

THE OFFICE OF
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LT. GOVERNOR KIMBERLEY DRISCOLL

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Secretary of the Executive Office
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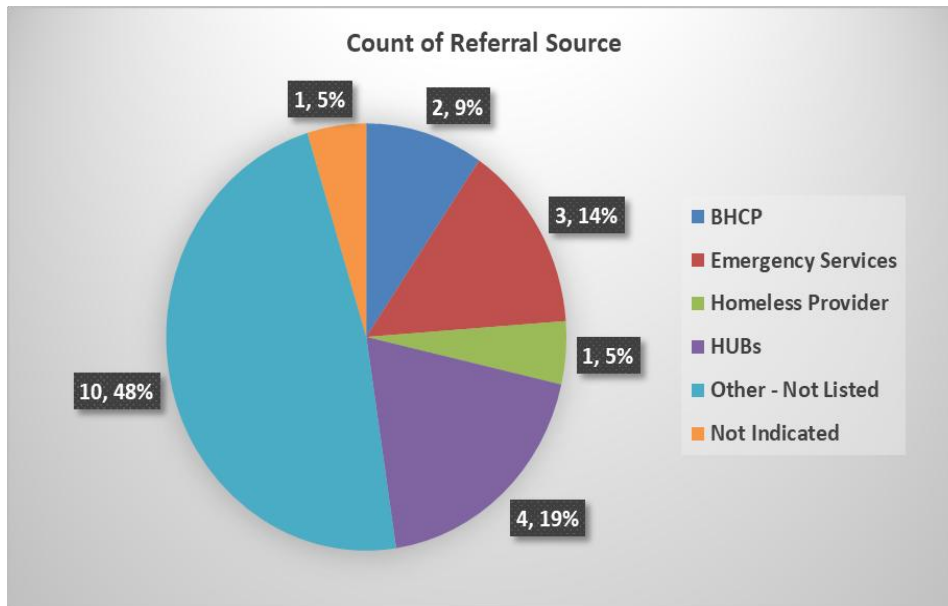
Emily Bailey
Commissioner

Enhanced Outpatient Treatment Pilot
Fiscal Year 2025

March 2025

Enhanced Outpatient Treatment

The Department of Mental Health's (DMH) Enhanced Outpatient Treatment (EOT) program focuses on providing assertive community outreach, engagement and support to the most under-served behavioral health population in the greater Metro North area. The Eliot EOT team is multidisciplinary and includes a Clinical Coordinator (LMHC), a Nurse Practitioner (PMNHP), Case Managers (BA) and a certified Recovery Coach. EOT referrals are not insurance based, which frees the team from potential fee-based restrictions, utilization demands and limitation on referrals to the program. In turn, this allows team members to focus on consistent engagement based on an individual's personalized needs, and their motivation and readiness for change. This low threshold approach to enrollment allows police departments, community mental health collaboratives (HUBs) and traditional providers struggling to support and engage clients to refer to EOT. In fact, of the 19 new admissions to EOT this past year, 19% were referred by police departments or HUBs and 48% were referred directly by community providers. In 2023 the average length a client was active in EOT by discharge was approximately .64 years or 7.8 months.



Of the individuals served, 52% experienced a dual diagnosis of trauma related and substance abuse disorders, resulting in compounding needs including:

- Homelessness and unstable housing;
- Mental health acuity resulting in reliance on Emergency Services and Emergency Departments;
- Current or past involvement with the criminal justice system;
- Disengagement and lack of health providers and health care;
- Poor social determinants of health; and
- Loss of community and natural supports.

This target population demonstrates a great need for services; yet traditional behavioral health treatment that would reduce stress, experience of symptoms and reliance on emergency-based services are not

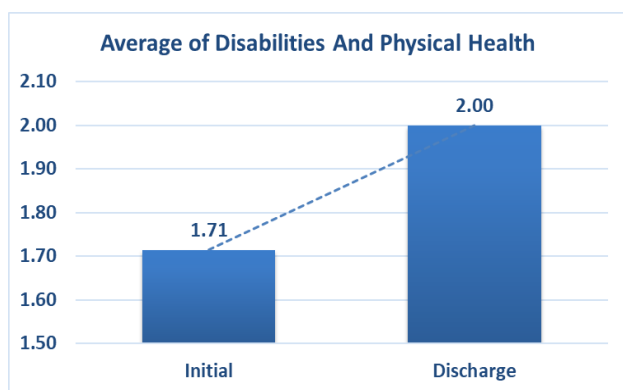
effective at promoting engagement. This population often needs immediate access to treatment services and community supports due to struggles navigating the behavioral health and larger health system. Even with the implementation of Accountable Care Organizations (ACOs), Behavioral Health Community Partners (BH CPs), and Community Behavioral Health Centers (CBHC) we have seen that this population struggles to engage with care coordination teams. This includes difficulty maintaining appointments with their Primary Care Physicians (PCPs), assigned ACO's, BH CP and OneCare care coordinators. There is a primary difficulty in the target population engaging with these entities at the start services, greatly limiting any outcomes in treatment planning and intervention. The EOT team has focused on creating partnerships with care coordination entities as a means to increase EOT individuals access to care.

The team outreaches and engages clients in the community, at their homes, or wherever they are to ensure services are provided. Engagement is the core strategy to deliver services and includes:

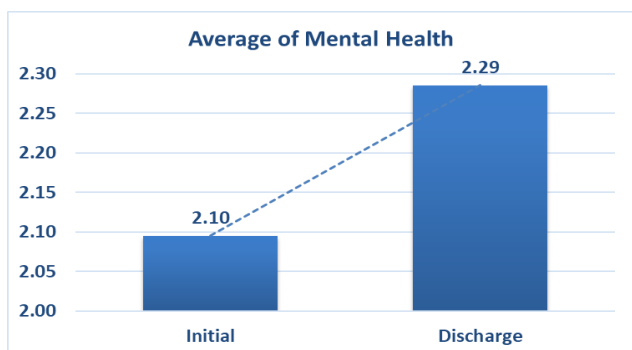
- In person outreach with consistent in-person follow up;
- Transportation and transportation assistance with app services, such as Uber and Lyft ;
- Assistance with accessing stable food and housing resources;
- Immediate and in time addiction services including recovery coaching and Medication Assistance Treatment; and
- Support and advocacy within the criminal justice system through frequent HUB meetings.

The EOT team's engagement strategies and approach to each individual has resulted in improving the services and supports available to each individual serviced. Compared to admission, EOT clients have seen up to a 90% increase in accessing benefits, including Food Stamps, SSDI, SSI, EAEDC, and Rep Payee services.

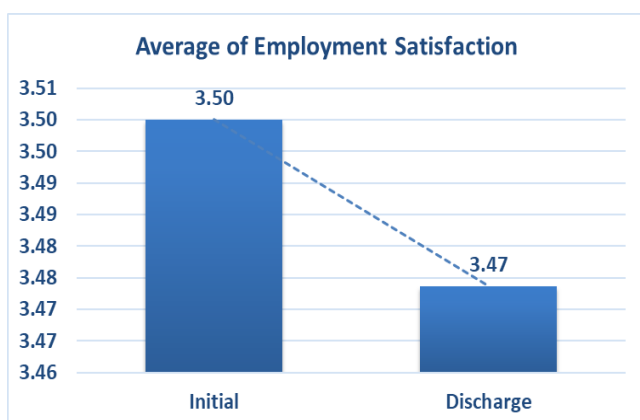
The following includes information about service outcomes that were derived from an outcome tracking measure that Eliot developed. EOT staff administer the outcomes measure directly with clients at 6-month intervals. The responses are based on a scale from 1 to 5, with 1 being in crisis and 5 as thriving. (Tool is attached for review).



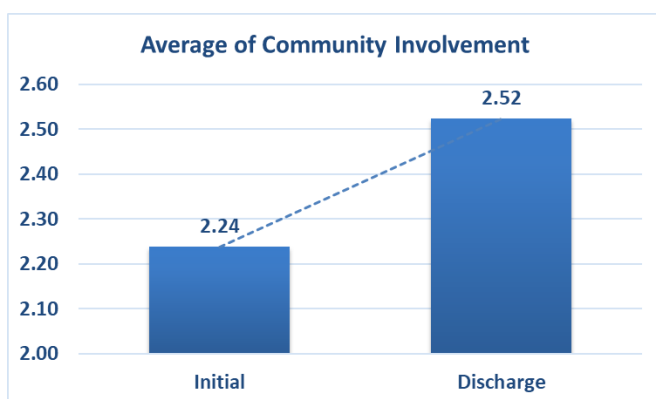
At admission, most clients identified being in crisis and acute or chronic symptoms were affecting housing, employment, social interactions, etc. Upon discharge, clients identified as feeling safer and that their concerns with medical needs were no longer affecting housing, employment, and social interactions.



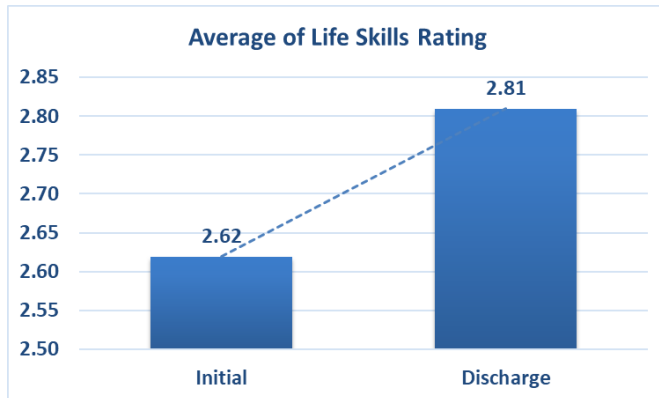
At admission, most clients identified that they were a danger to themselves or others, experienced recurring suicidal ideation, and/or were experiencing severe difficulties in their day-to-day life due to their mental health. Upon discharge, clients identified as having built greater coping capacity and having more consistent treatment with mental health providers.



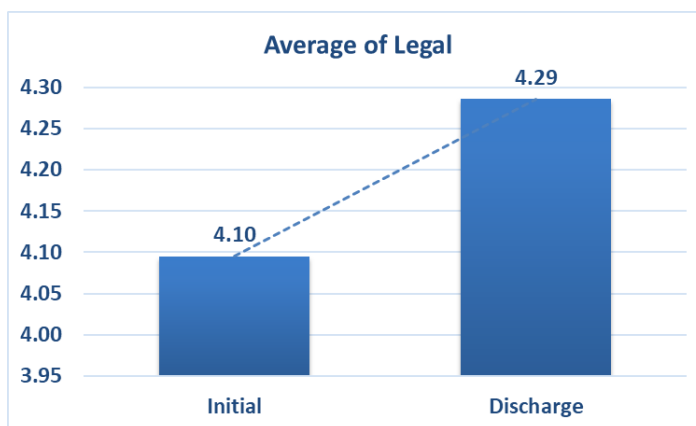
At admission, the comorbidities and socioeconomic impacts limited improved employment or fulfillment with employment. Upon discharge, most were employed full-time with adequate pay and benefits and feeling satisfied. Over the past year Eliot's EOT team has been looking into new ways to connect clients to employment rehabilitation and professional development or job training resources.



At admission, most clients identified being closer to crisis level, meaning they did not have community involvement due to being in "survival mode." Upon discharge, clients identified as having improved social skills and motivation to engage with their community.

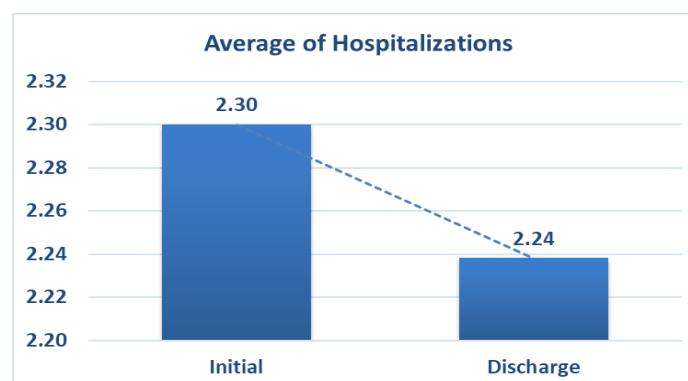


At admission, most clients identified being in crisis level, meaning that they were unable to complete any basic life skills without assistance. Upon discharge, clients identified as being able to complete between 2 and 3 skills without assistance.



At admission many EOT clients identify having legal status. This is often due to untreated SMI, homelessness, poverty and lack of natural supports. At discharge clients reported an improvement in their legal status due to accessing supportive resources through the EOT program.

EOT client hospitalizations have shown a decrease compared to ER utilization prior to admission in the program:



Over the past seven years, EOT has seen an increase in the number of entities referring individuals for service and the number of individuals we have served on an annual basis. Additionally, since 2018, EOT has been able to partner with BH CP, ACOs, and OneCare providers to leverage and coordinate services. The Eliot EOT program is also working closely with our CBHC programs in Lynn and Danvers, which connects the client to team-based care that provides multidisciplinary CSC intervention. This is in addition to stepping down EOT clients to a lower level of care in the general outpatient clinics within Eliot in Everett or Concord, when appropriate.

19 clients were enrolled in 2024, which is consistent with enrollment numbers in recent years, and there continues to be remarkable outcomes from the team's hard work. For example, EOT worked extensively with a client who was referred by Eliot's Jail Diversion clinician in the Everett Police department. This individual had complex needs and poor engagement due to untreated psychosis and homelessness and struggles with executive functioning. The client had long-term homelessness when he was referred to EOT, untreated Schizophrenia and substance use. The client also had medical problems that were not being addressed even with multiple emergency room admissions where there was minimal follow up care. He had significant loss in his hierarchy of needs, was malnourished, and sleeping outside with lack of natural supports. The EOT team time worked collaboratively with DMH to expedite an application for services and connected him to additional external resources to develop a workable treatment plan. After a lot of work with community partners and internal mental health treatment, the EOT team was able to engage with the client, connect him to medical care and get him housing support and services through the Eliot homelessness division.

EOT has been able to maintain a high percentage of face-to-face contact with individuals served. During 2024, over 70% of EOT's services were provided face-to-face. As clients begin to stabilize and needs are met, they often decrease contact from daily to multiple times weekly, weekly, and down to biweekly as aftercare services are determined. In addition, as the EOT team often helps clients increase access to affordable technology or phone services, some telehealth intervention and interactions take place as a client starts to meet outcome goals. In 2024, 80% of clients who were discharged, were discharged successfully. Successful discharges were most typically stepped down to outpatient services or were discharged to more long-term outreach services once stabilized, which including CBHC, BHCP, OneCare, DMH, Mystic Valley Elder Services and PCPs.

Eliot Community Human Services, Inc.
eHana EOT Outcomes Tracking Tool

EOT Outcomes Tracking

Home ▾

1. Document

This

2. Signoff

Employee:	McCabe, Jennifer
Case:	Test Client, Zack (Nickname?) (DOB: 01/01/1960) Admitted 2/1/2020 to EOT-Everett
Event:	4/4/2022
Review Type:	Initial
Review For:	
Referral Source:	
Is the person affiliated with or receiving services from any of the following:	☐ DMH ☐ DDS ☐ One Care ☐ PT1/Ride Services ☐ Other Specify... ☐ MRC ☐ BHCP ☐ ACO/MCO ☐ Elder Services ☐ SHIP
	All None
What benefits does the person receive:	☐ TAFDC ☐ Other Specify... ☐ SSDI ☐ Food Stamps ☐ Disability ☐ Veterans Benefits ☐ Rep Payee ☐ SSI ☐ Child Support ☐ EAEDC
	All None
How many hospitalizations and/or institutional stays (detox, medical, psych, etc.) did the person have in the year PRIOR to admission to EOT:	
For Periodic/Discharge Updates Only: How many hospitalizations and/or institutional stays (detox, medical, psych, etc.) has the person had in the last 6 months while engaging with EOT:	

Please review the following and indicate how the person rates in each area.

Medical/Physical Health/Symptom Management

Medical/Physical Health/Symptom Management	Rating
Connected to a PCP	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Connected to Medical Specialists	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Decreased Frequency of Medical Hospitalizations	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Regularly attending Medical Appointments	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Consistently Obtaining Medications	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Consistently Taking Medications as Prescribed	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed

Disabilities and Physical Health

- ☐ 1: In Crisis: acute or chronic symptoms currently affecting housing, employment, social interactions, etc.
- ☐ 2: Vulnerable: sometimes or periodically has acute or chronic symptoms affecting housing, employment, social interactions, etc.
- ☐ 3: Safe: rarely has acute or chronic symptoms affecting housing, employment, social interactions, etc.
- ☐ 4: Building Capacity: asymptomatic - condition controlled by services or medication
- ☐ 5: Thriving: no identified disabilities

▼ **Psychiatric Presentation/Symptom Management**

Psychiatric Presentation/Symptom Management	Rating
Connected with a Therapist	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Engaging in Therapy	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Connected with a Psychiatrist	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Attending Psychiatrist Appointments	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed

▼ **Mental Health**

- ☐ 1: In Crisis: Danger to self or others; recurring suicidal ideation; experiencing severe difficulty in day-to-day life due to mental health problems
- ☐ 2: Vulnerable: Recurrent mental health symptoms that may affect behavior, but not a danger to self/others; persistent problems with functioning due to mental health symptoms
- ☐ 3: Safe: Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health problems
- ☐ 4: Building Capacity: Minimal symptoms that are acceptable responses to life stressors; only slight impairment in functioning
- ☐ 5: Empowered: Symptoms are absent or rare; good or superior functioning in wide range of activities; no more than everyday problems or concerns

▼ **Substance Use/Abuse**

Substance Use/Abuse	Rating
Engaging with Recovery Coach	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Connected with Medication Assisted Treatment (MAT)	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Regularly attending NA/AA/SMART Recovery Meetings	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Achieved Sobriety	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Achieved Intermittent Sobriety/Decreased Use	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed

Please indicate where the individual is in relation to the Stages of Change:

☐ N/A

☐ Precontemplative

☐ Contemplative

☐ Preparation

☐ Action

☐ Maintenance

☐ Relapse

▼ **Housing**

Housing	Rating
Submitted Housing Applications	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Access to Hygienic Living Conditions	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Achieved Temporary Housing	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Achieved Long-Term Housing	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed

▼ **Housing Status**

- ☐ 1: In Crisis: Homeless or threatened with eviction
- ☐ 2: Vulnerable: In transitional, temporary or substandard housing; and/or current rent/mortgage payment is unaffordable (over 30% of total income)
- ☐ 3: Safe: In stable housing that is safe, adequate subsidized housing
- ☐ 4: Building Capacity: Household is safe, adequate subsidized housing
- ☐ 5: Empowered: Household is safe, adequate unsubsidized housing

▼ **Legal Issues/Concerns**

Legal Issues/Concerns	Rating
Connected with a Lawyer	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Adhering to Probation Parameters	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Following Through with Court Obligations	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed

▼ Legal

- ☐ 1: In Crisis: Current outstanding warrants
- ☐ 2: Vulnerable: Current charges/trial pending, noncompliance with probation/parole
- ☐ 3: Safe: Fully compliant with probation/parole terms
- ☐ 4: Building Capacity: Has successfully completed probation/parole within past 12 months, no new charges filed
- ☐ 5: Empowered: No active criminal justice involvement in more than 12 months and/or no felony criminal history

▼ Community Resources

Community Resources	Rating
Connected with Appropriate Cultural Resources	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Connected with Appropriate Religious Resources	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Connected with Community Centers	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Connected with Appropriate Coalitions	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Connected to Hobbies/Sports	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed

▼ Community Involvement

- ☐ 1: In Crisis: Not applicable due to crisis situation; in "survival" mode
- ☐ 2: Vulnerable: Socially isolated and/or no social skills and/or lacks motivation to become involved
- ☐ 3: Safe: Lacks knowledge of ways to become involved
- ☐ 4: Building Capacity: Some community involvement (advisory group, support group) but has barriers such as transportation, childcare issues)
- ☐ 5: Empowered: Actively involved in community

▼ Risk Factors/Concerns

Risk Factors/Concerns	Rating
Using Crisis Lines/Service Appropriately	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Connected to Domestic Violence Resources	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed

▼ Life Skills

Life Skills Options	Rating
Achieving ADLs	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Connected to Services to Support ADLs	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Learned Budgeting/Appropriate Money Management Habits	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Appropriately Advocating for Self	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Learned Time-Management Skills	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Learned Technology Skills	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Learned Problem Solving Skills	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed

▼ Life Skills Rating

- ☐ 1: In Crisis: Unable to meet basic needs such as hygiene, food, activities of daily living
- ☐ 2: Vulnerable: Can meet a few but not all needs of daily living without assistance
- ☐ 3: Safe: Can meet most but not all daily living needs without assistance
- ☐ 4: Building Capacity: Able to meet all basic needs of daily living without assistance
- ☐ 5: Empowered: Able to provide basic needs of daily living for self and family

▼ Employment

Employment	Rating
Searching for a Job	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Volunteering	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Working Part Time	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed
Working Full Time	☐ N/A ☐ Declined ☐ In Progress/Ongoing ☐ Completed ☐ Not Completed

▼ Satisfaction

Rate your/the person's satisfaction with their employment status

- ☐ 1: Not At All
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10: Full Satisfied
- ☐ Declined to answer