

Patient Safety Coalition

A Focus on Heart Failure



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KEYWORDS

- Hospitals • Skilled nursing facilities • Home care • Interdisciplinary collaboration
- Heart failure readmissions • Population health • Post-acute care

KEY POINTS

- Heart failure (HF) readmissions are costly and may indicate gaps in care.
- Developing a regional patient safety coalition is one strategy to address HF readmission rates.
- It is important to include skilled nursing facilities and home health care agencies in brainstorming for sustainable solutions to reduce HF-related readmissions.

INTRODUCTION

Heart failure (HF) is a significant health care issue. Approximately 5.7 million Americans have HF, with 870,000 new cases being diagnosed each year.¹ HF is reported to be the cause in 1 out of 9 deaths.¹ In 2011, there were 284,388 deaths for HF any-mention mortality, and HF was the underlying cause of 58,309 of these deaths.¹ The total cost for HF in 2012 was approximately \$30.7 billion, and 68% of this was direct medical costs.² The cost of HF will continue to increase. The total cost of HF is projected to increase an estimated 127% to \$69.7 billion from 2012 to the year 2030.² From 2012 to 2030, the prevalence of HF is projected to increase 46%, leading to more than 8 million adults older than 18 years with HF.²

HF patient readmissions result in escalated health care costs and indicate poor patient management and gaps in care. These gaps represent a significant patient safety

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issue and can negatively affect patient outcomes. Among Medicare beneficiaries, all-cause readmissions within 30 days following HF hospitalization approaches 25% nationally.³ One strategy to reduce readmission rates in patients with HF is to collaborate through a patient safety coalition. This article describes how the Indianapolis Coalition for Patient Safety (ICPS) addressed the issue of hospital readmissions for patients diagnosed with HF.

BACKGROUND OF PATIENT SAFETY COALITIONS

In several states, private and public health care providers, purchasers, consumers, and regulators have recognized the value of coordinating their efforts to create an environment that enhances safety. Regional public/private patient safety coalitions have been formed in several states.⁴ Patient safety coalitions typically have diverse membership, often including real or potential competitors within the group.⁴ They voluntarily come together to address the common goal of reducing the harm that comes to patients, professionals, and institutions when a medical error or an adverse event occurs.⁴ By using evidence-based strategies and process improvement projects, regional patient safety coalitions have shown a reduction in 30-day readmission rates of patients diagnosed with HF.⁵

The Indiana Hospital Association (IHA) has created 11 regional patient safety coalitions (including ICPS) that blanket the state geographically.⁶ These patient safety coalitions are made up of dedicated professionals, including hospital leadership, doctors, pharmacists, and nurses, who collaborate to improve patient safety⁶ (Fig. 1).

The ICPS provides a forum for Indianapolis-area hospitals to share best practices and work together to solve patient safety issues.⁷ A free-standing nonprofit organization, the ICPS Board is composed of chief executive officers and representatives from medical, nursing, quality/safety, and pharmacy from the 6 major health systems located in Indianapolis: Community Health Network, Eskenazi Health, Franciscan-St. Francis Health, Indiana University Health, Richard L. Roudebush Veterans Affairs Medical Center, and St. Vincent Health.⁷ Although competitors in the market place, hospital leaders came together and agreed to not compete on safety. Coalition hospitals pool their expert resources to accelerate patient safety improvements through community-wide efforts.⁷ In addition, ICPS⁷ works closely with many community partners, including IHA,⁸ Marion County Department of Public Health, schools of medicine, nursing, and pharmacy to name a few.

The ICPS historically achieved accelerated outcomes by sharing resources, evidence-based best practices, performance targets, accountability, and learning. ICPS members undertake projects that focus on patient-centered strategies to improve safety and patient outcomes. Pulling content experts from each of the health systems and community partners, ICPS has formed initiative-specific work groups addressing patient safety issues in medication safety, perioperative safety, blood safety, pediatrics, use of contrast media, workplace violence, multidrug-resistant organisms, and reducing HF readmissions.⁸ Simply stated ICPS' mission is to provide a forum for Indianapolis-area hospitals to share information about best practices and work together to solve patient safety issues in Indianapolis and surrounding county hospitals.⁸

The ICPS Targeting Prevention of Heart Failure Patient Hospital Readmissions within 30 Days following Hospital Discharge work group was formed in 2009 with

representatives from all 6 health systems. Over the next 5 years, work was completed in 4 primary focuses:

- Coalition consensus on implementable tactics to improve preventable HF patient readmissions
- Collaborating with Central Indiana skilled nursing facilities (SNFs) on minimum care standards for treatment of patients with HF
- Improving verbal handoff communication for patients transferred from hospitals to SNFs
- Collaborating with Central Indiana home health care agencies on minimum care standards for treatment of patients with HF in home health care agencies

The 2013 American College of Cardiology Foundation/American Heart Association's guidelines for the management of HF describe following common factors that may precipitate HF admissions and readmissions⁹:

- Nonadherence with medical regimen and sodium or fluid restriction
- Acute myocardial ischemia/infarction
- Uncorrected hypertension
- Valvular disease
- Atrial fibrillation, cardiac arrhythmias, ventricular tachycardia, bradycardia, conduction abnormalities
- Adverse effects of medications
- Initiation of medications that increase salt retention (eg, steroids, thiazolidinediones, nonsteroidal antiinflammatory medications)
- Recent addition of negative inotropic medications (eg, verapamil, nifedipine, diltiazem, beta-blockers)
- Pulmonary embolism
- Excessive alcohol or illicit drug use
- Endocrine abnormalities (eg, diabetes, thyroid disorders)
- Concurrent or systemic infections

The work group identified a need for each member hospital to perform a self-assessment for the root causes of HF related readmissions to their hospital systems. After reviewing the hospital self-assessments, eight root causes of HF readmissions emerged (**Box 1**).

Box 1

Root causes of HF readmissions identified through self-assessment

- Lack of timely access to outpatient follow-up after discharge from the hospital
- Failure of proper medications handoff between providers and across sites of care during transitions
- Lack of care coordination or ownership across sites of care
- Accountability for patients after discharge is not well defined between hospital and other providers.
- Lack of assigned or designated personnel for scheduling follow-up appointments
- Lack of HF clinic resources
- Lack of standardized processes to assess patient risk for readmission
- Patients inability to navigate the healthcare system

TACTICS TO REDUCE READMISSION RATES

The Case Management Society of America convened the National Transitions of Care Coalition (NTOCC) to develop recommendations on actions that all participants in the health care delivery system can take to improve the quality of care transitions, including the development of policies, tools, resources, and recommend actions and protocols to guide and support providers and patients in achieving safe and effective transitions of care.¹⁰

The NTOCC work group identified the following key elements of optimal transitions of care⁹:

- Accountable provider at all points of care transition
- An updated and proactive patient care plan including advance directives
- Medication reconciliation
- Admission and discharge planning
- Follow-up appointment tracking
- End-of-life decision making
- Adequate and accurate (transfer) communication between providers and care settings
- Patient and family education

Hospital-To-Home (H2H) is a national quality-improvement campaign of the American College of Cardiology and Institute for Healthcare Improvement.¹¹ The H2H initiative is a resource for hospitals and cardiovascular care providers committed to improving transitions from hospital to home and reducing their risk of federal penalties associated with high readmission rates.¹¹ The H2H initiative outlined three process improvement projects¹¹:

- See you in Seven: The goal is for all patients discharged with a diagnosis of HF to have a follow-up appointment scheduled within 7 days of hospital discharge.
- Mind your Meds: The goal is for clinicians and patients discharged with a diagnosis of HF to work together and ensure optimal medication management.
- Signs and Symptoms: The goal is to activate patients to recognize early warning signs and have a plan to address them.¹¹

Based on these projects, the ICPS Targeting Prevention of Heart Failure Patient Hospital Readmissions within 30 Days following Hospital Discharge work group members reached consensus on 4 key tactics to improve preventable HF patient readmissions:

- Assure that patients have access to their medications and are knowledgeable about the medications.
- Early follow-up: Patients have a follow-up appointment scheduled within a week of discharge and are able to get there.
- Symptom management: Patients fully comprehend the signs and symptoms that require medical attention and know who to contact should they occur.
- Care management after discharge: Patients are evaluated for home health care referral.

TRANSITIONS OF CARE: HOSPITAL TO SKILLED NURSING FACILITIES

In patients with HF, transitions of care typically refer to individual interventions and programs with multiple bundled activities that are designed to improve shifts or transitions from one setting to the next.¹² Most often, these interventions are focused on transitions

from hospital to home.^{12,13} There is a gap in the literature related to transitions from hospital to SNF, and little is known about interventions to reduce hospitalization of patients with HF who are discharged to post-acute care settings, specifically SNF.¹³ However, one SNF designed a skilled heart unit program that resulted in better HF care.¹⁴

The proportions of 30-day HF readmissions are greater among patients discharged to a SNF compared with patients discharged to home (27% vs 21%, $P = .031$). After adjustment for age and sex, patients discharged to an SNF had a 40% increase in the odds of having hospital readmissions within 30 days after HF compared with those discharged to home.¹⁵ Characteristics most associated with patients with HF admitted to an SNF were longer lengths of hospital stay, older age, history of depression or stroke, and female sex.¹⁶ For ICPS member hospitals, 2010 baseline data provided by the IHA showed that there was a 20.2% readmission rate for patients with HF for any reason from an SNF.

After identifying the need to collaborate with post-acute care facilities to improve outcomes, Indianapolis-area SNFs were invited to participate with the ICPS Targeting Prevention of Heart Failure Patient Hospital Readmissions within 30 Days following Hospital Discharge work group to improve care and care transitions for patients with HF in these post-acute care facilities. The ICPS Targeting Prevention of Heart Failure Patient Hospital Readmissions within 30 Days following Hospital Discharge work group expanded in 2011 to include SNF representatives to address care transitions of patients with HF discharged from hospitals to SNFs. Local SNFs embraced the opportunity to collaborate to reduce readmissions. In 2011, data provided by the IHA showed ICPS hospitals there was a 16.7% readmission rate for patients with HF for any reason from an SNF.

A retrospective review of bundled interventions for enhancing transitions of (care) heart failure patients that included weight monitoring, sodium restriction, medication review and reconciliation, importance of follow-up appointments, and education showed that these interventions led to better outcomes.¹² The ICPS work group reached consensus on 6 minimum standards of care for SNFs to provide better HF care that were then also endorsed by Indiana Society of Post-acute and Long-term Care Medicine (IMDA).¹⁷ Refer to [Table 2](#), Minimum SNF standards for the care of patients with HF. These standards were intended to be practical and achievable so that a broad level of SNF participation could be attained but SNFs were also encouraged to take initiatives beyond these minimum standards.

IMPLEMENTATION OF MINIMUM CARE STANDARDS FOR THE CARE OF PATIENTS WITH HEART FAILURE

The ICPS Targeting Prevention of Heart Failure Patient Hospital Readmissions within 30 Days following Hospital Discharge work group agreed that ICPS leaders should send a letter to SNF administrators to explain the initiative and invite their organization's full participation. The letter became the tool used to facilitate discussions between hospitals and their SNF partners. Work group members provided an educational session to SNF leadership to further educate and gain buy-in from SNF. Individual SNFs were further incentivized to participate because of the opportunity to be recognized by ICPS as committing to these minimum care standards and the potential to improve relationships with local health systems. Nearly 80 facilities signed letters of commitment to adopt the standards and implement them as protocol for their HF residents. The coalition posted a list of them online, where case managers could access it.

In 2015, the initial work with SNFs was revisited with revised minimum SNF standards ([Table 1](#)).

Table 1 Minimum SNF standards for the care of patients with HF	
Year 2011	Year 2015
1. Use best practices in transition of patients with HF: <ol style="list-style-type: none"> Medication reconciliation (focus on diuretic, beta-blocker, ACE-inhibitor and antiplatelet therapy) Discharge summary available in the chart within 72 h of admission Clarification of code status within 24 h of admission Initial plan of care goals within 72 h of admission 	1. Use best practices in transition of patients with HF: <ol style="list-style-type: none"> Perform medication reconciliation (focus on diuretic, beta-blocker, ACE inhibitor, and antiplatelet therapy) at the time of admission. Make all efforts to have the discharge summary available in the chart within 72 h of admission. Clarify patient advance care plans and code status within 24 h of admission and, when applicable, complete the POST^a form within a reasonable time frame. Establish initial plan of care goals within 2 h of admission.
2. Availability of a low-salt diet (2 g/d)	2. Assure availability of a low-salt diet (2 g/d).
3. Daily weights for 30 d and then 3 times per wk thereafter	3. Perform daily weights for 30 d and then 3 times per wk thereafter.
4. Initial provider visit within 48 h of admission and at least weekly follow-up visits	4. Facilitate the initial provider visit within 48 h of admission and at least weekly follow-up visits thereafter.
5. Activity as tolerated outside of therapy	5. Promote activity as tolerated outside of therapy.
6. Identification of an HF champion within the facility who leads the quality-improvement efforts for enhanced HF care and implements systems for patient and family education	6. Identify an HF champion within the facility who will assure systems are in place to <ol style="list-style-type: none"> Provide HF education for patients and families in the facility Provide HF education to the facility nursing and other staff members Train the staff for the use of valid communication tools (eg, STOP and Watch and Situation Background Assessment Recommendation available at www.interact2.net and The Society of Post-acute and Long-term Care Medicine (AMDA) Know-It-ALL series available at www.amda.com) to improve early recognition and communication of HF symptoms to prevent unnecessary hospitalization of patients with HF. Continually review quality-improvement efforts for enhanced HF care.

Abbreviations: ACE, angiotensin-converting enzyme; POST, Physician Orders for Scope of Treatment.

^a The Indiana Physician Orders for Scope of Treatment (POST) form is a new advance care planning tool that helps ensure treatment preferences are honored. It is designed for patients with serious illness.^{18,19}

Data from Refs.^{10,12,13}

Again, ICPS leaders sent a similar letter inviting SNFs to participate and join in committing to these minimum standards. Key changes included

- Inclusion of systems to clarify advance care plans in addition to code status
- Inclusion of Indiana Physician Orders for Scope of Treatment form¹⁸
- Delineation of the role of an HF champion

BETTER VERBAL COMMUNICATION

The provision of quality nursing care depends on the handover process. Miscommunication between caregivers may result in delay in treatment, inappropriate treatment, adverse events, omissions of care, increased costs, and inefficiencies from rework.²⁰ The SNF nurses that joined the ICPS Targeting Prevention of Heart Failure Patient Hospital Readmissions within 30 Days following Hospital Discharge work group reported several patient safety issues regarding verbal handoff communications from hospitals, including no diagnosis with medications (required for SNFs), no diagnosis, incomplete clinical information, lack of current status, lack of recent changes in condition, lack of a plan of care, and no relay of patient-/family-specific concerns. The impact of poor hand-off communications included delay in diagnosis or treatment, need for additional testing, potential for falls, and potential transfer back to the hospital.

Although requesting a commitment to the HF care standards fostered ongoing communication and collaboration between the discharging hospital and the admitting facility, in subsequent months the ICPS Targeting Prevention of Heart Failure Patient Hospital Readmissions within 30 Days following Hospital Discharge work group evaluated the potential to standardize verbal transfer information. Because of the complexity and uniqueness of electronic medical records, written/printed transfer information was beyond the scope of this work group.

In order to assess the existing handoff process, the ICPS Targeting Prevention of Heart Failure Patient Hospital Readmissions within 30 Days following Hospital Discharge work group conducted a survey to assess sender and receiver perceptions about the quality of key elements of communication, including timeliness, content of handoff, method, and overall satisfaction. The survey was completed by nursing staff on selected hospital units transferring patients to SNFs and SNF nursing staff in order to collect feedback. Using a Likert scale whereby 5 is strongly agree and 1 is strongly disagree, The ICPS Targeting Prevention of Heart Failure Patient Hospital Readmissions within 30 Days following Hospital Discharge work group agree, the senders (hospitals) rated it a 5 on a 1-to-5 Likert scale; in contrast, the receivers (SNFs) indicated the communication was unclear or incomplete, giving it only a 3 on the same scale. The survey highlighted that there was a disconnect between sending and receiving entities.

The SNF representatives took on the role of developing a tool that pulled pertinent information in a clear, usable way. Initially the work group leaned toward an electronic tool for the handoff, but the wide variation in technologies in use across the area caused them to reconsider. The ICPS Targeting Prevention of Heart Failure Patient Hospital Readmissions within 30 Days following Hospital Discharge work group members agreed that they did not need one more piece of paper. The SNF verbal handoff cue card was born (**Box 2**). The aim was to provide a complete and concise patient report that allowed the accepting nurse to provide care until the written report can be reviewed.

Chief nursing officers at the ICPS member hospitals supported the use of the verbal handoff cue card. Use of the verbal cue card has steadily spread among ICPS participants. Although its impact on HF readmissions is still being measured, early anecdotal reports indicate it has been well received by both senders and receivers. Using the cue

Box 2 SNF verbal handoff cue card
<i>Identifying information</i>
Name
Date of birth
Language
Male/female
Hospital admission date
<i>Current medical information/pertinent information</i>
Admitting diagnosis
Focused patient history
Comorbidities of relevance
Surgery history of relevance
Abnormal laboratory test results or diagnostic test results
Abnormal vital signs
Current weight (bariatric equipment)
Skin issues and treatments with frequency
Current medications
<ul style="list-style-type: none"> • Review critical medications • Next time of dosing • Not including supplements and vitamins
Invasive lines, location, use
Safety precautions (anticipatory concerns)
<ul style="list-style-type: none"> • Allergies • Fall risk • Infection control status
Diet restrictions or feeding precautions
Cognition/behaviors
Code status (Do patients have an out-of-hospital do not resuscitate order?)
Additional family/patient information that may affect transfer or stay
Call back number if there are questions and name of on-coming nurse
Give the receiving staff person the opportunity to ask any questions or clarify information
Send prescriptions for narcotics (if applicable)

card saves time by omitting irrelevant information and streamlines the transfer process.

TRANSITIONS OF CARE: HOSPITAL TO HOME HEALTH CARE

Expanding on the good work and relationship with SNFs, the ICPS Targeting Prevention of Heart Failure Patient Hospital Readmissions within 30 Days following Hospital

Discharge work group began collaborating with the Indiana Association for Home and Hospice Care (IAHHC).²¹ The ICPS Targeting Prevention of Heart Failure Patient Hospital Readmissions within 30 Days following Hospital Discharge work group developed minimum HF care standards in 2014 for patients receiving services from home health care agencies (Box 3). The standards are considered minimum care standards, and the agencies were encouraged to take initiatives beyond these minimum standards to improve care and reduce the readmissions of patients with HF. The ICPS Targeting Prevention of Heart Failure Patient Hospital Readmissions within 30 Days following Hospital Discharge work group created a letter outlining these minimum standards inviting all home health care agencies in Marion County to participate. By signing the letter, the home health care agencies committed to delivering care at this level and were recognized as such by the ICPS.

The ICPS Targeting Prevention of Heart Failure Patient Hospital Readmissions within 30 Days following Hospital Discharge work group and IAHHC produced an educational webinar for home health care agencies that outlined each standard, discussed the evidence, and gave real-life, practical examples. The webinar aired on September 30, 2014. In total, 110 individuals representing 23 different home health

Box 3

2014 home health care minimum standards for patients with HF

1. Start of care/resumption of care completed within 24 hours of hospital discharge
2. Medication reconciliation on admission (focus on diuretic, beta-blocker, ACE inhibitor, and antiplatelet therapy)
3. Initiation of telemonitoring/telehealth for all patients with HF on home health care admission; use of equipment or competent staff for daily monitoring of health metrics (BP, weight, and so forth)
4. Instruction of patients with HF education materials, using teach back method
 - a. Instructing and encouraging patients on the recommended low-sodium diet (2 g/d)
 - b. Instructing patients on the importance of daily weights, maintenance of recording daily weights, and when/who to call for weight gain
 - c. Instructing patients for confidence in the early recognition of HF symptoms and timely actions to resolve the problem and avoid an emergency
5. Instruction, and assistance if appropriate, for scheduling a physician appointment as indicated on discharge instructions; discussion of patients' transportation plans for appointment and encouragement of patients to attend
6. Licensed home health care professional patient visit at least weekly \times 4 weeks after hospital discharge
7. Identification of an HF champion within the agency who leads the quality-improvement efforts for enhanced HF care and implements systems for patient and family education regarding HF; must be a licensed health care professional
8. Staff training on HF management and HF patient education
 - a. Verification of standardized use of all staff training for all employees on hire and annually thereafter; must use approved training and testing
 - b. Verification of standardized nurse training for all licensed nurses on hire and annually thereafter; must use approved training and testing

Abbreviations: ACE, angiotensin-converting enzyme; BP, blood pressure.

Data from Refs.^{9,12,22–28}

care agencies participated in the webinar. In addition, ICPS work group members served as faculty for a panel discussion at the Indiana Association of Home and Hospice Care Annual Conference on May 6, 2015 outlining the same material included in the webinar.

OUTCOMES

From 2010 to 2014, the percentage of HF readmissions for HF has decreased 33%, and ICPS member hospitals have had a 19.2% reduction in HF readmissions for any reason from SNFs (Table 2). ICPS recognizes that all of the health systems are also independently working to improve processes and methods to reduce readmissions and does not assert that these improvements are attributed solely to the ICPS Targeting Prevention of Heart Failure Patient Hospital Readmissions within 30 Days following Hospital Discharge work group efforts.

DISCUSSION

The ICPS Targeting Prevention of Heart Failure Patient Hospital Readmissions within 30 Days following Hospital Discharge work group continues to meet regularly, monitors readmission rates, and provides a forum for additional sharing from ICPS members and the authors' SNF and home health care community partners. Work group members feel positive about the potential impact of a project distinctive in its level of collaboration. "By working together, we were able to leverage our size and the scope of what we covered to get the attention of some of our community partners. It is easier to make transformational change once you have a relationship." (Joanna Kingery, PharmD, personal communication, 2015).

SUMMARY

When addressing a complex issue like HF readmissions, there are clear benefits of working with a regional coalition and involving community partners. When forming a regional coalition, do not reinvent the wheel. Use the wealth of experience and knowledge within local entities as well as pulling best practices from evidence-based sources.⁴ Because of the complexity of issues and different levels of expertise among providers of care, prioritize the work to be done and work to reach consensus on areas of focus. Coalition meetings should be well organized with clear objectives, agendas, and assignments.⁴

Working with regional coalitions can also present challenges with the potential for conflicting priorities among entities that may otherwise be competitors. A critical element in the success of a coalition is identifying the right blend of stakeholders who bring the necessary talents and resources to achieve identified goals. Building the trust and relationships necessary to create the esprit de corps that comes from working together for a common good may take time.⁴

Table 2
HF readmissions data for ICPS hospitals from IHA

	2010	2011	2012	2013	2014
HF readmissions for HF (%)	7.37	7.03	5.98	5.33	4.92
HF readmissions for ANY REASON (%)	16.75	15.94	15.03	15.55	13.93
HF readmissions for any reason from SNF (%)	20.20	16.70	16.9	17.58	16.32

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