You could call it a huge psychological blow.

When Drs. Lyle Baade, Don Morgan and Glenn Veenstra leave KU School of Medicine-Wichita (KUSM-W) this year, the trio of psychologists will take with them 106 years of combined experience at the school. In addition to caring for patients and conducting research, their teaching has prepared hundreds of psychiatrists and psychologists through the decades.

“They have each had a major impact on just about every psychiatrist who’s practicing in this area,” said Matthew Macaluso, D.O., associate professor in the Department of Psychiatry and Behavioral Sciences and director of its psychiatry residency program. “More than 90 percent of the psychiatrists practicing in this area graduated from our residency program. So over the years, these three individuals had an impact on the training of every psychiatrist that’s gone through our residency program.”

Dr. Baade was the first to arrive, back in 1978, when part of the current campus was still being used as the E.B. Allen Hospital (formerly Sedgwick County Hospital) for elderly and indigent patients.

A South Dakota native, Baade earned a psychology degree from the University of Denver, then a master’s and doctorate from Florida State University before completing a fellowship in clinical neuropsychology at the University of Colorado.

At the time he came to Wichita, Baade was one of two psychologists on the faculty. Today, there are eight. Baade has served as department chair for most of the last six years, making significant changes in the staffing and overall direction of the psychiatry residency program. He’s the only Ph.D. — as opposed to school’s clinical departments. Baade’s specialties include general, forensic and geriatric clinical neuropsychology — the science that looks at the relationship between brain structure, function and behavior. He has conducted research in neuropsychological assessment, dementia and response bias. For years, he was the only board-certified neuropsychologist in Kansas. Now there are seven, including four on the KU faculty.

Dr. Veenstra has been at KUSM-W nearly as long Baade. An Iowa native, he earned a degree in engineering from Iowa State University before deciding his real interest lies in psychology. He earned his master’s and doctorate in that field from Michigan State University.

“In part, I was trying to figure myself out,” Veenstra said. “I struggled with a lot of anxiety and was trying to figure out how to overcome it. And I found working with people more interesting than working with numbers.”

Veenstra splits his time about equally between teaching and seeing patients. His specialties include anxiety disorders, depression, emotional problems such as anger, and family relationships.

Dr. Morgan — the “newbie” at 28 years with KU — is a New Mexico native who earned his bachelor’s degree in psychology from Eastern New Mexico University, then his master’s and doctorate from the University of New Mexico. Predoctoral and postdoctoral internships with the psych department at KUSM-W brought him here, and when a faculty job was offered, “It was just too good to pass up.”

Like Veenstra, Morgan splits his time between teaching and working with patients at the outpatient clinic, also he sees some at the Via Christi Behavioral Health facility. His specialties include personality assessment, pain and bariatric evaluations and sex therapy.

Baade said Morgan is beloved by students for his dry sense of humor. Morgan calls humor “an effective teaching and therapy tool.”

Read the full version of this story at [http://wichita.kumc.edu/news/psych-retirees-021618.html](http://wichita.kumc.edu/news/psych-retirees-021618.html)
The KU Wichita Clinical Trial Unit (CTU) is collaborating with both local and national organizations to study treatment-resistant major depressive disorder (MDD).

Matthew Macaluso, D.O., associate professor and director of KU Wichita Clinical Trial Unit, is the recipient of a subaward from the Patient Centered Outcomes Research Institute (PCORI) in collaboration with Massachusetts General Hospital (MGH) to study the following treatments: aripiprazole augmentation, rTMS augmentation and venlafaxine XR. Specifically, the study is a randomized, open-label, effectiveness trial comparing the three treatment arms in patients with MDD who are currently receiving ongoing, stable and adequate antidepressant therapy, but have not fully responded to treatment. This study is supported in part by an NIH Clinical and Translational Science Award grant awarded to the University of Kansas Medical Center.

The study is occurring at seven other centers nationwide with the goal of understanding how rTMS compares to other treatment options early in the course of the practice algorithm for treatment-resistant MDD. rTMS or repetitive transcranial magnetic stimulation was approved by the United States Food and Drug Administration (FDA) in 2008 for mildly treatment-resistant depression. rTMS is a brain stimulation technique that utilizes magnetic fields to promote electrical currents in the brain. It was hoped to provide similar benefits to electroconvulsive therapy (ECT) without the drawbacks of memory impairment and the need for general anesthesia.

The CTU is collaborating locally with Drs. Gary Fast and Mercedes Perales of Prairie View, who will be providing the rTMS services for the study. Prairie View is a large provider of mental health services in the greater Wichita community.

PCORI, the sponsor of the study, supports trials comparing outcomes of two or more current approaches to health care in order to understand comparative risks, benefits and effectiveness. They are particularly interested in conditions affecting large numbers of individuals that lead to significant disability with a focus including racial and ethnic minorities, older adults, and individuals from low income or rural areas.

MGH is coordinating the study across eight total sites in the United States, including University of Alabama School of Medicine, Baylor College of Medicine, University of Virginia, MGH, New York University, University of Pennsylvania, Stanford University, University of Texas Southwestern Medical Center, and University of Kansas School of Medicine-Wichita, placing the KUSM-W Department of Psychiatry & Behavioral Sciences among the top centers nationally studying treatment-resistant depression.

Patients and their health care providers could consider this study if they have treatment-resistant MDD and have failed adequate trials of two or more antidepressants. Individuals interested in learning more about the study should contact CTU at 316-293-1833. A staff member will discuss the study and review the eligibility criteria with the patient. If the patient is interested in pursuing the study, a face-to-face screening will be scheduled at the KU School of Medicine-Wichita, at 1010 N. Kansas. Patients are paid for their time participating in the study, which was approved by the Kansas University Medical Center IRB.

CONGRATULATIONS:
Matthew Macaluso, D.O., associate professor, who was elected to the board of directors of the American Society of Clinical Psychopharmacology, which is the premier professional organization for psychopharmacology in the United States.

Jana Lincoln, M.D., associate professor, who was confirmed to the status of Distinguished Fellow of the American Psychiatric Association.

Syed Quadri, M.D., on his marriage to Ms. Crystal Gamez in September.
Kamal Surineni, M.D., and his wife, Javanthi Theegala, on the birth of their daughter, Chaarvee, on Jan. 3.

Karl Martineau, D.O., on matching into child and adolescent psychiatry fellowship at the University of Utah in Salt Lake City.
What is telepsychiatry and how long has it been around?
Telepsychiatry, also called telemental health, is a provision of mental health and substance abuse services from a distance using advanced internet-based communication applications. Believe it or not, the first use of videoconferencing to provide psychiatric care was done by Nebraska Psychiatric Institute in the late 1950s. Telepsychiatry became increasingly common in the 1970-80s, and by the 2000s telepsychiatry was considered to be an effective way to deliver psychiatric care (1).

Is there any evidence to suggest that receiving care via telepsychiatry is better or worse (or the same), in terms of clinical outcomes, compared with face-to-face, in person care?
Telepsychiatry is considered to be equivalent to in-person care in diagnostic accuracy, treatment effectiveness, and patient and provider satisfaction. Research shows that patients suffering from depression, anxiety, psychosis (counters myth that patients would get paranoid), substance use, cognitive/attentional/behavioral issues (assistance for those with mental retardation or dementia) and personality/behavioral issues do well when cared for using telepsychiatry while in an outpatient psychiatric or primary care setting. More research needs to be done studying other settings (emergency rooms, jails, inpatient units, schools) and different patient populations. In some cases, such as young patients with autism spectrum disorder, it may be preferable to provide care in person (1).

How do patients respond to seeing their provider on a screen rather than in person?
Overall the patients respond well. We are able to develop a therapeutic relationship in the same way we would during in-person care. I have had a couple patients whose illness caused them to have strange beliefs about me and the purpose of the telepsychiatry equipment. Interestingly, the beliefs causing these behaviors did not hinder their care. Rather, the change of their behaviors during the teleconferencing became a nice indicator of the response to treatment.

What do you like about telepsychiatry?
I really like that it allows us to provide psychiatric care in underserved areas where a psychiatric provider may not be available otherwise. All you need is a decent computer able to accommodate videoconferencing software, access to the electronic medical record and an internet connection. I also like that we incorporated it into our PGY-2 and PGY-4 curriculum so our residents are trained in telepsychiatry. Telepsychiatry is now a well-established model of care and our residents need to have exposure and experience with it before they graduate.

What has the biggest adjustment been?
The adjustment to the telepsychiatry was relatively easy. If there is frustration, it is when technology doesn’t work the way I need it to. When you are miles away, you cannot just run to the unit and examine the patient. However, we have been able to rely on the report of nurses or other staff working on the unit to help me make decisions about the treatments if need be. Luckily, these technology lapses were always short-lasting.

How do you envision the future of telepsychiatry?
I think it will be used more and more. It provides access to a qualified mental health provider to patients from underserved areas. Telepsychiatry could be a good choice for psychiatrists who want to work from home because of their family situation, difficult commute or other issues.

Reference: (1) American Psychiatric Association: https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/telepsychiatry-toolkit-home
The ACE Curriculum: A new way to train physicians

This year began with a significant change in the way we train medical students. With the goal of providing students with active roles in their training, the ACE curriculum was born. The Active, Competency-based and Excellence-driven curriculum uses team-based learning and Flipped-Class learning techniques. These teaching modalities provide students with pre-work (readings, podcasts, etc.) that they review on their own. The students then come together to apply what they learned to clinical problems. Students start each week with a Big Case session that establishes the focus for the week using clinical presentations, descriptive cases of disease processes, public health challenges and patient panels. They learn through Flipped-Classroom sessions, during which the students use knowledge from pre-work to solve problems proposed by the instructor. Students are assigned to small groups of seven-to-eight students, which become close-knit learning groups. They meet several times a week in their small groups for Case-Based Collaborative Learning sessions (CBCL) that require them to apply the knowledge they are learning (and have reviewed in pre-work) to a clinical problem or case.

A strength of the new curriculum is its focus on developing each student’s ability to think through problems and apply the knowledge they learn. Problem-Based Learning sessions are especially helpful in developing critical thinking and clinical reasoning, using cases that include clinical tests and imaging. By engaging medical students in critical thinking and clinical reasoning from the beginning of their training, KU will be graduating physicians who enter residencies ready to learn their area of specialty and have critical reasoning abilities that will allow them to quickly develop strong clinical skills.