

OTO Care Service Description

Definition

One-to-One or “Specialing” is a service funded by the Department of Children and Families that is designed to assist children and adolescents in the care or custody of the Department who are experiencing a behavioral or emotional crisis that cannot be addressed within existing staffing parameters in the congregate care setting in which they reside. The service is designed to help the identified youth address specific behavioral issues while assessing and managing safety/risk factors. One-to-One care provides constant observation of and interaction with the child by a designated staff member/professional to ensure the child’s safety, assess immediate risk factors and lend support and nurturance during a time of crisis. Unless clinically contraindicated, the staff member providing this service must be within two arms lengths of the youth at all times. One-to-one care may be utilized when a youth needs to go to an Emergency Department due to behavioral or medical crisis or when a youth's behavior becomes so disruptive in an RTC, group home or other congregate care settings (including SWETP, STAR homes, SFIT/SFIT Respite and other congregate care respites) that the youth or other residents are placed in jeopardy of physical harm.

The use of One-to-One care is for crisis management purposes, and as such, programs must evaluate its effectiveness in stabilizing the youth over a defined period of time. One- to- One care is not to be included as part of an ongoing treatment plan and is not to be used as a supplement for inadequate program staffing. Rather, an episode of one-to-one care is expected to produce outcomes related to the child's improved functioning. Following an episode of one-to-one care, the designated staff member should be able to provide information related to the child’s immediate mental status, identify services necessary to ameliorate the immediate emotional crisis, recommend changes/enhancements to the existing treatment plan and make suggestions for revisions within the environment/milieu that may support the child’s stability. Children on hospital inpatient units are not eligible to receive this service.

Authorization Process and Time Frame for Service:

This service requires prior approval requested by the facility seeking the service. The first one-to-one staffing authorization shall be for a maximum of seventy two (72) hours/288 units (15 minutes per unit), within a ten (10) day time period. Additional hours can be approved if sufficient clinical need is demonstrated and if sufficient progress toward a more permanent solution/intervention is in progress. It is the provider's responsibility to identify the individual(s) to be engaged in this activity and to ensure that he/she meets all training and background check requirements.

*Facilities seeking one-to one service for a child who is in the Emergency Department do **not** need to seek **prior** approval but do need to call in seeking routine approval within 24 hours or the next business day of the child's arrival at the ED.*

Service Criteria:

Children for whom this service is deemed appropriate are those who are in the care or custody of DCF, who are residing in a DCF funded congregate care setting and who are exhibiting emotional or behavioral challenges beyond the level routinely or historically exhibited and beyond the ability of the current staffing complement to manage. A known precipitant to the emotional distress may or may not be evident or identifiable.

Symptoms and functional impairment must include at least one of the following:

1. Severe, aggressive outbursts that place the child and/or others at risk for injury or
2. Imminent AWOL risk or
3. Self-injurious behavior or
4. Suicidal gestures/ideation within past thirty days, or
5. Problem sexual behavior that may jeopardize the safety of others or;
6. Worsening of disruptive, idiosyncratic behavior due to mental retardation or other developmental disability (not related to baseline), or
7. Child requires frequent monitoring and/or assistance due to medical condition

and meet ALL of the following criteria:

1. Less intensive and intrusive interventions have failed or been ruled out, (i.e., inability to maintain safety on 5 minute checks, inability to confine youth to open, supervised areas, etc.)
2. A plan is being aggressively developed or implemented to maximize use of psychosocial, psychiatric or pharmacologic interventions designed to address any underlying psychiatric, medical or behavioral conditions as appropriate;
3. The youth's level of emotional and behavioral distress is not so severe as to warrant admission to an inpatient unit:
4. A behavioral plan is operational or under development and includes measures and timeframes to transfer oversight of member back to program staff.

The provision of overnight one-to-one care is only appropriate when there is clear and recent evidence that the Member's risk is such that the use of frequent checks during bed time hours are inadequate to assure safety.

In addition to stabilizing a crisis, one-to-one care should be authorized when treatment staff are unable to maintain the youth's safety in a particular setting and no other more secure setting is available due to access issues, such as:

- Youth is boarding in ED, residential or lower LOC due to lack of inpatient bed availability.
- Youth is boarding in any ED prior to a disposition determination.

If the youth does not meet the clinical/behavioral criteria cited above, one-to one care may be authorized under the following circumstance:

- Youth has just become known to the Department through emergency removal from home or bench order from the court and is exhibiting behaviors that reflect the impact of serious emotional or physical trauma or other psychiatric concern that requires time to research, diagnose, and treat.
- Care authorized under this mitigating circumstance must follow the guidelines articulated above pertaining to **service** criteria. In addition, documented efforts must be made to obtain necessary medical and psychiatric records to provide a working diagnosis and develop an appropriate treatment plan.

Extended Authorization:

Additional hours may be obtained if the provider seeks additional authorization and if the following criteria are met:

1. The youth is demonstrating some behavioral control (i.e., progress is evident) but requires additional assist before left unattended **and**
 - a) There are plans to incorporate the behavioral intervention into a more permanent treatment plan/crisis intervention plan **or**
 - b) Referrals have been made to a more restrictive level of care (i.e., inpatient, Residential) and the youth is waiting availability of such; **or**

any demonstrable improvement with the

2. The youth's behavior has not shown assist of one-to-one care and while documented efforts to further diagnose or clinically intervene are underway, the youth's safety and the safety of others can only be maintained with the assist of one-to-one care.

For one-to-one services more than 72 hours, but less than one Month. In cases where one-to-one staffing for a child may be required for a period longer than seventy two (72) hours, but less than one month, Beacon staff will review and authorize duration and frequency.

For one-to-one services over one Month. In cases where one-to-one staffing for a child may be required for a period of 30 days or more, the Program will contact Beacon to provide clinical rationale. Beacon will register the service and provide clinical documentation to the Clinical Program Director, DCF Director of the CT Behavioral Health Partnership and DCF Fiscal Management for a specialized rate request and generation of rate letter.