Post-Transitional Care Visit– for use at ROC or Follow up post ER

Information about why Client went to ER/was hospitalized

Client's own words –

Nurse impression/information from discharge paperwork –

Nurse Focused Goals

1) Provider engagement
    a. Post discharge appointment
        i. PCP or Specialist
        ii. Transportation to see PCP or Specialist
2) Fall prevention (if ER/hospitalization was fall related)
3) Medication management
    a. Medication reconciliation
        i. Simplify medication regiments wherever possible
        ii. Address medication adherence issues
4) Coaching for self- management
    a. Education on red/yellow/green zones
    b. Coach on managing chronic conditions
    c. Coach on self-care to prevent hospitalizations (use of as needed inhalers, glucose monitoring)
    d. Increase client awareness of utilization patterns
        i. Plan if they experience the same symptoms again – anything could have been self-resolved or resolved in urgent care/PCP office?
5) Engage supportive individuals
    a. Family, HHA

Client Focused Goals

To address the factors that contributes to Client's utilization, the Client will do the following in the next 30-days

1) utilize the Health Status Zoning Tool
    a. If applicable, use Diabetes, ESRD, COPD, Heart Failure Status Zoning Tool.
2) Post hospital specialist follow up visit
3)