JOURNAL OF THE NEW KANSAS CITY MEDICAL SOCIETY
THIRD QUARTER 2019

ADDRESSING RISING PATIENT MENTAL HEALTH CONCERNS

Current Issues in Mental Health Care
Integrating Behavioral Health in Primary Care
Mental Health Needs Rise Among KC Youth
Geriatric Psychiatry in the Continuum of Care
The Evolution of Mental Health Care in KC

FEATURES
Q&A with KCMS President Mark Brady, MD
Future Physicians Serve Community
Blue Valley Physical Therapy

4 LOCATIONS

K10 & Ridgeview
913-599-4600
F 913-599-4605

119th & Quivira
913-563-5500
F 913-563-5174

151st & Metcalf
913-897-1100
F 913-897-9696

Feel Better.
bluevalleypt.com

OVER 400 FIVE STAR GOOGLE REVIEWS

Don’t let pain or injury get in the way of your patients living their life to the fullest. Refer now so your patients can FEEL BETTER.
FROM THE Editor

04 Mental Health Maelstrom
SHORTAGE OF FUNDING FOR MENTAL HEALTH CARE IS COSTLY TO SOCIETY
By Michael L. O'Dell, MD, Editor, Kansas City Medicine

Editorially SPEAKING

06 In Praise of Artificial Intelligence
IT HAS GREAT POTENTIAL TO MAKE OUR LIVES BETTER AND OUR PATIENTS’ LIVES HEALTHIER. OR WILL IT BE ANOTHER EHR?
By Charles W. Van Way, III, MD, Editor Emeritus, Kansas City Medicine

News KCMS

03 HHS Official, Awards Highlight Annual Meeting

09 Physicians, Legislators Network at Social

Feature

10 Q&A with Mark D. Brady, MD, KCMS 2019 President
BRINGS EXTENSIVE EXPERIENCE IN ADVOCACY WORK

12 Future Physicians Serve Community
STUDENTS GAIN PERSPECTIVE ON NEEDS OF DIVERSE POPULATION, ORGANIZING COMMUNITY PROGRAMS

14 Prepare Now for 2020 CMS Appropriate Use Criteria Requirements
RULES APPLY TO CERTAIN OUTPATIENT IMAGING TESTS FOR MEDICARE PATIENTS
By David Smith, FACMPE

ON THE COVER: Three Kansas City-area physicians who are addressing rising patient mental health concerns on three fronts: Andrew Kerstein, DO, director of geriatric psychiatry at St. Joseph Medical Center; Sarah Soden, MD, division director of behavioral and developmental sciences at Children’s Mercy Kansas City; and William F. Gabrielli, Jr., MD, PhD, chair of the Department of Psychiatry and Behavioral Services at the University of Kansas Medical Center. See their comments in articles in the Mental Health special section of this issue of Kansas City Medicine.

The lime green background of the photo coincides with the lime green color of the depression awareness ribbon. October is Depression Awareness Month.

Special Section: MENTAL HEALTH

17 Patient Mental Health Concerns on the Rise

18 Current Issues in Mental Health Care
INTERVIEW WITH BEHAVIORAL HEALTH LEADERS OF THE UNIVERSITY OF KANSAS MEDICAL CENTER AND HEALTH SYSTEM

20 An Argument for Integrated Behavioral Health
JOINING BEHAVIORAL HEALTH WITH PRIMARY CARE IMPROVES ACCESS, QUALITY OF LIFE AND PROVIDER SATISFACTION
By Carlie Nikel, PsyD

23 Mental Health Needs Rising Among Kansas City-Area Youth
CHILDREN’S MERCY REPORT SHOWS STRIKING INCREASES IN DEPRESSION, ANXIETY AND OTHER CONCERNS

26 Johnson County Schools, Mental Health Center Launch Teen Suicide Prevention Campaign
Submitted by Johnson County Mental Health Center

28 Geriatric Psychiatry: A Step in the Continuum of Care
A REVIEW OF TREATMENTS FOR DEMENTIA AND OTHER CONDITIONS
By Andrew H. Kerstein, DO

31 The Science of Resilience
PROGRAM WORKS TO RAISE AWARENESS OF THE MENTAL HEALTH IMPACT OF TRAUMA
Submitted by Truman Medical Centers

32 The Evolution of Mental Health Care in Metro Kansas City
RESEARCH, EVALUATION AND EXPERIENCE HAVE LED TO BETTER TREATMENTS AND OUTCOMES
By Alan Flory

KANSAS CITY MEDICINE
GUEST SPEAKER
Vanila M. Singh, MD, MACM
CLINICAL ASSOCIATE PROFESSOR, ANESTHESIOLOGY, PERIOPERATIVE AND PAIN MEDICINE
STANFORD UNIVERSITY SCHOOL OF MEDICINE

Dr. Singh served as chief medical officer for the Office of the Assistant Secretary for Health, U.S. Department of Health & Human Services, from June 2017 through July 2019. During that time, she chaired a task force which presented a May 2019 report on acute and chronic pain management best practices.

BACK BY POPULAR DEMAND

WESLEY HAMILTON
Adaptive athlete and advocate for the disabled

Following up on his stellar appearance at the 2018 KCMS Annual Meeting, Wesley will discuss the impact of the social determinants of health in Kansas City.

PRESENTATION OF 2019 KCMS AWARDS

Lifetime Achievement Award - Charles B. Wheeler, MD
Former mayor, state senator and third-generation physician

Friend of Medicine Award - Rusty Ryan, PharmD
Longtime supporter of the KCMS Retired Physicians Group

MEMBERS AWARDS

Community Service Award - JayDoc Free Clinic
Innovation Award - Nathan Granger, MD, MBA
Patient & Community Advocate Award
Leland Graves, MD, and Peter DiPasco, MD
Rising Star Award - Carole Freiberger O’Keefe, DO
Exemplary Leadership Award - Mark Austenfeld, MD
Exemplary Leadership Award - James Vacek, MD

RESERVATIONS and INFORMATION
https://kcmedicine.org/annual-meeting
While reading the articles for this issue of *Kansas City Medicine*, I began to envision the terrible and powerful energy of untreated mental illness as a maelstrom. Energy capable of driving people deep into the depths. A downdraft that draws all near it into a spiraling descent.

Alan Flory provides a rich and intimate understanding of the waxing and waning of mental health services in the Kansas City area. In the late 1950s, hundreds of thousands of persons with mental illness were released from asylums into the community. There was an understanding that this was risky but important compassionate work, with funding provided to address community care of the newly freed, often in community mental health centers. The success of these centers was evident until funding became problematic. In addition, psychiatrists and other mental health workers came in short supply. Despite economist dogma, demand does not always drive supply. Demand accompanied by reimbursement drives supply. Those with untreated mental illness certainly need care; they just too often can’t pay for it.

Emergency departments have in recent history been the place where needed care is sought when it is not available elsewhere. The Emergency Medical Treatment & Labor Act (EMTALA) in 1986 codified this. The good intent of the EMTALA created a real-life Tragedy of the Commons.¹ Often our EDs are chaotic and crowded, yet those dealing with mental illness seek care in that environment as they have nowhere else to turn.

**Mental Health Maelstrom**

**SHORTAGE OF FUNDING FOR MENTAL HEALTH CARE COSTS SOCIETY DEARLY**

By Michael L. O’Dell, MD, MSHA, FAAFP, Editor, *Kansas City Medicine*

Those with untreated mental illness certainly need care; they just too often can’t pay for it.

Untreated mental illness is indeed a pull to the depths. Without treatment, many become unable to navigate employment, hold together relationships, or otherwise lead a stable life. Homelessness increases with untreated mental illness. Many estimate that over half of our incarcerated have mental illness.²

Maelstroms form from powerful opposing currents and obstacles. The opposing flows of the need for payment of the mental health workforce and the lack of funding for treatment create our mental health maelstrom. Our miserliness in financing psychiatric care ends up costing society dearly in lives lost and left damaged.

There are mitigating forces at work as well for persons with mental illness. The increasing integration of behavioral health into primary care offices permits early detection and treatment. Carlie Nikel’s article describes this approach. Dr. Gabrielli’s interview includes discussion of new drug therapy highlighting how available treatments are advancing quickly. Dr. Kerstein’s article describes specialized programs for elders. The piece on #ZeroReasonsWhy describes an early prevention program for teens. Both describe treatment that likely allows family caregivers the opportunity for employment and stabilization of the family.

Avoiding the maelstrom is generally the only way to escape being pulled into the depths. Where and however we can begin effective care for this population will keep them away from this vortex. It is encouraging to see so much work done well. But we recognize that a call to action for much more effort is needed.

Michael O’Dell, MD, MSHA, FAAFP, is chair of the Department of Community and Family Medicine at the University of Missouri-Kansas City School of Medicine, and associate chief medical officer for the Truman Medical Centers Lakewood campus. He can be reached at michael.odell@tmcmed.org.

**REFERENCES**


healthy vitals

ProAssurance has been monitoring risk and protecting healthcare industry professionals for more than 40 years, with key specialists on duty to diagnose complex risk exposures.

Work with a team that understands the importance of delivering flexible healthcare professional liability solutions.

ProAssurance
Treated Fairly

Healthcare Professional Liability Insurance & Risk Resource Services

When you are treated fairly you are confident in your coverage.
Artificial intelligence, usually known as AI, is definitely the New Big Thing. The media is flooding us with breathless accounts of the coming revolution in AI. AI will drive our cars, diagnose our ills, eliminate crime and bring peace to the Middle East and the U.S. Congress. Well, the last two may be too much to ask. The latest twist is quantum computing. Nobody is very sure how that works, but everyone who writes about it just knows that it will revolutionize computers and societies.

Why are we so eager to embrace AI? One might argue that we need artificial intelligence because there’s so little of the real thing around us. That’s a very defensible viewpoint. Especially lately. As the century wears on, perhaps they will call this the Stupid Decade. We can hope that subsequent decades won’t be more stupid. That would be too awful to contemplate.

And health care? There is much to anticipate. The future looks bright. AI will read our X-rays. No more waiting on a radiologist! AI will diagnose skin lesions. No more waiting to see a dermatologist! Patients will talk to a computer, get a couple of cost-effective diagnostic tests and out will come a diagnosis. Or maybe two or three diagnoses, at which point the doctor will get to have some input. Pick one of these three. But anyway, health care will cost much less, be more precise, and we will all live to see 100 years.

I have to admit, I’m nostalgic. In the Good Old Days, news reporters were hard-bitten and skeptical. Today, we don’t call them reporters any more, they’re “news analysts” or “media personalities.” “Info-
tainers.” And they are no longer cynical or skeptical. They are, in fact, credulous. They make Pollyanna look like a pessimist. When it comes to anything technical, most reporters, news analysts, media persons or whatever you call them, are totally uncritical. Some techie says a thing can happen? Then let’s all get with the program!! 1,2

One might argue that we need artificial intelligence because there’s so little of the real thing around us.

WILL AI WORK BETTER THAN EHR?

We need some perspective. We have had computers for 50 years now. We can do a lot with them. Computed Tomography. Magnetic Resonance Imaging. But our best approach to computers in the practice of medicine is the electronic health record. After the last few years, can anyone seriously claim that the EHR has made medicine more precise and less expensive? I didn’t think so. And if that’s our best effort to date, what makes us think that the Next Big Thing is going to make things all better?

The real pity with the media circus is that artificial intelligence has real potential to make our lives better and our patients’ lives healthier. AI is simply a type of software. It’s not a coming miracle. Consider: X-rays today aren’t actual prints, they’re just a matrix of pixels in a data base. Even CT “scans” are just a large collection of pixels in a three-dimensional array. Routine reading of plain X-rays? It’s a real possibility. (Apologies to radiologists, but if it works …) Multi-colored CT scans, with green livers, red spleens, purple kidneys? Detection of tumors? All of these are possible. Diagnosis of skin lesions? That’s a maybe. See the discussion below. For these possibilities, I write in praise of AI. I hope that just maybe we’ll move in a positive direction.

WHAT IS AI?

Really, what is AI? Basically, pattern recognition. The pattern can be visual, as illustrated in Figure 1, or in data. To computer software, everything is numbers in a matrix. With pictures, the numbers represent pixels. With data, they represent whatever is in the data. Figure 1 shows a group of images from a graduate-level class in AI.3 The student is tasked to write code which will distinguish among the images. It’s not a terribly difficult exercise. Simply scan the image as a matrix. The output is a big table of pixels. Then go through the table line by line, devising rules for each of the images in the assignment. At the end, the software will correctly pick out each image. But if you introduce a ninth image, say a checkerboard pattern, the software won’t know what to do. So you add some code to allow recognition of the new pattern. AI is simply an expansion of that code. And no matter how complex the code, it’s still not looking at the real world.

In Praise of Artificial Intelligence

IT HAS GREAT POTENTIAL TO MAKE OUR LIVES BETTER AND OUR PATIENTS’ LIVES HEALTHIER. OR WILL IT BE ANOTHER EHR?

By Charles W. Van Way, III, MD, Editor Emeritus, Kansas City Medicine

Editorially speaking

One might argue that we need artificial intelligence because there’s so little of the real thing around us.
It’s just looking at a matrix of dots.

German has a word, ersatz, which means artificial, but with the implication that it is somehow inferior to the real thing. What we have here might be called ersatz intelligence. But really, it’s not even that. Pattern recognition at its best is only one component of intelligence. It’s not real intelligence. But it’s an important component, and there is a great deal which can be done with it.

Pattern recognition can do a great deal for us. The great strength of computer software is that it can do the same thing, over and over, very reliably. And unlike people, it doesn’t get distracted or bored. Reading an ECG, for example, is a fairly boring task. It’s a task which would be better done if it could be turned over to a computer.

We do that now, to some extent. ECG machines can print out routine measurements and even suggest diagnoses. The diagnoses aren’t terribly accurate right now, but it is easy to predict great improvement over the next 10 years or so.

OVERCOMING BIAS IN THE DATA

Great publicity was given to a study showing that an AI program can diagnose skin lesions with 95% accuracy. At least in the U.S. In white people. It didn’t work so well in people with darker skin. Does that mean that the program has acquired a bias? Well, yes. The software was “trained” (i.e., the code was written) on a set of images. If that set was mostly in people with white skin, then the final code will indeed be “biased.” Of course, it may be that it’s simply more difficult to diagnose skin lesions in dark-skinned people, because there’s less contrast between lesion and the normal background. An engineer might say the signal to noise ratio is higher. That’s not bias; it’s something inherent in the data. Either way, the software is less useful than it might be.

AI is simply an expansion of that code. And no matter how complex the code, it’s still not looking at the real world. It’s just looking at a matrix of dots.
The big disadvantage of computer software is that it doesn’t handle something new. The corresponding advantage is that it doesn’t forget.

has been written into the code, it’s there forever. The big disadvantage of computer software is that it doesn’t handle something new. The corresponding advantage is that it doesn’t forget.

WHAT’S AHEAD?
What are we to do with AI? It’s coming along, like it or not. Our office systems will be programmed to do many routine tasks for us. Right now, most systems can remember patients’ prescriptions. In the future, they will be able to predict which side effects we should anticipate. Now, our systems can remember patients’ last office visits. Soon, they’ll be able to “remember” the last office visits to other doctors, ER visits, hospitalizations and lab tests done elsewhere.

With all our enthusiasm, let us still be careful. Consider the EHR. This software, deployed in every hospital, is poorly designed, intrusive and hard to use. Suppose that AI software is just as poorly designed. What harm could it do? Other industries than health care have moved further and faster in this direction. Consider air transportation. From scheduling to planes that almost fly themselves, the industry has dived headfirst into AI. Has that worked well? Sure, it has … except when it doesn’t. I’m still an optimist about artificial intelligence. I write to praise it. But remember that the road to hell is also paved with good software.

Charles W. Van Way, III, MD, is editor emeritus of Kansas City Medicine and is emeritus professor of surgery at the University of Missouri-Kansas City. He can be reached at cvanway@kc.rr.com.

REFERENCES

Nicotine in E-cigarettes Appears to Impair Mucus Clearance

E-cigarette vaping with nicotine appears to hamper mucus clearance from the airways, according to new research from the University of Kansas and two other institutions.

Exposing human airway cells to e-cigarette vapor containing nicotine in culture resulted in a decreased ability to move mucus or phlegm across the surface, a phenomenon called “mucociliary dysfunction.”

“This study grew out of our team’s research on the influence of tobacco smoke on mucus clearance from the airways,” said senior author Matthias Salathe, MD, chair of internal medicine and a professor of pulmonary and critical care medicine at the University of Kansas Medical Center. “The question was whether vape containing nicotine had negative effects on the ability to clear secretions from the airways similar to tobacco smoke.”

The study, published in June in the American Journal of Respiratory and Critical Care Medicine, found that vaping with nicotine impairs ciliary beat frequency, dehydrates airway fluid and makes mucus more viscous or sticky. These changes make it more difficult for the bronchi, the main passageways to the lung, to defend themselves from infection and injury.

Joining with KU in the study were the University of Miami and Mt. Sinai Medical Center in Miami Beach.

The Johnson County Mental Health Center has created a special website directed to reducing vaping among teens, https://endthetrend.me.
Physicians, Legislators Network at Summer Social

A great crowd of nearly 40 people, including 16 Kansas state legislators, enjoyed conversation and refreshments at the Medical Society’s Summer Social hosted by KCMS President Dr. Mark and Mrs. Jill Brady on August 21. The occasion was a great opportunity for informal networking among physicians and legislators. See the KCMS Facebook page, KCMedSociety, for a full album of photos from the event.

Rep. Rui Xu (D-Westwood); Chakshu Gupta, MD; Rep. Cindy Holscher (D-Olathe); Mark Brady, MD; Rep. Cindy Neighbor (D-Shawnee)

Linda and Jim Wetzel, MD; Rep. Nancy Lusk (D-Overland Park); Rep. Tom Burroughs (D-Kansas City, Kan.)

Cassie Dietrich, MD; Rep. Cindy Neighbor (D-Shawnee)

Joshua Mammen, MD; Rep. Jan Kessinger (R-Overland Park)

Sen. Pat Pettey (D-Kansas City, Kan.); Mark Brady, MD.

Bridget McCandless, MD; Rep. Stephanie Clayton (D-Overland Park)
How long have you been involved in the former Wyandotte-Johnson County Medical Society and the new Kansas City Medical Society? What prompted you to join and then take on leadership roles?

I became involved in the Wy Jo Medical Society and Wy Jo Care leadership about eight years ago. Dr. Art Snow, a colleague of mine at AdventHealth Shawnee Mission, encouraged me to become involved while we were in leadership together at AdventHealth. Since that time, I’ve been on both the Wy Jo society and foundation boards and subsequently now both KCMS boards. In addition, I have been the Wy Jo trustee to the Kansas Medical Society board for several years.

What results are you seeing so far from the merger?

Since the merger, I have seen many more physicians interested in what our Society is doing, and they have expressed the desire to participate in leadership within the Society. It is exciting to see young physicians reach beyond their medical practice and become engaged in the larger metropolitan medical community. I have also seen better coordination of resources for our Kansas City Medical Society Foundation, a work that I am quite proud of. When we polled our members in Kansas several years ago, they ranked their volunteerism in Wy Jo Care as number one because of their interest in helping those less fortunate. I believe we will see a much larger impact in helping that community of patients as the merger becomes more and more solidified.

What are your goals for this year?

I am hoping to involve more physicians in our Society, giving them leadership opportunities and also offering advocacy opportunities in the community. For two years now, my wife and I have hosted the first KCMS Summer Social advocacy events at our home and they were very successful. This year, 16 legislators and 20 physicians attended, and they were able to network with each other. We were able to educate the legislators about our Society and the Foundation. Physicians are a smart group—not just regarding medicine but politics as well. I want to be able to offer my experiences as a longtime leader in the American Society of Anesthesiologists Political Action Committee to physicians who are interested in extensive experience in organized medicine includes advocacy work in specialty society.
in politics but who are not sure how to get involved.

**KCMS recently endorsed Medicaid expansion and last year went on record as opposing medical marijuana. What role do you see for KCMS in taking on public issues such as these?**

All physicians are interested in what is best and safest for our patients. This applies to how we treat them in our day-to-day practices, as well as on a larger-scale policy basis on the local and national level. Our opposition to medical marijuana was natural; we are practitioners of evidence-based medicine. Medical marijuana has no evidence-based research to support its use. And regarding Medicaid expansion, physicians are believers in quality medical care for everyone regardless of income level. I believe legislators will craft a plan that supports this premise and look forward to that happening soon. KCMS provides an outlet for physicians to let their voices be heard on a larger scale.

**How did you become interested in medicine? What prompted you to choose anesthesiology?**

Starting in high school, I was a volunteer for children with muscular dystrophy for many years. Watching that disease progress encouraged me to follow the path to become a physician. I chose anesthesiology for many reasons—one of the main being that I treat patients of all ages. I also enjoy working in and around the operating room, taking care of critically ill patients in the ICU and performing procedures pretty much throughout the entire hospital. For example, few things are more gratifying than relieving a patient’s pain, especially women in labor. I believe that I have been blessed to be able to practice in one of the most noble professions in the world.

**Tell us about your family.**

My wife Jill is a nurse. We met in the ICU when I was in training, and we have been married for over 27 years. We have two children. Jessica is a nurse at Children’s Mercy and is pregnant with our first grandchild; she is married to Alec, an anesthesiology resident at KU. My son just completed his master’s of public health degree and is starting his third year of medical school at KU. His girlfriend is a medical student at KU-Wichita. I tell people not to ask our family about anything but medicine!

**What are your interests outside of medicine?**

For starters, there is my work in advocacy and also leadership within AdventHealth. My wife and I exercise together when we can and also spend time at our lake place. Faith is an important cornerstone of our family; we are members of Church of the Resurrection in Leawood. Plus, our entire family are avid Chiefs, Royals and Jayhawk fans.
Future Physicians Serve Community

STUDENTS GAIN PERSPECTIVE ON NEEDS OF DIVERSE POPULATION, ORGANIZING COMMUNITY PROGRAMS

Two current medical students will begin their careers with greater understanding of patients from diverse backgrounds through their experience with the AmeriCorps program through Rosedale Development Association (RDA) in Kansas City, Kan.

Primarily encompassing the 66103 ZIP code, Rosedale is a tightly-knit neighborhood adjoining the University of Kansas Medical Center campus in southeastern Wyandotte County. The neighborhood’s residents comprise a mix of incomes and ethnicities.

RDA works with residents, businesses and institutions to address community issues ranging from housing and crime to youth programming and health and wellness. The future physicians are among a larger group of AmeriCorps members serving at Rosedale.

Aaron Davis served in AmeriCorps in Rosedale from July 2015 to July 2016. A native of Salina, Kan., he graduated from Drake University in Des Moines, Ia., and is now a third-year medical student at the University of Kansas.

“I was the active living coordinator for the RDA,” Aaron said. “I managed youth sports for some 100 kids and built community partnerships. We worked to build the capacity of the programs and make them better known. There was also a healthy kids program that included walking kids to school as an option to the bus.”

He said the experience helped him learn to work with people from different backgrounds. “I had to work with kids and parents who grew up completely different than me. I also learned the importance of the community coming together to address an issue,” he said.

Jamal Jarrett, who grew up in Wyandotte County and attended Piper High School, served in the 2017-2018 year. He earned his undergraduate degree from Tennessee State University and now is attending the Medical College of Wisconsin in Milwaukee.

“I worked very closely with youth sports, nutrition education, summer youth employment and bicycle education,” Jamal said. “I also assisted with community gardening and minor home repair.”

In addition, Jamal attended the Building a Resilient Wyandotte Summit focusing on the effects of trauma on children and adults in the Rosedale community. Jamal described the day: “I attended breakout sessions on trauma in our community, what we need to do to be more resilient, and what assets we already have. I felt great being part of the discussion and as one of the youngest participants, to offer my ideas.”

From the experience, he said, “I learned...”
Feature

“The time at Rosedale helped me get to know these patients more. And, working with kids reinforced my desire to be a pediatrician.”

Aaron Davis, left, as part of his introduction to the neighborhood met Allison Edwards, MD, who operates Kansas City Direct Primary Care in Rosedale. (Photo courtesy StoryCorps, Inc.)

how much work and collaborating goes into nonprofit work. Without the generosity of people and businesses that make donations and their volunteers, this service would not be possible.”

How has serving in Rosedale affected them as future physicians?

Jamal: “These experiences have given me a practical glimpse of community health. I knew I wanted to practice in primary care and work in public health. But serving with the RDA reminded me that my future patients will bring multiple needs such as physical, emotional, mental, social, spiritual, environmental and occupational.”

Aaron: “At KU I am working with a very socioeconomically diverse population. The time at Rosedale helped me get to know these patients more. I heard their struggles, what they are going through. And, working with kids reinforced my desire to be a pediatrician.”

Je T’aime Taylor, program director for RDA, said the community has embraced the AmeriCorps members. The interaction has brought an important perspective to the future physicians. “They have gained a more holistic point of view. They have been able to work within the community and help build a thriving Rosedale.”

Appointed to State Medical Board

KCMS member and past board member Marc K. Taormina, MD, has been appointed to the Missouri State Board of Registration for the Healing Arts by Gov. Mike Parson. A gastroenterologist with Midwest GI Health in Lee’s Summit, Dr. Taormina also serves as a councilor for the Missouri State Medical Association. He is a graduate of the University of Missouri-Kansas City School of Medicine. Fellow KCMS member James A. DiRenna, Jr., DO, also continues to serve on the Board of Registration for the Healing Arts.

Named Membership & Events Director

Emily Whalen has been appointed director of membership and events for the Medical Society. A staff member since 2018, she will service the needs of KCMS members and coordinate logistics for KCMS events. She has a background in sales and marketing and holds a bachelor’s degree from the University of Nebraska. Emily may be reached at ewhalen@kcmedicine.org.

KCMS Website Expanded

The Medical Society’s website, kcmedicine.org, has been updated with expanded content including:

- KCMS Foundation section with details on the Wy Jo Care and Metro Care charitable programs for physicians, referral clinics and patients
- Advocacy section with information on Medicaid expansion, medical marijuana, Tobacco 21 and other pertinent issues, complete with resource links
- Top news highlights on the home page, updated regularly
Prepare Now for 2020 CMS Appropriate Use Criteria Requirements

RULES APPLY TO CERTAIN OUTPATIENT IMAGING TESTS FOR MEDICARE PATIENTS

By David Smith, FACMPE

The Protecting Access to Medicare Act of 2014 (PAMA) included an effort to improve quality and reduce imaging costs through consultation of Appropriate Use Criteria (AUC) via Clinical Decision Support Mechanisms (CDSM), both of which are approved by the Centers for Medicare and Medicaid Services. This applies to CT, MRI, nuclear medicine and PET orders. CMS has announced that effort will materialize in 2020.

Appropriate Use Criteria are designed to assist clinicians with selection of the best imaging study based on clinical indications. CMS has approved AUC developed by several physician-led entities.

Clinical Decision Support Mechanisms make it possible for ordering clinicians to consult AUC when ordering imaging studies.

ORDERING CLINICIANS

Beginning January 1, 2020, clinicians who order CT, MRI, nuclear medicine or PET studies for traditional Medicare beneficiaries will be required to consult Appropriate Use Criteria via approved Clinical Decision Support Mechanisms.

There are a few exceptions to this requirement:
- Inpatients
- Patients with an “emergency medical condition” as defined at Section 1867(e)(1) of the Social Security Act.*
- Many ED visits will not fall into this exception.
- Critical Access Hospitals (CAH) are excluded from the requirement. However, as of this writing, physicians who bill for the professional component of imaging studies done in CAHs are still required to report AUC consultations. Hopefully this disconnect will be addressed by CMS.

Ordering clinicians are responsible for performance of the AUC consultation. The consultation may be delegated to qualified clinical staff working under the direction of the ordering professional. The consultation may not be delegated to an outside furnishing provider, such as an imaging center or hospital.

While consultation of Appropriate Use Criteria will be required, adherence to AUC recommendations is not. However, in the future, CMS will require ordering clinicians with exceptionally high rates of non-adherence to obtain pre-authorization for their advanced imaging orders.

ADVANCED IMAGING ORDERS

CMS plans to issue HCPCS G-codes corresponding to each approved Clinical Decision Support Mechanism, along with modifiers to indicate whether the order conforms to Appropriate Use Criteria guidelines, or an exception applies. This information will have to be communicated from the ordering office to the furnishing provider along with each order.

Beginning in 2021, Medicare payment to imaging providers will be contingent upon submission of CDSM G-codes and AUC adherence modifiers on claims. Therefore, ordering professionals should expect that orders will generally not be accepted by outside imaging providers without this data.

FURNISHING PROVIDERS

Also beginning January 1, 2020, those who furnish CT, MRI, nuclear medicine or PET reimbursed under Medicare Part B will be required to report information about Appropriate Use Criteria consultations on their claims. This includes hospitals, imaging centers, clinics and physicians, and applies to those billing globally, as well as those who render the professional or technical component only. Claims must include:
- HCPCS G-code corresponding to the Clinical Decision Support Mechanism used to consult AUC
- Applicable modifier to indicate whether the order adhered to AUC guidelines or an exception applies
- Ordering professional NPI number

The year 2020 will serve as an operations testing period for claims reporting.
Beginning January 1, 2021, Medicare reimbursement for CT, MRI, nuclear medicine and PET will be contingent on this reporting.

WHAT NOW?

If your practice uses an EHR, reach out to your vendor to find out if they offer an integrated Clinical Decision Support Mechanism, whether it will be an add-on module, and if so, obtain a proposal to install before January 1, 2020. Be sure to confirm the CMS approval status of the CDSM and associated AUC, and carefully review the integration to avoid duplicate data entry.

If you don’t use an EHR or an integrated CDSM isn’t a cost-effective option, explore the web portal option. Some approved CDSMs include a free web portal option, and it is likely that many imaging providers will offer CDSM web portal access as well.

If you bill Medicare for CT, MRI, nuclear medicine or PET, (global, technical or professional components) work with your clinical partners and billing system vendors to ensure that you are ready to capture and report the new G-codes and AUC adherence modifiers on your claims, beginning in 2020.

POTENTIAL SILVER LINING

Setting aside the obvious benefit of ensuring that each patient gets the right imaging study the first time, there is a potential silver lining here. Some early adopters have successfully made the case to commercial payers that using Appropriate Use Criteria is a cost-effective alternative to pre-authorization, and they obtained permission to forgo pre-authorization for cases that conform to AUC. Eliminating the costs associated with imaging pre-authorization could be a win-win for providers and payers.

David Smith, FACPME, is executive director of United Imaging Consultants, a group of 35 radiologists based in Kansas City. He can be reached at dsmith@uickc.com. The practice website is https://uickc.com/

*Section 1867(e)(1) of the Social Security Act:*
(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—
(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
(ii) serious impairment to bodily functions, or
(iii) serious dysfunction of any bodily organ or part; or
(B) with respect to a pregnant woman who is having contractions—
(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

---

**KU School of Medicine Appoints New Dean**

The University of Kansas Medical Center has named Akinlolu O. Ojo, MD, executive dean of the University of Kansas School of Medicine. He will oversee the Kansas City, Salina and Wichita campuses.

Dr. Ojo most recently was associate vice president for clinical research and global health initiatives and professor of medicine and health promotion sciences for the University of Arizona in Tucson, Az. He is board certified in nephrology. He replaces Robert D. Simari, MD, who was named executive vice chancellor in July 2017 and has continued to serve as executive dean while a national search took place.

A national leader in research, Dr. Ojo has obtained more than $95 million in current grant funding and more than $200 million in total federal research grant awards during his career. His primary research interests are in the clinical epidemiology and clinical and translational research in chronic kidney disease and kidney transplantation; minority health and health disparities; and global health. He has authored more than 200 peer-reviewed manuscripts.

Dr. Ojo earned his medical degree from the College of Medicine of the University of Lagos in Lagos, Nigeria. He then served as a postdoctoral fellow in public health at the University of Alabama at Birmingham in Birmingham, Ala. He completed internship and residency at the University of Kentucky Hospitals in Lexington, Ky., and was chief resident for internal medicine. He also holds a PhD in epidemiology and an MBA from the University of Michigan.
Editor’s Note: The following is excerpted from an article appearing in the July-August issue of Missouri Medicine. For the full article, plus an AMA summary in slide form by Kansas AMA Delegate Art Snow, MD, visit https://kcmedicine.org/blog.

The annual meeting of the AMA House of Delegates (HOD), is democracy at its disorderly finest. Delegates representing all states and most medical societies meet in Chicago to consider what the AMA should do, whether direct action, policy, advocacy, or education.

Seema Verma, administrator of the Center for Medicare and Medicaid Services, spoke to the HOD. She opposes “Medicare for All,” in large part because it would destroy the program for seniors. She expressed the commitment of CMS to simplify the paperwork burden, improve the transparency of EHR systems, and, as she put it, “level the playing field” for independent physician practices.

Health equity is emerging as an important concern. Many factors, usually lumped together as “social determinants of health,” can lead to health disparities. These determinants include poverty, lack of education, adverse environments, previous trauma, as well as other factors.

The HOD has adopted new policy on artificial intelligence. AI will become increasingly common in both health care and in health care education. An extensive report on the place of AI in medical education was put out by the Council on Medical Education (CME).

In the area of medical practice, the HOD dealt with several important issues. Prior authorization continues to burden physicians and their staff. Medicare Advantage programs have become increasingly “Medicare Disadvantage” programs, with limited networks, low reimbursement and arbitrary administrative rules. The AMA has adopted an “Employed Physicians Bill of Rights,” continuing its commitment to ensure that all physicians can practice with as much autonomy and as few restrictions as possible.

Regarding legalization of marijuana, there was very little sympathy in the HOD for legalization, but there was also a general recognition that it has widespread public support. It is AMA policy that the restrictions should be relaxed enough to permit controlled research on marijuana and its derivatives.

Patrice Harris, MD, was inaugurated as the 174th president of the AMA. A child psychiatrist from Georgia, she is the first African-American woman to lead the AMA. Susan Bailey, MD, of Texas, was elected president-elect. Her election marks the first time that the president, past president and president-elect are all women.
Patient Mental Health Concerns on the Rise

This special section of Kansas City Medicine is devoted to the work of Kansas City-area physicians in addressing what many call a mental health crisis in the United States. Consider:

The rate suicide increased in the United States among all ages between 1999 and 2017, from 10.5 to 14.0 per 100,000 people.¹

56%
The rate at which suicide increased among youth ages 10-19, from 2007-2016.¹

Suicide replaced homicide as the second-leading cause of death among youth.²

1 in 8
The number of emergency department hospital visits in the U.S. involving mental health and substance use disorders.⁴

14M
While 5.8 million Americans are living with Alzheimer’s disease today, by 2050 this number is projected to rise to nearly 14 million.⁷

33%
The percentage of Kansas City-area youth who have been diagnosed with depression more than doubled, from 5.5% in 2015 to 11.7% in 2018.³

36th
MISSOURI
Missouri is rated 36th in access to mental health care, based on access to insurance, access to treatment, quality and cost of insurance, access to special education, and workforce availability. Missouri has 7.82 psychiatrists per 100,000 people; a population of 100,000 should be supported by 14.7 psychiatrists.⁶

32nd
KANSAS
Kansas is rated 32nd in access to mental health care, based on access to insurance, access to treatment, quality and cost of insurance, access to special education, and workforce availability. Kansas has 7.74 psychiatrists per 100,000 people; a population of 100,000 should be supported by 14.7 psychiatrists.⁶

REFERENCES
Current Issues in Mental Health Care

BEHAVIORAL HEALTH LEADERS OF THE UNIVERSITY OF KANSAS MEDICAL CENTER AND HEALTH SYSTEM DISCUSS NEW TREATMENTS, MENTAL HEALTH CARE ACCESS AND MORE

William F. Gabrielli, Jr., MD, PhD, has been chair of the Department of Psychiatry and Behavioral Services at the University of Kansas Medical Center since 1999. He also is clinical service chief for the University of Kansas Health System Mental and Behavioral Health program. A native Californian, Dr. Gabrielli received his undergraduate degree from California State University, Sacramento and his master’s and PhD in psychology from the University of Southern California. He entered the University of Kansas School of Medicine in 1983. After graduation in 1987, Dr. Gabrielli remained at KUMC to complete his combined residency training program in internal medicine and psychiatry. Subsequently he remained a faculty member at KUMC and was promoted to full professor in 1995. He is an internationally recognized expert for his research on familial factors in addictions, alcoholism, and psychiatric disorders.

Lauren M. Lucht, MA, is executive director of the University of Kansas Health System Mental and Behavioral Health program. An experienced health services administrator, she joined KU in 2017. She holds a master’s degree in clinical psychology from Washburn University and a bachelor’s degree from Rockhurst University.

How have treatments for mental illness improved in the last 5-10 years?

There are two major ways that treatments for mental illness have improved in the past 10 years. One is the continued advance in medical management of psychiatric illness and the second is in continuing refinement in evidence-based behavioral approaches. On the medical front, new and more highly targeted pharmaceuticals have come into use for mental illness, and several somatic treatments have advanced for refractory illness. Several new antidepressants that are similar to common classes of antidepressants (SSRIs and SNRIs) and which offer some unique advantages for specific patients are available. Very new medications in use include the ketamine enantiomer esketamine for refractory depression and allopregnanolone for post-partum depression. Neuro-modulator treatments with refinements in electroconvulsive treatment, vagal nerve stimulation, transcranial magnetic stimulation, and now re-emerging interest in deep brain stimulation are also in use. Overall, precision (individualized) treatment has started to come to psychiatry, not only with choosing medications using measures of individual pharmacogenetics, but also by providing individualized psychological strategies based upon unique patient features.

How might we expect treatments to improve in the next 5-10 years?

Treatments will continue to improve as the science continues to improve. The biggest improvements will come in finding more unique treatments for specific disease presentations. We will see more protocol-driven approaches that maximize outcome potential while minimizing the costs (economic and quality of life) of initial treatment failure. No longer will we be trying newer agents just because they are new, or older (and cheaper) treatments when we will be better able to predict treatment efficacy for each option. No longer will we spend countless psychotherapy sessions with patients that contribute limited progress when we can select more specific treatment approaches tailored to each individual patient’s needs.

The latest data (June 2019) from the CDC shows that the U.S. suicide rate increased 33% from 1999 to 2017. What are your thoughts on the reasons for the increase?

There are several reasons for increased suicide rates. One is that life is somewhat more complicated for our young people. Perhaps earlier in life than for previous generations, it seems, our children must navigate the complex social milieu. Expectations of performance have changed. And our kids have more open options for life pursuits. 24/7 media and social media continuously transmit messages of pursuing “something better out there,” reinforcing the message of failure and despair in a few vulnerable individuals who feel that they are not able to reach these ideals for themselves. Another reason is the existence of fewer opportunities for individuals to engineer less stressful lives for themselves. Third, social supports have declined (in per capita investment) over this timeframe, although the Affordable Care Act has...
moderated this in some areas of the country. At the same time, the biological causes of depression and the many factors that influence these have not gone away.

Is there a serious increase in teenage mental health issues? How much is due to the constant presence of social media in their lives?

Some of what we perceive as an increase in teenage mental health issues is probably better identification. However, there is a small “copycat” precipitating clusters of suicide attempts among vulnerable individuals. That is a bad thing, but social media can also be a good thing. It permits social supports and, if used correctly, access to help.

Do many people (all ages) with mental health conditions continue to go untreated? How can we encourage people to seek treatment? Does there continue to be a stigma associated with receiving mental health treatment?

More than half of all people with emotional issues potentially remediable by some kind of intervention do not seek any treatment. Most of these individuals “get by” and their autonomy in this regard must be respected. However, there is a misperception by many that emotional issues or coping difficulties reflect personal weakness. This is wrong most of the time, but the sentiment results in a stigma associated with reaching out for help. Further, many people don’t understand mental illness, and that lack of understanding leads to overvalued fear of interaction with others perceived as suffering from any kind of mental illness. The greater understanding of the medical, psychological and sociological bases for mental illness and the visible successes in treatment are slowly contributing to better acceptance.

The failure to provide adequate mental health care also results in increased need for alternative (and more expensive) care which falls on our jails and prisons.

Is there a shortage of psychiatrists in the Kansas City area? Missouri/Kansas? Nationally? What can be done to reduce the shortage?

Psychiatry (along with primary care medicine) is one area of medicine with significant shortage in many areas of the country, including Kansas and Missouri. There is a national effort to increase training program size in psychiatry, and there are programs designed to encourage doctors to specialize in the field. Practice in the field of psychiatry has also suffered because the field has not been perceived as one of the more glamorous or prestigious areas of medicine. Some of the reason is the stigma associated with the patient needs, and some of this is because brain science is so complex that the clinical neurosciences are the great frontier of medicine which means that precise effective interventions are less well-established. But this is changing as brain science is coming of age. The golden age of mental health care is soon at hand, and this generates excitement and attraction to the field.

To what extent is access to mental health care an issue in the Kansas City area? What can or should be done to ensure that more people who need mental health care can obtain it?

Access to mental health care remains a local and national issue. Mental health care is still limited by the system of insurance mental health “carveouts,” which sacrificed access to optimal mental health care with the objective of cost saving. But the cost savings were mainly in insurance plan expenditures, not the bigger picture costs to patient well-being and societal costs. Unlike many areas of medical care, quality mental health care can have benefits beyond individuals by reducing impact on others and upon society. The failure to provide adequate mental health care also results in increased need for alternative (and more expensive) care which falls on our jails and prisons. Adequate funding of community mental health centers, elimination of mental health insurance “carve-out” companies and expansion of Medicaid coverage will help. A buy-in option for Medicare or Medicaid by employers is something to consider.

Is there anything we haven’t covered or you would like to add?

Despite all of the excitement of the advancement of the science and the great possibilities that mental health care can provide, at the end of the day, it is important to recognize that maintaining the mental health of our communities depends upon the hard work of an army of mental health providers and peers at all levels, who most of the time are not working with new and exciting treatment options. Instead they are doing the best that they can to help people cope with their limitations and find ways to use available resources and techniques. These are the unsung heroes of mental health care.
Imagine you have a patient sitting in front of you, tearful and distraught. Describes feeling depressed and hopeless. Not being able to sleep or eat. Not feeling motivated to get out of bed, go to work or even spend time with family. This experience has made it hard for the patient to manage the illness or take prescribed medications.

What do you do? Do you provide the patient with care for their obvious depressive episode? Do you refer them to therapy? To psychiatry? Do you validate the patient then try to shift focus to what they are coming in to see you for? Do you ignore the symptoms completely?

These statistics may be familiar to some and surprising to others. One in every five U.S. adults experiences a mental illness at any given time. This equates to 43.8 million American adults each year. It has been estimated that 46% of U.S. adults will experience a mental illness or substance use disorder in their lifetime. Of those individuals, approximately 67% do not receive mental health treatment.¹ This may be related to mental health stigma, lack of insurance or financial resources, or limited access to specialty mental health including therapy and psychiatric medication management. Looking at our own patient population, it can be estimated that approximately 320,000 Kansas City metro adults are living with a mental illness. According to Mental Health in America, Kansas ranks 32nd and Missouri ranks 36th in access to mental health care.²

With the high rate of mental illness and limited access to specialty mental health care, but with a high likelihood of other treatment occurring in primary care, how can we ensure that proper care is available for our patients? The answer may lie in the collaboration of medical and mental health care.

**INTEGRATED BEHAVIORAL HEALTH**

Integrated Behavioral Health (IBH) has many definitions and variations in delivery. A 2013 Agency for Health Care Research and Quality paper described IBH as the following:

The care that results from a practice team of primary care and Behavioral Health Consultants (BHC), working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms and ineffective patterns of health care utilization.³

The model of IBH can be delivered in six levels of care within the following range:

- Minimal coordination of care with emphasis on communication
- Co-located care with emphasis on close proximity of team members
- Full collaboration between team members with emphasis on integration into every aspect of practice.

Each level of care provides benefits to the patient and team, with level six full collaboration having the greatest impact on overall care.

The aforementioned BHC is typically a licensed psychologist or a licensed clinical social worker (LCSW) who works as a member of the care team. The BHC addresses not only the mental health concerns often seen in medical settings but also health behaviors and physical conditions that are impacted by mental health issues. These may include treatment adherence, behavior change plan implementation and adjustment to a chronic medical condition.

**GOALS OF IBH**

Although the Agency for Health Care Research and Quality paper described the collaborative care provided in primary
care, the themes and goals outlined can be generalized to the care provided within various specialties such as oncology, sleep and pain management, just to name a few.

The four goals of IBH are simple: increase access to care, improve patient quality of life, improve satisfaction for patient and provider, and improve cost management and overall health care spending. To better understand how IBH can meet these goals, let’s break each one down.

- **Increase access to care.** As mentioned earlier, most individuals do not receive mental health treatment, and for the patients who do receive care, over 20% of them receive their treatment solely from primary care. Even when a provider refers a patient to outside specialty mental health, only 10% of those patients follow through on the referral. When there is a BHC integrated into that clinic, 90% of patients needing treatment for their mental illness receive it. Since most adults visit a primary care office within the course of a year, integrating a behavioral health specialist into that office can ensure that patient needs are met.

- **Improve quality of life for patients.**
  When a patient can have both physical health and mental health care needs met in one place, by one collaborative team, quality measures tend to improve. Reported symptoms of depression reduce in severity after one visit with a BHC.

- **Improve satisfaction for both the patient and providers involved in care.**
  Patients report greater satisfaction in care received, which may be associated with feeling heard and understood by their providers. When provider satisfaction was examined, nearly 94% of physicians thought IBH improves patient care and 90% believed IBH lowers physician stress. This lowered stress may be attributed to reduced time spent with patients focusing on nonmedical topics.

- **Reduce overall health care costs.** The CDC (2014) indicates that 75% of health care costs are due to chronic diseases, which can be influenced by lifestyle and behavioral changes. These changes can be the focus of treatment with a BHC. Additionally, the unnecessary use of medical service lines such as the emergency department has been reduced with the addition of IBH.

**DAILY PRACTICE**

The daily practice of a BHC can vary, dependent on the level of integration and the clinic workflow. This is an example of a typical workflow of a BHC in a level-six fully collaborative program:

The BHC often sits with the medical staff and is readily available for an on-demand consult. When the physician has identified a patient who would benefit from the BHC services, a brief consultation is provided to the BHC, who then sees the patient in real time. The interaction between the patient and BHC focuses on information gathering, psychoeducation, goal setting, brief therapeutic techniques and treatment planning. The interaction is brief and solution focused, and typically lasts less than 20 minutes. The BHC (continued)
documents the encounter in the same
electronic medical records system as
the physician. The BHC then collabora-
tes with the referring provider on the
care provided and team based decisions
can be made regarding treatment.

Let’s revisit the patient profiled in the
beginning of this article. If a patient in
a clinic with IBH described depressive
symptoms and mentioned how it was im-
pacting his or her ability to manage their
health, the physician could ensure that
the patient’s mental and behavioral health
needs are addressed. In a level-six fully
collaborative IBH program, the physician
could immediately consult the BHC in
person, and the patient would be seen
before the medical visit was concluded.
This would allow for collaborative decision
making to be done with the patient, physi-
cian and BHC. The BHC could continue to
meet with the patient at follow-up medical
appointments, make standalone BHC ap-
pointments, or coordinate the transfer of
care to specialty mental health if needed.

There are many great examples of IBH
in the Kansas City metro area, with one
of the most robust programs located at
Truman Medical Centers (TMC). Cur-
rently, within the TMC system, there are
eight psychologists integrated into several
primary care and specialty clinics. Within
those clinics, there is a range of integrated
care provided, from co-located to fully
collaborative between medical and behav-
ioral health providers. The IBH program at
TMC is actively expanding to better suit the
needs of the patient population it serves.

SUMMARY

IBH is a model of care that emphasizes
increasing access to mental health care,
meeting patient needs, decreasing health
care costs, and focusing on care team
well-being. IBH is a means to provide
treatment for not only mental illness but
also to assist in building patient self-man-
agement skills to better care for chronic
diseases or implement behavioral change.

Although the integration of behavioral
health into medicine can vary, the bene-
fits are palpable. I challenge each of you
to think of your patient population and
assess the utility of IBH in your practice.
How can IBH help you meet your patients’
mental and physical health needs?

Carlie Nikel, PsyD is an associate program direc-
tor for the Family Medicine Residency Program
and an assistant professor in the Department of
Community and Family Medicine at the Univer-
sity of Missouri-Kansas City School of Medicine.
She is also a clinical psychologist with Truman
Medical Centers where she provides integrated
behavioral health services at Truman Lakewood.
Dr. Nikel enjoys working with patients to man-
age chronic diseases and make positive lifestyle
changes in addition to educating residents on
behavioral interventions. She can be reached at
carlie.nikel@tmcmed.org

REFERENCES

1. Centers for Disease Control and Prevention. Percentage of
mental health-related primary care office visits, by age group -
national ambulatory medical care survey, United States, 2010.
Morbidity and Mortality Weekly Report. 2014;63(47);1118.
2. Mental Health in America - Access to Care Data. Mental Health
America website. https://www.mentalhealthamerica.net/
issues/mental-health-america-access-care-data
behavioral health and primary care integration: Concepts and
definitions developed by expert consensus. Agency for Health
Care Research and Quality. (p. 2) Rockville, MD. 2013.
integrated behavioral health services: The physician perspective.
5. Cummings NA, O’Donohue WT, Cummings, JL. The financial
dimension of integrated behavioral/primary care. J Clinical
Psychology in Medical Settings. 2009; DOI 10.1007/s10880-
008-9139-2.
of integrated behavioral health with primary care. J Am
Board Fam Med. 2017;30(2):130-139. doi: 10.3122/jab-
fm.2017.02.160234.

KCMS Journal Honored for Publication Excellence

The Kansas City Medical Society’s quarterly
journal, Kansas City Medicine, has received
a 2019 APEX Award for Publication Excel-
ence. The award is presented by Commu-
nications Concepts, a consulting firm and
newsletter publisher serving the communica-
tions and publications industry. The
APEX Awards recognize “excellence in
graphic design, editorial content and the
ability to achieve overall communications
excellence.”

Kansas City Medicine is among 100
Grand Award winners out of more than
1,200 entries in the competition, rec-
ognized in the category of magazines,
journals and tabloids. The award affirms
the Medical Society’s commitment to
providing a quality publication for the
membership.

Communications Concepts, Inc. helps
publishing, public relations and marketing
professionals improve publications and
communications programs through con-
sulting services and reports on business
writing and communications.
Mental Health Needs Rising Among Kansas City-Area Youth

CHILDREN’S MERCY REPORT SHOWS STRIKING INCREASES IN DEPRESSION, ANXIETY AND OTHER CONCERNS

By Jim Braibish, Kansas City Medicine

Young people today face greater stressors than past generations as they navigate the delicate path to adulthood. Besides social media, these can include pressure to succeed, family financial stress and other factors.

New data from Children’s Mercy Kansas City shows how this is affecting our children’s mental health. The incidence of mental health concerns among youth ages 5-17 in Jackson, Johnson, Clay and Wyandotte counties has risen considerably in the last three years:

- The percentage of youth who have been diagnosed with depression more than doubled, from 5.5% in 2015 to 11.7% in 2018.
- The portion of youth diagnosed with anxiety more than doubled, from 9.5% to 19.1%.
- Those who have ever taken a prescription medication for mental health doubled from 7.2% to 15.9% between 2015 and 2018.
- The percentage of youth who “felt sad or hopeless for two or more weeks and stopped performing their usual activities” more than tripled, from 3.0% to 10.7%.

The 2018 data lifts the Kansas City region above national averages. It is based on a survey of a random sample of 1,000 families in the four-county area with at least one child. The survey is conducted every three years as part of the health system’s community health assessment. The full assessment report will be published this fall.

Besides the public survey, the assessment also contacted nearly 300 community influencers such as physicians, public health officials, educators and others, and received responses from nearly 120. One physician expressed the seriousness of child mental health today:

“(Child mental health) is the number-one issue in pediatrics today. The number of grade school, high school and college-aged kids with treatable anxiety, depression and other mental health issues is appalling.”

“*This is the number-one issue in pediatrics today. The number of grade school, middle school, high school, and college-aged kids with treatable anxiety, depression and other mental health issues is appalling. Weekly, I have a patient who has attempted suicide.”*

REASONS FOR THE INCREASE

Why the sharp increase in depression, anxiety and other mental health problems?

Some of the increase may be the result of more people reporting mental health issues as the stigma around mental health decreases, according to Sarah Soden, MD, division director of developmental and behavioral sciences for Children’s Mercy.

“We hope that one of the reasons for a rise in reporting of mental health symptoms is that some people have become more comfortable talking about these issues. We are slowly chipping away at the stigma,” she said.

However, she emphasizes that external stressors clearly are on the rise. Social media and screen time are most often pointed to, but there is much more.

“There is overwhelming evidence from many scientific studies that youth mental health is linked to adverse events and stressors. For some young people, the stressors may be related to basic needs such as secure housing and nutrition. In other cases, it may be rooted in pressures to overachieve. For far too many young people, there is a blend of both,” Dr. Soden noted.

(continued)
“Social media, by its very nature, encourages comparison of self to others which exacerbates all of this,” she added. Related to social media is the problem of bullying. Among parents of school-age children (5-17 years old), 24.6% reported that their child has been bullied in the past year on school property. Another 11.7% reported that their child has been cyberbullied. Kansas City rates for both forms of bullying are higher than national rates. Locally reported rates have more than doubled since 2015.

**FAMILY STRESSES**

The health system’s report provides revealing data on Adverse Childhood Experiences—those stressors that impact a child’s healthy growth and development. According to the health assessment report, the ACEs most often impacting children age 0-17 in greater Kansas City in 2018 are:

- Financial strife, 27.3%
- Parental separation/divorce, 24.8%
- Household mental illness, 15.2%
- Parental domestic violence, 10.7%

Nearly all of these are up by 50% or more since 2015.

Also from the survey, more than 40% of respondents said they were worried or stressed about how to pay their rent or mortgage in the previous year. Another 29% said they ran out of food at some point.

The assessment report included data showing that more than 8,000 students in the Kansas City area reported being homeless at some point during the 2017-2018 school year.

“Parents are more stressed and this will affect their parenting,” Dr. Soden said, noting that more than 8% of parents surveyed reported being either “usually” or “always” angry with their children in the past month.
Many but not all children’s mental health issues are more prevalent among low-income families. The survey results showed that 30.2% of families living below the federal poverty level said their child experiences fair or poor mental health; the portion was 13.6% among families at 100% to 199% of the poverty level. At 200% or more above the poverty level, only 6.8% of families said their child has these issues.

SOLUTIONS

What are solutions the Kansas City community can undertake? The report suggests the development of collaborative efforts community partners to address high-priority mental health needs.

“We have begun working with community mental health centers and other large behavioral health providers in the region on a shared goal of making mental health services easier for the community to understand and access,” Dr. Soden commented. “Other important collaborative efforts are happening in schools and with pediatricians. Our training programs are also a priority.”

Increasing public and private funding for behavioral health care also is an urgent need, she added.

---

**Adverse Childhood Experiences (ACEs)**

(Clay, Jackson, Johnson and Wyandotte Counties, Ages 0-17 in 2018)

**Percentage of Students Bullied**

(Children Ages 5-17 in 2018)

(All Charts, Source: Children’s Mercy Community Health Assessment 2019)
Teen death by suicide nearly doubled in Johnson County, Kan., in the first six months of 2018. With 15 teen suicides during the 2017-2018 academic year, the superintendents for the six school districts in the county came together to respond to this tragic trend. From this meeting came the #ZeroReasonsWhy campaign.

The school districts in collaboration with a team of diverse local partners including Johnson County Mental Health Center, connected with Overflow, a Kansas City-based firm, to launch this disruptive teen suicide prevention initiative.

“One of the most critical parts of this movement,” said Johnson County Mental Health Center Director Tim DeWeese, “is that teens themselves drive the initiative. The Teen Council, made up of student representatives from each school district, provides leadership for the entire campaign shaping the vision, direction and initiatives.”

The campaign is designed to prevent teen suicide and drive productive conversations to affirm there are zero reasons why suicide is an option. There are two main components of the effort:

- **The Story Campaign** aims to destigmatize the conversation about suicide by featuring teens sharing their own stories, encouraging peers to talk about mental health and providing hope. Stories are shared with the community primarily through social media including Facebook, Twitter and Instagram.

- **The Community Mobilization Effort** is rooted by the three pillars that the Teen Council identified in their strategic plan. The pillars include: Remove the Stigma, Build Community Support and Commit to Education. Focused on empowering community members to take action toward change, the campaign is organizing, facilitating and supporting teens, parents, educators and practitioners in implementing action plans, programs, events and collaborative outreach efforts. #ZeroReasonsWhy has featured commitment events in the schools, public rallies and symposiums for community influencers and more. “Suicide isn’t a school issue. It’s not a church issue. It’s not even a Mental Health Center issue. Suicide is an entire community issue,” said DeWeese. “It takes the whole community coming together through means like this to reverse this trend. So far, we’ve seen some significant successes.”

The #ZeroReasonsWhy campaign is managed by the Johnson County Mental Health Center, whose mission is improving the quality of life for Johnson County residents by providing comprehensive mental health services driven by the needs of the persons served and providing services of the highest possible quality that are easily accessible to all residents. As part of its
The campaign is designed to prevent teen suicide and drive productive conversations to affirm there are zero reasons why suicide is an option.

#ZeroReasonsWhy was the Charity Partner for the 2019 KC Running Company Father’s Day Four Mile Run/Walk and Kids Run. Teen Council members, student ambassadors and volunteers represented the campaign at the race.

mission, the center is incorporating the campaign into its portfolio of initiatives and programming geared toward reducing and ultimately eliminating teen suicide.

“We are committed to the continuation of the #ZeroReasonsWhy campaign and to supporting these student-led initiatives until this epidemic is eliminated,” said DeWeese.

School districts supporting #ZeroReasonsWhy are Blue Valley, De Soto, Gardner Edgerton, Olathe, Shawnee Mission and Spring Hill.

For more information: jcmhcinfo@jocogov.org.

Three Physicians Join St. Joseph Medical Center

St. Joseph Medical Center announced the addition of three physicians:

Ahmad Al-Mubaslat, MD, will staff the hospital’s new endocrinology clinic that opened in August. Dr. Al-Mubaslat most recently practiced in Amman, Jordan where he spent the past two years establishing the first private diabetes center in Jordan, Khalidi DC, as well as serving as faculty at the internal medicine residency program and the endocrinology fellowship program at Jordan Hospital. Previously, Dr. Al-Mubaslat was head of the diabetes and endocrine department at Self Regional Medical Center in Greenwood, S.C., and the diabetes and metabolic unit at Research Medical Center in Kansas City. He is board-certified in both internal medicine and in endocrinology, diabetes and metabolic diseases.

Clint Gates, MD, a general surgeon, joined the hospital. He is proficient in robotic, laparoscopic and open surgical approaches with special interest in gastrointestinal surgery, endocrine surgery, ventral and hiatal hernia repairs, skin and soft tissue disease, anorectal surgery and dialysis access. A native of Kiowa, Kan., Dr. Gates graduated from the University of Kansas School of Medicine and completed general surgery residency at the University of Kansas-Wichita.

Frank Holladay, MD, a board-certified neurosurgeon, joins the hospital in conjunction with its new 24/7 neurosurgery coverage now available. Born and raised in southern California, Dr. Holladay attended the University of California at Berkeley for an undergraduate degree in zoology before pursuing medicine at Creighton University Medical School. After his fellowship in neurosurgery, he took a teaching position at the University of Kansas. He specializes in minimally invasive spine surgery, spinal fusion, trauma, and adult brain disorders.
Geriatric Psychiatry: A Step in the Continuum of Care

A REVIEW OF TREATMENTS FOR DEMENTIA AND OTHER CONDITIONS AND THE NEED FOR FAMILIES TO PREPARE IN ADVANCE FOR OLDER ADULTHOOD

By Andrew H. Kerstein, DO

The Senior Behavioral Health Unit at St. Joseph Medical Center (SJMC) offers psychiatric care for people with a variety of conditions. Most often, SJMC Senior Behavioral Health patients suffer from dementia, but our patients may also experience depression, psychosis, mania or other conditions. The unit provides short-term evaluation and treatment, with patients having an average stay of 10-14 days.

Geriatric medicine and geriatric mental health are indeed at a tense crossroads as the baby boomers quickly become engulfed in the diseases of older adulthood (also now referred to as “the silver tsunami”). It would be unfair to say that nothing can be done; however, much needs to be achieved in getting care to people earlier, instead of when they are grossly unable to care for themselves. By providing care earlier, we can ensure that the patients’ safety, comfort and dignity are upheld.

Presently, it is estimated that a quarter of people over 80 years old are likely to develop dementia, while more than half of people older than 90 years are likely to already have dementia.

LEGAL AND FINANCIAL IMPACT ON PATIENT AND FAMILY

I have found, while working in the field of geriatric psychiatry for more than a decade, that most patients and their families are not prepared for the financial, legal or emotional actions a dementia diagnosis will require. These may include 24/7 supervision of the patient and activation of surrogate decision makers. Failure to have these matters planned out in advance results in delay and chaos. Often, the patient’s premorbid wishes may not be carried out when a court-appointed guardian determines the placement and plan for the patient’s future.

Long before the onset of dementia, it is best for the patient to obtain a durable power of attorney (DPOA). Under the DPOA, the patient designates a surrogate to represent one’s interests and make decisions regarding placement, treatment and the affairs of the patient’s estate. By the time a dementia diagnosis is made, the patient may be too advanced in the dementia to have capacity to appoint a DPOA. If the patient does not have a DPOA, obtaining a surrogate for these purposes may necessitate a guardianship and conservatorship process through the state’s court system.

PAYING FOR LONG-TERM DEMENTIA CARE

Medicare and Medicaid are terribly misunderstood in our community and lead to much delayed efforts on the part of patients and their families to make provisions for their care. Medicare does not pay for long-term care. Currently, it only pays for up to 100 days of skilled nursing care after hospitalization if the patient qualifies according to Medicare rules. Medicaid becomes the payment source for many individuals.

Since the goal of inpatient geriatric psychiatry is generally not to cure the patient but provide for the patient’s safety, comfort and dignity, there must be a funding source for the patient’s ongoing care. Though legitimate care in a private residence is possible for well-resourced families, most commonly a dementia patient will need placement outside their home before the end of their life. The length of this placement varies as much as the duration of the disease, and the costs can be astronomical. Annual direct care costs can easily exceed $100,000.
TREATING DEMENTIA

Presently, there are not any cures or disease modification medications for most dementias including dementias resulting from Alzheimer’s disease. While much research is underway, achieving comfort, dignity and safety remain the primary care goals for most patients beyond age 75. Current treatments in geriatric psychiatry are still divided into the three groups of biological, psychological and social.

The inpatient environment, which is presently for a much more limited duration and scope than in previous decades, forces the emphasis on biological and social treatment. When a patient is admitted, he or she often is using too many medications from many disparate sources, including internal medicine and other specialties, as well as psychiatry. For other patients who are not being treated with medication at the time of admission, there may be the absence of at least one key medication to ameliorate undesirable behavior or symptoms such as impulsivity.

Antidepressants and cognitive enhancers like Aricept and Namenda have their role, but are deemphasized in modern inpatient geriatric psychiatry. Certain medications should be prioritized in light of the necessity of stabilizing a patient so they can be cared for in a less restrictive setting as rapidly as possible.

Currently, the popular medications for dementia patients with adverse behaviors are mood stabilizers, including antipsychotics and anticonvulsants. We generally try not to use lithium with demented patients due to issues regarding the side effects and the narrow therapeutic window of lithium. When using antipsychotics, it is important to be mindful of the “back-box” warnings for increased risk of stroke and death when used in dementia patients.

As one of my psychopharmacology attendings during residency would say, “Pharmaceuticals are not United States citizens, so ‘guilty until proven innocent’ is the standard.” A multi-million dollar study would have to be done to prove the antipsychotic is not “guilty” and therefore worthy of the back-box warning—which is generally cost-prohibitive for government and pharmaceutical industries. Therefore, the warnings are printed to cover any possible uncertainties regarding dangerous side effects.

ANTIPSYCHOTIC MEDICATIONS

In geriatric psychiatry we have historically and will continue to, for the foreseeable future commonly, use antipsychotic medications to treat dementia’s undesirable symptoms including adverse behaviors. When doing so, we carefully consider the dose, frequency and specific drug properties being entertained.

Moreover, consistent and vigilant blood pressure monitoring is necessary in the first 1-2 weeks of new drug therapy and in the event patients become ill with dehydration or flu-like illness. The antipsychotic medications cause hypotension inherently through their alpha baroreceptor effect. So, in general, the more antipsychotic medications prescribed, the more potential there is for hypotension. As a rule, and in keeping with good practice, we do not give dementia patients long-acting antipsychotics. This, in my opinion, would cause the highest risk for stroke and death because the side effects can persist for weeks, not hours, which compromises management of the patient’s physical condition. Baseline and as-needed electrocardiogram (EKG) monitoring for using antipsychotics is indicated and part of safer use of antipsychotics.

Mood stabilizer anticonvulsants like Depakote are among the most effective drugs for treating dementia. Depakote is presently the most potent agent used to treat impulsivity and agitation in dementia patients. However, stomach upset and gait disturbance are common side effects of Depakote. More rare, but possible, side effects are organ-specific risks such as hepatitis, pancreatitis and clinically hyperammonemic encephalopathy.

Additionally, electroconvulsive therapy (ECT) has long had a role in geriatric psychiatry. Presently, we do not have an ECT service at St. Joseph Medical Center; however, there are plans to change this. ECT is primarily used as a treatment for major depression, particularly (continued)
The challenges facing us as the “silver tsunami” continues to make landfall are huge, ranging from the speed and efficiency with which we can evaluate elders (especially those without existing surrogate decisions makers) to the process by which those patients can be placed.

INDIVIDUAL AND GROUP THERAPY

Psychological treatment includes individual and group therapies. Group therapies are still widely used in the inpatient setting including recreational therapy, social work, nursing and activities like art therapy. Individual therapy, as stated above, is generally reserved for outpatient treatment. Cognitive behavioral variants and supportive psychotherapy are the most commonly used with geriatric patients. With select patients, such as those with post-traumatic stress disorder, focused therapies such as eye movement desensitization and reprocessing (commonly referred to as EMDR) can be useful to reduce/eliminate the emotional and autonomic reactivity that trauma generated triggers cause.

One matter that is applicable to outpatient and inpatient geriatric psychiatry patients is the Beers List. This is the list of medications found to be harmful or potentially harmful to the elderly/over-65 population by the American Geriatrics Society. Most psychiatric medications are on this list as well as many medications prescribed by primary care physicians and specialists. Commonly, even over the counter drugs like oxybutynin and Benadryl are on the Beers List. Especially, without having Food and Drug Administration-approved medication for agitation and psychosis in dementia patients, it is not reasonable to avoid treating patients with medications on the Beers List. Rather the physician’s goal should be to minimize the number and nature of Beers List medications for geriatric patients because these medications may lead to falls or sedative hypnotic states and delirium. Certainly, using a larger variety of Beers List medications or stronger doses of the same is likely to increase the risk of adverse side effects.

SUMMARY

In summary, the Senior Behavioral Health Unit at St. Joseph Medical Center is one of many of resources for older adults. The criteria for admission of a patient to an inpatient psychiatric unit must have an emergent nature, and meet the present standard for psychiatric hospitalizations of adult and child/adolescent populations. The challenges facing us as the “silver tsunami” continues to make landfall are huge, ranging from the speed and efficiency with which we can evaluate elders (especially those without existing surrogate decisions makers) to the process by which those patients can be placed. This often consumes many additional and unnecessary days in the hospital as referrals to long-term care go unanswered, and families are unhappy with facilities that do accept their loved ones.

I suggest, going forward, to approach geriatric psychiatry not as a last resort, but to find ways to include it in geriatrics and primary care. As a result, our patients and their families would be less often faced with crisis scenarios such as inpatient hospitalization when they are forced to address care failure, surrogate decision making, placement and division of assets. I offer myself to our Kansas City area health care community for further discussion, article writing and feedback regarding the aforementioned topics.

Andrew H. Kerstein, DO is medical director and attending psychiatrist in the Senior Behavioral Health Unit at St. Joseph Medical Center. He is a Diplomate of the American Board of Psychiatry and Neurology. He can be reached at akerstein@primehealthcare.com.
The Science of Resilience

TRUMAN MEDICAL CENTERS PROGRAM WORKS TO RAISE AWARENESS OF THE MENTAL HEALTH IMPACT OF TRAUMA AND TOXIC STRESS

Submitted by Truman Medical Centers

The patient appears difficult and uncooperative, even suspicious of the physician. How can this patient be approached?

There is a growing awareness in behavioral health and across the community that patients such as this person are affected by trauma and toxic stress. The behavior is the result of the environment in which the individual has grown up—typically rampant with poverty, crime, family distress and more.

Truman Medical Centers (TMC) has established the Center for Trauma Informed Innovation (CTII) within its Behavioral Health department to help advance community awareness of trauma.

Center Director Dena Sneed suggested how this patient might be approached.

“Utilizing a trauma-sensitive lens means, perhaps, instead of thinking ‘What’s wrong with this person?’ you might consider, ‘What happened to this person?’”

As Sneed explains, “People aren’t behaving badly just to behave badly. People are reacting to a situation based on their experiences. Every patient has a story.”

To spread that message of compassion, the CTII offers training and consulting to the community. School districts throughout the country send representatives to attend its annual Building Resilient Trauma-Informed Schools Summit. Companies striving to offer better customer service, retain talent, and address mental illness and trauma in the workplace ask CTII for advice.

RECOGNIZING ADVERSE CHILDHOOD EXPERIENCES

Trauma-Informed Care recognizes that Adverse Childhood Experiences (ACEs) and other forms of trauma impact people throughout their lives and increase the risk of lifelong chronic illness. Examples of ACEs are domestic violence, physical and emotional neglect, substance abuse, homelessness and divorce. Adverse Community Environments, such as poverty, lack of safe and affordable housing, community violence, systemic discrimination, community disruption, and lack of opportunity, are strongly correlated with ACEs.

According the Centers for Disease Control, “Adverse Childhood Experiences have a tremendous impact on future violence victimization and perpetration as well as lifelong health and opportunity.”

TRAINING TO BE TRAUMA INFORMED

CTII connects with the community, particularly professionals, through educational programs about trauma-informed care principles and practices, empowering individuals, organizations and communities to be more resilient.

One CTII program targets those who work in demanding environments serving persons affected by trauma.

Called Compassion Without Fatigue, the program is led by Rev. Roxanne Pendleton. She is a former pastor and chaplain who has experienced the demands of being an emotional first responder for decades.

“This is an experiential training based in neurological science and best practices,” Pendleton said. “There is science supporting both the impact of trauma and stress and the practices of resilience. We now understand that when the brain stem is activated by the sympathetic nervous system in a stress response or with a trauma trigger, it overrides the pre-frontal cortex. The only thing that matters at that point is survival. We can see executive function and self-regulation diminish in the experience of trauma and with ongoing, overwhelming, toxic stress.”

Pendleton summarized, “Really, our work is about creating safety and cultivating calm. When someone has been traumatized, by an event or by their work, their brains can become so reactive that they can’t think logically and creatively. Stress chemicals can produce chronic, systemic inflammation and lead to a host of diseases. People can get stuck in survival mode and never thrive.”

For more information on the Center for Trauma-Informed Innovation, visit https://behavioralhealthkc.org/services/trauma-informed-care. ☝️
Mental health care in the Kansas City area has changed significantly in the past 100 years.

In the first half of the 20th century, if you were believed to have a mental health condition, you were most likely ignored, but if not, you would be sent to an institution, where there was little hope of recovery.

Treatment has evolved considerably as research, evaluation and experience have led to better treatments and outcomes.

**EARLY YEARS**

Prior to World War II, institutionalization was the primary treatment for mental illness. Few medications were available, and even fewer mental health professionals existed to provide safety net services. There was little hope for positive outcomes of services, where they existed.

Menninger Clinic opened in 1925 and operated a long-term institution in Topeka. They became considered a national model.

**BEGINNING FEDERAL AND LOCAL ACTIONS**

After World War II, veterans were returning home and needed support in numerous ways, one of which was mental health. President Harry Truman became active in passing a new law in 1946, the National Mental Health Act. This set national policy in the federal government for prevention and treatment of mental illness, an early step in moving treatment towards proven methods.

A major breakthrough in medications for mental illness occurred when Thorazine was approved in 1954. This and other psychotropic medications of this era provided some significant improvements in handling patients, but were not usually effective in recovery.

Locally, in 1950, the Greater Kansas City Mental Health Foundation was formed to upgrade quality of services. This group began operating inpatient and outpatient treatment, adding a psychiatric residency program in 1954. Later, this group was instrumental in starting mental health services in many areas of Jackson County.

**1960s BRING SIGNIFICANT CHANGE IN MENTAL HEALTH CONCEPTS**

President John Kennedy signed the Community Mental Health Centers Act of 1963, creating outpatient services in local areas throughout the U.S. This allowed treatment in the home community, focused on prevention and early intervention, began reversing alarming growth of mental hospitals, promoted psychiatric treatment in general hospitals, began the creation of a continuum of care,

Between 1962 and 1973, seven community mental health centers (CMHCs) were formed in the Kansas City area, covering all counties on both sides of State Line Road.
and initiated local citizen governance/participation. It assigned responsibility for a specified population/service area to different designated nonprofit agencies in the Kansas City area. Metro Kansas City, in both Missouri and Kansas, was among the first to implement this concept in the nation.

Between 1962 and 1973, seven community mental health centers (CMHCs) were formed in the Kansas City area, covering all counties on both sides of State Line Road. This began implementation of safety net mental health services in the region, which continue to evolve to this day.

One major difference in mental health in the Kansas City area is that the CMHCs were and are still very collaborative and not competitive with each other. While each serve their own local communities, most CMHCs work closely together on creating or improving services, creating shared crisis lines, jointly operating new programs, etc.

A second difference is that, other than the Johnson County Mental Health Center, the CMHCs in the Kansas City area are nonprofit agencies with locally controlled boards. Johnson County government runs their mental health center, appointing a local advisory board. The advantage of the local nonprofit governance is that the CMHCs are governed and led by people who live in the community served, and thus have considerable feedback about the outcomes. While most mental health providers throughout the nation and even in Missouri have merged into larger national or regional providers, the Kansas City CMHCs have remained governed by and responsible to the local communities served.

**SHIFT FROM FEDERAL TO INCLUDE STATE AND COUNTY INVOLVEMENT**

In the early 1980s, the federal government began creating block grants for many services to decrease federal involvement and turn funding and responsibility to the states. This was designed to shift the future burden from the federal government to the states and limit federal funding. One of these areas was mental health. As primary funding and control of safety net mental health changed from federal to state, the State of Missouri gave its community mental health centers (CMHCs) special, added responsibilities to be public servants, planning for community needs and caring for the people living in each service area.

While the federal government intended to reduce funding for mental health, in reality Medicaid has continued to grow over the past 30 years to eventually become the largest funder of safety net mental health in the Kansas City area. Missouri’s model of using Medicaid funding became a driving force in creating new programs to meet community need, as non-Medicaid funding became scarce or non-existent. By 2010, Missouri’s (and Kansas City’s) CMHC programs became national models for mental health and were frequently sought out by other states.

In the Missouri portion of the Kansas City region, voters passed an additional property tax levy and created the Jackson County Mental Health Levy Fund (later added for Clay, Platte and Ray counties). While this addition provided needed funds, it also created new, local involvement and control on the mental health services in our community.

Other nonprofit agencies were formed by local groups, usually to add and improve services for specialized populations and typically focusing on either indigents or clients with money, rarely both. These programs included youth services, domestic violence and many others. This increased focus on underserved groups and also created additional options for accessing mental health services.

**NEW MEDICATIONS VS. INVOLUNTARY COMMITMENT, INCARCERATION**

In the 1980s, additional new psychoactive drugs were approved for use. Many of these were improvements over previous drugs, allowing far more people to leave institutions and be placed in the community.

**In the 1980s, additional new psychoactive drugs were approved for use. Many of these were improvements over previous drugs, allowing far more people to leave institutions and be placed in the community.**
for drug abuse offenses, while federal funding for treatment decreased. This resulted in large increases in incarceration of people with mental illness or addictions. Most jails and prisons now have a majority of their inmates suffering from addiction or mental illness.

During the 1990s and beyond, insurance and other funding was driving the private providers to deliver shorter term services and less inpatient, gradually but dramatically reducing the number of inpatient psychiatric beds in Kansas City area. At the same time, government funding decreases reduced inpatient capacities in the state hospitals, including those near Kansas City, which caused rural areas to refer more people to the Kansas City State Hospital.

Menninger left Kansas in 2003. Their longer-term psychoanalytic approach was not sufficiently supported by funders to sustain its operation.

Funding shortfalls and deinstitutionalization left more people with mental illness on the streets, and many did not voluntarily go to needed community mental health services. The untreated homeless population increased.

While involuntary treatment for mental illness was and still is an option in Kansas and Missouri, it is used very sparingly. Civil commitment for inpatient is used for up to 72 hours, and while outpatient civil commitment is legal, it is virtually never used in Missouri, in the name of protecting civil liberties.

While before World War II, it was easy to commit family members to a mental institution for life, it is currently far easier for people to be left homeless or to be incarcerated than to commit someone to treatment. Thus, prisons and jails are overwhelmed.

PRIVATIZATION OF MISSOURI DIRECT CARE SERVICES TO LOCAL NONPROFITS

In the earlier years, the Missouri Department of Mental Health directly operated many mental health services in various communities. In the 1990s and early 2000s, Missouri began reducing its direct service role, resulting in several significant changes in Kansas City.

The state transitioned out of outpatient mental health in central Kansas City and transferred its services to Truman Medical Center's Behavioral Health program.

This significant change allowed the state to increase focus on its oversight role over mental health services, plus added needed services to the role of Truman Medical Center.

Later, Missouri also turned the operation of most of Kansas City's state hospital beds to Truman Medical Center. This increased Truman's role in inpatient and emergency mental health.

As the opioid epidemic was growing, Missouri privatized its state opioid treatment program to the community mental health center ReDiscover, transferring medication treatment for over 200 patients.

These changes placed more responsibility onto local agencies, including caring for some of the most vulnerable and challenging patients in Kansas City.

COMPREHENSIVE SAFETY NET SERVICES EVOLUTIONS SINCE 2000

In the 2000s, the health and mental health systems found that many patients...
Since 2008, mental health centers have been proactively working with local hospital emergency departments, jails, police and other stakeholders to respond to and reduce the rapid growth of uninsured mental health cases impacting our communities.

had multiple illnesses, such as mental health and addictions or mental health and chronic physical health conditions. Comprehensive safety net mental health services evolved to meet the increasingly complexities of the illnesses.

Traditional mental health services frequently mostly operated 8 to 5, Monday through Friday, even though mental health problems frequently present overnight or on weekends. Therefore, expanded 24-hour crisis access was required, both telephone and mobile.

Many private mental health providers operate as single or group practices. However, patients with more serious, chronic conditions function better with a multi-specialist, team approach. Comprehensive rehabilitation was started, which uses a full team working with seriously mentally ill patients, including utilizing a psychiatrist, nurse, licensed therapist, case manager, vocational services, peers and others.

Most patients with a substance use disorder have a co-occurring mental health diagnosis. While previously these programs were very separate, the national model is to integrate substance use treatment with mental health, so this became an expectation in Kansas City.

Patients with difficult or chronic conditions may present well in the office, but compliance outside the provider office can be problematic. The safety net mental health system evolved to use frequent provision of home visits for patients needing this support.

For patients with even more difficulty in the home, the mental health system created an array of supervised residential care, short-term or long-term, plus independent housing options. As a result, some local mental health centers are large providers of housing services.

Studies show that adults with serious mental illness die 25 to 27 years earlier than the average American. This was not primarily due to suicide, but to chronic physical health conditions that were untreated. These include diabetes, heart disease, COPD and others. Coordination with physical health, including having primary care services on location in CMHC sites, was needed due to high incidence of chronic physical health conditions among those with serious mental illness. Most CMHCs in metro Kansas City have that capacity.

Also, larger primary care providers began providing behavioral health consultations onsite, resulting in better coordination of care. (continued)
Medical and criminal justice agencies began understanding that mental health and substance use disorders are chronic medical conditions, rather than a short-term “weakness.” At the same time, providers of substance use treatment began recognizing that the short-term treatment approach and using “talk-therapy” as the primary treatment was having limited success. Better treatment coordination is evolving. The use of medications to treat opioid and some other addictions has been shown to be far more effective than other existing treatment approaches. Almost all local substance use treatment providers now embrace use of medications as a good option for treatment.

Police and mental health providers recognized that many people in a mental health crisis encounter the police before they see a provider. In 2005, mental health providers and advocates helped the Lee’s Summit Police Department start the Police Crisis Intervention Team (CIT) program in the Kansas City area. This program has since expanded throughout the region and into much of Missouri.

Many of the people needing safety net mental health services impact numerous parts of the community, especially when they are not receiving the care they need. These significant impacts include frequent, sometimes lengthy encounters with police, courts, jails, hospital emergency departments, shelters, schools, and most social service agencies.

Since 2008, mental health centers have been proactively working with local hospital emergency departments, jails, police and other stakeholders to respond to and reduce the rapid growth of uninsured mental health cases impacting our communities.

The method of reimbursement of health and mental health has historically been a fee-for-service environment. A new federal model is being tested with most Kansas City area CMHCs that changes funding from fee-for-service to outcome- and contact-based. It also expects the CMHCs to manage the care of all the people served from the community and the community at large. It requires use of evidence-based practices. While the model is more complex, it is anticipated that it will improve overall outcomes for people served, plus improve access for those needing care.

THE SAFETY NET CMHC SYSTEM HAS EVOLVED GREATLY IN THE KANSAS CITY AREA

While the mental health environment has grown and improved over the past 100-plus years, there are still challenges, as well as areas continuing to see improvement.

Funding shortfalls are the norm in the safety net mental health arena. It is a rare year that providers of services get increases, even for inflation. While there has been great progress, many more services are unavailable, and too many people cannot get services when needed, creating stress on hospitals, police, shelters, etc.

Prevention and early intervention services are known to be effective when using evidence-based practices, but they are rarely funded. Crisis services are more frequently prioritized over longer term resolutions.

COMMUNITY MENTAL HEALTH CENTERS IN KANSAS CITY

Following is a list of community mental health centers in greater Kansas City. These centers conduct joint educational activities including an annual conference under the Metro Council of Community Behavioral Health Centers.

- Comprehensive Mental Health
  https://thecmhs.com/
- Johnson County Mental Health
  https://www.jocogov.org/dept/mental-health/home
- ReDiscover
  http://www.rediscovermh.org/
- Swope Health Services
  https://www.swopehealth.org/
- Tri-County Mental Health
  https://www.tri-countymhs.org/
- Truman Medical Center Behavioral Health
  https://behavioralhealthkc.org/
- Wyandot Center
  http://www.wyandotcenter.org/
Due to the complexities of care needed and the scarce funding resources, the safety net mental health services in the Kansas City area have learned to manage the care of the people served while increasing services available. While many areas of the country contract with insurance companies or national managed care companies, the local CMHCs provide a similar service, using a local nonprofit, thus providing an outcome responsive to the local community, not shareholders.

When people needing treatment do not get the treatment required, they are in our jails, homeless, or continuing to struggle in schools or in jobs. Most people can succeed with treatment and become productive citizens.

There have been great gains in the mental health system to build on, and we have expectations that the mental health community will build on their successes to break new ground in the prevention and treatment of mental illness.

An important new service in Kansas City is diverting thousands of people each year with mental health and substance use disorders away from emergency departments and jails.

The Kansas City Assessment and Triage Center (KC-ATC) provides a safe place where individuals in crisis can be assessed and stabilized. It offers a setting and staff much more suited to handling behavioral health issues than the emergency department or jail. Individuals can stay at KC-ATC for up to 23 hours; they will then be referred to behavioral health outpatient or residential services for treatment as needed.

Located at 2600 E. 12th St. in downtown Kansas City, KC-ATC opened in October 2016. KC-ATC is a public and private partnership between Kansas City stakeholders including courts, law enforcement, hospitals, city officials and the Missouri Department of Mental Health, with ReDiscover as the lead agency for operations. Staff includes registered nurses, case workers, mental health technicians, licensed social workers and nurse practitioners.

During 2018, KC-ATC accepted 4,573 referrals, with 69% coming from hospital emergency departments, 11% from law enforcement and 20% from EMS and other sources. The program achieved a savings of $9.5 million in emergency department and incarceration costs.

Among clients served, 62% were referred back to their existing mental health or substance use treatment providers. Another 34% were referred for new mental health services or substance use treatment.

For more information, see the article on KC-ATC in summer 2018 Kansas City Medicine.

Google maps

Program Diverts Mental Health Patients from EDs, Jails

Alan Flory served as president and CEO of ReDiscover from 1994 to 2018. ReDiscover is a leading community mental health center with 14 facilities serving over 10,000 ongoing treatment clients annually. He is now retired. He can be reached at alflory@comcast.net.
“There are few things in life more upsetting than knowing you need health care but cannot afford to obtain it. Metro Care and Wy Jo Care provide a way for community physicians to aid in this most worthwhile endeavor. I am proud to be one of the many generous physicians who provide the care these patients need.”

~ Richard Hellman, MD, FACP, FACE

Hellman & Rosen Endocrine Associates
Supporter, Wy Jo Care and Metro Care

The Kansas City Medical Society Foundation recognizes Richard Hellman, MD, FACP, FACE, for actively demonstrating our values of health equity and access. Dr. Hellman is a nationally and internationally recognized endocrinologist, educator, researcher, lecturer and physician leader who continues to help the most vulnerable people in his community access the best medical care. He designed and directed the first comprehensive adult diabetes care program in Kansas City. Recognized by the Kansas City Medical Society with the 2017 Lifetime Achievement Award, Dr. Hellman continues to use his vast expertise to help the uninsured and low-income people he serves through Metro Care and Wy Jo Care.

*Join the KCMS Foundation in our mission to provide care to the uninsured.*