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The Use of Flexible Funds for Respite Services in a Managed Care Wraparound Program

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**Background:** Respite care has been identified as an important social support service for families of children with serious emotional disturbance (SED) (Stroul & Friedman, 1982). This service has been defined as “temporary care given to a disabled individual for the purpose of providing an interval of relief to the individual’s primary caregiver(s)” (Cohen, 1982, p.8). There are two major forms of respite. These are in-home, generally provided by a trained individual who comes into the home, and out-of-home, where respite may be provided in the home of another family or in a facility. To date, most of the literature around the use and efficacy of respite care has been focused on the developmental disability population. Specifically, a number of studies have demonstrated that respite results in a decrease in parental stress (Rimmerman, 1989; Chan & Sigafoos, 2001; Mullins, 2002). However, there is little research that focuses on children with emotional disabilities. Of the work in this area, literature has demonstrated that respite need is highest in children who are more functionally impaired, in younger children and in girls (Boothroyd, 1998; Trupin, 1991). In the only study examining efficacy in children with SED, respite care was shown to result in a reduction of caregiver personal strain and fewer incidents of out-of-home placement (Bruns and Burchard, 2000). Finally, there is little published research on the use of flexible funds to support services such as respite care for children with SED. Two studies have described the use of flexible funding dollars in providing supports for these children. The first study described “flex” dollars as being used for services such as respite care as part of a wraparound service program (Dollard, 1994). The other study, which examined child factors and “flex” spending concluded that a history of psychiatric hospitalization, but not other functioning and symptom factors, predicted flexible funds spending. This study did not look specifically at the use of flex dollars for respite care (Jenson, 2002).

**Objectives:** The goal of this study was to examine the use of flexible funding to support respite care as part of a wraparound service program for children with SED. The study utilized data collected during the evaluation of one such program to answer three specific questions:

1. What are the costs associated with these services on the program and individual client levels?
2. What types of respite programs are accessed with flexible funds (in-home vs. out of home)?
3. What is the relationship between child functioning/psychological symptoms and the use of respite services?
Methods: Data utilized for the study came from the evaluation portion of the Coordinated Family Focused Care Program (CFFC). CFFC is a five city pilot program initiated by the Commonwealth of Massachusetts. It is jointly funded by five public child serving agencies: the Department of Youth Services (DYS), the Department of Mental Health (DMH), the Department of Social Services (DSS), the Department of Education (DOE) and Medicaid. The program is managed by Massachusetts Behavioral Health Partnership (MBHP) which is the manager of the state’s Medicaid mental health benefit. The evaluation study, funded by the Center for Health Care Strategies, consists of administration of a number of standardized measures completed with the care providers, as well as through phone interviews with UMASS researchers. Furthermore, data is submitted by each provider for each client enrolled in CFFC. This data is compiled by MBHP and then provided electronically for evaluation purposes. All analyses were conducted using SPSS statistical software.

Subjects: There are 91 children in the present study. Subjects were included if they had been in the program for at least one year, had complete data for all variables and had consented for the overall program evaluation. Eligibility requirements for enrollment in CFFC (as well as the evaluation) include that the child:

- Is 3-18 years old (inclusive),
- Is Medicaid eligible,
- Has tried less restrictive services,
- Is at risk for residential or more restrictive placement,
- Attains a score of 100 or higher on the Child and Adolescent Functional Assessment Scale (CAFAS)(Hodges & Wong, 1996),
- Resides in one of the CFFC designated communities,
- Has a serious emotional disturbance.

Consent for participation in the study was obtained by the child’s care manager upon intake into services.

Measures: Data used for this study includes demographic information (e.g. gender, age), measures of service utilization (financial claims data) and information from standardized measures of child functioning (CAFAS) and psychological symptoms (Youth Outcome Questionnaire)(Burlingame, Wells & Lambert, 1996). The CAFAS is made up of 8 subscales each utilizing a 4-point scale scored in 10-point increments with higher scores indicating a higher level of impairment. The YOQ is made up of 6 subscales with higher scores indicating an increasing level of symptoms. Financial claims data was collected quarterly while the other measures were completed at intake. Specifically utilized in the study were flexible funds claims data categorized as Out-of-home respite (defined as respite, either crisis or planned, that occurs out of the home in a foster home, group home, or residential program, which is not otherwise paid for by insurance) and In-home and community supports (defined as including any 1:1, specialing or sitter services in the child’s home or a community setting).
**Results:** Of the 91 children meeting criteria for inclusion in the study group, 69 (76%) were male and 22 (24%) female. Additionally, 50 children (55%) were under 12 with the remainder between 12 and 18 years old. Also, the group was racially diverse with 36% identifying themselves as white, 29% as black, and 24% as hispanic.

**The costs associated with respite services:** During the study group's first 12 months in the program, a total amount of $162,426 was spent on respite care. The mean amount spent per child was $1784.90 with a range of $0-$18,621. Approximately 78% of children received respite care during this period.

**The types of respite care accessed:** Of the total amount of “flex” funds spent, 49% was spent on in-home respite while 2% was spent on out-of-home respite.

**The relationship between child functioning/psychological symptoms and respite use:** Analyses demonstrate that significantly more was spent on respite for females than males (p<.05). Additionally, analyses were conducted looking at DSM diagnosis as a predictor of respite spending. Of the children with recorded intake DSM Axis I diagnosis, Post Traumatic Stress Disorder (PTSD) was shown to correlate with a significantly higher amount spent on respite care (p=.006). Using regression analyses, predictors of respite spending were calculated over a child’s first year in the program. Three factors, score on the Somatic subscale of the YOQ, a diagnosis of PTSD, and a higher rating on the CAFAS Self Harm subscale, were significant (p<.01) and together accounted for 33% of the variance in respite spending. Beta weights indicated that each point on the Somatic YOQ related to an additional $199 of respite care, each 10 pints on the CAFAS Self Harm subscale corresponded to $597, and a diagnosis of PTSD related to $2443 spent on respite in the one-year period.

**Conclusion:** This study has served to broaden the research base regarding respite care in the SED population. First, the study has demonstrated a significantly larger need for respite than reported in the literature. Over their first year in the CFFC program, over 78% of children received respite care as compared to the 6.6% estimated need reported by Boothroyd (1998). Additionally, respite care accounted for half of the total program “flex” spending. Secondly, in-home respite was utilized far more often then out-of-home respite care. Lastly, we have identified several predictors of higher respite spending. These include PTSD, a higher level of somatic complaints, and higher ratings of self harm. There were a few limitations to the study that must be noted. First, financial data was used as a proxy for the amount of service utilized. This is significant as each of the five sites utilized different forms and providers of respite care and therefore different costs. If it were available, a factor such as the number of hours of respite care would have been a more valid measure. Also, the results of this study are only generalizable to children with SED, a high level of functional impairment, and from low-income families. Finally, the study does also suggest some areas for future research. The factors behind the increased use of respite care in children with a diagnosis of PTSD could be further explored. This could involve an analysis of the interaction of a trauma history with a child’s symptoms, behaviors, and family and why this results in a significant need for this specific family support.