Racial Disparities in Receipt of Hospice Services Among Nursing Home Residents
Frahm K, Brown L, Hyer K

This study examined the relationship between race and advance care planning, hospitalization, and death among nursing home residents receiving hospice care. Secondary data analysis using the 2007 Minimum Data Set (MDS) was used to identify documentation of these activities for White, Black, Hispanic, and Asian residents with linear regression models fitted to each dependent variable. Across different types of advance directives, compared to White nursing home residents, Black, Hispanic, and Asian residents who received hospice services were significantly less likely overall to have documented advance directives. All racial groups were also more likely to experience hospitalization while on hospice, regardless of whether they had a documented “do not hospitalize” order. As nursing homes become more diverse, recognizing differences in hospice use and end-of-life planning will continue to increase in importance. *Am J Hosp Palliat Med* 2015;32(2):233-237

Survey of Clinician Attitudes and Self-Reported Practices Regarding End-of-Life Care in Heart Failure

As heart failure often follows an unpredictable clinical trajectory, there has been an impetus to promote iterative patient-provider discussions regarding prognosis and preferences for end-of-life care. Aim: To examine clinicians’ practices, expectations, and personal level of confidence in discussing goals of care and providing end-of-life care to their patients with heart failure. Design: Multi-site clinician survey. Setting and Participants: Physicians, nurse practitioners, and physician assistants at Mayo Clinic (Rochester, Minnesota, USA) and its surrounding health system were asked to participate in an electronic survey in October 2013. Tertiary Care Cardiology, Community Cardiology, and Primary Care clinicians were surveyed. Results: A total of 95 clinicians participated (52.5% response rate). Only 12% of clinicians reported having annual end-of-life discussions as advocated by the American Heart Association. In total, 52% of clinicians hesitated to discuss end-of-life care citing provider discomfort (11%), perception of patient (21%) or family (12%) unreadiness, fear of destroying hope (9%), or lack of time (8%). Tertiary and Community Cardiology clinicians (66%) attributed responsibility for end-of-life discussions to the heart failure cardiologist, while 66% of Primary Care clinicians felt it was their responsibility. Overall, 30% of clinicians reported a low or very low level of confidence in one or more of the following: initiating prognosis or end-of-life discussions, enrolling patients in hospice, or providing end-of-life care. Most clinicians expressed interest in further skills acquisition. Conclusion: Clinicians vary in their views and approaches to end-of-life discussions and care. Some lack confidence and most are interested in further skills acquisition. *Palliat Med* 2015;29(3):260-267
**Multidisciplinary Care Plans to Support Unpreventable Outcomes in Four Geriatric Syndromes**

Vance J, Cefalu J, Cefalu C

Long-term care residents commonly experience pressure ulcers, falls, dehydration, and altered nutritional status contributing to undesired weight loss. The occurrence of these events is not always a result of poor care; in some cases, these events may not be preventable due to numerous other medical factors at play. To determine whether an outcome is unavoidable, long-term care staff must commit to identifying risk and implementing the appropriate interventions, a process that should be repeated throughout the course of a resident’s stay and documented thoroughly. A multidisciplinary care plan should be tailored to meet individual residents’ needs and risk factors, and reviewed and updated frequently. This tip sheet outlines the essential components of an interdisciplinary care plan to prevent pressure ulcers, fall, dehydration, and malnutrition/weight loss. *Ann LTC* 2015;32(1):37-38

**Inhaler Misuse in an Older Adult Population**


**OBJECTIVE:** To determine the prevalence of inhaler misuse in an older adult population. **DESIGN:** Prospective observational study. **SETTING:** Two primary care outpatient clinics in a Veterans Affairs Medical Center in North Carolina. **PARTICIPANTS:** Male veterans 65 years of age and older (N = 24) prescribed a pressurized metered dose inhaler (pMDI) or a dry powder inhaler (DPI). **MEASUREMENTS:** Inhaler technique was evaluated using placebo inhaler devices and a standardized technique assessment form that included critical steps. Potential risk factors for misuse were obtained from the medical record, and the time for technique evaluation was collected. **MAIN RESULTS:** Study participants yielded 44 unique device observations. Patients were male with an average age of 82 years. All patients made at least one error, with a mean error rate of 2.5 errors/patient/inhaler, while 20 of 24 (83%) patients made at least one critical error with a mean error rate of 1.2 critical errors/patient/inhaler. Assessment of inhaler technique required 2.3 minutes/inhaler. Critical errors were made during 15 of 19 (79%) pMDI observations and 22 of 25 (88%) DPI observations. Patients with multiple inhalers or a history of stroke committed errors more often, although no risk factors demonstrated meaningful differences in error rates. **CONCLUSIONS:** Inhaler misuse in older adults is common, including committing critical errors that have been shown to reduce drug delivery. The time necessary for technique evaluation is relatively small. The high rate of misuse observed should serve as motivation for increased vigilance, individualized technique education, and routine re-assessment in the highly heterogeneous older adult population. *Consult Pharm* 2015;30(2):92-100
Inhaled Corticosteroids in COPD: The Clinical Evidence
Ernst P, Saad N, Suissa S

In this article, we focus on the scientific evidence from randomised trials supporting treatment with inhaled corticosteroids (ICS) in chronic obstructive pulmonary disease (COPD), including treatment with combinations of long-acting β-agonist (LABA) bronchodilators and ICS. Our emphasis is on the methodological strengths and limitations that guide the conclusions that may be drawn. The evidence of benefit of ICS and, therefore, of the LABA/ICS combinations in COPD is limited by major methodological problems. From the data reviewed herein, we conclude that there is no survival benefit independent of the effect of long-acting bronchodilation and no effect on FEV1 decline, and that the possible benefit on reducing severe exacerbations is unclear. Our interpretation of the data is that there are substantial adverse effects from the use of ICS in patients with COPD, most notably severe pneumonia resulting in excess deaths. Currently, the most reliable predictor of response to ICS in COPD is the presence of eosinophilic inflammation in the sputum. There is an urgent need for better markers of benefit and risk that can be tested in randomised trials for use in routine specialist practice. Given the overall safety and effectiveness of long-acting bronchodilators in subjects without an asthma component to their COPD, we believe use of such agents without an associated ICS should be favoured. *Eur Respir J* 2015; 42(2):525-537

Dilemmas in End-Stage Heart Failure
Che-Scarabelli C, Saravolatz L, Hirsh B, et al

Heart failure (HF), a complex clinical syndrome due to structural or functional disorder of the heart, is a major global health issue, with a prevalence of over 5.8 million in the USA alone, and over 23 million worldwide. As a leading cause of hospitalizations among patients aged 65 years or older, HF is a major consumer of healthcare resources, creating a substantial strain on the healthcare system. This paper discusses the epidemiology of HF, financial impact, and multifaceted predicaments in end-stage HF care. A search was conducted on the U.S. National Library of Medicine website (www.pubmed.gov) using keywords such as end-stage heart failure, palliative care, ethical dilemmas. Despite the poor prognosis of HF (worse than that for many cancers), many HF patients, caregivers, and clinicians are unaware of the poor prognosis. In addition, the unpredictable clinical trajectory of HF complicates the planning of end-of-life care, such as palliative care and hospice, leading to underutilization of such resources. In conclusion, ethical dilemmas in end-stage HF are numerous, embroiling not only the patient, but also the caregiver, healthcare team, and society. *J Geriatr Cardiol* 2015;12(1): 57-65

Full text of this article is freely available at [http://www.ncbi.nlm.nih.gov/pmc/articles/pmid/25678905/](http://www.ncbi.nlm.nih.gov/pmc/articles/pmid/25678905/)
Forty Years of Work on End-of-Life Care — From Patients' Rights to Systemic Reform
Wolf S, Berlinger N, Jennings B

More than 2.5 million people die in the United States each year, most of them from progressive health conditions. Facing death is a profound challenge for patients, their relatives and friends, their caregivers, and health care institutions. Nearly 40 years of intensive work to improve care at the end of life has shown that aligning care with patients' needs and preferences in order to ease the dying process is surprisingly difficult — although there has been some incremental progress. Early optimism that the establishment of patients' legal and ethical rights to make decisions about their own care would lead to more appropriate end-of-life treatment faded in the face of sobering data showing that declaring these rights was not enough to alter treatment patterns and that systemic issues loomed large. This history has demonstrated the need to attack the problem at all levels, from individual rights, to family and caregiving relationships, to institutional and health systems reform. N Engl J Med 2015;372:678-682

Measuring What Matters: Top Ranked Quality Indicators for Hospice and Palliative Care from the AAHPM and HPNA

Measuring quality of hospice and palliative care is critical for evaluating and improving care, but no standard U.S. quality indicator set exists. Objectives: The Measuring What Matters (MWM) project aimed to recommend a concise portfolio of valid, clinically relevant, cross-cutting indicators for internal measurement of hospice and palliative care. Methods: The MWM process was a sequential consensus project of the American Academy of Hospice and Palliative Medicine (AAHPM) and Hospice and Palliative Nurses Association (HPNA). We identified candidate indicators mapped to National Consensus Project (NCP) Palliative Care Guidelines domains. We narrowed the list through a modified Delphi rating process by a Technical Advisory Panel and Clinical User Panel and ratings from AAHPM and HPNA membership and key organizations. Results: We narrowed the initial 75 indicators to a final list of 10. These include one in the NCP domain Structure and Process (Comprehensive Assessment), three in Physical Aspects (Screening for Physical Symptoms, Pain Treatment, and Dyspnea Screening and Management), one in Psychological and Psychiatric Aspects (Discussion of Emotional or Psychological Needs), one in Spiritual and Existential Aspects (Discussion of Spiritual/Religious Concerns), and three in Ethical and Legal Aspects (Documentation of Surrogate, Treatment Preferences, and Care Consistency with Documented Care Preferences). The list also recommends a global indicator of patient/family perceptions of care, but does not endorse a specific survey instrument. Conclusion: This consensus set of hospice and palliative care quality indicators is a foundation for standard, valid internal quality measurement for U.S. settings. Further development will assemble implementation tools for quality measurement and benchmarking. J Pain Symptom Manage 2015;49(4):773-781

Summary of this article is freely available at http://www.urmc.rochester.edu/news/story/index.cfm?id=4255
Exploring the Myths of Morphine in Cancer: Views of the General Practice Population
Grant M, Ugalde A, Vafiadis P, Philip J

Morphine is widely used in cancer care, and understanding the concerns and perceptions of patients, family and friends is vital to managing pain and distress effectively. The 'myths of morphine' have frequently been discussed in medical literature, yet the extent to which such views are held is not clear. This qualitative project explores the perceptions and attitudes of the wider community towards morphine use in cancer care, to understand this 'mythology' according to those who in the future may themselves require its use. Methods: Semi-structured interviews were held with patients presenting to a metropolitan general practice clinic in Melbourne, Australia. A grounded theory framework underpinned the data collection and thematic analysis undertaken. Results: Interviewees (15) were aged 24-81, with a variety of experiences with cancer care and previous morphine use. Interviewees were highly supportive of morphine use in cancer care, with this attitude founded on the perceived severity of cancer pain and the powerful nature of morphine. They described a number of reasons morphine may be used in cancer care: to treat pain, to enable peace and also as a treatment for cancer. Conclusion: The public view of morphine to emerge from this study is markedly different from that discussed in the myths of morphine. It is viewed as a medication that has the ability to provide peace and control both pain and the course of cancer. The participants in this study described a wish for greater involvement in pain control decisions, perceiving morphine as a facilitator rather than a barrier to good cancer care. Support Care Cancer 2015;32(2):483-489