



Hospice of the Calumet Area NEWS

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How to Attain a “Good Death”

In hospice we often refer to the phrase “a good death,” although that may at first seem like an oxymoron, in actuality it has come to represent ‘a job well done.’

When doing public presentations I’ll pose the scenario, “If you were told you had six months to live, how would you like to spend it?” Often people say they’d like to have the opportunity to say goodbye to loved ones. Others would like to take the vacation cruise that they’ve always envisioned. But invariably they talk about *making the most* of the time they have left. I have never had anyone respond, “I would like to spend that time receiving additional treatment.”

Does having “the conversation” help or hurt?

Informing patients that they’re suffering from an illness that won’t be cured is never easy, even for the professional. The conversation becomes even more difficult the longer a patient has undergone treatment, which can lead to the avoidance of it altogether.

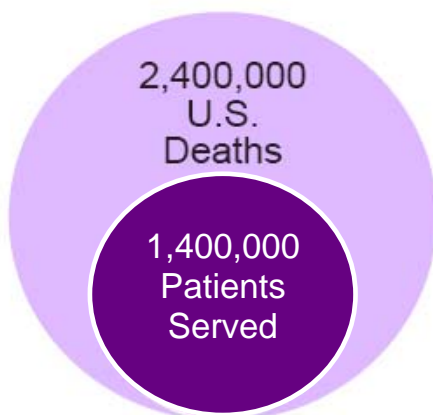


Figure 1. Hospice Utilization in U.S.

In 2007, an estimated 1.4 million patients received services from hospice.

The common notion that end-of-life conversations are unnecessarily stressful for patients and provide no benefit to either patients or caregivers is incorrect according to one study. These discussions were found to have “cascading benefits” for both. End-of-life conversations are associated with less aggressive medical care, earlier integration of hospice, less emotional stress, and a better quality of life near death for patients. These conversations also ease caregivers’ bereavement adjustment.

According to the study, there was a significant inverse relationship between time in hospice and the number of aggressive interventions. On the strength of these findings, the research team concluded that end-of-life conversations enable patients to participate in decisions about their terminal care in a manner that improves the quality of their final days.

The data also indicates that end-of-life conversations relieve rather than engender stress. Patients who had these discussions were significantly more likely to accept their illness as terminal and to value comfort more than life extension by invasive means. In general, they were less likely to suffer a major depressive disorder or any other mental disorder.

The study selected only patients who had a principal caregiver; in most cases a spouse, partner or adult child. When bereavement follow-up was conducted eight months following each patient’s death, the data indicated that caregivers had significantly more depression and regret when patients received aggressive terminal care, and were less prepared for the death of their loved ones. In contrast, when patients had an improved quality

Mission Statement

Hospice of the Calumet Area, a not-for-profit hospice, is dedicated to improving the quality of life through compassionate care for individuals and families facing an end-of-life illness.

of death, caregivers felt significantly better prepared and suffered less regret. In subsequent months, they enjoyed better physical function, mental health, and overall quality of life themselves.

Impact of hospice care on survival

Hospice care may prolong the lives of some terminally ill patients. In another recent study, the mean survival was 29 days longer for hospice patients than for non-hospice patients. In other words, patients who chose hospice care lived an average of one month longer than similar patients who did not choose hospice care. Researchers selected 4,493 terminally ill patients with either congestive heart failure or cancer of the breast, colon, lung, pancreas, or prostate. They then analyzed the difference in survival periods between those who received hospice care and those who did not.

Longer lengths of survival were found in four of the six disease categories studied. The largest difference in survival between hospice and non-hospice cohorts was observed in congestive heart failure patients where the mean survival period jumped from 321 days to 402 days. The mean survival period was significantly longer for hospice patients with lung cancer (39 days) and pancreatic cancer (21 days), while marginally significant for colon cancer (33 days).

Does hospice save money?

The financial impact that a long term-illness has on a family can be devastating for both the patient and the family. Surviving spouses can easily find themselves in difficulties from which they may never recover. Hospice services are covered 100% for Medicare eligible patients. During the last days and weeks of a patient's illness when the majority of expenses occur, hospice is an alternative that doesn't compromise quality of care.

Findings of a major study demonstrated that hospice services save money for Medicare and bring quality care to patients with life-limiting illness and their families. Researchers at Duke University found that hospice reduced Medicare costs by an average of \$2,309 per hospice patient. Additionally, the study found that Medicare

costs would be reduced for seven out of 10 hospice recipients if hospice had been used for a longer period of time. For cancer patients, hospice use decreased Medicare costs up until 233 days of care.

Ultimately, a "good death" occurs when a patient is asked, "How would you like to live out your last days?" and then their desires are carried out. This is precisely what Hospice of the Calumet Area strives to do.

-Craig Harrell, Director of Community Relations

Visit www.hospicecalumet.org for more information.

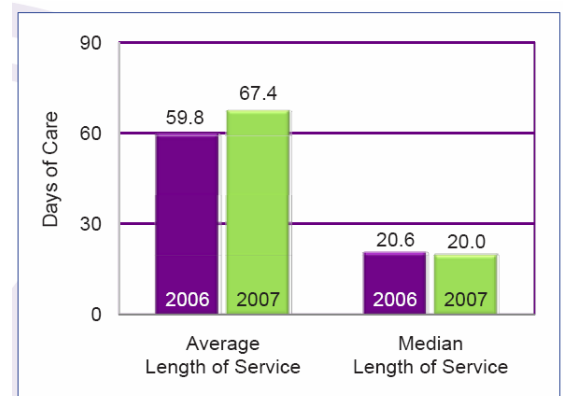


Fig 2. Length of stay in U.S. Hospices
Although criteria for hospice is a prognosis of 6 months or less, hospice continues to be used for the very end.

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Did You Know...?

Not all hospices are the same.
To assure that your patient receives care from **Hospice of the Calumet Area**, you need to specify us on the order.