In fact, most of the clinical and education focused initiatives that we have moved forward during my term as Chair have been strategically directed to help improve access. These include centralizing scheduling, redesigning clinic flow with a LEAN design approach, developing new residencies, integrating behavioral health care into primary care, and our consultation programs to name a few. Because of the crisis in our statewide community surrounding the need for access for behavioral health care, we took a population health focused approach and designed and developed the CPCP and the PERISCOPE Project.

Expanding our treatment teams to include advance practice providers and clinical pharmacists where the clinicians work at the top of their license is another important strategy we have implemented. Integrating behavioral health care into primary care is another important strategy that helps maximize the amount of behavioral health care that a primary care clinician can provide for their patients. This allows the PCPs to manage mild-moderate behavioral health needs of their patients and only refer the more severe cases to our behavioral health care providers.

The VA has been a national leader in providing mental health care integrated into primary care. This approach also improves quality of care and leads to downstream cost savings. With our primary clinical partners at CHW, Froedtert, and the VA, we continue to expand behavioral health care. Froedtert Health and Children’s Hospital of Wisconsin are partnering with us to develop and implement behavioral health focused strategic plans.

There continues to be tremendous need for behavioral health care across our community, but we are doing great things to help improve access to behavioral health care and to improve the quality of behavioral health care. Here are some of the strategic next steps for our department’s clinical mission: At Froedtert Hospital, we are strategically planning the possibility of building a new mental health inpatient unit which will improve access to inpatient care in our community. At the VA, we are expanding our addiction care and adding more support staff to our addiction clinic. At Tosa Center we will purchase a new transcranial magnetic stimulation system and we will develop a specialty clinic for depression. We plan to develop a Suboxone treatment program. We will apply for the State addiction psychiatry consultation program request for proposals, and I am optimistic that we will build this new program.

In our CPCP, we will expand the program to serve the northeast and northwest parts of the state, and we will also expand actively into Waukesha and Ozaukee Counties. We will continue to expand the reach of the perinatal psychiatry consultation program. We will continue to expand our collaborative care model across more primary care clinics. We will continue to work on expanding our integrated care into more specialty care clinics across Froedtert, Children’s Hospital Healthcare System, and MCW.

Finally, we will continue to work on the design and business plan for an interprofessional Memory Care Center. With our clinical expansion, we will be adding more faculty and staff in our department, and we will continue to improve access for the communities we serve.

This is an exciting time for us. Our future is bright.

Jon A. Lehrmann, MD
Charles E. Kubly Professor and Chairman, Department of Psychiatry and Behavioral Medicine • MCW Associate Chief of Staff for Mental Health, Milwaukee VAMC
Notes from Administration

CLINICALLY SPEAKING...

When asked to financially describe the Department, I always note that Psychiatry’s budget mirrors its programmatic engagement in all of MCW’s missions of education, research, patient care and community service. The pie chart below represents a breakdown of the financial support behind these missions.

Approximately 62% of Psychiatry’s $30 million budget is clinically focused, derived from affiliated hospitals such as Froedtert, CHW and the VA plus professional fees collected for clinical services delivered by faculty and staff. Clinical programming and the financial support attached to it is exceedingly important to the financial health of the department. Clinical programs and services provide the platform for the department’s other missions and without clinical programs, education and research and community engagement would suffer.

Administratively, we use a number of tools and analytics to manage this portion of Psychiatry’s financial portfolio. For example, to ensure that we are optimizing the charges and collections of Psychiatry’s clinical providers we monitor indicators such as the time between the service and the first bill to the patient (charge lag), charges held for missing fields or quality checks, contractual adjustments to charges, denial rates and days in Accounts Receivable, to name a few. A significant variance in any of these indicators can signal a potential problem that always merits more inspection.

Psychiatry’s clinical revenues are only as good as its delivery of clinical care. Tools we use to monitor this delivery of care include tracking new patient visits, patient satisfaction scores, 60-day provider bump rates, patient cancellation rates, new patients scheduled in 10 days or less and, everyone’s favorite, work relative value units (wRVU’s).

Finally, we carefully review the department’s professional fee schedule with a goal of optimizing collections, maintaining parity between services, and competitively positioning the department in the marketplace. We do this annually, as part of a larger group practice exercise, soliciting the input of many of our senior clinicians in the process.

In the end, it’s the cumulative effort of our faculty and staff engaged in clinical programs coupled with a management focus on measures and metrics that ensure a solid clinical financial foundation in support of all of Psychiatry’s missions.

David Peterson, MBA, FACMPE  •  Department Administrator Clinical
Clinical Notes

A NEW TOOL FOR DELIRIUM SCREENING

Delirium is a common neuropsychiatric syndrome in hospitalized medical patients. It is an independent risk factor for increased morbidity and mortality, and has been associated with increased lengths of stay along with higher associated costs of care. Despite this, it frequently goes unrecognized.

As part of a hospital-wide delirium prevention protocol the Confusion Assessment Method (CAM) was introduced to nursing as the standard delirium screening instrument on the general medical and surgical units throughout the hospital. However, despite significant educational efforts, quality monitoring determined that the CAM was exhibiting a poor sensitivity rate. As a result, a new tool was identified with the aim of improving sensitivity without sacrificing specificity.

The Nursing Delirium Screening Scale (Nu-DESC) was tested on two general medical units. Data points were collected from 192 patients who were hospitalized on these units on six separate days. Delirium screening was performed by nursing using both the CAM and the Nu-DESC. Two blinded physician-raters independently utilized the DSM-IV criteria (gold standard) to determine delirium rates in these patients on the same days as the nursing evaluations.

The results of the work suggest that the Nu-DESC is a useful delirium screening tool on general medical units. Nu-DESC correctly identified 77.1% of patients with delirium compared to the CAM's 8.6%. The simplicity of Nu-DESC administration, coupled by the fact that the data points required to complete the Nu-DESC are obtained during routine nursing care, may also make the Nu-DESC less resource-intensive to implement.

As a result of this study, the Nu-DESC instrument has been introduced throughout the general medical and surgical units in both the academic and community hospital divisions of F&MWC. Nursing will be performing delirium screening upon patient admission and three times a day thereafter. When a patient screens positive for delirium the nurse will inform the clinician caring for the patient.

The potential onset of delirium represents a change in condition for the patient with the very real possibility of significant morbidity and mortality.

Tom Heinrich, MD
Professor and Vice Chair of Clinical Affairs
Behavioral Health Center
I’m proud to share The Periscope Project (TPP) has been operational for over five months. The Project is running efficiently and exceeding our expectations. TPP set a goal to enroll 250 providers by July 2018. As of November 30th, 249 providers have enrolled with 89 unique providers using the service at least once for a total of 113 inquiries to TPP.

Our clinical operations are staffed by a .5 FTE psychiatrist and a 1.0 FTE triage coordinator Monday through Friday from 8am to 4pm. Given the unpredictability, I’ve changed my outpatient practice schedule to accommodate TPP inquiries. This allows me flexibility to return TPP inquiries within our 30-minute turn around goal. So far, we are exceeding our 30 minutes return call goal, and on average, a provider’s call is returned within eight minutes, making their entire experience from start to finish 20 minutes. We’ve heard positive feedback from providers saying TPP saves them time in their practice. They can connect with TPP while the patient is still in their office. As the program expands and demand grows, it’s our expectation to keep the teleconsultations timely and user friendly.

Providers can inquire for any number of reasons related to the mental health disorder of a perinatal patient from diagnosis and treatment, to information on community resources, to tips on how to talk to a mom about her mental health symptoms. We’re seeing approximately 60% of teleconsultations surrounding psychotropic medication use with diagnostic clarification as the second most common consultation topic.

We are asking every provider who contacts us if they would be interested in additional resource information for their patient to support moms in treatment. We’ve provided 26 providers with information on therapists, support groups, and family support programs.

As we continue to grow the program, we are focusing on the needs of our enrolled providers. We are continually expanding our resource list and provide ongoing provider education. We will continue to strive for timely consultations that educate providers, with the goal of providers utilizing the information learned during the consultation and apply it to other patients in their practice. Please help us continue to spread the word about The Periscope Project.

Christina L. Wichman, DO, FAPM
Associate Professor
Medical Director, The Periscope Project

Did you know that 20% of people with high blood pressure do not know their blood pressure is too high? And that 50% of people with hypertension (high blood pressure) do not have their blood pressure controlled? Hypertension is the world’s most common and modifiable risk factor for heart attacks and strokes. This is why the Medical College Physicians (MCP) practice organization has prioritized blood pressure as its ambulatory quality measure.

The FMCW Blood Pressure Program has developed training materials for accurate blood pressure measurement and MCP now emails providers monthly reports of prioritized metrics. In areas like Psychiatry, where blood pressure measurement has historically not been routine, we are targeting 50% of new patient visits have a documented blood pressure and a blood pressure recheck if the first check is high. Psychiatry is on track to achieve this goal.

Recently, the American College of Cardiology updated their guidelines for hypertension. These guidelines define hypertension as 130/80 or higher on more than one occasion after a screening blood pressure.

For the blood pressure program, we are using the cut-off of 140/90 as the trigger for recheck and referral to primary care. We are using the higher cut-off to limit the number of false positive screens.

Patients benefit from this population health approach to clinical excellence, where every touch is an opportunity to improve care. Depression screening is launched in primary care, and blood pressure screening is happening in psychiatry.

Importantly, Medicare’s new Quality Payment Program will pay physicians and other clinicians based on value. Our practice will either receive a reward or pay a penalty, depending on how well we—our whole practice as a group—perform in ambulatory quality measures like blood pressure screening and control. And, our performance will be publicly reported on the PhysicianCompare website. The Blood Pressure Program aligns with Community Physicians and our Froedtert and the Medical College joint strategic plan.

How can you help FMCW succeed in high value care? Please tell us about your success stories with the Blood Pressure Program. I welcome feedback: julie.mitchell@mcw.edu.

Julie Mitchell, MD, MS
Professor of Medicine (General Internal Medicine)
Chief Population Health Management Officer, MCP
With the LCME’s emphasis on student mental health (Standard 7.2 addressing student well-being) and the ACGME’s revision of Common Program Requirements (Section VI on well-being); there is much impetus at MCW and MCWAH to enhance our efforts supporting the behavioral health and well-being of students and housestaff. As our first-ever student mental health “climate” survey demonstrated, MCW is not immune to the devastating statistics on the prevalence of stress, depression and anxiety among medical trainees. We found that around 30% of our respondents screened positive for depressive symptoms and 7.4% had suicidal thoughts in the previous two weeks.

While the great majority of our students were aware of the behavioral health services available to them (93%), there was evidence that these services are underutilized especially by those that need them the most. In looking at barriers to access to care, we carved out time on Thursday afternoons (when the medical students have the most flexibility) dedicated to medical students only. Staffed by Tera Carman, MSW, LCSW, Hillary Pick, MA, LPC and Abigayle Musholt, PA; we have seen a steady build in filling these appointment times.

Another barrier to access to care is the stigma surrounding mental health. One of the most powerful antidotes to this is seeing people we look up to or who look like us share their journey through emotional struggles. We have begun to record testimonials by students opening up about such challenges and sending the message that even having depression or anxiety, one can still be a great doctor. We will upload these onto our website soon.

Being proactive and offering tools for managing the stress of training is another important focus for us. A group of us concerned with student well-being, including a contingent from the Kern Institute have been meeting to discuss these issues. We have named ourselves the Learning Environment Committee and will be making recommendations to the CEC to benefit our students. Part of an arsenal of tools to combat trainee stress includes digital resources.

We are looking at a variety of tools including a proven stress-reducing strategy, journaling. I am working with a current medical student and the college’s webmaster to develop a digital shared journaling site.

David Cipriano, PhD, MS
Assistant Professor, Behavioral Health Center–Tosa Health Center and Columbia–St. Mary’s Family Practice Center

Transcranial magnetic stimulation (TMS) is a relatively new treatment modality that has great promise as an effective treatment for psychiatric illnesses. For several years its availability as an FDA-approved treatment has been limited to treatment resistant depression, but clinical research shows potential for treating other psychiatric conditions, including PTSD, addiction, ADHD, obsessive-compulsive disorder and chronic pain.

A TMS device uses a high-powered electromagnet (like an MRI machine) to generate a magnetic field that is sufficient to stimulate brain tissue when held close to the surface of the head. Because magnetic fields are generally unimpeded by biological structures, the field generated by TMS can be focused on specific areas of interest. Research has demonstrated relationships between symptoms of clinical illnesses, like depression, and abnormal activity in specific brain regions. When TMS is used to stimulate these areas in patients who experience clinical symptoms, their condition can improve.

TMS is applied clinically by delivering a series of repetitive magnetic pulses to these areas, which is termed repetitive TMS, or rTMS. Unlike most other treatments that use direct stimulation of the brain, rTMS is remarkably tolerable and has relatively few contraindications. In fact, available data suggests a lower incidence of side effects compared to pharmacologic treatments for depression. Sessions last 20 to 50 minutes and are typically repeated five days per week for four to six weeks. Most patients do not experience any significant side effects, and the most common side effect is a mild headache. There is no sedation or anesthesia; patients can expect rTMS treatments have no impact on their day aside from the time spent in the office. It is now covered by most insurances. From a clinical perspective, it has a very favorable benefit to side effect ratio.

Because TMS is a relatively new technique for clinical treatment, there is a great deal of room to explore TMS applications. Ongoing research suggests the possibility that the future of TMS may use data from fMRI and other imaging to guide treatment parameters for individual patients.

The Department of Psychiatry is excited to provide TMS as a treatment option and to participate in clinical research. For those interested in learning more about our program, please feel free to contact myself or the Tosa Center staff.

Michael Montie, DO
Assistant Professor, Behavioral Health, Tosa Health Center
GETTING TO KNOW...
Faculty and Staff from the Department of Psychiatry and Behavioral Medicine

MATTHEW STOHS
Assistant Professor, Psychiatry and Behavioral Health, Tosa Center and Froedtert Center for Advanced Care

What is your educational background?
My BS is in biology from Valparaiso University, in Valparaiso, Indiana. My MD is from Tulane in New Orleans. My psychiatry residency and fellowship in addiction psychiatry are from the Mayo Clinic in Rochester, Minnesota.

How long have you worked at MCW?
I started at the end of July of 2017.

Describe your typical day.
On Mondays, I see patients at Tosa Clinic. Tuesday mornings I see transplant psychiatry patients at Froedtert. Tuesday afternoons I work on research and lectures. Wednesday mornings are spent at the Tosa Clinic. And Wednesday afternoons through Fridays I see patients with substance use disorders at the VA.

What do you like most about your job—what attracted you to this field?
Rehabilitation and recovery are why I enjoy helping people with addictions, mental illness, and chronic pain. It’s extremely rewarding to see people go back to living their lives according to their values without their illnesses getting in their way. I really enjoy seeing the results.

Tell us about life outside of MCW.
When not at work, I enjoy spending time with my wife, Sarah, and our daughters Hannah, 4, and Brenna, 18 months. I enjoy being involved in our church, walking/jogging, and swimming.

Just for fun—what are your favorite movies, books, music?
I’m an avid reader, and especially enjoy reading military history and historical biographies. Some of my favorite reads are the Bible, The Last Lion: Winston Spencer Churchill: Alone, 1932-1940 by William Manchester, and Neptune’s Inferno: The US Navy at Guadalcanal by James D. Hornfischer.

Tell us a fun/unique fact about yourself.
I used to be an NCAA Division I track and field athlete specializing in the hammer throw, shot put, and discus.

NICHOLAS YOUNG
Pediatric Psychologist
Integrated Behavioral Health Program, Children's Hospital of Wisconsin

What is your educational background?
I did my undergrad at UW-Madison (On, Wisconsin!) and my MA/PhD at the University of Nebraska–Lincoln. I stuck around the land of corn for Predoctoral Internship at the U of N Medical Center Munroe-Meyer Institute continuing training in behavioral pediatrics and integrated primary care. I completed the Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program as well, which inspired me towards a Postdoctoral Fellowship in intellectual/developmental disabilities at Children's Hospital Colorado.

How long have you worked at MCW?
I’ve been here since September of 2017.

Describe your typical day.
That’s one of the best parts about the gig—there isn’t a typical day! I have clinical hours, but I’m generally doing some combination of physician consultation, warm handoffs, research, and QI. There’s a lot of interesting variation in primary care. I see everything from tantrums to sleep problems, to feeding/eating behavior concerns. Never a dull moment!

What do you like most about your job—what attracted you to this field?
Rehabilitation and recovery are why I enjoy helping people with addictions, mental illness, and chronic pain. It’s extremely rewarding to see people go back to living their lives according to their values without their illnesses getting in their way. I really enjoy seeing the results.

Tell us about life outside of MCW.
I have a wonderful family life with my wife Fay and our dog-child Bucky. It’s been great to sort of “rediscover Milwaukee” after 10 years away. We lived in Colorado before coming back, so we’re slowly replacing formerly mountain-oriented hobbies bit by bit. It’s tough to snowboard on a Friday here, but you can’t beat a Wisconsin fish fry!

Just for fun—what are your favorite movies, books, music?
The Room (not the Oscar-nominated Room…THE Room). It’s the Citizen Kane of bad movies.

Tell us a fun/unique fact about yourself.
I’m a classically trained violinist and have been playing since the age of 5.
What is your educational background?
I spent a few years at Mount Mary College for art therapy, art education, and psychology. I returned later to MATC for computer education.

How long have you worked at MCW?
It will be 15 years this upcoming February, with my entire tenure spent in the role of residency coordinator.

Describe your typical day.
I take care of 32 residents and have interim care of 11 fellows, which encompasses a large variety of tasks and fun. Depending on the time of the year, the days run from recruitment of medical students to graduation, orientations, and helping residents navigate rotations that are both in our Department and throughout many of the other departments at MCW. There’s also monthly meetings, maintaining resident documents, proctoring exams to payroll, and more.

What do you like most about your job—what attracted you to this field?
Being a part of learning in any aspect is a joy for me. I have worked in the educational field most of my working life, starting out teaching at an alternative school in Wauwatosa with high school age students who had emotional, mental, or health issues and being a part of helping them succeed was extremely fulfilling. Having the opportunity to assist in any area of education, my supervisor, faculty, residents and fellows to achieve what they strive for is the best.

Tell us about life outside of MCW.
My husband, Rodd, have a daughter, Kate, and two sons, James and Christopher and one very perfect golden retriever named Grace. My mom Ruth shares our home, and we so love having her there—she’s such an important part of our comings and goings. Hobbies and interests range from gardening, quilting, sewing, crafts, reading, fishing, camping, baking, travel, and—a bit rusty—but the piano.

Just for fun—what are your favorite movies, books, music?
I love all genre of music, but in particular anything by Michael McDonald and The Doobie Brothers. And when it comes to movies, I can always do marathon Harry Potter and Star Wars.

Tell us a fun/unique fact about yourself.
Starting around 11 years old, I have had over 75 people from around the world as pen pals—writing the old fashioned letters! I spent a summer in Sweden and Denmark, visiting one pen pal who became a close friend and her family.
CELEBRATING EXCELLENCE

Each year the David J. Peterson Excellence Award recognizes employees for job performance in the Department of Psychiatry and Behavioral Medicine, celebrating service excellence at both the senior level (15+ years of service) and from the less senior level (1 to 15 years of service). Through Survey Monkey, this initial group of individuals were nominated by their peers, the faculty, and staff within the Department. There were 14 nominees and 19 nominations.

After thoughtful consideration, three nominees were selected and were recognized at the September 26, 2017 combined faculty and staff meeting. Winners Linda Cotton, Dawn Driscoll, and Tom Lytle were each awarded a gift and an additional day off, and their names were added to a Department plaque in recognition of the Award.

“I am extremely proud of the accomplishments of Linda, Dawn, and Tom as the recipients of this recognition,” said Peterson. “They go above and beyond the expectations of their positions within the Department.”

Congratulations to both the nominees and winners! The 2017 Peterson Award committee members consisted of Bob Huberty, Chair; Ruzanna Aleksanyan, Dawn Driscoll, LaRhonda McConnell, and Beverly Pernitzke.

DEPARTMENT WINS FOREMAN RECOGNITION

Provost Joseph Kerschner and Jon Lehrmann showing off the Spencer Foreman Community Engagement Second Place Award at the AAMC Awards Banquet in Boston. Congratulations to the whole Department of Psychiatry and Behavioral Medicine, who helped MCW receive this great honor.

MCW REPRESENTS...

Student doctors Laura Ledvora (l) and Alexandra Lynch (r) recently presented at the 64th Annual Meeting of the American Academy of Child and Adolescent Psychiatry (AACAP), held October 23-28, 2017 in Washington, DC. Ledvora and Lynch are mentored by Kathleen Koth, DO, MCW Assistant Professor, and the Director of the Child and Adolescent Psychiatry Fellowship Program.

SHOW US WHAT YOU’VE DONE!

Staff Bulletin Board • jehlenba@mcw.edu