

- HOME
- SEARCH
- CURRENT ISSUE
- PAST ISSUES
- JOBS
- SUBSCRIBE
- E-MAIL ALERTS
- CME
- ADVERTISE

COLLECTIONS

- Blogs
- Clinical Protocols
- Coding Tips
- What Works

CAREER CENTER

- Career Tips
- Practice CloseUps
- Jobs

QUICK LINKS

- Access
- Subscribe
- E-mail Alerts
- Contact Us
- About Us
- Editorial Board
- Management
- Privacy Policy

Should hospitalists be caring for these patients?

The challenges of managing psychiatric inpatients

by Bonnie Darves

Published in the April 2008 issue of Today's Hospitalist

Earlier this year, the hospitalists at the Medical College of Wisconsin and Froedtert Memorial Lutheran Hospital in Milwaukee found more than a dozen patients on their census who, 10 years ago, probably would not have been under their care.

Fifteen of the patients occupying medicine-unit beds in the 450-bed hospital were suffering from acute mental illness and were waiting to be placed in a psychiatric facility, recalls Michael Radzienda, MD. While the situation is not uncommon at his hospital, it strains the facility's resources and taxes its physicians.

"These are patients with acute decompensated mental health issues who literally have nowhere else to go but to some of the ERs," says Dr. Radzienda, Medical College of Wisconsin's chief of hospital medicine. "Because many hospitals have closed their psychiatric units, hospitalists are the default group to take care of these patients."

The problem is hardly limited to hospitals in the Milwaukee area. Across the country, county and state mental health facilities are at capacity and under-staffed, and community hospitals are closing psychiatric units because they are not financially viable. At the same time, psychiatrists are abandoning inpatient practices, often for financial reasons.

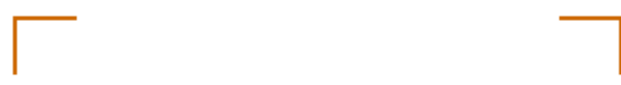
The convergence of those factors is trickling down to hospitalists who, in many facilities, are the last physicians standing.

Co-management dilemma

Typically, hospitalists provide medical clearances or history and physicals for psychiatric patients going to psychiatric facilities.

"Hospitals are looking to our hospitalists to provide those services because the community PCPs do not necessarily want to do them anymore," observes Felix Aguirre, MD, vice president of medical affairs for IPC-The Hospitalist Company, which is based in North Hollywood, Calif. "Those clearances need to be done within 24 hours, so for the hospitals, having hospitalists ready and willing to do these services is a one-stop-shopping solution."

But co-managing these patients is a different story. In hospitals that still have psychiatric units, hospitalists providing co-management sometimes find that they don't really use their clinical skills. According to Marcus Zachary, MD, medical director of the hospital medicine program run by Cogent Healthcare at Saint Francis Memorial Hospital in San Francisco, the nine-hospitalist group agreed to provide medical clearances and address the



"It becomes a morale issue when you don't have the resources to effectively care for your patients."

**-Michael Radzienda, MD
Medical College of Wisconsin/Froedtert Memorial Lutheran Hospital**



medical needs of patients admitted—either directly or through the emergency department—to the psychiatric unit. (The unit, which is located within the hospital, is operated as a stand-alone facility.)

But all too often, he says, the nurses call the hospitalists to address minor issues. “They’re psych nurses, so their trigger points for getting excited are extremely low,” Dr. Zachary explains. “We may get paged three times within 10 minutes because somebody’s blood pressure is 150 over 100.” Those frantic calls, he adds, “aren’t really emergencies, and they can wear on you and affect your job satisfaction.” Only rarely does the situation warrant a hospitalist’s intervention or a transfer to an acute-care floor.

No beds

But many more hospitalists are grappling with the opposite problem: They don’t have a psych unit or facility to which they can transfer patients.

According to the National Center for Health Statistics, the number of available beds in state and county mental hospitals dropped 52% between 1986 and 2004.

There are few reliable data on the number of psychiatric units that have recently closed or on the shortage of psychiatrists with inpatient practices, says Kathleen McCann, RN, PhD, of the National Association of Psychiatric Health Systems, an advocacy group that represents behavioral health providers.

But “clearly there have been unit closures,” points out Dr. McCann, the group’s director of clinical and regulatory affairs. “We believe they are the smaller units, under 20 beds, that are difficult to operate efficiently.” Those units sometimes face pressure from their own hospitals, she adds, due to growing demand for other inpatient services that may be more financially viable.

To address that widening care gap, national hospitalist companies are being asked to launch dedicated psychiatric hospitalist programs. Last year, IPC established its first psychiatric- hospitalist program. (See [“Hospital medicine model continues to expand.”](#)) Cogent, based in Brentwood, Tenn., has been asked to start up similar programs, but has declined to date.

“It’s not something that we have chosen to do,” says Rachel George, MD, MBA, a regional medical director for Cogent, which staffs programs in 16 states.

Common scenarios

While Cogent hasn’t ventured into dedicated psychiatric services, its physicians struggle with co-management, Dr. George adds. Hospitalists in Cogent programs, which operate primarily in community hospitals, can usually get a psychiatric consult within 24 hours, she says.

“But sometimes it takes a few days, and hospitalists may find themselves taking care of a patient that they don’t feel comfortable dealing with.”

When psychiatrists aren’t available, Dr. George points out, “some hospitalists are not comfortable prescribing the initial dose of certain psychiatric medications, like the newer antipsychotics.” While most hospitalists may be comfortable starting patients on antidepressants, “much further beyond that and their comfort level goes away.”

That situation is all too familiar to Dr. Radzienda and his colleagues at Froedtert Memorial. The hospital does not have a psychiatric unit, and it has been overwhelmed by local ER and hospital closures.

Consider a typical patient the 25-hospitalist group sees: a young, depressed woman who presents to the ER after a suicide attempt with an overdose of benzodiazepines. The woman is often uninsured, and because there’s no bed at the county mental health facility, she is admitted to—and stays in—the medical ward.

“She may sit in that bed for up to two weeks awaiting transfer, and during that time she’ll require a 24-hour sitter,” Dr. Radzienda says. “This happens every day.”

The service sees another common patient, a male with undifferentiated agitation who is admitted to the medicine floor. The medical nurses, who are untrained in psychiatric nursing, may not recognize that the patient is becoming acutely psychotic—so they not attempt to “de-escalate” or calm him. The patient may wander into another room, assault a patient or a staff member, or even elope.

“Ask hospitalists at other urban hospitals,” Dr. Radzienda says, “and they will tell a similar story.” When trying to co-manage patients with an overburdened psychiatry consult service, he says, it is the patients who end up suffering.

And “it becomes a morale issue when you don’t have the resources to effectively care for your patients.” The situation has become so acute, he adds, that the hospital has convened a summit of local health care systems to address the problem of under-resourced mental health services.

Mental illness fast facts

- About 5% of ICU admissions and 10% of general medical admissions are for suicide attempts.

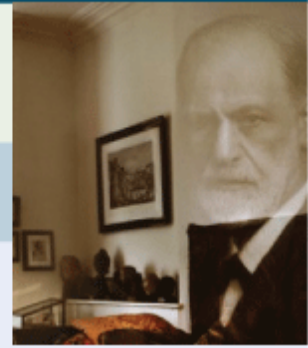
(Source: Handbook of General Hospital Psychiatry, 2004)

- Approximately 5% of suicides occur in a hospital setting.

(Source: Psychiatric Annals, 1993)

- Between 30% and 60% of inpatients have a psychiatric comorbidity.

(Source: Psychosomatics, 1998)



Getting up to speed
Sources agree that most hospitalists have an adequate working knowledge

of basic psychiatric medications, such as antidepressants and tranquilizers. The management situation becomes more problematic when restraints—chemical or physical—are required.

“There is some degree of a knowledge deficit for hospitalists in dealing with these patients, which is reasonable,” observes psychiatrist Thomas Heinrich, MD, chief of the psychiatric consult service at Froedtert Memorial. He notes that only 25% of general medical hospitals still have dedicated psychiatric units.

Despite the challenges of managing psychiatric patients, Dr. Heinrich, who is also certified in family medicine, says that with modest training, hospitalists can safely manage a broader range of situations than they think.

They may not know much about the newer antipsychotics, he points out, but hospitalists and nurses can learn how to verbally calm agitated patients. They can also learn how to use medication-based rapid tranquilization regimens, which may include antipsychotics and/or benzodiazepines. Those drugs can go a long way to help hospitalists manage these patients until the psychiatrist arrives.

“The idea is to engage patients in their treatment, to calm them without sedating them,” he explains. “Physical restraints, because of their inherent risks, should be used as a last resort.” He adds that the hospital has established a multidisciplinary task force to identify patients at admission who might be agitated enough to cause harm. The center’s psychiatrists are also working with hospitalists to develop protocols for managing agitated patients.

Potentially more problematic than managing agitation is dealing with the suicidal patient. “Determining when patients no longer represent an acute danger to themselves,” Dr. Heinrich says, “isn’t something I would expect hospitalists to be able to do comfortably.”

Expectations and cut-off points

The pressure hospitalists face in managing psychiatric patients speaks to the need for clearly defined expectations in co-management arrangements—and the need to establish cut-off points to govern how patients are transferred to specialists’ care.

IPC, for instance, helps its groups craft hospital procedures or policies regarding who will admit which patients and prescribe controlled medications.

“We are careful with our contracts to ensure that we are truly co-managers on virtually every case,” IPC’s Dr. Aguirre says. “We take care of the acute episode if it is within our realm, but there has to be psychiatric backup if that level of expertise is required.”

Regardless of whether hospitalists provide traditional co-management or consultation, they need to negotiate the “rules of engagement” between their service and psychiatrists, says Sylvia McKean, MD, medical director of the Brigham and Women’s/Faulkner Hospital hospitalist service in Boston.

At her hospitals, for instance, when the primary reason for admission is not general internal medicine, consultants—whether they’re psychiatrists, medical subspecialists or surgeons—are expected to see the patient within 24 hours and provide 24/7 beeper availability. They may also be required to see the patient more than once during the day and/or participate in team meetings at the bedside.

And if hospitalists are going to take care of a growing number of psychiatric patients, “they should identify gaps in their knowledge and skills and ask for additional training,” Dr. McKean says. “This may include the ABCs of how to manage patients with decompensated acute psychiatric illness, avoid the use of restraints and titrate the newer psychiatric medications.”

Hospitalists can usually find that additional training, she adds, in local CME. In the meantime, if psychiatrists want

hospitalists to adjust the doses of certain psychiatric medications, they need to provide explicit instructions and tell hospitalists when they should call for help.

Targeting hospital resources clearly does not address the country's deepening crisis in mental health care. But even if communities and governments tackle that issue, hospitalists will likely figure prominently in any solution.

"The reality is that the vast majority of patients who are admitted to non-psych beds are cared for by medicine, whether it's in Massachusetts or Oregon," Dr. McKean says. "These co-management models are starting to sprout up because they're meeting a recognized need."

Bonnie Darves is a freelance writer specializing in health care. She is based in Lake Oswego, Ore.

State-of-the-art care; drop-in-the-bucket treatment

WHEN IT COMES TO involving hospitalists in psychiatric patient care, the hospitalist service at the University of California, Irvine (UCI) has taken the lead. Hospitalists there not only manage the medical needs of patients admitted with a primary psychiatric diagnosis, but they also jointly operate a geriatric-psychiatric inpatient unit with psychiatry faculty.

UCI's hospitalist program takes an all-comers' approach to managing a range of patients, from critical care to neurology. While hospitalists now care for psychiatric patients in several capacities, notes program founder Alpesh Amin, MD, MBA, the centerpiece of those efforts is the dedicated 12-bed "gero-psych" unit.

"It's not just the hospitalists giving [medicine] recommendations and telling the psych service to primarily follow them," he explains. "We actually do the co-management" with dual-unit staffing.

The unit, which was started six years ago, quickly proved its worth by addressing unmet needs in the 400-bed facility. For one, the unit allows hospitalists to discharge psychiatric patients sooner, says Dr. Amin. Second, "we're able to hold patients to prevent 'soft admissions,' " patients who don't necessarily need acute care, he explains, but whose medical issues may be outside the comfort zone of psychiatrists and their nursing staff.

The unit also gives UCI a competitive and marketing advantage over other local hospitals that don't offer co-management, says Dr. Amin.

But he admits that the initiative barely scratches the surface of community needs. "There are only a few county psychiatric beds for the entire indigent population in Orange County, so it's very difficult to discharge those patients," says Dr. Amin. "We have nowhere to send them."

Hospital medicine model continues to expand

LATE LAST SUMMER, IPC-The Hospitalist Company launched its first U.S. psychiatric hospitalist program. (Several other psychiatric hospitalist programs have been launched nationwide.)

The site is the 912-bed St. Luke's Episcopal Hospital in Houston. The program intends to meet the need for inpatient psychiatric consultations, while reducing the number of complications and protracted stays, says Jennifer Pate, MD, chief of psychiatry at St. Luke's and IPC's practice group leader for psychiatry.

"I think there's greater recognition now that psychiatric issues increase length of stay and often affect re-admission rates," she says. She cites untreated delirium as one major culprit, and patients with under-recognized suicidal ideation or psychosis as another.

Dr. Pate and her colleagues—the program will include three more psychiatrists and may extend to other hospitals in the Texas Medical Center system—will also provide consults to patients and donors involved in organ transplants. And St. Luke's psychiatrists will also be on hand to help medicine hospitalists address active substance withdrawal and agitation, and to educate hospitalists about psychiatric issues.

The care model, Dr. Pate adds, can save hospitals money. But "you also have to think of this from a basic safety and liability standpoint," she says. "You need a physician available who can provide an assessment of suicidal behavior."

