Psychiatry Consultations in the Hospice Setting: A Case Series

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Introduction

Traditionally, palliative medicine services have served patients with cancer diagnoses. However, with our aging population, increasing numbers of older adults are being enrolled into hospice with diagnoses of debility, dementia, or cardiopulmonary disorders (1, 2). Depression, anxiety, delirium, cognitive impairment, and neuropsychiatric symptoms often accompany these diagnoses. Mental suffering can be as debilitating as physical pain, and can magnify pain symptoms. Additionally, patients with personality disorders can challenge palliative medicine team members, who often have had limited training in managing this patient population. Differentiating acute delirium from terminal delirium can be difficult, and treatment protocols are divergent for these etiologies. Although hospice provides a holistic approach to the patient, psychiatric services are not routine in this setting. With the aging demographic of hospice patients, the intensive, multidisciplinary training of a geriatric psychiatrist should provide expertise to the palliative care team. We explored characteristics of hospice patients referred for a psychiatric consultation to identify recurring clinical questions, patient characteristics, psychiatric diagnoses, medical comorbidities, and recommendations.

Method

We present and summarize all psychiatric consultations requested by a university-affiliated non-profit hospice between September 1, 2010 and February 25, 2011. The case series was categorized by demographic information, residence (acute general inpatient hospice (GIP), home, facility (ECF)), hospice admission diagnosis, consult question, psychiatric diagnoses, medical comorbidities, medications, interventions, and course. Descriptive statistics are used to explore the most common entries in each category. Illness burden is calculated with the Charlson comorbidity index (3). Hospice admission diagnosis (cancer/non-cancer) for the psychiatric consultation patients will be compared to the referring hospice organization’s demographics, and nationwide statistics.

Results

In the study period, 34 psychiatric consults were performed. Five patients were evaluated twice. Consults on two of these patients were combined as a single entry due to the similarity of the consult question and recommended interventions. This resulted in 32 unique consultations for analysis.

Demographic data are displayed in Table 1 comparing the psychiatric consultation population to the demographics of all Arbor Hospice admissions and national hospice data (4) at similar time points.

Conclusions

1. Hospice patients are aging, with more non-cancer than cancer patients enrolled locally and nationally.
2. These trends are reflected in the hospice patients referred for psychiatric consultation.
3. Behaviors and anxiety are the top two referral questions.
4. The hospice patient referred for psychiatric consultation is complex, having:
   - Multiple medical comorbidities (average Charlson index score > 4.2)
   - Polypharmacy (average 10.8 medications)
   - Multiple psychotropic medications (average 3.3 medications)
   - Anxiety and depression (59%)
   - Cognitive impairment (59%, 31% with behavioral disturbances)
   - Delirium (22%)
5. Psychiatric symptoms (depression, anxiety and dementia) negatively impact caregivers’ abilities to provide the optimum palliative care, and limit management of physical and emotional pain.
6. Hospice teams can benefit by geriatric psychiatric expertise, both in educating about and managing distressing psychiatric symptoms in these complex and challenging patients.

References