USA HEART FAILURE TEAM TRANSITIONS OF CARE RECOMMENDATIONS

ED Criteria for Transition to Outpatient

1. Adequate diuresis (*urine output > 500 ml over 1 hr*)
2. No significant alterations in electrolytes
3. Relief of dyspnea/orthopnea
4. Able to ambulate in ED for several minutes with minimal dyspnea (*over baseline*)
5. No high risk conditions
6. Able to be seen in HF clinic within 1-3 days

High Risk Conditions – Consider Admit

1. BNP > 1000 pg/ml
2. Abnormal Troponin
3. BUN > 40 mg/dl
4. Cr > 3 mg/dl
5. Na < 135 mEq/l
6. Systolic BP < 100 mmHg
7. Hypertensive urgency
8. Resp rate > 32/min
9. Signs of poor perfusion
10. New ischemic changes on EKG
11. Significant comorbidities requiring acute intervention
12. New onset of AHF where a rapid outpt etiologic w/u is not available
13. Elderly

USAMC HEART FAILURE CLINIC

(251) 445-8242

❖ Located in USAMC Cardiology Clinic (Hospital basement)

❖ Notify HF Coordinator for patient F/U appt

❖ After 4 PM or weekends call Cardiology Fellow to give information

❖ Give the patient clinic contact and appt information prior to discharge!

❖ New patients must be seen by Cardiology during their hospitalization to be seen in the HF clinic

HEART FAILURE DISCHARGE CHECKLIST

Final Primary and Secondary Diagnoses

Hospital Course – Include:

1. Etiology of heart failure
2. Triggers for exacerbation
3. Ejection fraction (date obtained)
4. In-hosp therapies/interventions & pt response
5. In-hosp total diuresis
6. Discharge weight
7. Admit BNP/ discharge BNP
8. Follow-up studies/interventions needed

Condition at discharge – including euvolemic state, functional status

Discharge destination – (home, home health, hospice)

Social issues identified

Documentation of pt education (***60 min required)***

1. 2-GM sodium diet
2. Fluid restrictions
3. Weight daily monitoring
4. Activity
5. Signs and symptoms of heart failure
6. What to do if HF symptoms worsen
7. Review of medications
8. Smoking cessation (if appropriate)
9. **Follow-up appts**

Discharge Medications:

1. Written schedule – Include purpose/cautions
2. Comparison with pre-admission meds (new changes in dose/freq, unchanged, "meds should no longer take"
3. High risk medications that need close f/u and monitoring (warfarin, diuretics, etc)
4. GDMT/ HF indicators: *If not used **MUST** indicate reason*
   a. ACEI (if LVSD)
   b. ARB (if LVSD and ACEI not tolerated)
   c. B-Blocker (if LVSD, use only carvedilol, metoprolol succinate or bisoprolol)
   d. Aldosterone antagonist (if LVSD and mod-sev HF symptoms despite use of ACEI & BB)
   e. Hydralazine + nitrate (if African American and LVSD and HF symptoms despite use of ACEI & BB)
   f. Anticoagulation for afib/flutter

AICD/CRT – (assess need, future plans)

Smoking counseling – (if appropriate)

Follow-up appointments: ***MUST see a provider within 7 days of discharge***

(except when discharged to home health, nursing home, hospice)

1. Appt with Primary care MD
2. Appt with Cardiologist
3. Appt with Heart Failure clinic (if appropriate)
4. Appt with Coumadin clinic if indicated
5. Give pt name, date, address, contact info
6. Give pt 24/7 call-back number

Specific instructions to out-pt providers

1. Titration of meds
2. Follow-up labs/studies

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