	Early Recognition	Admission (First 24 hours)	Stabilization (Day 2-3)	Discharge/Transition (Day 3-4)
Order Sets	• Use Order Set **1182: CAR IP Heart Failure Focused** • For inpatient admission: combine with order set **1530 General Admission, 1219 Critical Care Admission** or **829 ED Quick Admit**	• Consider order set **1162: Nicotine Replacement** • Use order set **1384: Influenza/Pneumonia Vaccine**		

Medical Milestones/ Discharge Criteria	• **Clinical Indications for Admission**
	  • Hypoxia
	  • Evidence of fluid overload (crackles, anasarca, pulmonary edema on CXR)
	  • Electrolyte abnormalities
	  • Symptomatic arrhythmias
	  • Acute renal failure
	  • Acute peripheral ischemia
	  • Failed outpatient therapy
	  • Hemodynamic instability
	  • Mental status changes
	  • Positive troponins – possible ischemic injury – R/O ACS
	• Target weight loss or urinary output for the first 6 hours (≥ 500 ml urine output 6 hours after diuretic therapy)
		• Screen (seasonal) for Pneumococcal and Influenza status and administer, if indicated
		• Screen for VTE Prophylaxis
		• Determine cause of current exacerbation
		• Titrate oxygen to the minimum amount required to keep saturations ≥ spO2 90%
		• Improving lung sounds and respiratory status
		• Diuresing (Output > Input)
		• Improving hemodynamic stability
		• Tolerating increased activity
		• Obstructive Sleep Apnea screen (STOP BANG or similar tool)
		• Establish/Clarify Code status, goals of care
		• Depression screen (if available)
		• Subjective SOB assessment
			• 02 therapy to keep saturations ≥ 90 %, wean as able
			• If O2 Sat ≤ 88% with and without ambulation, then arrange for home O2 study within 24 - 48 hours of DC
			• Improving lung sounds and respiratory status
			• Stable vital signs and hemodynamics
			• Medication adjustments as indicated
			• Diuretics to PO, as able
			• Tolerating discontinuation of Inotropic agent, if applicable
			• Wt. loss: >0.5-1 kg/day if volume overloaded
			• Patient tolerating increased activity
			• Subjective SOB re-assessment completed with improvement
			• Readmission risk re-evaluation per Case Management
				• If O2 Sat ≤ to 88% with and without ambulation, then arrange for home O2 study within 24 - 48 hours of DC
				• Patient tolerating baseline activity level
				• Hemodynamics stable
				• Patient has been clinically stable for 12 to 24 hours (no IV vasodilator or inotropic agent for 24 hours)
				• Oral diuretic(s)
				Output=intake on stable diuretic (s) for 24 hours
				Total output >total intake for entire hospital stay (if admitted with volume overload)
				• Clinically euvolemic
				• Guideline Directed Medical Therapy prescribed including ACE inhibitor for LVEF <40, EB Beta Blocker, on anticoagulation for afib or contra-indication(s) documented

Consults	Consider consult to: • Cardiology • Electrophysiology • Endocrinology • Internal Medicine • Nephrology • Pulmonology • Cardiac Rehab • Dietary/Dietician • HF Navigator/Coach • Pharmacy	Consider consult to: • PT/OT Consult • Palliative Care • Hospice • Dietary • Diabetic educator • Spiritual Care • Pharmacy • Pulmonary rehab • Case management/Social Work • Cardiac Rehab/Cardiac Services • Transitional Care - HF Navigator/Coach • Care Transition Center	Consult recommendations reviewed • Home health/Telehealth • Physical therapy • Transitional Care - HF Navigator/Coach • Care Transition Center • Cardiac Rehab/Cardiac Services • Consider outpatient services	• Case Management to finalize discharge planning • Consider transition of care, post discharge-document follow-up appointments for PCP or cardiologist within 7 days or 3 days for high risk for readmission • Consult recommendations addressed/ complete • Home health/Telehealth • Consider outpatient services
RT	• Titrate oxygen to the minimum amount required to keep saturations ≥ spO2 90%	• Titrate oxygen to the minimum amount required to keep saturations ≥ spO2 90%	• Oximetry at rest and with ambulation • Home 02 evaluation as indicated • Nocturnal Oxygen Saturation Study 24- 48 hours prior to DC if Obstructive Sleep Apnea suspected • 6 minute walk test	• If O2 Sat ≤ 88% with and without ambulation, then arrange for home O2 study • Tolerating room air, or home 02 as appropriate
Education	**Initiate education (via teach back) on topics below** • Fluid Restriction (provider discretion) • Importance of daily/scheduled weight • Tobacco Cessation Program, if appropriate • Sodium restricted diet (≤ 2 Grams/day) • Symptoms/recognition of HF and action plan, health caregiver follow-up • Importance of medication adherence • HF journal, if available	**Provide education (via teach back) and document for pt. and family** • Fluid Restriction (provider discretion) • Importance of daily/scheduled weight • Tobacco Cessation Program, if appropriate • Sodium restricted diet (≤ 2 Grams/day) • NSAIDs avoidance • Symptoms/recognition of HF and action plan, health caregiver follow-up • Importance of medication adherence	**Reinforce education (via teach back) for pt. and family** • Fluid Restriction (provider discretion) • Importance of daily/scheduled weigh • Tobacco Cessation Program, if appropriate • Sodium restricted diet (< 2 Grams/day) • NSAIDs avoidance • Symptoms/recognition of HF and action plan, health caregiver follow-up • Importance of medication adherence • Address identified self-management deficits • Readmission risk	**AVS review with patient(must have printed copy):** • Medications/scripts/timing of next dose • F/U appt: within 3-7 days of DC, if not SNF • Physician(s) contact information • Labs scheduled for F/U • Outpatient testing if applicable • Admitting diagnosis • Home health if appropriate • HF instructions: diet/weights/action plan/activity/medications • CM/Discharge Planning: DC packet if appropriate/ Equipment arrangement as indicated. • Refer to HF support group, if applicable

	Early Recognition	Admission (First 24 hours)	Stabilization (Day 2-3)	Discharge/Transition (Day 3-4)
Assess/Treatment	• Chest X-ray • 12 lead EKG • Echocardiogram if not done within last 3-6 months • Strict I/O • Daily weights, standing if able • Initial Labs – BMP, CBC, BNP, Troponin, TSH, Magnesium, PT/INR as indicated • Presence of peripheral and/or pre sacral edema • Telemetry	• Smoking assessment • Baseline activity assessment • Device interrogation if present/ adjustments per Cardiology/EP • Telemetry • Echocardiogram if not done within last 3-6 months • Strict I/O • Daily AM weights post void, standing if able • Daily BMP • CBC, BNP, Troponin, Magnesium, PT/INR as indicated • Peripheral and pre sacral edema	• Strict I/O • Oximetry at rest, on RA and with ambulation, wean O2 as able • Telemetry • Daily AM weights post void, standing if able • Daily BMP • Daily PT/INR as indicated • Peripheral and pre sacral edema	• I/O • Documented discharge weight • F/U PT/INR checks scheduled as indicated • BMP/BNP at discharge, as appropriate • Improved peripheral and pre sacral edema • Decreased standing weight • Improved respiratory effort • Consider BMP 48-72 hours after D/C to check for possible Acute Kidney Injury (AKI) & electrolyte abnormalities
Medication	• Review all prior to admission medications and continue heart failure medications, if appropriate • Initiate IV diuretic therapy • Consider vasodilators/inotropes	• IV diuretic therapy/ potassium replacement therapy as indicated • ACE/ARB (requirement for LVEF<40, or document contraindication) - consider holding for aggressive diuresis • Evidenced Based (EB) Beta Blocker (only if a PTA medication, is in known systolic failure, is euvolemic, or document contraindication) • Anticoagulation for afib as indicated • Inotrope therapy as indicated • Add meds for patients not tolerating ACE/ARB with a hydralazine/nitrate combination	• Medication adjustments, as indicated • Consider change to PO diuretics if appropriate • ACE/ARB (requirement for LVEF<40, or document contraindication) - consider holding for aggressive diuresis • Consider adding second diuretic if inadequate diuresis Consider Aldosterone receptor antagonist • Consider hydralazine/nitrate therapy in African American population • Consider digoxin, aldosterone antagonist • EB Beta Blockers if pt. is euvolemic and in systolic heart failure	• Reconcile discharge medications • Verify vaccines administered • ACE/ARB (requirement for EF<40, or document contraindication) • EB Beta Blocker (or document contraindication) • Anticoagulation for afib as indicated • Consider digoxin, as indicated • Consider aldosterone receptor antagonist, as indicated • Consider diuretics, as indicated • Hydralazine/nitrate combination, as indicated
Activity	• As tolerated if O2 is ≥ 90%	• Activity as tolerated • Encourage ambulation and titrate O2 as needed to keep O2 ≥ 90%	• Activity as tolerated • Encourage ambulation	• Activity as tolerated • Encourage ambulation
Diet	• 2 gram Sodium diet (consider diabetic and/or renal diet, as appropriate) • Fluid restriction (provider discretion) • Evaluate and/or maintain home restrictions	• 2 gram Sodium diet (consider diabetic and/or renal diet, as appropriate) • Fluid restriction (provider discretion) • Evaluate and/or maintain home restrictions	• 2 gram Sodium diet (consider diabetic and/or renal diet, as appropriate) • Fluid restriction (provider discretion) • Evaluate and/or maintain home restrictions	• 2 gram Sodium diet (consider diabetic and/or renal diet, as appropriate) • Fluid restriction (provider discretion) • Evaluate and/or maintain home restrictions
Other			• ICD and Resynchronization therapy screen for outpatient F/U • Advanced therapy screening per cardiology if transfer indicated • Consider Lifevest as bridge to ICD per cardiology	