As we searched online, we found two different definitions from two different innovation experts. Nick Skillicorn, Chief Editor of *Idea to Value*, and CEO and founder of *Improvides Innovation Consulting*, uses the definition, “Turning an idea into a solution that adds value from a customer’s perspective.” Stephen M. Shapiro, author of *Best Practices are Stupid* and *Personality Poker*, uses the definition, “Staying relevant.”

We really liked both definitions and felt like they were rather meaningful and complemented each other. Skillicorn’s definition nicely and directly pulls the importance of stakeholders (customers) and incorporates solving a problem into its meaning. Shapiro simplifies it by summarizing the critical impact of innovation as “staying relevant.”

Thinking about our customers in Psychiatry and Behavioral Medicine would vary depending upon which of our four missions we consider:

- In clinical care, our stakeholders could be our patients and their families, or it could be our medical colleagues who seek consultation.

- In education, our customers would be primarily our students (medical students, graduate students, residents, psychology interns, and faculty students).

- In research, our customers would include patients, peers, study participants, the Institutional Review Boards, collaborators, and sometimes industry.

- From a community engagement perspective, our customers include the diverse communities that we continue to serve.

The “solution” part of the definition would pertain to solving problems and challenges we encounter in each of the mission areas with new ideas. Shapiro’s definition points to the importance of continually staying relevant in the work that we do.

One thing that has contributed to CAIR’s success under Dr. Jeff Kelly’s leadership is the ongoing practice of strategically monitoring where the field of AIDS behavioral research is going by staying closely aligned with the National Institutes, and then planning research projects that intersect with and lead the direction of the field. This practice keeps CAIR at the front of the cutting edge of AIDS intervention behavioral research. To paraphrase hockey great Wayne Gretsky, CAIR is “skating where the puck will be, not where it is.”

We would also argue that being active in community engagement (one of our missions) is another method that if done thoughtfully, can be useful in guiding us in keeping our work relevant.

Have you heard the term “disruptive innovation?” This is a term used in the field of business administration which refers to an innovation that creates a new market and value network and eventually disrupts an existing market, displacing established market leading firms, products, and alliances. Can you think of some examples of disruptive innovations? Some obvious examples would include when DVDs came out and videotapes became obsolete. (continued on next page)
This happened again when Netflix and online movies became available, DVDs and stores like Blockbuster went out of business. Since Kindle and eBooks arrived, many bookstores are closing. Can you think of any disruptors in medicine? How about when electronic medical records came out?

What are some of the innovations being developed and utilized in our department, and in behavioral health? We are proud of the many innovations that we are developing and/or utilizing. Some of these include:

- Introducing SilverCloud as a depression treatment tool;
- Adding repetitive Transcranial Magnetic Stimulation (rTMS) as a service to treat refractory depression;
- Building consultation programs like the Child Psychiatry Consultation Program (CPCP) and the Periscope Project;
- Designing a comprehensive consultation program;
- Developing a hospital-wide delirium recognition and treatment project;
- Building accredited psychiatry residencies attached to MCW’s community medical schools;
- Educating leaders of social networks to get people with high risk behaviors to change these behaviors or to get tested (CAIR-based research);
- Using teleconferencing to teach didactics across great distances;
- Delivering telepsychiatry services to remote, underserved areas; and
- Developing new methods of integrating behavioral health care into primary and specialty medical care.

As you can see, innovation adds incredible value to an academic department of psychiatry and behavioral medicine across all our missions. Sometimes the innovation is applying an older idea in a new way. Research is a critical bridge that often takes us to innovation. As mentioned previously our community engagement also helps inform us—so our work can stay relevant.

Administratively we regularly seek opportunities to reinvent ourselves, adopting and adapting to new systems, evaluating workflows and ever-seeking more effective and efficient ways to support the Department’s missions.

Will there be disruptive innovation in our field? We would argue that this is likely so. How we work will likely continue to change. However, we do not see the day in our lifetime when behavioral health care is no longer necessary.

What innovations are you currently working on with your creative minds? We look forward to learning about them. In this edition of Psyched, you will learn in more detail about some of these important innovations.

Jon A. Lehrmann, MD  
Chairman and Professor  
Associate Chief of Staff for Mental Health, Milwaukee VAMC

David Peterson, MBA, FACMPE  •  Department Administrator Clinical
SILVERCLOUD LAUNCHES ACROSS OUTPATIENT BEHAVIORAL HEALTH

There have been many recent advances in healthcare that have affected the practice of behavioral health and opened new opportunities. The widespread availability and use of “digital technology” or “mHealth” has indirect and direct impact on professional practice because it:
- Fits into our daily lives
- Reaches populations
- Personalizes interventions
- Is as effective as face-to-face treatments, with support
- Can be used to augment face-to-face treatment
- Reduces costs

One such opportunity at FH/MCW is the use of the online cognitive-behavioral therapy program, SilverCloud. It is an evidence-based program started as a seven-year research project at Trinity College Dublin before becoming a three-year translational research project. It is now widely used in over 170 healthcare organizations worldwide. At FH/MCW, four SilverCloud programs (anxiety, depression, anxiety+depression, and stress) can be ordered at no-charge to patients via the EPIC Digital Care tab. Patients complete their prescribed SilverCloud program at their own pace, over approximately 8 to 12 weeks, to augment face-to-face treatment visits with their provider. SilverCloud is designed to be personal, supportive, interactive, and social. Modules are composed of the following sections:
- Introduction to the upcoming topics
- Quiz for the user to start thinking about the covered topics
- Main psychoeducational content section
- Personal real-life people and clinical knowledge stories
- Activities help the user get the most out of the module and really reflect on anything new they have learned. Completing these activities will help the user get the most benefit from their program
- Review key take-home points to reflect on (and see what other people have said) and a place for module feedback

Since July 2017, over 600 patients across FH/MCW have used SilverCloud. 93% of patients “agree” or “strongly agree” that it is helpful in supporting them to make progress towards their goals, which is also evidenced by reductions (3 points on average) in depression and anxiety (PHQ-9 and GAD-7) scores. For more information and resources about SilverCloud, contact me or go to: http://intranet.froedtert.com/404/default.aspx?404=http://intranet.froedtert.com:80/digitalcare

Lawrence Miller, PsyD
Assistant Professor, Psychiatry and Behavioral Medicine
Co-Director, Behavioral Medicine and Primary Care (BMPC)
Psychology Clinic

NEUROSCIENCE RESEARCH & COMMUNITY ENGAGEMENT

Our research focuses on reducing racial and socioeconomic disparities in the incidence of and mortality from lung cancer. Milwaukee has the largest racial disparity in lung cancer deaths in the United States, and much of this disparity is driven by differences in tobacco use. Thus, we use functional neuroimaging to better understand brain systems and processes that contribute to nicotine dependence with the goal of developing better smoking prevention strategies and smoking cessation interventions. Two strategies that we have used to make our research innovative are cross-disciplinary approaches and community engagement.

Historically, laboratory studies of smoking used a “cue reactivity” paradigm that compared brain responses to smoking-related and neutral stimuli. Although these studies found reliable differences in brain activity between the stimulus categories, they did not predict relapse, limiting their predictive validity and clinical utility. To address this issue, we combined the traditional cue reactivity paradigm from the field of addiction neuroscience with an “emotional reactivity” paradigm from the field of affective neuroscience. We compared brain responses not only to smoking-related and neutral stimuli, but also highly-arousing pleasant and unpleasant stimuli.

We found that smokers with larger brain responses to smoking-related cues than to other categories of highly rewarding stimuli were more likely to relapse over the next 6 months. This neural biomarker of relapse also predicted the efficacy of smoking-cessation medications. By using a cross-disciplinary approach to combine laboratory paradigms from two different sub-fields of neuroscience, we were able to innovate and develop a laboratory model of relapse that had both predictive validity and clinical utility.

In order to reduce lung cancer disparities in a diverse population of smokers, we need to better understand nicotine dependence. This diverse group of smokers will have the opportunity to both inform the design of and participate in our research. We are currently working with the Wisconsin Tobacco Prevention and Poverty Network and other community groups. Community engagement will expand the impact of our research to the entire community. The research will include those who are most vulnerable to lung cancer, but who have historically been underrepresented in behavioral and neuroscientific studies of risk factors such as nicotine dependence.

Jeffrey M. Engelmann, Ph.D.
Assistant Professor
Psychiatry and Behavioral Medicine/Cancer Center
**THE PSYCHIATRY EXTENSION SERVICE**

There are many barriers for patients to access behavioral health care. We know that access to psychiatrists can be limited or delayed. Even when access is available, many patients prefer to be seen by a primary care provider (PCP). In fact, PCPs provide 50% of mental health care for common behavioral health conditions. Even when a referral is made to behavioral health, only 50% of patients follow through—likely for a myriad of reasons.

It is no surprise that one of our Department’s clinical goals is to improve access to psychiatrists via consultation programs. One way to do this is to provide timely assistance in caring for adult patients with behavioral health conditions within their primary care home.

As such, efforts began over a year ago to develop the Psychiatry Extension Service (PES): a psychiatric support service for providers caring for adult patients with behavioral health conditions within Froedtert and MCW primary care clinics. We were fortunate enough to utilize lessons learned from The Periscope Project (TPP) and the Child Psychiatry Consultation Program (CPCP) in order to develop PES. Like TPP and CPCP, PES offers three core services: teleconsultation, provider education, and community resources.

The teleconsultation service allows eligible providers to access a psychiatrist via phone (414-955-8977) within 30 minutes and via email (psychextension@mcw.edu) within one business day. PES is available Monday through Friday, 8 am to 4 pm, excluding holidays. Eligible providers include physicians, advanced practice providers, nurses, therapists, psychologists, social workers, and pharmacists who are caring for adult patients as part of a Froedtert and MCW primary care clinic.

Our psychiatrists provide an array of general recommendations regarding screening, diagnosis, treatment, or appropriate level of care. We have the ability to offer one-time face-to-face consultations for select patients. We also anticipate e-consults will be part of our toolkit in the future.

I am very pleased to announce that on September 4th, 2018 we began rolling out the Psychiatry Extension Service to primary care clinics within the Froedtert and MCW system. We are eager to collaborate with our primary care colleagues in caring for adult patient with behavioral health conditions within their primary care home.

Deepa Pawar, MD, MPH
Assistant Professor, Psychiatry and Behavioral Medicine

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**DEPRESSION CLINIC & TMS**

Clinical depression represents a complicated and diverse group of conditions that can be difficult to distinguish and resistant to conventional treatments. Notwithstanding, the immense thought and study that has been invested into characterizing depression, the neurobiological and psychological basis of depression remains largely elusive. Typical treatment approaches often lead to modest and inadequate results and can take prolonged periods to lead to improvement.

With these challenges in mind, outcomes can be improved when diagnoses are accurate and advanced treatment modalities are appropriately used. To this end, The Department of Psychiatry and Behavioral Medicine has established a depression clinic at the Tosa Center for providing specialized evaluations and care to patients who suffer from depression. Through these evaluations, the clinic seeks to provide diagnostic clarity and recommendations for pharmacotherapy and psychotherapy and to identify appropriate candidates who may improve with neuromodulation treatments. When psychotherapy and evidence-based medication management has not succeeded in treating depression, neuromodulation techniques like electroconvulsive therapy (ECT) and transcranial magnetic stimulation (TMS) may improve symptoms.

TMS is a relatively new therapeutic modality that is available as a treatment option at the Tosa Center. It has been approved by the FDA for the treatment of major depressive disorder and is covered by most insurance plans. TMS works by delivering a series of magnetic pulses that depolarizes neurons within the range of the magnetic field. When this is applied repeatedly to areas like the left dorsolateral prefrontal cortex, the symptoms of clinical depression can improve. Unlike ECT, TMS does not require anesthesia and generally has a lower rate of side effects than other medical treatments for depression, including medication management. There are few contraindications and it is generally well-tolerated. A treatment course of TMS typically lasts four to six weeks with treatments being administered five days per week. Visits last about 30 minutes and do not require a chaperone.

Referrals to the depression clinic and TMS can be made by calling the Tosa Center Psychiatry and Behavioral Medicine clinic or by using the Epic referral. The Epic referral can be found under the order for Amb Behavioral Health Referral under Adults (18-65), Mood Disorders, and Neurmodulation for Depression.

Michael Montie, DO
Assistant Professor, Psychiatry and Behavioral Medicine
In August 2018, the Department embarked on a new project: the Captain John D. Mason Peer Outreach Program, a program with the goal of helping Veterans get enrolled in VA healthcare. This idea was proposed by Bert Berger and Jon Lehrmann, and funded through a philanthropic donation by Joseph and Jen Tate, and I was brought on as program manager and evaluator.

Mr. Tate was moved to start a program that would benefit Veterans because of the loss of a friend of his, Captain John Mason. John served in Vietnam with the Second Battalion, Twelfth Marines, Third Marine Division and was awarded the Bronze Star Medal with the Combat “V” for his valor and honorable service. After his military service was complete, John married and had two children. His family remembers him in this way:

“John's experience in the military was very important to him, and he often reflected on his military training and values when he was faced with personal and professional challenges. He felt a true camaraderie with other veterans. John was known as kind, smart, funny, hardworking and a man of impeccable values and integrity who loved his family and his friends deeply.

Every day, John's family and friends face a painful void that can never fully heal. He missed his son and daughter's weddings and the birth of his first grandchild. His wife navigates life without her soul mate, and friends dearly miss the man who made everything fun. Heavy on their hearts are so many unanswered questions and missed opportunities. However, John believed in the camaraderie among veterans because they often understand each other in ways no others can.

Unfortunately, Veteran death by suicide is not uncommon. Nationally, approximately 20 Veterans a day died by suicide in 2014 (including 133 in Wisconsin). Most Veterans who die by suicide have little to no contact with the VA; in fact, approximately 70 percent of Veterans who die by suicide are not VA healthcare users. However, the VA has not made outreach or advertising a main part of its mission. These statistics, combined with a focus on the camaraderie mentioned above, led to the idea to hire a Veteran to reach out to other Veterans, increasing engagement in VA healthcare services, and ultimately decreasing the number of Veteran suicides.

John struggled silently many years with depression and Post-Traumatic Stress Disorder, much stemming from his time in Vietnam. He never wanted to burden his family or friends with his inner struggles, and this mindset, combined with the stigma of mental illnesses, prevented him from seeking sufficient treatment for these conditions. In August 2013, financial distress and a back injury that left him in pain and unable to exercise caused his illnesses to overpower him, and he took his own life.

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The VA and other community agencies are increasingly employing peer specialists, people with lived experience in the area of service, as a way to better support and outreach to particular populations. Peer support started as an offshoot of the mental health consumer movement of the 1970s, and has found new applications in chronic disease management, screening and prevention, and reducing health disparities. Yet the use of a peer (Veteran) to outreach to other Veterans with the goal of enrollment in VA healthcare is new.

We are excited to announce that a Veteran has been hired into the inaugural role of peer outreach specialist: Steve Heiges comes to us uniquely qualified for this role, having been engaged in the Veteran community for years. He was active duty army and reserves for nearly 30 years, working in operations, change management, logistics, and leadership. He has also worked as a peer specialist with Dry-Hootch and been involved in the Warrior Partnership and other Veteran initiatives. We are proud that he will be the first “peer” hired by MCW.

In this inaugural year of an innovative program, we are hoping to set a template for what activities would be most helpful in reaching out to under-served Veterans. This will involve, for instance, having a booth at local festivals, creating relationships with other Veteran-serving organizations, and identifying Veterans who may not already be connected to the Veteran community. We will also evaluate the project, so that we can identify best practices moving into future years.

Sadie E. Larsen, Ph.D.
Assistant Professor
Program Manager, Captain John D. Mason Peer Outreach Project
Co-Director, Behavioral Medicine and Primary Care Psychology Clinic
Associate Training Director, Health Psychology Residency
AMY CAMPBELL
Administrative Assistant
Department of Psychiatry and Behavioral Medicine

What is your educational background?
I have two degrees that are non-healthcare related, one being CNC machining/mold building, and the other in nail technology. So, if anyone has metal to be milled, a die built, or you would like your nails done, come and find me! Prior to MCW, I have been in the health care field for 14+ years, most recently ten years at the University of Iowa. The Departments I previously scheduled for were Internal Medicine, Medicine Specialty, Orthopedics, GI, Cardiology, Radiation Oncology, Radiology, Food and Nutrition, and Transplant. The remainder of my time at the University of Iowa was spent as a scheduler amongst other roles in the Holden Comprehensive Cancer Center/Chemo Center.

How long have you worked at MCW?
I have been in the Department since August of 2017.

Describe your typical day.
My typical day begins with welcoming the patients and visitors to our office. The majority of my day is spent at the front desk answering calls, and requests. The remainder of my time is spent in the back office completing Administrative duties.

What do you like most about your job—what attracted you to this field?
What primarily attracted me to this clinic were the people. When I originally met with Bob Huberty, I was most impressed with how nice everyone was, and it seemed very team oriented. Plus, I really enjoy the interaction with patients, and not being solely behind the scenes.

Tell us about life outside of MCW.
I have two adult children—Alisha, 28, and Nathaniel, 22. I'm a grandma, and I have an 80-pound rescue dog, Abby, who thinks she's a lap dog. I love biking and outdoor activities.

Just for fun—what are your favorite movies, books, music?
I am a self-proclaimed Harry Potter nerd and cannot get enough!

Tell us a fun/unique fact about yourself.
I grew up in a small town in Iowa, with K through 12 attending the same school. I had 24 classmates in my graduating class.

ALAN NYITRAY
Associate Professor
Cancer Center and Center for AIDS Intervention Research (CAIR)

What is your educational background?
I received an MS from Oklahoma State University in mass communications in 1988 and a PhD from the University of Arizona in 2008. I majored in epidemiology and minored in biostatistics. In between, I worked in HIV prevention in a service capacity for health departments and community-based organizations.

How long have you worked at MCW?
I started on July 30, 2018.

Describe your typical day.
This is my “ideal” typical day: Grant or manuscript writing for two hours to start the day followed by responding to email. I’m currently launching two research projects up and running—recruiting gay, bisexual and other men who have sex with men (GBM) here in Milwaukee and another that's recruiting GBM in Houston and Chicago. So if I’m lucky I get an hour to look at raw data before I head to the gym!

What do you like most about your job—what attracted you to this field?
I love the HPV infection and anal cancer screening research I do. I really enjoy hypothesizing about how the world works and then trying to resolve that hypothesis with rigorous research. After I went back to school in 2004 for training in epidemiology, I learned about the high incidence of HPV-associated anal cancer in GBM. I’m gay and I thought I could make a difference in my community and others at increased risk for anal cancer.

Tell us about life outside of MCW.
My husband Jason and I enjoy going to live music, mostly underappreciated rock and hip hop. I also enjoy bicycling, backpacking, sampling craft beer, and our cat Liam.

Just for fun—what are your favorite movies, books, music?
I read a lot of non-fiction but Anthony Doerr’s 2014 novel All the Light We Cannot See blew me away.

Tell us a fun/unique fact about yourself.
My mom learned she was pregnant with me the day Alan Shepard became the first American in space. That’s why my name is spelled A-L-A-N.
COURTNEY BARRY
Health Psychologist
Department of Psychiatry and Behavioral Medicine
Department of Family and Community Medicine

What is your educational background?
I received my doctorate in clinical psychology, with a specialization in health psychology from the Chicago School of Professional Psychology.

How long have you worked at MCW?
I have been at MCW for three years. I completed a primary care research fellowship in the Department of Family Medicine. During this fellowship, I conducted research on trauma within primary care.

Describe your typical day.
I will be conducting bariatric evaluations, providing postsurgery follow-up consultations, teaching residents and medical students, and also conducting research/program development.

What do you like most about your job—what attracted you to this field?
I like being a health psychologist and have a strong interest in obesity. I have a strong interest in integrated care and mind/body wellness and really enjoy working with others to promote wellness. I also have a passion for helping people work towards their values and help achieve their health goals.

Tell us about life outside of MCW.
I like to spend time with my husband, Vinit, our two-year-old Arya, and our two dogs, Brady and Piper. I love hiking, taking walks, and exploring new cuisines. I also enjoy traveling! I am a big fan of the museum and love to learn about history!

Just for fun—what are your favorite movies, books, music?
I have way too many favorite action/drama movies to just name one—so I can’t! And the book I’m currently reading is Wonder by R.J. Palacio.

Tell us a fun/unique fact about yourself.
I LOVE any and all Italian food!

JIMMY STEVENS
Child and Adolescent Psychiatrist
Children’s Hospital of Wisconsin and Sojourner Truth Family Peace Center

What is your educational background?
I studied Anthropology and lots of random languages as an undergraduate. I have a teaching degree in French and English as a Second Language. I went on to graduate school and got a PhD in linguistics, and I went to medical school.

How long have you worked at MCW?
I have worked here since July, but I was a trainee here as a resident and a fellow with the Medical College of Wisconsin Affiliated Hospitals.

Describe your typical day.
Professionally speaking, my typical day involves clinic either at Children’s Hospital Clinic Building or Sojourner Truth. Some days, I teach classes or have meetings with teams to discuss more complex patient cases. When I have downtime, I have several research projects in which I am involved.

What do you like most about your job—what attracted you to this field?
I love how I can be directly helpful to families who are stressed, either by their children’s psychiatric conditions or simply by life circumstances that have led to current behaviors and symptoms distressing to everyone. I am attracted to this field because it serves as a place of junction between so many different ways of thinking of life, including a biomedical model, philosophical perspectives, social justice issues, as well as intersections with the law and religion.

Tell us about life outside of MCW.
My wife Candance and I have a house on the east side by the University of Wisconsin–Milwaukee, where she works as a professor of literacy education. We have three children, all boys, who keep us busy and frankly quite haggard with their energy level and chronic destructiveness. We will have no pets so long as I have voting power in the family, but I adore plants and try to maintain quite a few. I love learning languages in my free time and really enjoy music.

Just for fun—what are your favorite movies, books, music?
The whole Kind of Blue album by Miles Davis is heaven sent. My favorite book is The Little Prince by Antoine de Saint-Exupéry.

Tell us a fun/unique fact about yourself.
I’m not very handy.
DEPARTMENT HAPPENINGS

2018 GREATER MILWAUKEE
HEART & STROKE WALK / 5K RUN
Saturday, September 29 | 8am’til Noon
Veterans Park | Milwaukee’s Lakefront
1300 North Lincoln Memorial Drive

Walk with Team Psych!
http://www2.heart.org/site/TR?px=2037378&pg=person-al&fr_id=3582&et=URQD469--N3mFt0-lYnRuQ

FUTURE DEPARTMENT MEETINGS
(all on Wednesdays beginning at 8:00 a.m.)

2018 FACULTY
October 24 • VA, Matousek Auditorium

2019 FACULTY
January 23 • February 27 • May 22 • July 24
Tosa Center Classrooms A & B
October 23
VA, Matousek Auditorium

2019 COMBINED FACULTY/STAFF
April 24 • September 25
Research Park, Learning Centers 1 & 2

7th Annual Depression Recognition Day
IN MEMORY OF CHARLES E. KUBLY AND
SUPPORT FROM THE STEPHEN T. SEXTON
MEMORIAL FOUNDATION
Tuesday, October 9, 2018 • 12–5 p.m.

1st Floor, Rooms HRC Auditorium
Medical Education Building
8701 Watertown Plank Road

Entertainment • Giveaways • Presentations
Informational materials about depression
Free depression self-rating scale
Arrange to speak with a mental health professional
Lunch provided

For more information and to RSVP
please contact Joy Ehlenbach
414-955-8991 • jehlenba@mcw.edu
Presented by the MCW Department of Psychiatry and Behavioral Medicine

SAVE THE DATE

HOLIDAY PARTY
Wednesday, 12-19-18 • 6–8 pm
University Club
924 E. Wells Street
Downtown Milwaukee

SHOW US WHAT YOU’VE DONE!
Staff Bulletin Board • jehlenba@mcw.edu