1 Patient Information

Name:	Gerald R. Hutchinson
DOB:	March 4, 1948
Age / Sex:	77 years / Male
MRN:	MRN-6647201
Date of Admission:	April 20, 2025
Date of Discharge:	April 26, 2025
Attending Provider:	Dr. Priya Mehta, MD, FACC — Cardiology
Discharging Provider (if different):	Dr. Samuel Okafor, MD — Hospitalist Medicine

2 Reason for Hospitalization

Primary admitting diagnosis: Acute decompensated heart failure (ADHF) with reduced ejection fraction (HFrEF), EF 30%.

Clinical indication: Patient presented with a 5-day history of progressive dyspnea on exertion now present at rest, orthopnea requiring 3-pillow positioning, bilateral lower extremity pitting edema (3+ to the knees), and a 12-lb weight gain over 7 days. Precipitating factors included dietary sodium non-compliance and self-discontinuation of furosemide 3 weeks prior. Inpatient care was necessitated by severe respiratory compromise (SpO2 88% on room air at presentation), inability to manage symptoms in the outpatient setting, and requirement for IV diuresis and hemodynamic monitoring.

3 History of Present Illness

Mr. Hutchinson is a 77-year-old male with ischemic cardiomyopathy (EF 30%), atrial fibrillation on anticoagulation, CKD Stage 3b, and type 2 diabetes who presented from home via EMS. Five days prior to admission, he noted increasing shortness of breath with minimal exertion. By day of presentation, he was dyspneic at rest and unable to lie flat. His wife noted bilateral ankle swelling that had rapidly progressed to involve the calves and lower thighs. He denied chest pain, fever, productive cough, or recent illness. On arrival: BP 168/94, HR 102 (irregularly irregular), RR 26, SpO2 88% RA. BNP 4,820 pg/mL. CXR showed pulmonary vascular congestion and bilateral pleural effusions.

4 Hospital Course

ADMISSION (April 20): Patient admitted to cardiac step-down unit. IV furosemide initiated at 80mg BID. Supplemental O2 via nasal cannula at 4L/min. Daily weights and strict I&O monitoring initiated. Cardiology consulted.

HOSPITAL DAYS 1-2 (April 21-22): Urine output responded — 2.8L net negative on day 1, 2.2L on day 2. Dyspnea improved. O2 weaned to 2L NC. Weight decreased 6 lbs. Creatinine bumped from 1.6 to 2.1 (baseline CKD); potassium repleted. Furosemide adjusted to 60mg BID IV.

HOSPITAL DAYS 3-4 (April 23-24): Continued improvement. Patient ambulating in hallway. SpO2 95% on room air. Transitioned to oral furosemide 80mg BID. Repeat echo: EF 28%, moderate MR, PASP 52 mmHg. Renal function stabilized — creatinine 1.7. Sacubitril/valsartan uptitrated from 24/26mg to 49/51mg BID. Metoprolol optimized to 50mg BID.

HOSPITAL DAYS 5-6 (April 25-26): Patient ambulating independently. SpO2 96% RA. Weight 183 lbs (admission 195 lbs — 12 lb net loss). Edema improved to trace bilateral. Patient and wife educated on daily weights, sodium restriction, fluid restriction, and furosemide self-adjustment protocol.

5 Procedures Performed

1. Echocardiogram (April 23, 2025) — Reassessment of LV function. Findings: EF 28%, moderate MR, PASP 52 mmHg.
2. 12-lead ECG (April 20, 2025) — AF with RVR on presentation. Findings: AF rate 102, no acute ST changes, LBBB (known).
3. IV furosemide administration via peripheral IV — continuous monitoring throughout.
4. Potassium replacement therapy — PO and IV as indicated.

6 Discharge Diagnoses

6a PRIMARY DIAGNOSIS

Acute decompensated heart failure with reduced ejection fraction (HFrEF)
ICD-10: I50.20 (Systolic congestive heart failure, unspecified)
EF 28% on repeat echo — ischemic cardiomyopathy, prior LAD territory MI (2017)

6b SECONDARY DIAGNOSES

1. Atrial fibrillation, persistent — I48.19 — rate-controlled, on anticoagulation
2. Chronic kidney disease, Stage 3b — N18.32 — creatinine 1.7 at discharge
3. Type 2 diabetes mellitus — E11.9 — A1c 7.4%, stable
4. Hypertension — I10 — BP controlled at discharge 128/76
5. Moderate mitral regurgitation — I34.0 — managed medically
6. Hypokalemia — E87.6 — corrected during hospitalization

7 Condition at Discharge

Mr. Hutchinson is hemodynamically stable at discharge. BP 128/76 mmHg, HR 74 bpm (AF, rate-controlled). SpO2 96% on room air. Ambulatory and independent with ADLs. Lower extremity edema reduced to trace bilateral ankle swelling. Dyspnea resolved at rest and with mild exertion. Discharge weight 183 lbs (12 lbs below admission). Creatinine 1.7 mg/dL at baseline. Mental status intact — alert, oriented x4, demonstrates understanding of discharge instructions. Mood appropriate.

8 Medications at Discharge

NEW MEDICATIONS

1. Potassium chloride 20mEq PO BID — initiated for hypokalemia prophylaxis with diuretic therapy

CONTINUED MEDICATIONS

1. Furosemide 80mg PO BID — DOSE INCREASED from 40mg daily; self-adjustment protocol reviewed
2. Sacubitril/valsartan 49/51mg PO BID — UPTITRATED from 24/26mg during hospitalization
3. Metoprolol succinate 50mg PO BID — OPTIMIZED from 25mg BID
4. Apixaban 5mg PO BID — continued for AF
5. Atorvastatin 40mg PO nightly
6. Metformin 500mg PO BID — HELD during hospitalization, restarted at discharge
7. Linagliptin 5mg PO daily
8. Aspirin 81mg PO daily

DISCONTINUED MEDICATIONS

1. Spironolactone 25mg — HELD at discharge due to creatinine bump and potassium supplementation; to be restarted by cardiologist at follow-up once renal function confirmed stable

9 Allergies

1. Penicillin — anaphylaxis (throat swelling, urticaria) — red-band allergy bracelet worn during hospitalization
2. Iodinated contrast — urticaria — CT with contrast avoided; pre-medication protocol on file
3. No food or latex allergies documented

10 Discharge Instructions

ACTIVITY: Resume light activity as tolerated — short walks encouraged, gradually increasing. Avoid heavy lifting (>10 lbs) for 2 weeks. No strenuous activity until cleared by cardiologist.

DIET: Strict sodium restriction <2 grams per day. Limit fluid intake to 1.5 liters per day. Avoid processed foods, canned soups, deli meats, fast food. Heart-healthy diet pamphlet provided.

DAILY WEIGHTS: Weigh every morning before breakfast after urinating. Record weight daily. Call clinic if weight increases >2 lbs in one day or >5 lbs in one week.

MEDICATIONS: Take all medications as prescribed. Do not skip diuretics. Furosemide self-adjustment protocol reviewed.

WARNING SIGNS — CALL 911: Sudden severe dyspnea, chest pain, inability to speak in full sentences, SpO2 <90%, fainting. CALL CLINIC: Weight gain >2 lbs/day, increased leg swelling, worsening dyspnea, dizziness.

11 Follow-Up

1. Cardiology (Dr. Mehta) — within 7 days (May 3, 2025, 10:00 AM, Vanderbilt Cardiology Clinic). Labs day before: BMP (Cr, K, BUN).
2. Primary Care (Dr. James Holloway) — within 14 days (to be scheduled by patient).
3. Cardiac rehabilitation program referral placed — coordinator to contact patient within 5 business days.
4. Heart Failure Nurse Navigator follow-up phone call scheduled April 28 (2 days post-discharge).

Disposition (discharge location / level of care): Discharged to home with spouse. Single-story home, no stairs required. Wife present and demonstrated understanding of discharge instructions including daily weight monitoring and dietary restrictions. Home health nursing not arranged — patient ambulatory and independent.

12 Time & Billing

Total Time Spent: 55 minutes

Counseling / Coordination of Care Time: 35 minutes — patient and family education on HF management, medication reconciliation, dietary counseling, daily weight protocol, warning signs, and care coordination

E/M CODING

E/M Level (e.g., 99238 / 99239): 99239 (Hospital Discharge Day Management >30 minutes)

Basis for Billing (Time-based / MDM): Time-based — 55 minutes total discharge day management

ICD-10 CODES

Primary Diagnosis Code + Description: I50.20 — Systolic (congestive) heart failure, unspecified

Secondary Diagnosis Code(s): I48.19 — Persistent AF; N18.32 — CKD Stage 3b; E11.9 — Type 2 DM; I10 — HTN; I34.0 — Mitral regurgitation; E87.6 — Hypokalemia

Physician Name, MD: Dr. Samuel Okafor, MD

Specialty: Hospitalist Medicine / Cardiology co-management

Date: April 26, 2025

Time: 11:30 AM CST