HospiLink™
Linking you to the most up to date clinical information

Volume 17, Issue 10 October 21, 2025

Deprescribing for People with Dementia: A Roadmap

Green A, Boyd C, Quiles R, et al

People with dementia (PWD) are frequently exposed to polypharmacy and potentially inappropriate medication use, in which the risks of medication use outweigh the benefits or the medication is not aligned with treatment goals. Appropriate deprescribing of unnecessary or potentially inappropriate medications is essential to high-quality care for PWD, to avoid iatrogenic harm and improve health and well-being for patients and their care partners. In this article, we review the risks of polypharmacy in PWD and evidence for the safety and efficacy of deprescribing in this population. Building off existing deprescribing frameworks for older adults with multimorbidity and limited life expectancy, we provide a roadmap for deprescribing in PWD that addresses the unique challenges of living dementia, including the variable disease course, high prevalence of distressing behavioral symptoms, and central role of care partners. The steps include: (1) identify potential targets for deprescribing by eliciting medication-related goals and considering tradeoffs, (2) develop a tapering plan, (3) complete additional actions that are necessary before deprescribing, and (4) provide close follow-up. Lastly, we provide evidence-based strategies for communicating with patients and their care partners about deprescribing, adapted from the FRAME tool. *Drugs Aging*. 2025;42(9):795-806
Full text is freely available at https://pmc.ncbi.nlm.nih.gov/articles/PMC12436473/

Tailoring Hospice Care to the Veteran Population

Kommer C, Nadolny A

United States Military Veterans are an increasingly elderly population, and more and more veterans are choosing hospice care at the end of life. These veterans, particularly if they served in combat, can bring unique management challenges and opportunities to a hospice team. This review highlights the physical and psychosocial traumas experienced by many veterans, and discusses how these issues can affect their hospice care. Traumatic injury-related issues such as chronic pain, neuropathic pain, insomnia, and chronic headaches can worsen for veterans at the end of life, and the psychological sequelae of these traumatic events such as Post-Traumatic Stress Disorder (PTSD), Chronic Anxiety, Substance Abuse, and increased risk of suicide can also be magnified during this time. This review details these and other commonly seen service-related comorbidities, and offers evidence-based recommendations regarding their diagnosis and treatment. In addition, it discusses what is important to veterans at the end of life, and provides suggestions on how hospice programs can individualize and optimize their care of this special population. Honoring their service and respecting their sacrifices are also important aspects of “Best Care” for veterans at the end of life, and this review provides suggestions on how to do so and includes a list of resources that can greatly assist hospice programs, veterans, and families in delivering the most respectful, comprehensive, and thoughtful care possible. *Am J Hosp Palliat Med*. 2025;42(10):1054-1060

Common Antimicrobial Treatment Considerations for Patients Receiving Comfort-Focused Care: What the Hospice Provider Should Know

Crowley P, Siegel L, Dickinson D

Antimicrobials are used in the final few months of life in an attempt to palliate symptoms or treat potentially reversible infections. Antimicrobials cause side effects such as nausea, diarrhea, rash, and allergic reactions. Clinicians should select the narrowest and shortest treatment duration appropriate to the infection. Here, we present common oral antimicrobial agents used at the end of life, highlighting microbial coverage and important prescribing considerations. Providers should be aware of the limitations of antimicrobial treatment for patients at the end of life, particularly those enrolled in hospice, to inform discussions with patients and their families. This will allow tailoring of treatment to the patient’s clinical situation and wishes. *J Palliat Med*. 2025;28(8):1006-1012

© 2025 Fuze Health Inc. All rights reserved.

Voluntarily Stopping Eating and Drinking: Systematic Review of Empirical Studies

Ness R, Pope T

Objective: To systematically review studies presenting quantitative data on the experiences of patients and providers engaged in VSED. **Background**: Voluntarily stopping eating and drinking (VSED) to purposefully accelerate the end of life is uncommon but likely accounts for thousands of deaths per year. A single systematic review of literature was published in 2014. **Methods**: We systematically searched English-language articles and books in MEDLINE/PubMed and reference lists of retrieved articles and books. Studies that provided empirical results from surveys or qualitative studies were selected. We obtained from each study publication year, study type, country, population source, sample size, outcomes, and results, and graded each on quality. **Results**: Of the 17 empirical publications not included in the 2014 review, 3 were conducted in the US. Eight surveys were rated as moderately high/high quality and six as moderately low/low quality. Incidence estimates ranged from 0.4%–1.7% of all deaths. VSED was generally attempted among the elderly, often 80+ year-olds. About half of participants had dementia or other conditions that would make them ineligible for medical aid in dying. Incapacitating depression was rare. The mean time to death was 10 days with a range of one to two weeks. Most experiences were considered satisfactory by the patient. Caregivers often found preparation for and the emotional toll from VSED challenging. Theoretical support for VSED was ubiquitous among health care professionals in Europe, who expressed the importance of palliative support. However, professional experience was lacking. **Conclusion**: VSED, albeit uncommon, still accounts for many, typically satisfactory, deaths. Little research to guide best practice is available, particularly in the United States. Caregivers and health care providers generally indicate support however, extensive preparation and caregiver assistance make the practice challenging. Practitioners express a need for training. *J Palliat Med*. 2025;28(8):1114-1120

Qualitative Scoping Review of Massage and Massage Therapy on the Mental Health and Well-being of Individuals Living with a Serious and Potentially Life-limiting Physical Illness

Fogarty S, Moore R, Cates C

Serious illness "is a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life or excessively strains their caregivers." **Purpose**: The aim of this review was to explore the contribution of massage and massage therapy to the mental health and well-being of individuals living with a serious and potentially life-limiting illness. **Methods**: A scoping review was conducted following Arksey and O'Malley's six-step scoping review framework and the PRISMA-ScR guidelines. The electronic databases PubMed, CINAHL, MEDLINE (OVID), PsychINFO, CENTRAL, Web of Science, PROQUEST Dissertations and Theses, and Scopus were searched to identify qualitative or mixed-methods studies. The qualitative data were coded from the studies and themes emerged. For the final stage of analysis, a thematic synthesis was utilized. **Findings**: Sixteen papers were included from eight countries. The overarching theme was "the effable and ineffable impacts of massage" informed by the following themes: massage as a transcendent experience, existential respite, massage helping to preserve dignity, increased inner resources, well-being and relaxation as part of the individualized and personalized vocabulary for massage for the seriously ill, and varied outcomes of the effect of massage on physical symptoms. **Conclusion**: Good mental health and well-being are important aspects of living well with serious illness. The review found there is a considerable body of research which points to the value and impact of massage on outcomes of well-being and mental health and, broadly, on patient experience. *Int J Ther Massage Bodywork*. 2025;18(3):14-41

Full text is freely available at https://pmc.ncbi.nlm.nih.gov/articles/PMC12370317/

© 2025 Fuze Health Inc. All rights reserved.

Factors Associated with Hospitalization for Hypoglycemia and Hyperglycemia Among Older People in Long-Term Care Facilities

Wondimkun Y, Caughey G, Inacio M, et al

Individuals with diabetes newly entering long-term care facilities (LTCFs) encounter changes in care needs and facility and care process-related factors, which potentially impact diabetes treatment outcomes. This study examined the 12-month incidence of hospitalizations for hypoglycemia and hyperglycemia in residents with diabetes and factors associated with these hospitalizations following LTCF entry. **Methods** This retrospective cohort study included residents aged ≥ 65 years with diabetes who entered a LTCF between 2015 and 2018 using data from the Registry of Senior Australians. Cumulative incidence of hospitalization for hypoglycemia or hyperglycemia in the 12 months following entry was evaluated. Factors associated with hypoglycemia or hyperglycemia hospitalizations were examined using a Fine–Gray model, accounting for the competing event of mortality. Subdistribution hazard ratios (sHRs) were reported. **Results** Of the 55,734 individuals included (median age 84 years), 1.0% were hospitalized for hypoglycemia, and 0.5% for hyperglycemia in the 12 months after LTCF entry. Factors associated with a higher rate of hospitalization for hypoglycemia included high or medium level of care needs, renal disease, prior hospitalization with hypoglycemia or hyperglycemia, use of insulin, sulfonylureas, or angiotensin-converting enzyme inhibitors. Factors associated with a higher rate of hospitalization for hyperglycemia included preferred spoken language other than English, dementia, prior hospitalization with hyperglycemia or hypoglycemia, use of insulin, or metformin. **Conclusions** The risk of hospitalization for hypoglycemia or hyperglycemia may be reduced through diabetes care planning at LTCF entry informed by the identified risk factors for these complications. *J Am Geriatr Soc*. 2025;73(9):2859-2867
Full text is freely available at https://pmc.ncbi.nlm.nih.gov/articles/PMC12460984/

Diabetes Deprescribing in Older Adults: A Randomized Clinical Trial

Grant R, Peterson I, McCloskey J, et al

Medication-related hypoglycemia is the leading cause of iatrogenic complications among older adults with type 2 diabetes. **Objective**: To compare physician academic detailing (AD) with or without patient previsit activation for insulin and/or sulfonylurea deprescribing in older patients with diabetes. **Design, setting, and participants**: This randomized clinical trial was conducted from September 2020 to March 2024 with 6 and 12 months of follow-up in a large integrated health care system in Northern California. Primary care physicians (PCPs) and their patients with type 2 diabetes who were 75 years and older, had hemoglobin A1c of 8.0% or lower, and were treated with insulin and/or sulfonylureas were included. **Interventions**: Participating PCPs attended at least 1 AD session that provided evidence to support diabetes medication reassessment and potential deprescribing strategies in older patients with type 2 diabetes. Prior to their visit with a participating PCP, trial patients were randomly assigned to receive either a previsit activation deprescribing handout (AD plus previsit arm) or an attention control healthy lifestyle handout (AD-only arm). **Main outcomes and measures**: Primary outcomes (assessed at 6 months) were diabetes medication deprescribing (an aggregate measure) and any patient-reported severe hypoglycemia episodes. **Results**: A total of 211 PCPs were able to attend at least 1 AD session and treated 450 eligible patients (mean [SD] age, 79.9 [4.0] years; 223 [49.6%] female; mean [SD] concurrent chronic conditions, 6.2 [3.6]; and mean [SD] hemoglobin A1c, 7.5% [1.1%]). At 6 months, there was a statistically significant higher diabetes medication deprescribing rate in the AD plus previsit activation arm compared with the AD-only arm (36 of 232 patients [15.8%] vs 19 of 218 patients [9.0%]; adjusted risk difference [RD], 7.5%; 95% CI, 1.5%-13.6%; P = .01); this difference persisted at 12 months (50 of 232 patients [22.8%] vs 33 of 218 patients [16.3%]; adjusted RD, 7.9%; 95% CI, 0.4%-15.5%; P = .04). There was not a statistically significant difference in severe self-reported hypoglycemia at 6 months between the AD plus previsit and AD-only arms (10 of 232 patients [4.7%] vs 13 of 218 patients [6.5%]; adjusted RD, -2.3%; 95% CI, -7.1% to 2.5%; P = .04). **Conclusions and relevance**: In this randomized clinical trial, AD with previsit activation was a simple and effective strategy for increasing diabetes medication deprescribing in older patients with type 2 diabetes. *JAMA Intern Med*. 2025;185(8):926-035

© 2025 Fuze Health Inc. All rights reserved.

End-of-Life Outcomes and Staff Visits for Hospice Recipients Residing in Assisted Living

Guo W, Cai S, Li Y, et al

Objectives: To examine (1) whether hospice staff visits are associated with end-of-life (EOL) transitions, place of death (POD), and live discharges among assisted living (AL) residents, and (2) whether state AL regulations on staffing and medication administration influence these outcomes. We hypothesized that more frequent staff visits and specific regulatory provisions would be associated with improved EOL outcomes. **Design**: Retrospective cohort study using Medicare claims data from 2018-2019. Sensitivity analyses used logistic regression models to assess robustness. **Setting and participants**: National, population-based study of Medicare decedents residing in licensed AL communities across the United States. The main analytic sample included 42,466 AL residents who received hospice and died during enrollment. A separate sample of 61,851 was used to assess live discharges. Participants were identified by linking 9-digit ZIP codes of 10,452 licensed ALs to Medicare enrollment files. Individuals younger than 55 years, not enrolled in hospice, or enrolled in Medicare Advantage were excluded. **Methods**: Key exposures included the frequency of hospice staff visits (clinical vs nonclinical) and the presence of state AL regulations related to staffing and medication delegation. Outcomes included EOL transitions within the last 7 days of life, POD in AL vs other settings, and live discharges from hospice. **Results**: More frequent clinical staff visits were associated with lower rates of EOL transitions [-12 percentage points (pp)], reduced live discharges (-4 pp), and increased likelihood of dying in place (+4 pp; all $P < .001$). Nonclinical visits showed modest but consistent associations with improved outcomes. State regulations requiring on-site staffing and permitting medication delegation were associated with fewer transitions and higher rates of in-place death. **Conclusions and implications**: Hospice staffing intensity, especially clinical visits, appears to be associated with EOL outcomes for AL residents. AL state regulations are also associated with hospice quality. These findings underscore the role of both organizational practices and regulatory policy in shaping hospice experiences in AL settings. *J Am Med Dir Assoc*. 2025;26(12):105887
Full text is freely available at https://pubmed.ncbi.nlm.nih.gov/41022144/

Clinical Assessment Tools for Dyspnea in People with Intellectual and Developmental Disabilities

Moore C

Effective symptom assessment and management are the cornerstone of quality palliative care, yet unique barriers exist for people with intellectual and developmental disabilities (IDD). More recently, there has been growing interest in pain assessment for people with IDD, but other symptoms, such as dyspnea, have not been as readily explored. People with IDD experience death due to respiratory conditions at rates higher than the general population, yet not much is known about dyspnea assessment in this population. Individuals with IDD are often left out of research, including studies that validate clinical assessment tools. Communication differences or cognitive abilities can impact the reliability of self-reports for some people with IDD, making the understanding of clinical assessment tools for this population more important for palliative care clinicians in managing symptoms. Currently, no clinical assessment scales have been validated for use in people with IDD. This article examines 4 commonly used and validated clinical assessment tools for dyspnea and offers recommendations for future research and comprehensive dyspnea assessment in people with IDD. *J Hosp Palliat Nurs*. 2025;27(5):253-261

HospiLink includes news briefs and abstracts of the current literature related to hospice and palliative care. Since abstracts are not always accurate reflections of the content of the article, please refer to the complete journal article before making changes to practice or patient care based on the information contained in this update. Editor: Bridget McCrate Protus, PharmD, MLIS, BCGP, CDP bridget.protus@fuzehealth.com

© 2025 Fuze Health Inc. All rights reserved.