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Volume 18, Issue 1 January 20, 2026

Knowledge, Attitudes, and Practices Surrounding Safe Medication Disposal in a Hospice Setting

Godzik C, Waliji-Banglawala A, Tjia J, et al

Opioids provide important relief from pain associated with end of life and are paramount to quality care in home hospice. Aligned with the need to provide this access to care is a responsibility to support proper disposal of unused medication. Medication disposal kits are becoming more popular as an effective and environmentally friendly choice. Education and training on this topic are paramount for providers after the 2018 federal law allowing hospice staff to dispose of patient medications in the home. The goal of this study was to assess knowledge, attitudes, and practices of hospice clinical staff about medication disposal before and after an online medication disposal training. In Fall 2020, frontline clinical staff at a not-for-profit hospice completed an anonymous survey about medication disposal before and after a one-hour synchronous online training about medication disposal. Patient medical record review was conducted to determine frequency of medication disposal methods. After training, more clinical staff reported always educating patients on medication disposal at time of hospice admission and routinely disposing of medication(s) with patients and families. This training has the potential to contribute to improved medication disposal in the hospice setting. J Pain Symptom Manage. 2026;71(1):1-7

Rehab and Death: Improving End-Of-Life Care for Medicare Skilled Nursing Facility Beneficiaries

Singh S, Furman C, Flint L, Teno J

Hospitalized older adults with serious illness may be discharged to a skilled nursing facility (SNF) with the hope of improving strength to live independently and receive further disease-directed treatment, or because it is one of the few insurance-covered options for care that provides room and board coverage. For those that do not improve, discharge to a SNF can begin a cycle of costly care transitions between hospital, home with home health care, SNFs, and long-term care facilities, leading to fragmented care and missed opportunities for discussions about preferences for care, illness understanding, and to address distressing symptoms. It can also lead to dying in the emergency room and other locations that are not consistent with patient wishes. In this article, we describe key policies that contribute to high-cost, low-value care near the end of life for older adults using the Medicare SNF benefit. With this foundation, we propose next steps to understand the scope of the problem better and offer solutions to improve care, including increasing palliative care delivery in SNFs and changes to the Medicare SNF benefit to improve hospice access and utilization for beneficiaries who currently experience multiple care transitions near the end of life. J Am Geriatr Soc. 2026;74(1):26-32
Full text is freely available at https://pmc.ncbi.nlm.nih.gov/articles/PMC12747579/

Determinants of Antibiotic Prescription in Outpatient Hospice: A Regional Observational Study

Crowley P, Whalen F, Siegel L, Challener D

Patients enrolling in hospice care are asked their preferences for antibiotic treatment. There is little information regarding which patients are more likely to receive antibiotics. To better inform discussions, we sought to characterize the use of antibiotics in the outpatient hospice setting. **Methods** Retrospective review of patients enrolled in outpatient hospice within the Mayo Clinic Health System from 1/1/2017 - 1/1/2023. We calculated what percent of patients received antibiotics based on Hospice Qualifying Condition (HQC), age at enrollment, sex, survival time, and Charlson Comorbidity Index and calculated adjusted odds ratios (aOR). We documented which antibiotics were prescribed based on HQC. **Results** Of 6452 patients identified, 1259 (19.5%) received antibiotic prescriptions. Cephalosporins were the most common class of antibiotics (22.8% of antibiotics prescribed), followed by fluoroquinolones (20.3%) and penicillin derivatives (14.9%). Patients with Pulmonary HQCs were most likely to receive antibiotics (28.6%), those with neurologic HQCs were least likely (14.9%). There was no difference of age for those receiving antibiotics (80.7 yr) vs those not receiving (80.3 yr), or for sex. 4.6% of those surviving <7d received antibiotics, compared to 47.7% of those surviving >6mo. **Discussion** 19.5% of patients will receive antibiotics during their hospice course, with more frequent prescriptions in those surviving longer periods and those enrolled for pulmonary conditions. Clarify patient preferences regarding antimicrobial utilization at the time of hospice enrollment. Am J Hosp Palliat Med. 2026;43(2):172-178

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Association of Reported Collaboration Quality with Hospice Providers and Hospice Utilization in Assisted Living

Wang X, Teno J, Clark M, et al

Hospice is crucial in meeting the increasing care needs of dying residents in assisted living (AL) and supporting dying in place. We know little about how AL-hospice collaboration relates to staying in AL at the end of life. We conducted a national survey of AL administrators in 2021-2023 about end-of-life care processes in large ALs (25+ beds) with instruments adapted from other long-term care settings, including items about AL-hospice collaboration quality (e.g., AL staff know when to expect a hospice nurse visit for all/most/some/none of the time). The sample included 9,069 AL residents who died in 2021 or 2022 in 1,501 surveyed ALs. We operationalized "staying in place with support at the end of life" as the number of days with hospice in AL in the last 90 days of life, excluding days receiving hospice in other settings. Two-part models were used to estimate the relationship between reported AL-hospice collaboration quality and days receiving hospice in AL, accounting for individual-, AL-, and market-level characteristics. Decedents spent 2.6 more days on hospice in AL if administrators reported residents were always assessed within 24 hours of hospice referrals, compared to residents in ALs where this happened none/some/most of the time. This difference represents 11% more days in place for residents who lived in ALs where administrators reported that hospice providers always respond timely to hospice referrals. The collaboration between hospice and AL staff is a modifiable factor that can improve end-of-life care experiences. Innov Aging. 2025;9(Suppl 2):igaf122.704

Full text is freely available at https://pmc.ncbi.nlm.nih.gov/articles/PMC12760368/

Safely Easing Pain in Home Hospice Patients With Opioid Infusions: A Quality Improvement Project

Abbott L, Kim S, Ashcraft A

Opioid infusions are critical for managing pain in home hospice care but carry a high risk of medication errors. This quality improvement (QI) project evaluated adherence to a standardized PCA opioid infusion procedure and examined whether a nurse education intervention improved compliance. **Measures** Compliance was assessed using a ten-item checklist that captured key safety and documentation behaviors, including double-check verification, verification of nurse documentation and identification, expiration-date documentation, photo verification, documentation of pump lock and unlock, near-miss event reporting, compliance with the protocol, and identification of adverse events. Weekly average compliance scores were calculated for 47 weeks (29 pre-intervention and 18 post-intervention). **Intervention** The intervention consisted of a nurse education program focused on the standardized PCA opioid infusion procedure. Education covered double-check processes, standardized documentation using smart phrases, photo verification, and adherence to required safety steps. No patient-identifying information was collected. **Outcomes** Weekly average compliance scores significantly improved after the intervention. Several checklist items were significantly associated with the intervention period. The intervention remained a significant predictor of higher compliance after controlling for nurse role and travel distance. No adverse events occurred during the study period. **Conclusions** Standardizing PCA opioid infusion procedures through focused nurse education, supported by digital documentation tools, improved compliance and strengthened patient safety in home hospice care. QI teams should consider combining education with standardized workflows and mobile documentation supports to reduce variability and enhance adherence. J Pain Symptom Manage. 2026;71(2):e183-e189

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Sociodemographic Disparities in the Use of Hospice by U.S. Nursing Home Residents

DeForge C, Ma H, Dick A, et al

Hospice can improve end-of-life (EOL) outcomes in U.S. nursing homes (NHs). However, only one-third of eligible residents enroll, and substantial variation exists within and across NHs related to resident-, NH-, or community-level factors. We conducted a review of English-language, peer-reviewed articles 2008 to 2023 describing this variation in NH hospice use to characterize disparities and inform educational and quality initiatives to improve EOL care in NHs. We followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines. We screened 1595 records, reviewed 82 articles and included 13 articles. Eleven used pre-2009 data. Six evaluated national data and 7 used regional (n = 1), state (n = 4), or local (n = 2) data. One assessed hospice referral, 10 hospice use, and 3 length-of-stay. Twelve conducted regression analyses; 1 stratified by race, another evaluated interaction terms, and a third compared racial differences within-and between-facilities. Unadjusted and adjusted differences were evaluated by resident race-and-ethnicity (n = 6 unadjusted, n = 10 adjusted, respectively), sex (n = 5, n = 9), or payor (n = 1, n = 4), or by NH race-mix (n = 1, n = 2), ownership (n = 1, n = 7), payor-mix (n = 1, n = 5), or urban/rural location (n = 1 adjusted). Unadjusted differences showed lower hospice use by Non-White residents and varied results by sex. Studies adjusting for resident-, NH-, and community-level factors found lower hospice use among male residents, Black/Non-White residents, and residents of rural NHs, with mixed results by payor and ownership. Results were mixed for hospice referral and length-of-stay. These findings suggest complex influences on NH hospice use. Further study is warranted to identify targets for improving hospice access. Am J Hosp Palliat Med. 2026;43(1):102-112

Full text is freely available at https://pmc.ncbi.nlm.nih.gov/articles/PMC12210520/

Hospice, Palliative Care, and Care Experiences Among Medicare Beneficiaries with Cancer

Lines L, Fujita M, Danforth K, et al

Palliative care (PC), including hospice, can improve quality of life by helping manage distressing symptoms. PC is underutilized among people with cancer in the United States. We studied whether (1) sociodemographics and illness burden were associated with receipt of PC, and (2) whether PC use was related to self-reported care experiences.

Materials and methods: Using Surveillance, Epidemiology, and End Results (SEER)-Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, we analyzed illness burden (using the SEER-CAHPS Illness Burden Index [SCIBI]), race/ethnicity, and self-reported care experiences in three cancer cohorts: those receiving hospice (with or without other forms of PC); PC encounters without hospice; and no PC. We included fee-for-service and Medicare Advantage beneficiaries with cancer (n = 37,025) diagnosed 2007-2017, surveyed 2007-2017, and followed up to five years post-diagnosis (through 2019). Multivariable survey-weighted logistic regression models adjusted for clinical characteristics, social determinants of health (SDoH) (dual enrollment in Medicare and Medicaid; neighborhood poverty; education; language), demographics, and clinical characteristics.

Results: Among 37,025 Medicare beneficiaries with cancer, 11.1 % received hospice (with or without PC) and 7.4 % received PC only. Nearly 30 % of the sample died within five years of diagnosis; fewer than one-third of decedents received hospice. Factors associated with receiving hospice included increasing age, non-Hispanic ethnicity, American Indian/Alaska Native and multiracial identities, living in higher-income neighborhoods, survey-completion proxy assistance, fair/poor general health, advanced stage at diagnosis, and more illness burden. Independent predictors of PC encounters included age 75-79, female identification, no dual enrollment, no proxy assistance, and more illness burden. Differences in care experience associated with hospice or PC use were shown for two care experience measures: doctor communication scores and doctor rating scores were higher among beneficiaries who received neither hospice nor PC relative to beneficiaries who received hospice. **Discussion**: Variability in hospice and PC receipt across sociodemographic characteristics suggest the continued need to ensure equitable service provision. Worse doctor communication scores associated with hospice or PC encounters suggests a potential avenue for improving care experiences. J Geriatr Oncol. 2026;17(1):102795

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Decision-Making and Downstream Outcomes of the Gabapentinoid-Diuretic Prescribing Cascade

Growdon M, Tjota N, Campbell P, et al

Prescribing cascades are an underrecognized driver of polypharmacy among older adults (aged ≥65 years). The clinical decision-making processes underlying cascades and their downstream consequences are poorly understood. **Objective** To explore clinical reasoning leading to prescribing cascades and downstream outcomes (eg, falls, electrolyte abnormalities) via the exemplar gabapentinoid (gabapentin and pregabalin)–loop diuretic (LD) cascade. **Methods** This cohort study randomly selected medical records from a cohort of US veterans aged 66 years or older between January 1, 2013, and August 31, 2019, who potentially experienced the gabapentinoid-LD prescribing cascade. The medical record review and data analysis were performed between October 24, 2023, and July 22, 2025. Abstractors evaluated clinical documentation in the 30 days prior to and 60 days after LD initiation to evaluate decision-making processes and potential downstream outcomes of the gabapentinoid-LD cascade. Secondary analyses examined whether a dementia diagnosis was associated with clinician decision-making and patient outcomes. **Results** The analytic cohort comprised 120 patients (mean age, 73.9 years; 96.7% male; 88.3% taking ≥5 long-term medications). Documentation of a differential diagnosis for edema was noted in 73 patients (60.8%), referencing congestive heart failure (n = 47 [39.2%]) and/or venous stasis (n = 16 [13.3%]). Gabapentinoids were rarely noted in the differential (n = 4 [3.3%]). The majority of clinicians documented the indication for LD (96.7%) for lower-extremity edema (86.7%), congestive heart failure (13.3%), and/or dyspnea (12.5%). In the 60 days following LD initiation, 28 patients (23.3%) experienced 37 events potentially attributable to LD initiation. The most common downstream events were worsening kidney function (7.5%), orthostasis (5.8%), electrolyte abnormalities (5.0%), and falls (4.2%). Six patients were evaluated in the emergency department and/or hospital for potential downstream events. Documentation of differential diagnoses, indications, actions taken regarding gabapentinoids, and downstream events generally did not vary between patients with and without dementia. **Conclusions** Among older veterans who received LD following gabapentinoid initiation and experienced a potential gabapentinoid-LD prescribing cascade, clinicians almost never explicitly considered gabapentinoid adverse drug effects in their treatment of edema. These findings suggest that potential downstream harms of this overlooked prescribing cascade are common, underscoring the importance of addressing prescribing cascades in clinical practice. JAMA Netw Open. 2025;8(12):e2545274

Full text is freely available at https://pmc.ncbi.nlm.nih.gov/articles/PMC12673415/

An Explicit Live Discharge Protocol for Hospice-Initiated Live Discharges

Wladkowski S, Enguidanos S, Schroepfer T

Hospice-initiated discharges, or those not requested by patients or caregivers, are distinct from voluntary disenrollment from hospice because they often occur without adequate preparation. Hospice patients who have stabilized and been deemed no longer terminal can disrupt continuity of care, leaving patients and their caregivers unprepared for the complex medical, emotional, and logistical needs posthospice. Currently, no standardized guidelines exist to support hospice clinicians in planning for and conducting these live discharges. To address this gap, an explicit live discharge protocol (LDP) was developed to guide hospice clinicians in supporting patients who are no longer eligible to receive hospice and are discharged alive and their caregivers. The LDP is intended to support continuity of care by providing hospice clinicians a clear, evidence-informed framework for collecting information and communicating needs before the discharge. This paper outlines the development, structure, and intended use of the LDP as a tool to facilitate compassionate, coordinated, and continuous care transitions out of hospice care. J Am Med Dir Assoc. 2026;27(1):105968

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