



Benefit Design Initiative



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Services



Charge for Benefit Design

- To design a benefit package and financing methodology for community-based mental health services

Goals of Benefit Design

Better Define:

- who we serve
- what services we offer
- how service utilization is managed
- price we will pay for a service
- outcomes - individual and system

Evidenced-Based Practice

- Services and programs based upon scientific advances are not routinely available to meet the needs of individuals who have mental illness.
- Mental Health: A Report of the Surgeon General, 1999.

Process

- Literature Review
- Consensus Conference
 - Judith Cooke
 - Charlie Rapp
 - Debra Ott
 - Dr. Solomon
 - Gary Bond
 - Bob Drake
 - Dr. Bellack

Local Experts

- Mary Gerlach - Lubbock Regional MHMR
- Phyliss Gudarian - Hill Country MHMR
- Sonia Gains - Tarrant Co. MHMR
- Gary Fox - Texas Panhandle MHMR

Service Package 1

- Eligibility
 - Any diagnosis
 - TRAG scores
- Services
 - TIMA - 12 visits per year
 - Consumer and Family Support - 1.5 to 3 hours per year
 - Case Coordination - 6 hours per year

Service Package 2

- Eligibility
 - Major Depression without Psychosis
 - GAF under 50
 - TRAG
- Services
 - TIMA- same
 - Consumer and Family Education - same
 - Case Coordination - same
 - Psychotherapy - 20 sessions

Service Package 3

- Eligibility
 - Schizophrenia and related Disorders
 - Bi-Polar Disorder
 - Major Depressive Disorder with psychotic features and a GAF of 50 or less
 - TRAG
- Services
 - TIMA - same
 - Rehabilitative Case Management 7.5 hours per month (Supported Housing and COPSD also)
 - Specialty Services Supported Employment

Service Package 4

- Eligibility
 - Schizophrenia
 - Bi-polar Disorder
 - 2 or more hospitalizations in 180 days or 4 in 2 years
- Services
 - TIMA
 - ACT - 10 hours per month

Rehabilitative Case Manager (CM)

Functions

- Central point of responsibility for developing and carrying out treatment plan (tp), in partnership with client
- Conducts assessments, evaluates tp outcomes, revises tp accordingly
- Ensures consumer's access to housing, medication, benefits/entitlements, avoidance of rehospitaliation + CJ involvement
- Engages in skills training in individual and small groups
- Links consumer to peer supports, self help, and natural supports
- Refers consumer to specialist team members
- Coordinates with family per consumer preferences
- Provides on-going support for PSR goals once attained

Supported Employment (SE) Specialist

- Provides job finding assistance, assistance making an initial adjustment on the job, assistance developing strategies for job retention with CM.
- CM provides follow along after stability on the job.
- Provides consultation and SE training to other team members.
- Person stays on the CM caseload as well.
- Average amount of combined service (CM and SE) per month: 10

Service Package 3 Assumptions

- Individual caseload carried
- Provides some small group services (limit 8 persons)
- Recipients average 7 hours of rehabilitative case management per month



Clinical Override

- If clinical needs justify services outside the guidelines, override may be requested



• • • **Adult-TRAG Dimensions for Assessment**

- I. Risk of Harm**
- II. Support Needs**
- III. Psychiatric-Related Hospitalizations**
- IV. Functional Impairment**
- V. Employment Problems**
- VI. Housing Instability**
- VII. Co-Occurring Substance Use**
- VIII. Criminal Justice Involvement**
- IX. Response to Medication Treatment for
Major Depressive Disorder**



Outcomes

- Adults

- ACCESS
- QUALITY
- BEST VALUE
- CRIMINAL JUSTICE INVOLVEMENT
- FUNCTIONING
- SYMPTOMATOLOGY
- HOSPITALIZATIONS
- EMPLOYMENT
- HOMELESSNESS
- DUAL DIAGNOSIS
- CONSUMER SATISFACTION

- Children

- ACCESS
- QUALITY
- BEST VALUE
- JUVENILE JUSTICE INVOLVEMENT
- FUNCTIONING
- SYMPTOMATOLOGY
- HOSPITALIZATIONS
- CONSUMER SATISFACTION



Other Benefits

- Crisis Services
- Rental Assistance
- Transportation



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Cognitive-behavioral therapy (CBT) has been extensively studied and is considered an empirically-validated treatment for MDD. Over 50 randomized, controlled trials have demonstrated that CBT is an effective treatment when compared to medication or wait-list controls. There is compelling evidence that CBT is as effective as treatment with antidepressant medication

(Elkin, et al, 1989; Murphy, Simons, Wetzel & Lustman, 1984; Rush, Beck, Kovacs, & Hollon, 1977; Scott, Tacchi, Jones, & Scott, 1997; Thompson, Coon, Gallagher-Thompson, Sommer, & Koin, 2001

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One possible benefit to CBT over medication is that it appears to have some long-term superiority in relapse prevention. This finding has occurred in the long-term follow-up of acute treatment with CBT versus medication (Simons, Murphy, Levine, & Wetzel, 1986). In addition, CBT may be beneficial for those individuals who have been treated adequately with antidepressant medication but continue to experience residual symptoms. Many individuals who receive acute treatment for their depression are left with residual symptoms. These residual symptoms have been found to be associated with increased risk for relapse (Paykel, Ramana, Cooper, Hayhurst, Kerr, Barocka, 1995; Faravelli, Abonetti, Palanti, & Pazzagli, 1986). Studies investigating the impact of CBT to treat residual symptoms following acute treatment of depression have fairly consistently found CBT to have some advantage in relapse prevention over medication management (Fava, Grandi, Zielezny, Canestrari, & Morphy, 1994; Fava, Grandi, Zielezny, Rafanelli, & Canestrari, 1996; Fava, Rafanelli, Grandi, Conti, Belluardo, 1998; Paykel, et al., 1999). Several studies have also shown that CBT has value in preventing relapse when provided in the maintenance phase of treatment (Jarret, et al., 1998; Teasdale, Segal, Williams, Ridgeway, Soulsby, & Lau, 2000). Overall, cognitive-behavioral therapy is an important component of a system of care serving adults with major depressive disorder, and is particularly important in a system that primarily serves individuals with recurrent forms of the illness

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...first-line treatment for most people with depression today consists of antidepressant medication, psychotherapy, or the combination (Potter et al., 1991; Depression Guideline Panel, 1993).

Mental Health: A Report of the Surgeon General

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In outpatient clinical trials, about 50 to 70 percent of depressed patients who complete treatment respond to either antidepressants or psychotherapies (Depression Guideline Panel, 1993).

Mental Health: A Report of the Surgeon General