Heart Failure Discharge Plan FAQ

Section I: General Patient Information

What do I put in for the weights?

For Admit Weight –utilize the first weight obtained once admitted; it is OK to use the clinic weight if patient is admitted from the clinic.

For Discharge Weight— utilize the last weight obtained within 7 days from discharge; if none obtained, just leave blank

What do I put in for the height?

Any height documented during the admission or ± 1 month of the admission is OK. This will allow us to calculate BSA and to calculate GFR

What if there are no EF's on echo reports?

This is why we have put qualitative ventricular function in the discharge form. We'd prefer to have quantitative EF, but if not available, a qualitative estimate is next best. As a guideline, "Normal" would be an EF >55%, or SF >28%; "Mildly decreased" would be an EF 40-55% or SF 22-28%; "Moderately decreased" would be EF 30-39% or SF 14-21%; and "Severely decreased" would be EF <30% or SF <14%.

What EF calculation would you like me to use?

There are many ways to calculate EF on echocardiogram. We are not recommending one calculation of EF over another. Instead, we recommend you use the EF calculation customary in your institutional—that is the one you typically use in clinical practice or the EF that the echocardiographer thinks best quantifies the patient's ventricular function. Therefore, the EF calculation you choose to report should be determined by your site.

What precipitating factors should we include?

Please circle the precipitating factors listed that apply; if "other" please indicate in the field accordingly.

Section II: Follow Up Schedule

What information do we put in the "Follow Up" section?

In this section, put the date information for HF, echocardiogram, labs, and PCP visits in MM/DD/YYYY form. If timing is known but the exact date not yet set, it is okay to put "2 months" or "2 weeks", etc. If these are not known or have not been determined at discharge, please leave blank.

Section III: HF Medications

Do you want the dose of medications listed in weight-based or absolute dose?

Please input medication dosage in absolute dose (mg). We will use the weight information captured at the top of the form to back-calculate the dose in weight-based formulation; if applicable,

How should goal medication dose be listed?

Please include the absolute dose (mg) and frequency; if applicable (i.e. an infant), please include the mg/kg/day goal dose as well. The absolute dose may change based upon weight gain as an outpatient, but please use the discharge weight. There will also be a difference in practice patterns for goal dose—this is expected.

What information should be included under "Congestion/Exacerbation Plan" under the Diuretic subsection?

If you have a plan to give a PRN dose of diuretic for a specific weight increase or symptoms, etc., this is where you can indicate that. If you do not have a "congestion" plan, then you can leave this blank. There will also be a difference in practice patterns —this is expected.

Section IV: Fluid and Diet

What type of information should I enter for "Diet"?

If the patient goes home with a formula, special diet, or instructions for mechanism of delivery, this section is where this type of information should be entered. "Similac 30kcal/oz, 40cc every 3 hours via NG tube" would be an appropriate entry, as well as "Low sodium diet" or "Normal for age".

What if I do not send a patient home on a fluid restriction?

If you do not send a patient home on a fluid restriction, please select "none/ad lib"; if you send a patient home on a Free Water restriction but not a Total Fluid restriction, please enter the data for Free Water restriction and leave the Total Fluid section blank, or vice versa based upon the individual patient. Same applies for sodium restriction.

Sections V and VI: Labs and Other

What if labs were not obtained at admission?

Labs drawn within 48 hours of admission, or from clinic in the event the patient is admitted from clinic, can suffice. Please indicate if the lab is BNP or NT-proBNP.

What if labs were not obtained at discharge?

Please put the most recent values within 7 days of discharge. Please indicate if the lab is BNP or NT-proBNP. If only 1 value was assessed during the hospitalization (at admission), it is OK to leave the discharge value blank.

What is the time frame for assessment of iron deficiency?

If iron status has not been assessed within 3 months, please circle "Not Assessed"

What should I include in the Additional Information or Instructions section?

Please include any discharge instructions or patient information (e.g. other medications) not captured above.

Section VII: General Information and Data Entry Guidance

How should I complete the Discharge Plan for the patient, and how should I submit a copy of the plan to ACTION?

There are several ways to fill out and submit a copy of the plan to ACTION; you or a member of your team can:

1) Complete the electronic version of the Discharge Plan, save a PDF of the generated document, and share the PDF with other provides, the patient, and family members (data will already be captured in REDCap via this electronic form).

2) Incorporate the Discharge Plan into discharge documentation in the EMR at your respective institution, print off the Discharge Summary from the EMR, and scan/upload the document into the patient-level HF REDCap.

3) Print out a paper version of Discharge Plan, complete the form by hand, and scan/upload the plan to the patient-level HF REDCap.