CYCI

CHILD & YOUTH PSYCHIATRIC CONSULT PROJECT OF IOWA

Provider Handbook

100 Hawkins Drive
Iowa City, IA 52242

855-275-4444

August 2014

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HANDBOOK PURPOSE

This handbook serves a twofold purpose.

1. To clarify CYC-I policies for Primary Care Providers using the CYC-I service.

2. To familiarize stakeholders on the CYC-I project.

WHAT IS CYC-I?

The Child and Youth Psychiatric Consult Project of Iowa (CYC-I) is a service for Primary Care Providers (PCPs) caring for children and youth with mental and behavioral health needs.

The project consists of 4 components targeting the 0-21 population:

1. Psychiatric consultation between a Child Psychiatrist and PCP
2. Mental Health focused training for the PCP and staff
3. Care coordination/family support services for children and families
4. Internet based resources specific to the needs of PCP's and the families they care for www.cyc-i.org

Background and History

Numerous national reports recognize the importance of children's social and emotional development to overall health and well-being, school readiness, and academic success. A child's mental health is an intrinsic part of their overall health and well-being. At least one in 10 children—as many as 6 million youth—experience a mental illness that severely disrupts his or her daily functioning at home, in school, or in the community.[1] Another 16% of children have symptoms that do not rise to the level of a diagnosis but have some functional impairment, and another 9% have a mental health diagnosis without current functional impairment.[2] Fewer than 20% of these children receive mental health services in any given year.[3]

It is widely recognized, that mental health systems are not fully equipped to meet the holistic treatment needs of children, let alone implement mental health promotion and early identification efforts for this population. These systems are highly fragmented, under-resourced, and limited in scope[4] . Many reports have called for sweeping reforms to the mental health system, including services to children and their families.

It is well known and documented that there is a severe shortage of child and adolescent psychiatrists in the United States. A recent study estimated a national need for 30,000 child psychiatrists, but found only 6,300 in practice.[5] The state of Iowa is no exception as the study, with data from 2001, recorded a total of 35 child and adolescent psychiatrists in the state of Iowa. Efforts to increase the psychiatric workforce including enhanced recruitment and expansion of training for psychiatric subspecialty care are underway in Iowa, led in part by the University of Iowa and Iowa's Mental Health Consortium.

Children's primary care providers (PCPs) meet much of this need. For a number of years, PCP's have been the most frequent prescribers of psychotropic medications, accounting for 85% of all such medications prescribed to children in 1997.[6] Despite their critical role in identifying and treating psychosocial and mental health concerns, most primary care providers have relatively little preparation for such issues.

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[1] US Public Health Service. *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda.* Washington, DC: Dept of Health and Human Services; 2000. Available at: http://www.hhs.gov/surgeongeneral/topics/cmh/cmhreport.pdf August 23, 2007

[2] Burns BJ, Costello EJ, Angold A, et al. "Children's mental health service use across service sectors." Health Aff (Millwood), 1995;14(3):147-159

[3] Costello EJ, Angold A, Burns BJ, et al. The Great Smoky Mountains study of youth: functional impairment and serious emotional disturbance. *Archives of General Psychiatry*. 1996;53:137-1143

[4] The Collaborative for Academic, Social, and Emotional Learning (CASEL) is a national organization housed at the University of Illinois at Chicago that provides leadership, research, policy, and technical assistance to establish social and emotional learning as an essential part of education. www.casel.org; February 2, 2007

[5] C. R. Thomas and C. E. Holzer, "The Continuing Shortage of Child and Adolescent Psychiatrists," *Journal of the American Academy of Child and Adolescent Psychiatry*, Sept. 2006 45(9):1023–31.

[6] R. Goodwin, M. S. Gould, C. Blanco et al., "Prescription of Psychotropic Medications to Youths in Office-Based Practice," *Psychiatric Services,* Aug. 2001 52(8):1081–87.

Recognizing that the healthcare landscape is changing due to the formation of Accountable Care Organizations and continuous emphasis on whole person integrated care, PCP's have voiced a need for additional assistance to support them as they treat patients with mental health concerns. Family practice physicians and pediatricians located in Northeast Iowa completed a short informational survey regarding their comfort level and willingness to treat children/youth with psychosocial/behavioral/emotional issues. A total of 32 family and pediatric practices in Eastern Iowa were surveyed. The results indicated that knowledge and understanding of psychotropic medications is both needed and desired by clinicians. Of those who responded to the survey, 100% requested resources, educational opportunities, and psychiatric consultation time as options that would be most beneficial to them, and would assist them with their patient population.

Some respondents offered specific commentary on their capacity to treat mental health and behavioral issues in children/youth. The comments are as follows:

- *"I have concerns about committing kids to a diagnosis when it is not a high volume part of my practice. I feel very uneasy about potential long term treatment for a misdiagnosis."*
- *"It's certainly an area we feel especially ill prepared for. We end up doing a lot of prescribing to try to stabilize situations that blow up out here in the community and schools. It is extremely helpful to be able to talk to someone on the phone to get some ideas of where we should head. In short, we need all the things mentioned. It is probably the most underserved segment of our patient load and I especially feel helpless many times and probably under treat kids that could be helped if I weren't afraid of harming them with some of the meds."*
- *"Mostly we are interested in receiving CEU's for medications used to treat prevalent mental health disorders in children and information regarding psychotropic medication interactions with other meds."*
- *"I look at it this way, I am a pediatrician, but also credentialed to do surgery. I don't do surgery on a regular basis so I know I would not be very good at it. I feel psychiatric meds are similar since I don't use them often, I would not be good at it."*

The Child and Youth Psychiatric Consult Project of Iowa (CYC-I) was created in 2010 to assist Primary Care Providers (PCPs) caring for children and youth with mental and behavioral health needs. CYC-I was developed in partnership with community providers and Iowa's Title V program for Children and Youth with Special Health Care Needs, utilizing the expertise of University of Iowa Child Psychiatrists. It is an evidenced based child behavioral health consultation program, based on the Massachusetts Child Psychiatry Access Project (www.mcpap.com)

VISION

The Vision of the CYC-I project is to assure that children and youth with mental health needs receive timely, quality care within their medical home.

The Mission is to enhance the existing System of Care in Iowa, for children with serious emotional disturbance by increasing capacity among Primary Care Providers to treat children and youth, with mild to moderate emotional and/or behavioral challenges, within their medical home, providing continuity and local access to specialty care.

GOALS

The goals of the CYC-I program include the following:

- To support Primary Care Providers (PCPs) in managing the care of children and youth with mild to moderate mental and behavioral health needs, allowing the limited psychiatric resources to manage the care of the most complex and high risk children.
- Improve access to treatment for children and youth with mental and behavioral health needs through consultation services offered to PCPs in local area.
- To support PCPs in providing local resources, services, and care coordination to families in order to keep their children locally served and in their own homes and communities.
- To provide education and promote the use of appropriate mental health screening tools that can be used in the context of well-child care.
- To enhance relationships between PCP and Psychiatry to better serve common patients.
- To enhance confidence among PCPs in their expertise of assessing, diagnosing and managing those with mental health and behavioral concerns.
- To create familiarity among PCPs with the wide spectrum of community-based mental health services offered in private and public sectors.

CYC-I COMPONENTS

Psychiatric Consults

CYC-I offers consults between a University of Iowa Child Psychiatrist and a PCP. The Child Psychiatrist can provide information regarding a collaborative plan of care including information on preliminary assessment, treatment, and ongoing monitoring. Individually identifiable patient information is not discussed/provided during a psychiatric consult.

PCPs are required to answer a four question survey following each consult. The CYC-I Coordinator will send the survey to the PCP to complete and fax or email back.

Mental Health Focused Training for the PCP and staff

CYC-I offers training opportunities for participating PCPs developed and presented by University of Iowa staff including Child Psychiatrists and Psychologists. The focused trainings are designed to meet the needs of the PCP and the staff. Trainings might be delivered via several venues including phone conferencing, or internet webinar. Examples of courses taught may include common child mental health diagnosis, black box warnings and psychotropic drug use, and interactions with commonly used medications in children. Other trainings may include overviews of specific treatment interventions or services.

Internet Resources

CYC-I offers internet-based resources for Primary Care Providers including research articles, practice parameters, screening tools for early identification and other resource useful for PCPs. The PCP can access the resources via **www.cyc-i.org**

Care Coordination Services for Families

Care Coordination services can be requested by a PCP along with, or independent of a Psychiatric Consultation. Care Coordination will be directed by local CHSC Staff Nurse and may be implemented by a CHSC Nurse, Family Navigator, or Social Worker. The CYC-I Program Coordinator will connect the PCP with the local CHSC Staff member who can begin the Care Coordination process. Consent to Obtain and Consent to Release Information Forms signed by the legal guardian are required and must be faxed or sent to the local CHSC staff when Care Coordination services are delivered. See Appendix A & B for the consent forms.

Examples of Care Coordination activities the local CHSC staff can provide include:

- Finding, coordinating and promoting effective and efficient use of resources
- Assisting families in accessing therapy or counseling services
- Assisting families in navigating insurance, Medicaid or other financial assistance for health care
- Providing information and support to access local treatment interventions such as behavioral health intervention services and other in home and waiver services
- Providing educational information for the Individualized Education Plan (IEP) and or 504 plan
- Advocating with families as they work with their school, daycare, or health care provider
- Providing information and support regarding transition issues
- Assisting families in accessing camp information
- Linking families with other families for support
- Providing educational information and resources to the family on diagnosis, medications, school topics including IEPs, 504 plans, educational rights of the child, etc

INTAKE LINE

CYC-I Intake phone line: 855-275-4444

CYC-I Intake fax line: 641-782-9519

Three simple steps:

1. **Call** the Intake line and provide preliminary information. Providers may choose to fax the CYC-I Consult Request Form. See Appendix C for the CYC-I Consult Request Form and the preliminary information needed.
2. **Consult** is scheduled by phone with University of Iowa Child Psychiatrist.
3. **Care Coordination** is provided as needed.

Any provider staff can call the intake line to provide the preliminary information and request the telephone consult or request Care Coordination for a family. However, ***telephone consults are offered solely to the practitioner (Physician, ARNP or PA).***

The CYC-I intake line is available:

- **8:00-4:00 Monday - Thursdays** excluding holidays.
- Message can be left on the intake line at anytime.
- All messages will be returned as soon as possible.
- Messages left Thursdays after 3:00 through the weekend will be returned on the next business day.
- Messages left on holidays will be returned on the next business day.

PROVIDER ENROLLMENT

The CYC-I Project is being piloted in identified areas across Iowa where PCPs are managing the care of children and youth with mental and behavioral health concerns. To participate in the project, PCPs are asked to sign an agreement to ensure the PCP is knowledgeable about the project and the services it provides. See Appendix E to view the CYC-I Provider Agreement.

Enrolled Physicians, Advanced Registered Nurse Practitioners (ARNPs) and Physician Assistants (PAs) are invited to participate in the consultation component of the project. Any staff in the enrolled practice may participate in the focused training sessions, request care coordination services for a family and/ or access and utilize the resources on the CYC-I website.

The CYC-I project is offered to select geographic areas and is funded by Title V block grant funding. At this time, CYC-I does not submit for reimbursement to insurance for the service provided. We will gather outcomes data and share this information with stakeholders to demonstrate the benefits of the program and advocate for financial support and statewide expansion.

To enroll, simply call 855-275-4444.

DOCUMENTATION

Consent to Obtain and Consent to Release Information Forms

Consent to Obtain and Consent to Release Information forms signed by the legal guardian are required when Care Coordination services are delivered. The Consent to Obtain and Consent to Release Forms are to be faxed to the local CHSC which the Care Coordination is being provided. The CYC-I Coordinator will connect you with the appropriate local CHSC office. See Appendix A & B to view the consent forms.

Intake Information

CYC-I project requires the following information regarding the patient in order for the CYC-I Child Psychiatrist to consult with a PCP. Individually identifiable patient information should not be discussed/provided. The information can be provided to the CYC-I intake line or completed in the CYC-I Consult Request form and faxed to the CYC-I Coordinator. See Appendix C for the CYC-I Consult Request Form.

1. Name and address of requesting provider
2. Call back phone number and best time to reach the requesting provider
3. Patient's age
4. Patient's gender
5. Patient's weight
6. Reason for requesting the consult
7. Current Mental Health and Medical diagnosis's
8. General Question for Child Psychiatrist
9. Rating of complexity of child's care
10. Insurance type

CYC-I PROVICER SATISFACTION SURVEY

A brief survey will be completed by the PCP after each consult. This information is vital in our efforts to ensure we meet the Primary Care Provider's needs. We will also use this information as we approach stakeholders for support to sustain and expand the CYC-I project. See Appendix D for a sample of the CYC-I Satisfaction Survey.

APPENDIX A Hosp #_____

CONSENT TO OBTAIN INFORMATION

University of Iowa Hospitals and Clinics (UIHC)
Child Health Specialty Clinics (CHSC)
Please PRINT (except signatures) and provide complete answers/addresses in each section.

Patient Name: Birth Date:

I understand that by signing this form I am allowing CHSC and/or the University of Iowa Hospitals and Clinics (UIHC) to obtain information concerning the above patient from:

Person / Institution Name:
Address:
City, State, Zip:

Check the information to be disclosed (include dates where indicated): ☒ Minimum necessary or specify:

☐ Most recent discharge summary/evaluation report _____	☐ Most recent history and physical date _____	☐ Test results date _____
☐ Most recent education evaluation/report or specific date _____	☐ Consultation reports specific date _____	☐ Other (specify) anything pertaining to emotional or behavioral issues. ☐ Parent/Legal Guardian consents to the use of e-mail for communicating patient information to the specific agency/provider listed.

The reason for obtaining information is: ☐ transferring care ☐ other medical care ☐ personal file
☒ other (specify) care coordination _____

This authorization is voluntary and I may cancel this consent to obtain information at any time by sending written notice to Child Health Specialty Clinics _____. I understand that any release, which was made prior to my cancellation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized redisclosure and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Child Health Specialty Clinics at the above address.

I understand that CHSC/UIHC may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services.

I understand that the information to be released may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).

Substance Abuse _____ Mental Health _____ HIV-related information _____

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months)

_____
Signature of Patient or Legal Guardian Date

_____
Complete Mailing Address/Street/P.O. Box City, State, Zip Code

_____ _____
Relationship, if Not the Patient Witness Signature

UIHC use only: *Upon satisfying this release, date & sign, record on the Release of Information Tracking (ROIT) system and scan the form in to Epic.* ***If unable to satisfy this release or if unable to enter/scan this information on the ROIT system, forward to the Release of Information Office, Health Information Management (HIM) Department, 2 SRF, for processing.***

Info. sent: _____ Recorded on ROIT System: _____
Name/Dept. Date Name/Dept. Date

1/11

APPENDIX B

Hosp #_____

CONSENT TO RELEASE INFORMATION

University of Iowa Hospitals and Clinics (UIHC)
Child Health Specialty Clinics (CHSC)
Please PRINT (except signatures) and provide complete answers/addresses in each section.

Patient Name: Birth Date:

I understand that by signing this form I am allowing CHSC and/or the University of Iowa Hospitals and Clinics (UIHC) to release information concerning the above patient to:

Person / Institution Name Address City, State, Zip

Check the information to be disclosed (include dates where indicated): ☐ Minimum necessary or specify:

☐ Most recent discharge summary/evaluation report _____	☐ Most recent history and physical date _____	☐ Test results date _____
☐ Most recent education evaluation/report or specific date _____	☐ Consultation reports specific date _____	☐ Other (specify) anything pertaining to emotional or behavioral issues. ☐ Parent/Legal Guardian consents to the use of e-mail for communicating patient information to the specific agency/provider listed.

The reason for disclosing information is: ❒ moving out of area ❒ transferring care ❒ 2nd opinion ❒ other medical care

❒ personal file ❒ legal ❒ insurance ☒ other (specify) Care coordination _____

This authorization is voluntary and I may cancel this consent to release information at any time by sending written notice to Child Health Specialty Clinics _____. I understand that any release, which was made prior to my cancellation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized redisclosure and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Child Health Specialty Clinics at the above address.

I understand that UIHC may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services.

I understand that the information to be released may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).

Substance Abuse _____ Mental Health _____ HIV-related information _____

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months)

_____
Signature of Patient or Legal Guardian Date

_____
Complete Mailing Address/Street/P.O. Box City, State, Zip Code

_____ _____
Relationship, if Not the Patient Witness Signature

UIHC use only: *Upon satisfying this release, date & sign, record on the Release of Information Tracking (ROIT) system and scan the form in to Epic.* ***If unable to satisfy this release or if unable to enter/scan this information on the ROIT system, forward to the Release of Information Office, Health Information Management (HIM) Department, 2 SRF, for processing.***

Info. sent: _____ Recorded on ROIT System: _____
Name/Dept. Date Name/Dept. Date

1/11

Appendix C

CYC-I
CHILD & YOUTH PSYCHIATRIC CONSULT PROJECT OF IOWA

CYC-I CONSULT REQUEST FORM

Call this information into the Intake Line at 855-275-4444 *or fax the information to* 641-782-9519

Date:	Name of Person Providing information:	Name of Facility:
Clinician's Name:	Phone number to call clinician back:	Best time to reach clinician:

I want the provider survey sent to me via:

❒ FAX: Fax #_____ ❒ Email:_____

❒ Mail: Address_____

*Please **do not** include any other patient information other than what is request below unless a Consent to Release and Consent to Obtain form is signed by the patient's legal guardian and provided to CYC-I.*

Age _____ **Gender** _____ **Weight**_____

Indicate the reason you are requesting the consult. *Mark all that apply:*

❒ Screening question
❒ Diagnostic question
❒ Medication Management
❒ Multi-model treatment plan
❒ Increase confidence
❒ Care Coordination
❒ Resource Information
❒ Other _____
_____

Current Mental Health diagnosis('s) _____

Current Medical Diagnosis ('s) _____

State the general question you have for the Child Psychiatrist:

_____

_____

Rate the complexity of the patient's care you are requesting services for. *Mark all that apply:*

❒ Mild severity – single diagnosis, single medication
❒ Moderate severity – single diagnosis, multiple medications
❒ Significant severity – multiple diagnosis, multiple medications

❒ Mild psychosocial challenges requiring Care Coordination
❒ Moderate psychosocial challenges requiring Care Coordination
❒ Significant psychosocial challenges requiring Care Coordination

Insurance:

❒ BCBS
❒ HAWK-I
❒ Medicaid
❒ United Healthcare
❒ Wellmark
❒ Other_____

updated 2-17-2011

APPENDIX D

CYC-I PROVIDER SATISFACTION SURVEY

Thank you for taking a few minutes to complete this survey

We will use your responses to help us improve the services that we offer and to demonstrate to the potential payers whether this model has been helpful to the involved Primary Care Providers in serving children with mental and behavior health needs.

1) What was your reason(s) for using CYC-I Consult Line? *Check all that apply:*

- ☐ Screening question
- ☐ Diagnostic question
- ☐ Medication management
- ☐ Multi-model treatment plan
- ☐ Increase confidence
- ☐ Care Coordination
- ☐ Resource Information
- ☐ Other _____

2) Rate the complexity of the patient's plan of care. *Check all that apply:*

- ☐ Mild severity – single diagnosis, single medication
- ☐ Moderate severity – single diagnosis, multiple medications
- ☐ Significant severity – multiple diagnosis, multiple medications
- ☐ Mild psychosocial challenges requiring Care Coordination
- ☐ Moderate psychosocial challenges requiring Care Coordination
- ☐ Significant psychosocial challenges requiring Care Coordination

3) Use of the CYC-I consult result in the following: *Check all that apply:*

- ☐ I am able to continue to manage the patient's care plan in his/her medical home.
- ☐ I received assistance in transitioning this patient to a mental health provider to manage their care.
- ☐ I received assistance in hospitalizations for the patient.
- ☐ Improved coordination of care.
- ☐ Consultation was not found to be helpful.

4) In absence of CYC-I services, patient's outcome may have resulted in: *Check all that apply:*

- ☐ No impact to the patient or family.
- ☐ Referral to DHS.
- ☐ Patient's outcome continued to deteriorate.
- ☐ Transferred to a Mental Health provider.
- ☐ Directed to Emergency Department.
- ☐ Hospitalization.

Comments: _____

_____

Name : _____Practice _____

APPENDIX E

CYC-I PROVIDER AGREEMENT page 1

CYC-I
CHILD & YOUTH PSYCHIATRIC CONSULT PROJECT OF IOWA

100 Hawkins Drive Iowa City, Iowa 52242 -- Phone: 855-275-4444 -- Fax: 641-782-9519 -- www.cyc-i.org

Provider Group: _____

Practice Type : ___ Family Practice Physicians ___ ARNPs
___ Pediatricians ___ PAs

Address: _____

Phone/FAX: _____

Medical Director: _____

Office Manager: _____

List individual participating practitioner's names on page 2 of this form.

Estimated total number of patients in practice: _____ Estimated total number of children as patients: _____

Your practice accepts: **Iowa Medicaid Yes ___ No___**
HAWK-I Yes ___ No ___

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1. **We agree to participate in the Child and Youth Psychiatric Consult Project of Iowa.**
2. **We agree to participate in training at the beginning of the project and continuing education as needed during the project.**
3. **We agree to complete periodic satisfaction surveys.**
4. **We understand that the CYC-I Psychiatrist will not prescribe medications or assume care for patients discussed on a phone consult. The PCP will continue to manage the patient's care and prescribe medications.**

The undersigned represents that he/she has authority to bind the provider group to the terms herein.

Signed: _____ **Date:** _____

Title: _____

Printed Name: _____

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CYC-I PROVIDER AGREEMENT page 2

CYC-I
CHILD & YOUTH PSYCHIATRIC CONSULT PROJECT OF IOWA

Participating Practitioners:

Name:	**Email:**