Case Profile: STAAR/ASAP Collaboration

A 63 year old female was referred to Elder Services for Transition coaching from Saints Medical Center after a 2 day stay due to exacerbation of COPD. Additional diagnoses include, HTN, Depression, Anxiety, obesity and new diagnosis of CHF.

Transition coaching met with patient in her home. First order of business is to ask the patient what is your personal goal? For this patient it was to return to her previous level of independence and functioning which included walking 1 mile a day.

The Transition Coach asked her to bring out all her medications and reviewed them one by one to assess her knowledge of them. Consumer reported that she has 2 days left of her Prednisone and Doxycycline prescriptions and was concerned because she is still noticing congestion in her chest and is worried that her infection has not cleared. Transition coach discussed with her what she should do and whom she should call if she continues to feel this way. Transition Coach introduced the Personal Health Record and showed her how to fill it out and the importance of bringing it to all of her medical appointments.

The Transition coach reviewed the Red Flags with the patient and asked her to take out her Heart Failure packet that she received from Saints Medical Center. The patient was able to verbalize that she now realizes that she was in the red zone at the time of her last hospitalization but was too stubborn to believe she needed assistance. Transition coach reviewed the zones with her and reiterated the importance of monitoring her weight daily and any edema in her legs. They discussed the dietary recommendations listed in the Heart Failure packet and she is adhering to them well.

Transition coach asked patient when she is to see her PCP and she had an appt. scheduled. She provided the PCP with her discharge summary from Saints Medical Center. Transition Coach asked consumer about her attendance at Pulmonary Rehab which was ordered at time of discharge. She reported that she knew she was supposed to attend and was awaiting a call from Rehab to schedule her services. Transition Coach indicated that this should have offered by now. Follow up to Pulmonary Rehab reported that they did not have orders for her to attend and she seemed to slip through the cracks. Patient reported that her PCP said it was a great idea during her follow up appointment but apparently PCP was supposed to submit the orders at that time and did not.

<u>Transition Coaching follow up for the next 4 weeks</u>

Patient is doing well. Her breathing is less labored. She advocated for herself to call her PCP to get another antibiotic which she feels is working much better. She states that she is weighing herself daily and adhering to her diet. She reports less anxiety over going to the bathroom as she knows that she is not retaining the fluid as she was prior to her CHF dx.

She is now very aware of her Red Flags and is keeping up with her medication regime. She keeps an updated medication list on her at all times.

She attended the Pulmonary Rehab program and did quite well.

<u>How Elder Services reaches beyond the acute phase</u>

Transition coach spoke to her about attending the Chronic Disease Self Management Program that she can attend at Saints Medical Center. She has enrolled along with her sister and they are thrilled with the added support to keep her on the healthy track. She also has expressed her pleasure that the transition coach has taken such an interest in how she is doing and that she knows she has someone she can contact for support.