Discharge Summary Checklist (Complete)

Standard Discharge Summary

- Help close the gap between the time the patient is discharged from the hospital and when seen by his/her PCP. Provide critical information for SNF or other receiving institution.
- Direct communication between the hospitalist and the PCP is important to prevent avoidable readmissions
- Important information needed to help the PCP understand what should have been done to prevent an avoidable readmission
    - Pending test results
    - Medications reconciled or changed in the hospital
    - Equipment the patient had been provided at the time of hospital discharge
    - Referrals to specialists or chronic disease case managers
- Standardize the discharge summary to include a specific section that outlines for the PCP what needs to be done during the post hospital visit
- Discharge summary includes:
    - Admission and discharge diagnoses (<u>separate entries</u>)
    - A brief description of why the patient was hospitalized and the LACE+ (readmission risk) score at the time of discharge
    - Tests and results pending at the time of discharge
    - Hospital findings requiring further workup
    - Durable medical equipment required
    - Code status, HCPOA if completed (note if activated or not)
    - Condition at discharge – "based on the physician's clinical findings during the face-to-face encounter"- Nature and extent of functional limitations.
        - Homebound due to:?
        - SNF required due to:?
        - Mental Competency – HCPOA activation or not
    - Discharge Destination
    - Reconciled medications including a comment on why medications before admission may have been discontinued and why new medication regimens were started
    - Recommendations of and follow-up with specialists or chronic-disease case managers.
    - Anticipated problems and suggested interventions
    - Name and 24 hour number for physician / hospital records
    - <u>Home Health / PPOC Statement:</u>
        - I acknowledge that I had a Face-to Face Encounter with the patient on *** and that the content outlined in this discharge summary serves to provide documentation of the clinical findings of the encounter and reason for homecare.
        - The patient will be followed post hospitalization by the patient's physician, and a copy of this discharge summary has been provided to Dr. ***.

        - Discharge Plan: Discharge to home health services for the following skilled services: (examples or possibly selections could include):
        - Skilled nursing to: Perform skilled assessment, medical condition education related to the above clinical and medical condition
        - Therapy assessment and treatment if appropriate
- <u>SNF / PPOC Statement:</u>
    - I certify that post hospital SNF care (skilled nursing and/or skilled rehabilitation) is required on behalf of the above named patient that can only be provided in an SNF. The SNF care is needed for a condition in which the individual received inpatient care in a participating hospital.
        - Rehab Potential: __ Good __Fair __Poor
    - I certify that this individual has been screened for the presence of clinically apparent communicable disease that could be transmitted to others, including screening for tuberculosis within 90 days prior to admission, or a physician, physician assistant or advanced practice nurse prescriber has ordered procedures to treat and limit the spread of any communicable disease the individual may be found to have.
    - Last Screening for Tuberculosis (PPD/CXR) – Date: ___/___/_____
- **DISCHARGE SUMMARIES ARE TO BE COMPLETED IN THE EMR BEFORE THE PATIENT LEAVES THE HOSPITAL**

A Template was created (which includes PPOC statements and durable equipment attestation) to assist in completion of discharge summary: ".wwdproviderstandard" – choose WWD Adult Discharge Summary. This can be made a button on discharge order set.