Understand and overcome language, cultural barriers

As the demographic of the country changes and the number of people who cannot speak English rises, overcoming language and cultural barriers has become an increasingly difficult problem for hospitalists who rely on effective communication with their patients.

As we discussed in last month’s Hospitalist Management Advisor, language barriers are not just frustrating for physicians and patients; recent studies show they can have a direct effect on patient care, including readmission rates (See “Take the reins on your program’s readmission rates,” September). But before you can effectively address the language barrier, you must understand the scope of the issue.

By the numbers

There are roughly 50 million people living in the United States today who speak a language other than English, and more than half come from Spanish-speaking countries, according to the latest U.S. census. The census also reveals that 14 million people have trouble speaking English.

Hospitalists may regularly find themselves on the frontlines of this issue because they are often the first ones to see, communicate with, and refer a patient to other specialists.

Alex Smith, MD, a hospitalist who specializes in palliative care at Brigham and Women’s Hospital in Boston, is researching ways to provide culturally congruent care. Smith says, for him, language is only the most superficial challenge in navigating these relationships.

According to Smith, the largest numbers of non-English-speaking patients at Brigham and Women’s Hospital are Haitian and Latino, as well as Chinese and Vietnamese.

“Fortunately, we have a fantastic interpreter services department that helps not only with interpretation of language, but of cultural beliefs, norms, and explanatory models of illness,” says Smith. “In the biomedical explanatory model, the sources of disease can be traced back to germs, genes, or the environment. In other cultures, the explanatory model of illness may be completely different.”

He cites several Asian cultures as an example. “In many Asian cultures, illness is said to arise from an imbalance in energy or equilibrium,” he says. “In a faith-based model, illness may arise from beliefs, misdeeds, or spirits. In some explanatory models, humans use...
Overcome barriers
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supernatural powers to cause illness, such as the evil eye. Without eliciting and understanding the patient’s explanatory model for illness, hospitalists may be frustrated by repeat admissions and nonadherence, and label patients ‘noncompliant.’

Smith has seen this firsthand. “In one case, I had a Cambodian patient who believed that her shoulder injury was due in part to the trauma of losing a baby as she fled Cambodia during the rise of the Khmer,” he says. “In another, friends of a woman from the Azors believed her daughter’s severe degenerative neurological condition was caused by failure to use a folk remedy for a childhood ailment.”

Bridging the divide

Hablamos Juntos, an $18.5 million initiative funded by the Robert Wood Johnson Foundation based in Fresno, CA, is helping hospitalists bridge this cultural gap by developing different models for cultural and language competency. According to its reports, one in five Spanish-speaking patients has not pursued necessary care due to the language barrier. Spanish speakers in the United States constitute a ratio of more than one in 10 residents.

“We know that providers see helping Spanish-speaking patients benefit from the healthcare system as an important priority,” says Yolanda Partida, executive director of Hablamos Juntos. “Nearly seven in 10 [healthcare] providers, or 68%, see the issue as a top or important priority.”

According to Partida, some hospitalists say the primary barrier to doing more is the cost of building an infrastructure to accommodate these changes.

But as the potential liability for hospitals grows, the higher costs of mistakes made by using untrained interpreters, and the cost of poorer healthcare due to inadequate communication, must also be taken into consideration.

Strategies to overcome barriers

The following are seven strategies hospitals and hospitalists programs can implement to deal with language and culture barriers.

1. Hire bilingual staff

Healthcare organizations often use family members and friends of the patient as interpreters, and that can present a series of problems. Such interpreters may lack the appropriate language skills and knowledge of medical terminology. Additionally, such communication compromises confidentiality, censors important information, and jeopardizes family dynamics, especially when children are used to interpret. According to Partida, studies show
that the skills of trained interpreters go beyond an ability to speak a language, especially when technical concepts have no translation in their language.

Having a provider on staff who speaks the same language as his or her patients, especially if he or she is of a similar cultural background, can help your program accomplish the following:

- Save time
- Eliminate errors in communication
- Aid proper and effective diagnosis and treatment

Recruiting for bilingual positions can be difficult, but Diversity RX (www.diversityrx.org), a comprehensive Web site that contains tools to address linguistic and cultural barriers, offers this suggestion: “Foreign-trained healthcare workers can be retrained and utilized in professional or paraprofessional roles. Special programs can assist them to become certified or licensed in their original profession, or can train them for other healthcare roles, such as physician assistant or community health worker.”

2. Use a professional interpreter service

Just over two years ago, the National Council for Interpreters in Healthcare developed national standards of practice for medical interpreters in order to define the characteristics and competencies of a qualified healthcare interpreter. (See www.ncihc.org for the full report.)

Healthcare organizations currently use a variety of approaches to obtain professional interpreter services.

For instance, a hospital can obtain interpreter services through an outside agency. Such an agency may specialize in medical interpreting or provide a spectrum of interpretation specialties. Alternatively, an organization with another set of services, such as an immigrant social service agency, may market an interpretation service. Use of an outside agency works well when your needs are intermittent and diverse, and your organization can also use an interpreter service to supplement your regular staff of interpreters.

Your organization can also employ telephone interpretation—through outside agencies. Often, hospitals use these services for the following situations:

- Emergencies, when it will take too long to get an interpreter in-person
- Rare languages in which a local interpreter is not available
- Simple communications (e.g., setting up appointments or giving lab results)

An interpreter should be physically present, however, for more complex communications where nonverbal cues are an important part of the communication and the accuracy of the interpretation is critical.

For a list of interpreter associations that focus on healthcare interpreting, go to www.ncihc.org/hciaus.aspx.

3. Use universal healthcare symbols

Hablamos Juntos is working to develop and test universal symbols for health signage that will be more effective at helping all patients navigate around hospitals, regardless of what language they speak. This information can include the following nonverbal cues:

- Maps and signs
- Overt clues in the architecture and interior design of a facility
- Use of color, pattern, and texture

4. Standardize language assessment tests

Although native speakers are generally proficient in the target language, problems can arise. The dialect may be inappropriate, sociocultural differences may interfere, and medical terminology may be lacking depending on where the provider received medical training. Standardized evaluation tests of a provider’s linguistic skills and cultural awareness would help to address this issue, and help hospitalists identify the best person to call for each situation.

5. Offer interpreter skills training to volunteers

One cost-effective strategy, long popular with

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hospitals, is to utilize employees who speak other languages as volunteer interpreters when needed. This strategy is particularly useful in emergency situations. However, without a formal evaluation of language skills, this approach can cause problems and, in some cases, even be dangerous. Few employees have received any training in medical interpreting skills, ethics, or vocabulary.

Diversity RX offers two examples of volunteer interpreters: “A hospital housekeeper, in the United States for two years, fluent in her native language but barely speaking English, may be called upon to interpret for a patient being prepared for surgery. Or an American-born nurse with two years of college French under her belt may be asked to interpret for a Creole-speaking Haitian refugee with a grade school education. In either situation, can we be sure that communication, let alone informed consent, has truly occurred?”

It is important to note that job conflicts may arise when these voluntary interpreters are called away from their regular duties and asked to fill gaps they were not originally hired for. Job responsibilities may not be met, and the interpreter may feel uncomfortable and ill-prepared for the situation he or she is put in.

6. Create a hospital language bank

Formalizing the structure of your language bank will help keep things organized. Diversity RX suggests taking the following steps:

- Assign a coordinator to assess the language and interpretation skills of employees
- Maintain updated lists of bilingual employees
- Provide interpreter training
- Assess the quality of service provided

In addition, you should include interpretation as a listed job duty, enlist the support and cooperation of supervisors, and provide compensation for bilingual skills as a bonus or differential.

7. Make sure your written language materials are effective

Researchers at Hablamos Juntos found that many hospitals were wasting money on poor translation materials that patients couldn’t use because they couldn’t understand them.

Translation materials should be tailored to the reading level of the audience and adapted and tested for cultural appropriateness. Protocols for translating materials need to be standardized and clearinghouses developed to aid in the dissemination of appropriate and effective materials. Translated forms, documents, and health education materials play an increasingly important role in boosting access to service.

Looking for more? Some hospitals are already putting interpreter strategies to work

A number of hospitals are already using some of the tips described above. Here are some model programs for hospitalists to look at that reflect different approaches to the provision of interpreter services in a hospital setting:

- Jackson Memorial Hospital in Miami, with only two major language groups to serve, has gone with an in-house staff interpreter model.
- The University of Massachusetts Medical Center in Worcester also has implemented a staff model, with a strong emphasis on both provider and interpreter training.
- In contrast, hospitals in Seattle found that their diverse patient populations made a shared interpretation program an efficient and cost-effective mechanism for obtaining interpreter services. This led to the development of the Community Interpretation Service, a program sponsored by an outside, nonprofit agency that contracts with the hospitals.

Credential for hospital medicine is one step closer

It’s exciting times for hospitalists—the American Board of Internal Medicine (ABIM) has given the green light to the creation of a hospital medicine credential.

The American Board of Medical Specialties (ABMS) will review ABIM’s formal proposal, with approval expected by September of next year.

If approved, the credential—which ABIM is tentatively calling a focused practice in hospital medicine—would make medical credentialing history, as no other subset of internal medicine has ABIM certification. It will also be the first time that there is a focused recognition for a subset of any specialty.

“There is an interest on the part of ABIM to recognize that hospitalist medicine is a unique specialty within internal medicine, and as such, there is a strong justification for unique recognition in the form a certification process,” says Russell L. Holman, MD, president of the Society of Hospital Medicine (SHM) and chief operating officer at Irvine, CA–based Cogent Healthcare. “There are many ways to achieve that [recognition], and ABIM felt that it was most appropriate to achieve it through [its] Maintenance of Certification process.”

According to Holman, physicians would begin by seeking out certification in internal medicine. After a certain period of time, they would then be eligible to update their certification with a focused recognition status in hospital medicine.

“It would be part of their Maintenance of Certification. Somebody training in medicine would have to go through the maintenance process every 10 years in order to recertify and keep his or her certification active,” says Holman.

“Through this [mechanism] a hospitalist would be able to maintain [his or her] certification in such a way that the exams and modules would be focused on hospital medicine,” he says.

Charting a course

The process of creating the focused practice in hospital medicine has been a work in progress for the past three years. In 2004, SHM approached leaders at ABIM regarding the creation of a hospital medicine certification. As a result, a group of stakeholders in internal medicine convened to discuss the credential.

The group included representatives from SHM, the American College of Physicians, the Society of General Internal Medicine, the Alliance for Academic Internal Medicine, the Association of American Medical Colleges, the AMA, residency review committees, and ABIM.

“We wanted this to be a collaborative process with other organizations,” says Holman. “We want to work hand in hand with the American Board of Internal Medicine to provide input and expertise.”

In the beginning, he says, many people had lots of different ideas about the process, and not everybody necessarily thought it was a good idea.

“Early sessions focused on why this might be good, what are potential pitfalls, and [we spent] a lot of time listening to the collective wisdom of the group,” he says.

“Over time there was more convergence toward this being a positive thing for hospitalists and for internal medicine overall. Three years of time for this discussion is actually a relatively short time frame with such an important topic.”

Details are still in the works

ABIM still must develop details concerning the specifics of the exams and models for the credential, and its panel of experts will contribute to developing materials and exam questions to delineate the overall goals and objectives of the certification process. It is also possible that ABMS will establish some of the criteria in conjunction with its review process.

“There would be a development process in terms of creation of the certifying exam, as well as other elements involved in the Maintenance of Certification process,” Holman says. “The good news is that the current...
Certifying exam for internal medicine contains some elements of hospital medicine, so that would just need to be expanded.”

Expectations are high
Hospitalists may be looking forward to the credential for many reasons.

“Within the field of medicine, there is recognition among peers that there is a unique body of knowledge and unique skill set that is required to practice hospital medicine,” Holman says. “This certifying process serves to reinforce that body of skills. Without such a process there can be a huge variation in both the scope of practice and skill sets within the scope of hospital medicine.”

Ken Simone, DO, a board-certified family physician in a private family practice in Brewer, ME, agrees that the credential is a great idea.

“It is a tribute to the accomplishments of each and every hospitalist provider nationally, as well as to the Society of Hospital Medicine and its leadership advocating for this,” he says. “The certificate reinforces the fact that being a hospitalist requires the physician to be proficient in very specific areas.”

Simone says it is important for the process to recognize all hospitalist physicians, whether they are general internists, medical subspecialists, pediatricians, or family practitioners.

“I believe this recognition will have a positive impact on established academic hospitalist training programs and residencies considering the development of such programs or training tracks,” he says. “The formal certification process, along with the core competencies, can and probably will guide the curriculum of these programs.”

According to Simone, the acknowledgment may also affect the credentialing of hospitalists with healthcare insurers.

For example, it is possible that only those hospitalists possessing a certificate will be credentialed and appear as a participating hospitalist provider on the insurers provider panel. However, this remains to be seen.

Although details have yet to be fleshed out, Holman says if things remain how they look today, once a hospitalist has obtained his or her recognition of focused practice, he or she would be able to update his or her certification every 10 years by going through a Maintenance of Certification process that would be directly related to hospital medicine.

“I think ABIM is very progressive in terms of wanting to make a certification process that is highly relevant to practice and to those [whom] the physician is serving,” Holman says. “It’s pretty tough to say what it would look like.”

Holman speculates on some possibilities—with the caveat that the possibilities are his ideas alone, not ABIM’s or SHM’s:

*I think there will be an examination of some type, where there would need to be demonstration of numbers of patients cared for in a given period of time in the hospital. Much like a surgeon has to document the number of patients he or she has seen in a certain period of time, it’s possible the physician would have to document the number of patients he or she has seen in the hospital. There might need to be verification that a hospitalist participated in an activity related to quality improvement or patient safety.*

Issues remain
The question of whether long-practicing hospitalists will be grandfathered in without having to apply for certification still needs to be answered.

However, doctors who trained more than 20 years ago in internal medicine do not have to recertify to maintain their board certification status, according to Holman.

“It is possible that those who are practicing as hospitalists may turn around to say, ‘Do I need to take a recertifying exam to recertify?’ ” he says.

And not everybody is completely happy with the idea of a hospital medicine credential. Some physicians—
hospitalists and nonhospitalists—worry that such a credential might lead hospitals to require that physicians possess this credential to care for inpatients.

This could, in some instances, exclude many primary care physicians from working in the hospital.

But this is a risk that you take with any credentialing process, Holman says.

“There is always the potential for the credential to be misused or misapplied,” he says. “This credential is not intended to exclude other people from providing hospital care.”

The recertification process for physicians who are not hospitalists will still include elements of hospital medicine as well, Holman says.

Now that ABIM’s board has approved the certification, ABMS will begin its review of the proposal this month. ABMS typically takes one year to render a decision as to whether it will approve the credential. ■

Ask the expert

What factors should I take into consideration when developing our hospitalists’ schedule?

The process of developing a hospitalist schedule is unique to each program. It is typically based on a number of factors, including the following:

- The hospital’s and medical staff’s needs
- The program’s objectives and mission
- Financial resources
- Scope of services offered
- Number of providers in the practice

When evaluating the merits of various practice models/schedules (e.g., seven days on and seven days off, rotating 36-hour shifts [traditional call], block scheduling, shift work, or some other arrangement), carefully consider the following:

- Continuity of care
- Anticipated volume/daily census/growth

Added-value services your hospitalist program will offer to the institution (e.g., staffing rapid response teams, training/educating key hospital personnel, participating in key committees or leadership positions, etc.)

Considerations also include time allotted for a hospitalist’s vacation, continuing education, sick leave, and maternity leave. A premium should be placed on the model that provides practice stability and schedule flexibility. This will support your practice’s recruitment and retention efforts. ■

Editor’s note: This month’s “Ask the expert” question was answered by Kenneth G. Simone, DO, coauthor of Tools and Strategies for an Effective Hospitalist Program, available at www.hcmarketplace.com/prod-4013.html. If you have a question you’d like to have answered by our field of experts, e-mail Executive Editor Erin E. Callahan at ecallahan@hcpro.com.

Get the latest on the hospital medicine credential

For more information or to follow the process over the coming months, hospitalists can contact the following organizations:

- Society of Hospital Medicine, 190 North Independence Mall, West Philadelphia, PA 19106; Phone: 800/843-3360; Fax: 215/351-2536; Web site: www.hospitalmedicine.org.
- American Board of Internal Medicine, 510 Walnut Street, Suite 1700, Philadelphia, PA 19106-3699; Phone: 800/441-2246; Fax: 215/446-3590; Web site: www.abim.com.
- American Board of Medical Specialties, 1007 Church Street, Suite 404, Evanston, IL 60201-5913; Phone: 847/491-9091; Web site: www.abms.org.
Recruiting tip of the month
Partnership and equity ownership opportunities

Partnership and ownership opportunities are one of the most effective initiatives for retaining today’s physician. According to the Cejka Search and American Medical Group Association’s (AMGA) 2006 Physician Retention Survey, 51% of respondents mentioned partnership opportunities as one of the most effective initiatives on an ongoing basis.¹

These partnership and equity ownership options have proven successful among groups with established opportunities in place.

Of the 62% that already offer their physicians these opportunities, 79% of respondents said partnership opportunities were their most effective retention tool, followed by profit-sharing opportunities (60%).

Be aware of what your competitors are offering and how your group’s partnership and equity programs stand out.

For example, most groups offer partnership after two years. Consider the following questions as you evaluate your group’s program:

- If your group’s income is divided equally among the doctors, are all doctors eligible or just shareholders?
- After how much time does your organization offer partnership and equity opportunities?
- How does your partnership buy-in price compare to the salary you are offering and the benefits a partner stands to gain?

Some other partnership trends to be aware of include the following:

- 65% of groups offer the opportunity to part-time physicians
- 94% of physician-owned groups offer the option
- Partnership opportunities are most common in smaller practice groups

Although a lack of partnership opportunity was never cited as a main reason for leaving a group, it has proven effective for recruiting and retaining successful physicians.

Editor’s note: This tip was submitted by Paul Smallwood, vice president of physician search with St. Louis–based Cejka Search, a nationwide firm specializing in physician and healthcare executive recruitment. For more information about recruiting and retaining hospitalists, go to www.cejkasearch.com or call 800/678-7858.

¹The Cejka Search and AMGA 2006 Physician Retention Survey was completed by 92 members of the AMGA who collectively employ more than 16,833 physicians.
In the spotlight

Huang uses his hospitalist skills to change the world

Part one of two

When 35-year-old Chi Huang, MD, a pediatric and internal medicine hospitalist at Boston Medical Center, was seven years old, he saw a Save the Children commercial with Sally Struthers asking viewers to give money to starving children. At the time, his family was struggling to survive on welfare in the projects of Columbia, SC. But he was so upset that he asked his mother if they could send their food to the starving children. His mother, a recent immigrant from Taiwan, said they couldn’t give money now, but “maybe in the future.” Perhaps she knew that her son would grow up to be a physician who would travel the world, devoting his life to marginalized and underserved communities.

Huang, now the father of three daughters, has spent the past 15 years working with impoverished children. He earned his medical degree at Harvard Medical School in Boston, graduating cum laude in 1998, and completed his residency training at the Harvard Combined Internal Medicine/Pediatric Program in 2002. Since then, Huang has worked in Mexico, Honduras, Ecuador, Bolivia, Switzerland, Hungary, and Serbia. He speaks at conferences and events around the country about his research on the socioeconomic risk factors of abandoned street children, their healthcare needs, and human rights abuses.

One of his greatest contributions is the creation of the Bolivian Street Children Project, a nonprofit that provides healthcare, housing, and education to abused children living on the streets of Bolivia. His critically acclaimed book When Invisible Children Sing describes his experiences there.

Huang has received numerous awards for his work, including the Civil Servant of the Year award from the Taiwanese American Foundation. He was nominated for the Reebok International Human Rights Award and received the Boston University School of Medicine AAMC Humanism Award. He was given the Brigham and Women’s Hospital Physician Organization Community Service Award, and he received the Dean’s Community Service Award from Harvard Medical School, among many others.

Today, Huang works as an internal medicine hospitalist at Boston Medical Center, where he serves as the medical director of the pediatric inpatient service. He is the director of the Boston Medical Center Pediatric Global Health Initiative and is an associate physician in the division of health inequalities and social medicine at Brigham and Women’s Hospital. He is also an assistant professor at Boston University School of Medicine in the department of pediatrics and internal medicine.

Huang discusses some of the lessons he has learned over the years and talks about why being a hospitalist is the greatest job in the world.

How did you first decide that you were going to become a hospitalist?

I knew I wanted to become a physician in 1990 while I was a peace observer in Serbia during the Croatian war. In Belgrade, people were coming up to me speaking in Serbian, Hungarian, and Croatian, and I didn’t understand anything that was being said to me. I was 18 years old, and I realized that I wanted to have some type of skill or occupation that transcended boundaries not dependent on who they were or who I was or even where we were. I wanted to be of service and see a transformation, even if it was for a very short amount of time.

How did you decide to become a pediatric hospitalist?

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In the spotlight  < continued from p. 9

I went into pediatrics because I knew that when I was going abroad, I would be the only doctor within 100 miles, and I wanted to learn both adult and pediatric medicine. So I did a double residency program. I became a hospitalist because I really enjoy taking care of sick patients where I can spend time with them over a period of three or four weeks and really get to know them. I love the complexities and intricacies of hospital medicine. You can have your heart malfunctioning and your kidneys failing at the same time, and it’s challenging to [know] all of your symptoms . . . in order to be able to care for the patient as a whole. I also enjoy the fast pace. It’s a constantly changing practice, so it’s intellectually stimulating. It’s also a limited period of time when I’m working, which gives me the flexibility to do things I am passionate about, whether it’s international health or spending time with family or colleagues. The last reason is I really enjoy working as a group, learning from people and teaching what I’ve learned.

What’s a typical day like for you?

I usually get in around 6 or 6:30 a.m. I go through the charts and see patients who are sick. At 7:30 a.m. I have rounds with staff [members] and medical students, which usually lasts until 10 a.m. At 10:30 a.m. we usually have radiology rounds. We review x-rays, CT scans, and MRIs. At 11 a.m. I have attending rounds and then I teach house staff [members] and medical students some medical topic. At noon there is a conference for the department of medicine or pediatrics. Then, from 1 to 5 p.m., I’m checking up on studies and touching base with families. I like to make sure I’m seeing patients twice a day, so I try to make a second round.

What do you enjoy most about your job?

From an internal medicine standpoint, I love seeing the patients and talking to little old ladies or men, the elderly ones, about their lives. I ask them about what their life was like or how they spend their days. Learning from them from a life standpoint allows me to understand what they go through. If Mrs. Jones has dementia that nobody has picked up, then she needs social services to help her take care of herself. If she has Alzheimer’s, it’s important to start medical therapy. Spending time listening makes me a better hospitalist and physician. It’s a twofold occupation for us, [we are] learning clinical medicine, but also learning how to be there and take care of patients in a holistic manner. From a pediatric standpoint, the thing I enjoy most is being able to reassure mothers. Knowing that they stay up all night and being able to tell them that their child doesn’t have meningitis is incredibly satisfying. It’s one of the few privileges of getting to know a family and giving back something.

What are some of the personal experiences that have influenced you as a hospitalist?

One of the major experiences I had when I was a junior in high school was the passing away of my younger sister. It had a dramatic effect; it was incredibly traumatic, but I’m also grateful for that experience. I wish she was still alive, but that being said, it allowed me to understand the perspective of the patient. She was diagnosed with leukemia when she was younger, but she recovered. Then she got a kind of flu which attacked her heart and gave her a heart attack. She died at around 3 a.m., but I found her on Christmas morning.

Drop us a note!

Do you know a hospitalist who has gone above and beyond and deserves to be recognized? Let us know about it, and they could be featured in an upcoming Hospitalist Management Advisor! E-mail Executive Editor Erin E. Callahan at ecallahan@hcpro.com.
Afterward I went on a spiritual journey to discover the greater meaning in life. I became a Christian when I was a junior in college and have tried since to fulfill the major commandment of loving others. If God pushes me and calls me to go to other countries, then we go and take care of the folks there.

Editor’s note: In next month’s edition of Hospitalist Management Advisor, we will bring you the second half of the interview with Chi Huang, including his experiences abroad, his founding of the Bolivian Street Children’s Project, and advice for other hospitalists who are looking for ways to give back to the community.

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Pioneering psychiatric program hits the ground running

A trailblazing effort by an enthusiastic and determined hospitalist at St. Luke’s Episcopal Hospital in Houston has resulted in what may be the first psychiatric hospitalist program in the country.

The program, developed by St. Luke’s Chief of Psychiatry Jennifer Pate, MD, and facilitated by IPC-The Hospitalist Company, Houston, seeks to fill a large, unmet demand for psychiatric consultation and treatment of a significant population of medical and surgical inpatients.

Some studies estimate that between 30% and 60% of all inpatients suffer from a significant psychological dysfunction secondary to their medical illness that could necessitate a psychiatric consultation.

Having psychiatric input during hospitalization may decrease length of stay and play a role in helping to prevent unnecessary readmissions, according to Fred Grates, executive director of IPC Houston, which provides management services to hospitalist practices in more than 200 facilities across 15 states.

Not-so-typical days

Pate sees a wide variety of patients, including those who are depressed and suicidal as well as surgical patients whose medication may be causing adverse psychological reactions.

She also works closely with St. Luke’s organ transplant services, providing the required psychological consultations for donors and recipients.

“I work very closely with the liver transplant program,” she says. “Two of the most common reasons people need liver transplants are alcohol-related or because they have hepatitis C from drug use. It’s a psychosocial complex situation.”

Pate evaluates pretransplant patients to determine whether they are sober, whether they have the skills to take care of themselves after the transplant, and to treat ongoing disorders such as depression.

She also works closely with kidney donors to make sure that people who want to donate their kidneys understand the risks involved and that their motives are appropriate.

“We want to make sure [patients] are not hoping to sell a kidney or have some financial incentive,” she says. “Some people have a criminal charge and think, ‘Oh, it will look good if I donate kidney.’”

Pate also monitors her patients after the transplant.

“One of my new consults this afternoon is for somebody who had a liver transplant several days ago, who is now confused and agitated and has begun seeing things that aren’t really there,” she says. “I will evaluate that and see what the cause of the new confusion is.”

Pate says she never knows how many consults she will have in a given day, but she likes the wide range of patients and the general unpredictability that a hospital setting brings.

“I never have two days that are identical; they’re always different,” she says. “There’s a different patient population and different psychiatric problems. I don’t know when my day will end and I don’t have the same control, but I don’t think working with a single

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type of patient in [an] outpatient setting would be as interesting.”

On the day of this interview, Pate arrived at the hospital just before 4 a.m. She saw eight ICU patients, followed by a meeting with medical students around 7 a.m. She then saw three transplant clinic patients. She planned to spend the remainder of the day finishing two new consultations and meeting with several follow-up patients.

Pate says she finishes up around 8 or 9 p.m., but that she is on call 24/7 for the hospital ER. Although she is called almost every night, she usually has to go into the hospital on these calls only about once a week.

“It’s much easier to have a private practice,” she says. “But it’s also not as much fun. I wouldn’t enjoy sitting in an office all day, and I think all hospitalists would say that.”

Unique challenges
Developing the psychiatric hospitalist program was not without its systemic challenges, including billing and coding and working with insurance companies.

That’s where IPC Houston comes in. Pate approached Grates with her idea for the program.

“There have been a lot of systemic challenges that IPC has been willing to take on,” says Pate. “Reimbursement is not the same for psychiatric services. I have an assistant who spends time talking with insurance companies to get consults preauthorized so we can get paid, and that’s very labor-intensive.”

“When patients go into the hospital with chest pain, that is covered by insurance,” Pate says. “But if patients go in and are depressed, the psychiatrist needs to go in and make sure that [the condition is] covered. [He or she] really [needs] somebody on [his or her] team who knows how to do psychiatry billing.”

To that end, IPC Houston provides the support and infrastructure for her billing and collections, a service Pate says she couldn’t practice without.

“There are some unique characteristics of the practice that have evolved here. We have a small outpatient component here with the transplant services,” Grates says. “This introduces a different billing and coding and then you couple that with [the fact that] the codes she is using are different than codes typically associated with hospitalist practices . . . We had to do some homework.”

Tangible success
Grates says the psychiatric hospitalist program, initiated in March of this year, has been such a success that they are looking to hire another hospitalist for it.

“I’ve been in healthcare 30-some years and it’s rare to find somebody like Dr. Pate [who] really would be interested in devoting [his or her] time and energy in developing these consultations and services,” he says. “This frontier has been there a long time, but the willingness to address it, I think, is unique and new. Dr. Pate’s a very strong-willed, determined young lady who has embarked on this career path to show that this is a viable alternative.”

Perhaps the best benefit has been what the program brings to St. Luke’s hospital, especially its transplant services.

“It’s overwhelming,” says Grates. “The fact that she’s available has enhanced the position of the hospital in inpatient services. People are thrilled to death that there is somebody immediately available and able to provide the assistance they need. There are many hospitals that provide transplant services, but not all hospitals [also offer] psychiatric services.”

Questions? Comments? Ideas?
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