Basics of a Care Transition Visit

Four Pillars©:

1. **Medication Self-Management**

- Goal: Patient is knowledgeable about medications and has a system.
- Task of FCN: Discuss importance of knowing medications, reconcile pre and post hospitalization medication lists, identify and correct any discrepancies, answer any remaining medication questions

2. **Personal Health Record**

- Goal: Patient understands and manages a Personal Health Record (PHR)
- Task of FCN: Explain PHR, Review and update as needed, review discharge summary, encourage sharing PHR with PCP and/or specialist

3. **Follow up with PCP/Specialist**

- Goal: Patient schedules and completes follow-up visit
- Task of FCN: Recommend PCP follow-up visit, emphasize importance of follow-up, practice and role-play questions for PCP, provide advocacy in getting an appointment, if necessary.

4. **"Red Flags" or warning signs/symptoms and how to respond**

- Goal: Patient is knowledgeable about indications that condition is worsening and how to respond
- Task of FCN: Discuss symptoms and side effects of medications, reinforce when/if PCP should be called

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Also to consider:

5. **Home Safety Assessment**
6. **Spiritual Needs**
7. **Behavioral Health-Depression and/or Cognitive Impairment**
8. **Social Supports**
9. **Resources**