Expanded Protocol Schema 4: Discharge Planning & Transition of Care

Society of Hospital Medicine

DISCHARGE READINESS VERIFICATION (48 Hours Prior to Discharge)

ALL criteria must be met before initiating discharge process

CLINICAL STABILITY: Euvolemic or near dry weight (stable x48 hours) | Symptom improvement (NYHA class I-II) | Hemodynamically stable (SBP greater than 90, HR 50-100) | On oral medications *24-48 hours | No IV vasoactive medications | Ambulating without significant dyspnea

THERAPEUTIC OPTIMIZATION: GDMT initiated (≥3/4 pillars if HFrEF) | Oral diuretic regimen established | Laboratory values stable/acceptable

COMPREHENSIVE MEDICATION RECONCILIATION

Pharmacist-Led Review with Physician Sign-off

DISCHARGE MEDICATION LIST (Complete ALL fields):

GDMT MEDICATIONS: 1. RAAS Inhibitor: ___ mg, ___ times daily | 2. Beta-Blocker: ___ mg, ___ times daily | 3. MRA: ___ mg, ___ times daily | 4. SGLT2i: ___ mg, once daily

DIURETIC REGIMEN: 5. Loop Diuretic: ___ mg, ___ times daily | 6. Thiazide (if applicable): ___ mg, ___ times daily

MEDICATIONS DISCONTINUED/CHANGED: DISCONTINUED: ___ (Reason: ___) | DOSE CHANGED: ___ (From: ___ To: ___)

ANTICOAGULATION (if applicable): Warfarin ___ mg daily (INR goal: 2-3) | Next INR check: ___ | DOAC: ___ mg ___ times daily

MEDICATION TEACHING COMPLETED: Purpose explained | Side effects reviewed | Dosing schedule clarified | Missed dose instructions | Pill box organized | Prescriptions sent | Financial barriers addressed | Patient assistance enrolled

POST-DISCHARGE MONITORING PLAN

LABORATORY CHECKS: BMP in 1 week after RAAS/MRA change | BMP in 2 weeks after SGLT2i initiation | BNP/NT-proBNP in 4-6 weeks

FOLLOW-UP VISITS: PCP: ___ | Cardiology: ___ | HF Clinic: ___ | Target: Within 7-14 days of discharge

HOME HEALTH: Nursing visits | PT/OT services | Telemonitoring

OTHER REFERRALS: Cardiac rehab | Palliative care | Social work | Dietitian | Case manager

COMPREHENSIVE PATIENT & CAREGIVER EDUCATION

Use Teach-Back Method - Document Patient Understanding

1. DISEASE UNDERSTANDING: Explain heart failure in simple terms ("heart muscle weak/stiff") | Discuss chronic nature requiring lifelong management | Explain symptom occurrence mechanism | Review patient-specific cause | Teach-back: "In your own words, what is heart failure?"

2. WARNING SIGNS - SEEK HELP IF: Weight gain greater than 2 lbs in 1 day or greater than 5 lbs in 1 week | Increased shortness of breath (especially at rest/night) | New/worsening swelling in feet, ankles, legs, or abdomen | Persistent cough or coughing up pink, frothy mucus | Teach-back: "What symptoms would make you call your doctor?"

3. DAILY SELF-MANAGEMENT: Weigh yourself EVERY morning, same time, same scale, after urinating, before eating | Record weight in log | Call doctor if weight increases greater than 2 lbs/day or greater than 5 lbs/week | Take medications exactly as prescribed | Restrict sodium to 2-3 grams/day | Fluid restriction if ordered: ___ mL/day

4. LIFESTYLE MODIFICATIONS: Stay active - walk 20-30 min most days (as tolerated) | Avoid smoking/alcohol | Get flu/pneumonia vaccines annually | Elevate legs when resting | Sleep with head elevated if SOB | Cardiac rehab referral provided | Use herbs/spices instead of salt | Dietitian consulted

DISCHARGE DOCUMENTATION BUNDLE

Provide ALL documents to patient - Confirm receipt

REQUIRED DOCUMENTS: Discharge Summary (diagnosis, hospital course, discharge plan) | Medication List with Clear Instructions (typed) | Follow-up Appointment Schedule (dates, times, locations, phones) | Daily Weight Log Template | Heart Failure Action Plan

EDUCATIONAL MATERIALS: "Living with Heart Failure" booklet (in patient's language) | Low-sodium diet guide with sample meal plans | Medication guide (purpose, side effects, when to call) | Emergency contact card (wallet-sized) | Digital resources (apps, websites)

EQUIPMENT & SUPPORT SERVICES

EQUIPMENT NEEDS: Home scale ordered | Blood pressure cuff | Pill organizer | O_2 if indicated | Walker/wheelchair | Hospital bed

SUPPORT ARRANGED: Home health nursing | Physical therapy | Occupational therapy | Meal delivery | Transportation assist | Caregiver support | Financial counseling

SAFETY ASSESSMENT: Home safety eval if at risk for falls | Environment safe for discharge

CARE TEAM COMMUNICATION & COORDINATION

OUTPATIENT PROVIDER NOTIFICATION: Discharge summary faxed to PCP within 24 hours | Discharge summary faxed to cardiologist within 24 hours | Follow-up appointments confirmed with offices | Home health agency notified with orders | Pharmacy notified of new prescriptions

PATIENT CONTACT PLAN: Phone call scheduled for 48-72 hours post-discharge | Assess: symptoms, medications taken, weight trend | Confirm follow-up appointments scheduled | Answer questions, address concerns | Document call in EHR

QUALITY METRICS DOCUMENTATION

PERFORMANCE MEASURES COMPLETED: LVEF documented | Discharge on ACEi/ARB/ARNI (if HFrEF) | Discharge on evidence-based beta-blocker | Discharge on MRA (if eligible) | Discharge on SGLT2i | Discharge instructions provided | Post-discharge appointment scheduled less than 14 days | Weight monitoring plan documented

30-DAY READMISSION RISK ASSESSMENT

RISK FACTORS: Prior HF admission | Multiple comorbidities | Low health literacy | Social barriers | Living alone | Depression/anxiety | Medication non-adherence

FINAL DISCHARGE DAY CHECKLIST

Complete before patient leaves hospital

CLINICAL: Final vitals stable | Weight at/near dry weight | Patient ambulatory | No acute issues | Prescriptions written | DME ordered/delivered | Transportation arranged

DOCUMENTATION: Discharge summary completed | Medications initiated | All orders signed | Bills/coding complete | All consults closed | Summary faxed to providers | Quality metrics entered

EDUCATION/COORDINATION: Patient/family teaching done | Teach-back verified | All documents provided | F/U appointments confirmed | Pharmacy notified | Home health contacted | Questions answered

POST-DISCHARGE PHONE CALL PROTOCOL (48-72 Hours)

ASSESS: Taking meds as prescribed? | Any side effects? | Daily weights recorded? (trending up/down/stable?) | Breathing comfortable? | Swelling improving? | Following diet? | FUU appointments scheduled? | Questions/concerns?
ACTION: Reinforce teaching | Address barriers | Escalate concerns to provider | Document in EHR
GOAL: Prevent readmission by early identification of decompensation and medication adherence issues

TARGET: Zero preventable 30-day readmissions | Patient satisfaction greater than 90% | GDMT prescribing greater than 80%

Evidence: Project Re-Engineered Discharge (RED), STRONG-HF, COACH Trial | 2022 AHA/ACC/HFSA Guidelines.[197, 24, 158, 4]

The development of this resource was funded by Bayer in 2026.