups)
 - viii) Other services

Open Access—Beliefs and Motivations for Implementation

1. What were the reasons your organization adopted open access?
2. What is your general belief about how open access has helped your organization?
3. What have been some of the challenges for you in implementing open access?
4. Do you recommend that providers adopt open access, if they don't have it now?
5. Do you think open access will be taken up by more MA providers? Be eliminated by providers? Or stay about the same?
6. What do you think the “state of open access” will be in 3–5 years?
7. Are there other techniques/approaches/practices that your organization uses, or plans to use, that would reduce or eliminate the need for open access?

If the organization stopped offering open access...

1. Why did you stop offering open access?
2. Would you consider offering this service in the future? What would have to change in order for you to consider offering this service again? (i.e., change in payment structure, continued policy changes, etc.)

Finances

1. What impact, if any, has open access had on the clinic's financial performance?
 - a. Does open access increase, reduce, or have no impact on revenue? Can you give us any data, such as revenue from intakes before and with open access? Overall clinic net revenue (after expenses) for open access sites vs. non-open access sites?
 - b. How does open access affect staff productivity? Front Desk/registration, intake clinicians, other clinicians? Are there any other efficiency metrics related to open access?
2. Do any payers provide financial incentives for open access? If so, which ones and what are the parameters?

COVID-19

Organizations still providing open access services...

1. How is your organization continuing to provide open access during the pandemic?
2. Tell us about the role of technology in adaptation to COVID-19. Has your organization purchased/utilized any software and/or hardware to facilitate virtual communication, particularly to facilitate open access services?
3. How has service delivery been affected and how have these effects varied by clinic location or target population?
4. Have HIPAA/42 CFR presented any obstacles in providing telehealth services?
5. Have payers loosened their rules concerning telehealth billing during this time and, if so, how have these changes affected open access? Please tell us if there have been any other notable changes to payers' rules for billing, authorizations, service delivery, etc.
6. Do you plan to expand, reduce, or eliminate open access in the foreseeable future? How does Covid-19 affect your planning regarding open access; for example, its financial feasibility during the pandemic?
7. Do you think that telehealth will continue to expand after Covid-19, and if so, what impact if any will that have on open access?

Organizations that have discontinued open access...

1. Do you have plans to resume services? Does your organization plan to purchase/utilize any software and/or hardware to facilitate virtual communication, particularly to facilitate open access services?
2. What obstacles/challenges did you face in adjusting to virtual services?
3. Do you plan to expand, reduce, or eliminate open access in the foreseeable future? How does Covid-19 affect your planning regarding open access; for example, its financial feasibility during the pandemic?
4. Do you think that telehealth will continue to expand after Covid-19 and, if so, what impact if any will that have on open access?

Client Satisfaction and Outcomes

1. Have you surveyed clients regarding their satisfaction with open access services? If so, what feedback have they given?
2. Are there any aspects of open access that either enhance or detract from the client's treatment experience?
3. What anecdotal information have you gotten from staff or clients regarding client satisfaction with open access, especially as it pertains to hard-to-reach populations?
4. Have the number of clinic visits increased since implementing open access (more clients/more visits per client)?
5. How has open access affected clients in measurable terms vs. traditional intake/service provision? For example, "connect-to-care" rates from intake to first therapy appointment.
6. Have you measured any other client outcomes for clients who have participated in open access vs. traditional service delivery? For example, engagement in treatment as measured by treatment completion vs. ATA, number of therapy sessions, no-show/cancellation rates, etc.
7. Are clients engaging in more sessions? If so, do you attribute this to the availability of open access or to another reason?

Staff Satisfaction

1. How does staff feel about the open access scheduling model?
 - a. If you were at your organization when open access was implemented, what was staff morale in response to this change? Did this require a change in culture?
2. Are there particular staffing challenges that this model presents either for individuals or organizationally from an operations perspective?

Open Access Policy Recommendations

1. What recommendations do you have for changes on a policy level, such as changes in regulations, funding policies or legislation that would facilitate open access?
[Probe if the interviewee offers specifics]
 - a. Which authorities do you think would be involved, e.g., DPH, DMH, BSAS, MassHealth, Medicaid carve-outs, other third-party payers, etc.?
 - b. Recommendations that would require new legislation?
 - c. Which changes should be permanent (after the immediate COVID-19 crisis ends)?

ENDNOTES

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