OPTUMHealth™ Education

Q&A Summary:
Management of Comorbid Behavioral and Physical Illness Near the End of Life

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1. For palliative care, is there a time where it could be applied in a chronic debilitating condition where the life expectancy is over 12 months?
    a. Palliative care is focused on symptom relief, quality of life, and smooth transitions in care. I believe it can be applied to just about any "serious" illness. Due to the way the field has evolved and the limited number of practitioners, it is typically limited to a prognosis of one year or less (in hospice in the U.S., it is ≤6 months). Recall from the talk that it evolved from end-of-life cancer care to last year of life care for complex serious illness. There is no reason why it cannot evolve further. I'm not sure what you have in mind, but many neurologic issues seem to fall in this category in my mind.
2. Did you say we would discuss palliative care with member if prognosis is 6 months or 12 months to live?
    a. See the answer to question 1.
3. Do hospice settings have psychiatric care?
    a. Many do not, but some have access to consultants. Social work is a mandated part of hospice care, and can address many psychosocial issues.
4. Can a patient be in hospice for as long 5 years? For example, patients with Alzheimer disease?
    a. The criteria for debility, failure to thrive, and Alzheimer in the U.S. is very specific (see hospice guidelines). The test is whether today, if the disease ran its natural course, do we expect that this patient has a high probability of dying in the next six months? If yes, they are hospice eligible (with exceptions noted above). This gets recertified at specific time periods, and as long as the answer is the same, patients may be on hospice for a year or longer. Five years is probably pushing it. For Alzheimer disease, based on the criteria, it really must be end-stage disease.
5. Do you find a significant difference in emotional responses between men and women in palliative care and hospice? Suggestions for working with those who are reluctant to talk about their emotions would be helpful.
    a. In my experience, everyone is different, even within "groups": men, women, various faiths, races, and ethnicities. Approaching people as individuals, trying to find common ground, building rapport, utilizing the team to find who can make the most inroads, and utilizing questions from the talk all may help.
6. What is a psychostimulant?
    a. Typically, dopamine agonists, such as Ritalin (methylphenidate) or dextroamphetamine (Dexedrine). They are most often used for attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD).
7. Should psychostimulants such as Ritalin be used solely as a bridge between the initiation and therapeutic level of antidepressants, or in conjunction for best results?
    a. I use them as monotherapy. When I first entered the field, the practice was to start a stimulant and an antidepressant, such as a selective serotonin reuptake inhibitor

(SSRI), and taper the stimulant in 8 weeks or so. The reason I stopped this is that if I get a side effect, I do not know which medication caused it. Further, I have a 30% chance of the standard antidepressant working over a 12-week period (a long time for these patients). Lastly, there does not appear to be any risk or downside to continued use of stimulants in this population, and it may help with other things, such as lowered analgesic requirements.

8. What are your thoughts on primary care physicians (PCPs) prescribing antidepressants (many of my patients are reluctant to see a psychiatrist)?
    a. The vast majority of antidepressants are prescribed by PCPs. Psychiatry is a core competency in medical school, and it is thought that 60% of a PCP's practice is psychiatric. That said, in my experience, often they start too low or keep people on sub-therapeutic doses. Once it gets complicated, as it already is with the patient population we are describing, a psychiatric consult may help, even if it’s just one time to give the PCP guidance and next steps depending on how things go.
9. Can a PCP order a psychostimulant?
    a. Any physician can order any medication for any purpose if benefits outweigh the risks and they justify their medical decision making. There is no reason why a PCP cannot order these. I am not sure if they do for ADD/ADHD or not. Geriatricians are usually comfortable with using these medications.
10. Federal regulations regarding psychotropic drugs in long-term care are adversely affecting end of life care. How can we change this?
    a. Unfortunately, federal regulations incentivize the wrong thing, which is lowering the use of antipsychotics. They should incentivize appropriate use of them. I am not sure how we can change this on a large scale, but I do on a small scale by advocating for my patients. If there is justification, monitoring, and using the lowest possible dosage, the auditors should have no issues. I have had charts of my own audited, with panicked nursing home administrators watching, and there were no issues because of what I documented and how. When in doubt, with some back up evidence and medical reasoning, no auditor can argue with the phrase “in my medical opinion…..”
11. Are all medications in one drug class similar? If one SSRI fails, should we try another in the same class?
    a. Evidence shows that if you try three SSRIs, you have up to 80% chance of finding something that works. I tend to try different classes. The best way to start is to find out if the patient has had good results with something in the past or if a 1st degree relative has. If not, in my hands, I like starting with bupropion, just a personal choice based on my own experience. I might switch to an SSRI or add an SSRI. Make sure to check drug-drug interactions with SSRIs, especially fluoxetine and paroxetine. I advocate checking for drug-drug interactions for all medications a patient is taking. Often some symptoms have their explanation there. See the STAR-D depression study for more information on the approach to needing multiple trials of antidepressant.
12. What is the mental health therapist's role in caring for a person who has severe cognitive dysfunction (i.e., advanced Alzheimer disease, Huntington disease, etc.)?
    a. A therapist’s role, in the traditional sense, not much, as one needs the ability to communicate and have insight. In a non-traditional role of talking to people about their past, things they loved as a child, music from their past, etc., they can be very helpful. A psychiatrist can add the psychopharmacology for agitation, sleep, and discern any other underlying issues.

13. Are you seeing an increase in anxiety and depression over the last 18 months due to the current political environment?
    a. I would say I have seen exacerbation of pre-existing symptoms, but then again, I would not be seeing these patients if they did not have pre-existing symptoms. I have not yet seen anyone with a primary complaint of political anxiety.
14. What is the definition of anxiety?
    a. See slides 41-45 and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V). Often, I find Wikipedia pretty good for first-step, general definitions of scientific stuff.
15. Is there a difference between what is a "normal" or expected reaction to a terminal diagnosis and anxiety and/or depression? Or are they both treated in the same way?
    a. It is hard to say what is "normal." Everyone reacts differently. The biggest differentiator is the amount of impairment the symptoms bring to someone's life. I believe there is a spectrum from normal grieving, to trouble coping, to adjustment disorders (see DSM-V or Wikipedia), to full blown anxiety and mood disorders.
16. Do you support the use of transcranial magnetic stimulation (TMS) in "regular depressed" patients? Has it been considered for end-of-life (EOL) patients?
    a. I believe there is good evidence for repetitive TMS in patients with treatment-resistant depression (who have failed multiple other interventions); however, this is not my area of expertise. Theoretically, it could be a good intervention, as could electroconvulsive therapy (ECT), for EOL patients. However, often the logistics of getting it to a very ill patient get in the way. The logistics are much easier for repetitive TMS than for ECT.
17. Can you speak to the gabapentin every hour comment on the anxiety slide? When would you use this?
    a. I try to avoid benzodiazepines for medically ill patients. However, sometimes we need immediate anxiety relief vs what antidepressants (eg, SSRIs) can offer. The "every hour" is based on how to rapidly titrate medications for symptoms that are out of control. The model is use of long-acting opiates for pain with short-acting for break through symptoms. So, long-acting medications are given on the half-life, and break through medications are given on the time to maximum concentration in the blood (Cmax). For most medications, the latter is based on route. So, for the oral route, be it pain medications or gabapentin, the time to Cmax is 1 hour, and if the medication does not work at its maximum concentration (in general), it will not work beyond that. So, if one has anxiety, I use gabapentin or trazodone, and think of them as both short-acting and long-acting. So I have the as-needed break through based on Cmax, and then I schedule a standing dose based on the half-life. As-needed usage is assessed, and if frequent and constant, it is added to the standing dose until as-needed usage becomes infrequent and random, if needed at all. A good example can be found here: https://www.ncbi.nlm.nih.gov/pubmed/23480299

18. Can you please highlight the differences between delirium and dementia?
    a.

Feature	Dementia	Delirium
Onset	Slow	Rapid
Duration	Months to years	Hours to weeks
Attention	Preserved	Fluctuates
Memory	Impaired remote memory	Impaired recent and immediate memory
Speech	Word-finding difficulty	Incoherent (slow or rapid)
Sleep–wake cycle	Fragmented sleep	Frequent disruption (e.g., day–night reversal)
Thoughts	Impoverished	Disorganized
Awareness	Unchanged	Reduced
Alertness	Usually normal	Hypervigilant or reduced vigilance

(Adapted from Lipowski ZJ. *Delirium: Acute Confusional States*. Oxford: Oxford University Press; 1990.)

19. What are some of the ways you help patients feel more valued?
    a. By understanding what they value and honoring it, as well as trying to help them to participate in those things that make them feel valued. I refer you back to the slides that discuss what is often most important to patients at the end of life, as well as the questions proposed by Chochinov.
20. The integrated care model is a wonderful model for holistic patient care. How common is it being used at the present time?
    a. Frequently in the Veteran's Administration and primary care. Not frequently in cancer care, and I believe hospice care is one model of how this is implemented.
21. What strategies are being utilized to identify patients/decrease the number slipping through the cracks?
    a. I believe the collaborative care model (see Katon, Unitzer, Fann, Sharpe) is one of the best ways to achieve this. Hospice models also are similar.
22. What to do with family members who will not let go from their dying family member?
    a. This is a tough one, and tough to answer briefly, but exploring what their expectations are, what they see in front of them, what their hopes are, and what is driving their emotions are all good approaches.
23. What study does this return on investment (ROI): $6.5 saved / $1 invested come from?
    a. For overview of this model, see papers by Katon, Unitzer, Fann, Sharpe. See also http://www.ahrq.gov/about/nac2012/nac0712/cohenmeyers/cohenmeyerssl10.htm And Hussain M, Seitz D. *Psychosomatics*. 2014:55:315-325.
24. How accepting are people who have life-limiting illness of psychiatric care?
    a. It depends. Many have never had exposure to psychiatric care or a psychiatrist. However, they recognize they are suffering, and are usually accepting if I can offer relief. Some want to make sure they are not “crazy” just because they are seeing a shrink. I reassure them that what they are going through is common and can often be addressed.
25. Can you elaborate a bit on the non-pharmacologic options?
    a. See slides 36-38 and 46-47. Any form of support without medications.

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