RESPITE CHALLENGE

Presented to the Children's Behavioral Health Executive Leadership Team (ELT) by the Statewide Family Youth System Partner Round Table (FYSPRT)

Description of the Challenge

At the August 8, 2017, Statewide FYSPRT meeting, the following information was gathered from the Regional FYSPRTs and state system partners regarding the availability of respite across Washington.

Respite is currently accessed through Children's Administration (CA) and Developmental Disabilities Administration (DDA). Within CA, respite is offered to caregivers; including licensed foster parents, unlicensed relative caregivers, suitable other placements, and in some cases, biological parents when the child/youth is a state dependent. Respite is offered as a way to stabilize a placement, give time, space, and rest to the child/youth and caregiver, or when the caregiver requests it for various reasons. Respite is offered through DDA when a DD waiver is accessed and the amount of hours is dependent on the need for services. Respite can be offered through an agency, in-home, in a child-care setting, and in the community.

At the Statewide FYSPRT, Great Rivers Regional FYSPRT brought forward a challenge around an ongoing need for respite services to support children, youth and their families when difficult behaviors increase. Regional FYSPRTs expressed that respite is a significant need in most areas. Greater Columbia, Pierce/Optum, North Central, Thurston/Mason, North Sound, Southwest, Salish, and Great Rivers Regional FYSPRTs report having no formal access to respite. Some of these regions report that families have access to respite through DDA if the child/youth qualifies for a waiver program or through CA if the child/youth is dependent, however there is a lack of respite resources in rural areas even through CA and DDA. These regions report that most often, the only forms of respite utilized are through natural supports. Challenges include the identification of homes available for respite even within DDA and CA, the cost of respite with no way to pay for it if it is not accessed through those agencies, and rigid guidelines and paperwork needed in order to access it within those systems. Identification of people (natural supports) to provide respite is often a challenge.

In Spokane there are two agencies who provide respite up to 48 hours per month. Youth Family Adult Connections and Crisis Residential Centers provide the respite. This respite must be planned and is only available for children 10-18 years of age. Respite is paid for by sales tax dollars and not funded through Medicaid. It is accessed through the Spokane Behavioral Health Organization. Salish has adequate access to respite in Kitsap and Jefferson Counties through CCS and Korean Woman's Services, but is based on receiving service as a DDA client. Although respite can be offered through DDA and paid to a caregiver, families report that caregivers are difficult to find and not unique and creative to meet a child/youth and family's need. In general, there are limitations of respite for behavioral health (mental health and substance use).

Solutions Tried:

- Great Rivers is developing a regional clinical stabilization team under their crisis redesign.
- Greater Columbia is currently creating volunteer respite groups that are family driven, looking at using space at an empty hospital.

- North Sound offers a senior respite program for caregivers through Senior Services of Snohomish County through a voucher.
- Thurston/Mason will provide "informal activities" with children and youth in order to offer some type of hourly respite for the family.
- Through Crisis Stabilization Services within Oak Grove and Oak Bridge (Lower Columbia), a youth can call to access respite.
- Wraparound with Intensive Services (WISe) providers continue to build up natural supports within Child and Family Teams for respite, utilizing relatives, family friends, and child care. This sometimes consists of overnight respite or a few hours so that the parents and the child/youth can have a break.

Possible Solutions to challenges:

- Develop a statewide registry to access respite care and services.
- Form a facility and train staff where families can access respite for up to 72 hours.
- Support respite providers to come to the home so family/caregivers can go to appointments, take a break, etc.
- Case aids to provide in home support.

Desired outcome(s):

- Breaks for families to reduce stress and support recovery.
- Child/youth being kept in home without outside placement.
- Promote stability within the home.
- Reduce child abuse and neglect.
- Reduce burnout for caregivers.
- Reduce inpatient hospitalization.

Recommendations from the Statewide FYSPRT

Options for Consideration from the Statewide FYSPRT outlined below were presented by the Statewide FYSPRT Tri-Leads at the October 11, 2017, Children's Behavioral Health Executive Leadership Team (ELT) meeting

Option 1: Work on State Plan to include respite offered through behavioral health, much like personal care and nursing is currently offered through Health Care Authority.

> **Pros:** Keeping child/youth in-home without needing to access outside placement.
>
> **Cons:** A new request for respite may affect funding for other programs (Children's Administration/Developmental Disabilities Administration).
>
> **Potential outcomes:** Respite accessed for children/youth receiving outpatient behavioral health services [mental health, substance use, and Wraparound with Intensive Services (WISe)].

Option 2: Offer additional support to informal and natural supports through Child and Family Teams.

> **Pros:** Keeping child/youth in-home without needing to access outside placement and child/youth has a relationship with or is familiar with natural support respite provider.
>
> **Cons:** No outside respite to access when informal/natural supports are not available.
>
> **Potential outcomes:** Increase in identified natural supports for families.

Response from the Children's Behavioral Health Executive Leadership Team

This respite challenge, with information from the Statewide FYSPRT membership, has been beneficial for highlighting the need for respite services offered through behavioral health across the state. The details of this briefing form have been shared with the Children's Behavioral Health Unit at the Division of Behavioral Health and Recovery (DBHR) and with the Children's Behavioral Health Executive Leadership Team (ELT) to bring more awareness and details from the Regional FYSPRTs and State Partners around this challenge. Below is a more detailed response to the two options presented by the Statewide FYSPRT to the ELT.

***Historical information about respite services in Washington**: Respite services were provided through Medicaid as part of the 1915(b)(3) Waiver through July 1, 2012 when this waiver was terminated, due to Legislative action and proposed budget cuts. The waiver allowed the state to use Medicaid for respite services. Although the waiver was terminated, it did not require that Regional Support Networks (RSNs) now Behavioral Health Organizations (BHOs/Integrated Managed Care Regions (IMCs) stop providing respite services and that depending on the availability of other funds, RSNs, now BHOs/IMCs may be able to continue to provide these types of services. This would be dependent on the needs in their communities and their expenditure plans for state or block grant funding as submitted to and approved by the Division of Behavioral Health and Recovery.*

ELT Response to Option 1 recommended by the Statewide FYSPRT

- A State Plan amendment is not something the state will pursue at this time. This decision was based on the following information and challenges.
    - Adjusting the State Plan requires an extensive amendment process that would take approximately 9–18 months. An amendment process would need to include stakeholder collaboration around a specific definition of the service, ensuring the service can be provided statewide, development of a decision package, a public comment process, tribal consultation and time for the Centers for Medicare and Medicaid Services to ask questions and provide a response. An amendment to the State Plan would also require additional funding and workforce availability to establish the service for all ages and in all counties across the state. Providers would need to be behavioral health professionals and the service must be an active form of treatment for Medicaid to pay for it.
    - Additional considerations:
        - The budget cycle has passed for this year.
        - Adding respite to the State Plan makes it an entitlement under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) which changes the way Developmental Disabilities and Children's Administration waivers for respite like services can be offered.
        - Washington is currently experiencing a workforce shortage for services already included in the State Plan that are affecting WISe implementation and behavioral health services across the state.

- Next Steps:
  - Regional FYSPRTs - Regional FYSPRTs have the ability to coordinate with individuals in their regions to impact their local systems. With transitions to fully integrated care continuing across Washington this brings a unique opportunity to impact change. Talking with BHOs for what might be possible now or with MCOs/ASOs about what might be possible during future transitions could affect respite services regionally.
  - Division of Behavioral Health and Recovery – DBHR Leadership will have a dialogue with BHO Administrators and MCO/ASO Administrators about the respite challenge brought forward by the Statewide FYSPRT to bring awareness to the challenge.

ELT Response to Option 2 recommended by the Statewide FYSPRT

- Behavioral Health Organizations and Managed Care Organizations are currently using the Plan Do Study Act (PDSA) method to explore strategies to increase natural and informal supports on Child and Family Teams.
- The Executive Leadership Team also encourages continued exploration of resources or programs at the Regional or community levels.

Additional Potential Options from the Children's Behavioral Health Executive Leadership Team:

- Grant opportunities
  - DBHR will continue to monitor grant announcements from Substance Abuse and Mental Health Services Administration (SAMHSA) and when appropriate, include proposal to fund and implement this level of care.
  - Counties and communities can also monitor the SAMHSA website and other community resources for grant announcements and funding opportunities at https://www.samhsa.gov/grants.
- With many changes across multiple layers of the system, the Division of Behavioral Health and Recovery will continue this conversation with other state and local system partners such as:
  - Department of Early Learning (DEL) or the Department of Child Youth and Families (DCYF)
  - Office of Homeless Youth
  - Behavioral Health Organizations (BHO), Managed Care Organizations (MCO), and Behavioral Health Administrative Services Organizations (BH-ASO)
  - And others

The ELT also encourages these conversations to continue within the regions and in communities.