CASE STUDY:
Home Hospice Care Improves End-Of-Life for a Very Ill and Non-Compliant Patient

A 60-year-old patient

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Patient is a 60-year-old male with past medical history of: Acute on Chronic Congestive Heart Failure (CHF); Diabetes; Chronic Obstructive Pulmonary Disease (COPD); Paroxysmal atrial fibrillation; Coronary Artery Bypass surgery; Mitral Valve Replacement. Patient has a history of noncompliance with care plan, and in fact, missed the last nine scheduled primary care physician and cardiologist appointments. Patient does not take his medications as confirmed by pharmacy.

Hospitalizations
2015 – 2 Admissions:
Congestive Heart Failure and Chest Pain

2016 – 4 Admissions:
(1) for Hyperglycemia; (3) for Congestive Heart Failure and NSTEMI

2017 – 1 Admission:
CHF/ Abnormal Troponin levels

Intervention
On a post-discharge phone call with the patient, the population health nurse reviewed medications, diet, and physician appointments with patient. The patient stated he is short of breath, depressed, and does not want to go to the hospital anymore. A multidisciplinary huddle was held with the primary care physician and population health nurse to review plan of care for this patient who is at high risk for readmission due to noncompliance with complex care plan. Care team discussed hospice and offered that option to patient, who agreed.

Results
The patient is stable on hospice. He is able to ambulate without the use of oxygen, and has no complaints of shortness of breath. His appetite remains good. The patient is pain-free and has not required the use of antidepressants. He is pleased to be able to remain in his own home, surrounded by his family and friends, and remains comfortable. The patient has not been hospitalized or had an Emergency Department visit since starting hospice.

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