Feature Article

Building Excellence: The Journey to American Heart Association Certification

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Heart failure patients often arrive at hospice with advanced symptoms, variable care plans, and limited coordination across settings. To address this, Samaritan Healthcare and Hospice pursued the American Heart Association Palliative/Hospice–Heart Failure Certification. The initiative required a full system redesign focused on standardizing education, documentation, care coordination, and performance measurements. This article outlines the challenges encountered, including low compliance rates and documentation barriers, and describes the process used to achieve certification in October 2025. Key strategies included forming an interprofessional Advanced Illness Management Committee, implementing new triage and clinical tools, launching performance improvement plans, and fostering a culture of collaborative learning. The resulting care model now serves as a framework for additional serious illness pathways and offers a replicable approach for hospice and palliative care programs seeking to strengthen cardiac care delivery.

KEY WORDS
American Heart Association, certification, heart failure, hospice, palliative medicine

INTRODUCTION

Over a 2-year period, Samaritan identified significant fragmentation in the care of patients with advanced heart failure. Patients frequently arrive with complex symptom burdens, fragmented documentation, and care that vary depending on prior points of contact within the health care system. Heart failure was becoming one of the most common serious illnesses within the community, and each referral source, hospital, cardiology practice, or primary care, brought differing expectations and care patterns. Clinicians across care settings were working diligently but without a shared roadmap to guide consistent, coordinated care.

Other hospice and palliative care organizations have begun redesigning cardiac care models aligned with national standards, reporting improvements in care coordination, staff confidence, and utilization outcomes. Hospice of Cincinnati, for example, redesigned its cardiac care model, reporting measurable reductions in emergency department visits and hospitalizations in patients during the final months of life.[1] Standardization of heart failure care has historically been anchored in acute care settings through evidence-based protocols and guideline-directed medical therapy. The American College of Cardiology/American Heart Association (AHA) heart failure guidelines emphasize structured assessment, care coordination, and planned transitions after hospitalization, yet implementation beyond the hospital setting remains inconsistent. Recent literature highlights that failure to translate acute heart failure protocols into postacute, community-based, and hospice settings contributes to fragmentation, delayed palliative involvement, and avoidable utilization.[2,3] The AHA Palliative/Hospice–Heart Failure Certification provides a nationally recognized framework for evaluating care delivery for individuals with advanced heart failure.[4] Grounded in evidence-based guidelines, the certification emphasizes standardized program management, patient and caregiver education, interdisciplinary coordination, and performance measurement.

For Samaritan, the certification served not only as an external benchmark but as a catalyst for internal system redesign across hospice, palliative medicine, and home-based primary care. This article describes the process used to achieve AHA Palliative/Hospice–Heart Failure Certification and outlines the governance, clinical, and educational strategies that support development of a sustainable Advanced Cardiac–Heart Failure Pathway.

BACKGROUND AND CONTEXT

Founded in 1980, Samaritan is South Jersey's largest hospice and palliative care provider, delivering comprehensive serious illness services including hospice, palliative medicine, grief support, and primary care at home. The organization's mission emphasizes dignity, comfort, and coordinated, person-centered care across the continuum of serious illness, positioning it well to respond to the growing complexity of patients with advanced heart failure.

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In 2024, Samaritan served 2101 hospice patients, with 136 admitted with a primary diagnosis of heart failure. The average daily hospice census was 474, reflecting the scale of operations and the growing prevalence of cardiac disease. Approximately 46% of heart failure referrals originated from regional hospital partners, underscoring the need for reliable postacute cardiac care pathways capable of managing high-acuity transitions.

Patients admitted with advanced cardiac disease frequently require ongoing management of complex therapies such as inotrope infusions, implantable cardiac devices, and left ventricular assist devices (LVADs). Variation in clinician comfort, documentation practices, and assumptions about the compatibility of advanced cardiac therapies with hospice care created inconsistency across the organization. Combined with late referrals to palliative medicine and fragmented care transitions throughout the trajectory of heart failure, they highlighted the need for a standardized, evidence-based approach to advanced heart failure care.

The Boccolini Institute, Samaritan's center for education, research, and innovation, was positioned to lead a coordinated organizational response. Charged with advancing interdisciplinary education and system-level improvement, the institute provided the governance structure and strategic oversight necessary to pursue AHA Palliative/Hospice–Heart Failure Certification as a mechanism for improving quality, consistency, and care coordination.

METHODS/PLANNING AND APPROACH

The planning approach combined structured quality improvement methods and journey mapping to examine the experience of patients with advanced heart failure across Samaritan's service lines. The AHA Palliative/Hospice–Heart Failure Certification gap analysis tool was used to evaluate existing workflows, policies, education, and performance measures against national standards. This assessment identified the need for a formal governance structure to guide program development and ensure consistency across hospice, palliative medicine, primary care at home, care navigation, and bereavement services.

In response, Samaritan established the Advanced Illness Management (AIM) Committee as the central governance and oversight body for the certification initiative. The interprofessional committee included representation from nursing, social work, chaplaincy, advanced practice providers (nurse practitioners and physician associates), physicians, quality, clinical education, operational leadership, and administration. The AIM Committee reviewed certification standards, prioritizing gaps, aligning resources, and coordinating implementation across the organization. Decision-making occurred within the committee and flowed through the organization's Quality Assessment and Performance Improvement structure, embedding the work within existing accountability processes.

Planning activities unfolded through a structured sequence that included completion of the AHA gap analysis, journey mapping of patient transitions across internal and external settings, development of a future-state Advanced Cardiac–Heart Failure Pathway, alignment with organizational strategy and resources, and preparation for implementation through workflow redesign, education planning, and documentation updates.

FUTURE-STATE ADVANCED CARDIAC–HEART FAILURE PATHWAY

The future-state model for advanced heart failure care at Samaritan is organized around a single "One Door" approach, ensuring that patients, caregivers, and referral sources enter the organization through a single, coordinated access point. This eliminates the need to know when the right time is to access support and what kind of support is needed. Regardless of referral origin, patients are connected to the appropriate level of care based on symptom burden, goals, and treatment complexity. A Care Navigator anchors the journey, providing education and proactive transition support as needs evolve across settings.

Patients earlier in the disease trajectory are managed through primary care at home, where heart failure symptom management occurs in collaboration with cardiology partners. Advance care planning and caregiver education are integrated early, supporting shared understanding of disease progression and future decision points. Standardized education tools and monitoring frameworks promote self-management and early identification of clinical changes.

As disease burden increases, palliative medicine provides consultative and longitudinal support focused on symptom control, prognostic understanding, and goals-of-care conversations. Palliative clinicians follow patients across care settings, including home, rehabilitation, and long-term care facilities, maintaining continuity during transitions and serving as a bridge between acute care teams and community-based services.

When patients meet hospice eligibility, hospice teams deliver comprehensive end-of-life care informed by AHA-aligned standards for advanced heart failure management. Hospice clinicians demonstrate competence in managing complex therapies, including inotropes and cardiac devices, supported by standardized assessment tools, escalation pathways, and interdisciplinary coordination. Consolidated documentation and anticipatory planning reduce crisis-driven care and support alignment with patient and caregiver goals.

Throughout the pathway, caregiver support and bereavement risk assessment are integrated early, allowing emotional, educational, and logistical needs to be anticipated rather than addressed reactively. The pathway is sustained through organizational learning led by the Boccolini

Institute, which provides ongoing education, competency development, and performance monitoring to ensure fidelity to evidence-based standards and readiness for ongoing certification cycles.

GAP ANALYSIS

Articulating this future-state Advanced Cardiac–Heart Failure Pathway clarified when patients would benefit from services and the changes necessary to make that happen. Systematic examination of policies, workflows, competencies, education practices, and communication structures was guided by AHA standards and a structured gap analysis tool. Areas of pre-existing alignment and areas of focused improvement were identified.

The gap analysis identified deficiencies in program management, clinical practice, education, communication, and data infrastructure. Program management gaps included the absence of a standardized cardiac care plan and inconsistent documentation practices. Clinically, there was variation in how advanced therapies, such as milrinone, LVADs, and implantable cardiac devices, were managed, with no unified symptom management algorithms or cardiac-focused intake templates to support consistent assessment and intervention.

Patient and caregiver education showed similar inconsistencies. Readiness to learn was assumed rather than assessed, documentation varied widely, and tools such as the National Partnership for Healthcare & Hospice Innovation (NPHI) Advanced Cardiac Care Patient & Caregiver Guide[5] and the Green/Yellow/Red monitoring system were not deployed systematically. Handoff reports from hospital partners varied in completeness; internal communication across service lines lacked standardization, and discharge processes were not aligned with AHA criteria. Complex cases, especially those involving advanced therapies, highlighted the need for structured interdisciplinary review and coordinated decision-making.

Our data infrastructure also presented barriers. Key performance measures such as care plan utilization, education documentation, fluid status monitoring, and advanced care planning required manual chart review, and definitions for length of stay (LOS), hospital readmission, and hospice enrollment needed clarification to ensure consistency with AHA metrics.

Finally, the GAP analysis surfaced workforce education needs. Early in the project, compliance with heart failure onboarding and annual education stood at just 0.1%, reflecting the absence of a structured assignment and tracking system. Staff across disciplines expressed discomfort managing advanced therapies and identified the need for standardized training, simulation, and competency-based education.

This gap analysis became the inflection point. It clarified the distance between current practice and the coordinated future-state Advanced Cardiac–Heart Failure Pathway, one where every patient enters through a single One Door approach, receives the right care at the right time, and is supported by a Care Navigator throughout their journey. The Advanced Cardiac–Heart Failure Pathway offered the blueprint for the interventions described in the next section, guiding our redesign of governance, clinical practice, education, communication, and measurement.

IMPLEMENTATION/ROLL-OUT

Standardizing Clinical Practice and Care Planning

A major focus of early implementation was establishing a unified clinical approach for managing advanced cardiac therapies. Using evidence-based sources, including AHA guidelines, Lippincott procedures, and the NPHI Advanced Cardiac Care Guide, symptom algorithms for fluid overload, dyspnea, pain, milrinone, and LVAD management were designed. These tools were embedded into care delivery policies and integrated into admission, triage, and escalation workflows. Cardiac-focused assessment elements were identified within the electronic health record and clinicians were guided to consistently capture New York Heart Association Classification, assist device details, advanced therapies, symptom trends, and patient/caregiver self-care capacity.

Care plan utilization became a performance expectation rather than a discretionary practice. Explicit interventions were added to the care plan, such as "Educated patient/family using the NPHI guidebook" and "Reviewed the Green/Yellow/Red tool, "so documentation could reflect real teaching, reinforcement, and symptom management."

Rebuilding the Workforce Through Structured Education

The implementation phase included a comprehensive redesign of cardiac education processes. A learning management system was used to develop a structured assignment and tracking framework for onboarding, annual refreshers, and advanced cardiac competencies. Staff were enrolled in educational modules addressing heart failure management, palliative approaches to cardiac disease, LVAD and other cardiac device considerations, symptom management algorithms, and communication skills.

Discipline-specific education was implemented across the interdisciplinary team. Nurses, social workers, chaplains, aides, advanced practice providers, and physicians received training tailored to their clinical roles, including readiness-to-learn assessment, caregiver distress, and use of the Green/Yellow/Red symptom monitoring framework. Nurses received additional instruction in cardiac-focused assessment, symptom algorithms, and documentation standards, while advanced practice providers and physicians were trained in escalation pathways, prescribing practices, and interdisciplinary communication.

Experiential learning strategies complemented didactic education and included small-group workshops, expert guest speakers, and a cardiac escape room—an interactive, simulation-based educational activity in which clinicians work through time-sensitive heart failure scenarios using evidence-based protocols to promote critical thinking, teamwork, and applied learning. Educational escape rooms are increasingly described in the health care simulation literature as effective methods for reinforcing clinical reasoning, communication, and team-based practice and are supported by systematic evidence in health professions education.[6] Education participation was monitored quarterly, with completion rates increasing from 0.1% at baseline to 80% within 6 months.

Improving Communication, Handoff, and Transitions of Care

Communication templates were redesigned to ensure safe and effective transitions across the continuum. The intake and admission process was revised to capture AHA-required elements, specifically (heart failure measures, device information). The AIM Committee created best practice examples for admission reports, interdisciplinary team documentation, and discharge summaries to ensure consistent capture of cardiac-specific data.

A structured complex care review process was implemented. For high-acuity cardiac patients, especially those using LVADs or inotropes (ie, milrinone), case review occurred at the time of referral and included the registered nurse case manager, provider (nurse practitioner or physician), team leader, and cardiac champion. This process replaced earlier reactive approaches with proactive, coordinated planning.

Communication with external partners (cardiology, hospitals, rehab facilities, senior living communities (ie, skilled nursing facilitys, assisted living facilitys), and primary care was strengthened through standardized workflows and clear expectations around intake, hospitalization notification, discharge communication, and post-death reports.

Enhancing Patient and Caregiver Education

Patient education was redesigned to align with the Green/Yellow/Red monitoring system and the NPHI Patient/Caregiver Guide. Readiness-to-learn assessments and education interventions were embedded directly into care plans. Documentation guides supported clinicians in capturing what was taught, how it was reinforced, and how patients and caregivers responded. This created a consistent approach and allowed teams to build on each other's teaching through a shared language.

Building Data Infrastructure and Performance Monitoring

The AIM Committee established monthly and quarterly reporting cycles for care plan utilization, caregiver education compliance, advanced care planning documentation, symptom management processes, and outcome measures such as hospice LOS, hospital readmission rates, and hospice discharges. Definitions for data measures and metrics were standardized to eliminate ambiguity. Chart reviews and audit processes were strengthened through coordination between quality, compliance, and education, and clinical leadership. This informed rapid-cycle improvements and guided each performance improvement plan.

What Stretched the Team the Most

Although many operational challenges were addressed throughout the project, several moments stretched the team in ways that ultimately strengthened the program. The first was the recognition that highly skilled clinicians were working within systems that did not yet support consistency, particularly in documentation, education tracking, and symptom-based workflows. The second involved confronting deeply held assumptions about the compatibility of advanced cardiac therapies with hospice and palliative care, a cultural shift that required as much reflection as clinical redesign. Finally, the team had to acknowledge that sustainable improvement depended not on individual effort or expertise, but on building durable processes, algorithms, and education systems that could support excellence across all disciplines and services. These moments grounded our redesign and shaped our readiness for AHA certification.

Learning and Adaptation

Early in the certification process, Samaritan admitted its first hospice patient supported by a LVAD. Although clinicians brought experience and commitment, the case exposed gaps in infrastructure, including the absence of a standardized intake process, formal complex care review, device-specific management algorithms, and defined visit frequency. Care delivery during this admission relied heavily on individual expertise rather than coordinated systems. In response, the organization developed an LVAD-specific intake assessment, standardized escalation and discontinuation protocols, and a cardiac-focused complex care review process. Dual initial visits by a registered nurse and an advanced practice provider were implemented to ensure comprehensive evaluation of device function, symptom burden, goals of care, and caregiver readiness. Visit frequency standards were established to provide predictable oversight during the early phase of hospice enrollment.

Subsequent hospice admissions of patients with LVAD support demonstrated the impact of these changes. Referrals triggered immediate interdisciplinary review, documentation was complete and consistent, escalation pathways were clear, and caregiver education occurred early. Clinicians reported improved confidence and alignment, and families experienced care as calm, coordinated, and goal-concordant. This contrast reinforced a central lesson of the certification process: excellence in advanced cardiac care depends not on individual

heroics, but on reliable systems that support clinicians, protect patients, and sustain quality across settings.

Outcomes and Impact

The implementation of the Advanced Cardiac–Heart Failure Pathway was associated with observable changes in clinical practice, documentation, education, and care coordination. Early outcomes primarily reflect process and system improvements achieved during certification preparation rather than mature clinical outcome data.

At the time AHA Palliative/Hospice–Heart Failure Certification was awarded (October 2025), formal pre- and postimplementation analysis of rehospitalization rates, timing of hospice enrollment, and palliative care utilization had not yet reached sufficient duration for comparative evaluation. During the certification period, emphasis was placed on establishing standardized definitions, data infrastructure, and reporting mechanisms required to support reliable longitudinal measurement.

Ongoing evaluation efforts are now underway to assess trends in emergency department utilization, hospital readmissions, hospice LOS, timing of hospice referral, and upstream palliative care engagement. These measures align with AHA certification metrics and organizational quality priorities. Process measures demonstrated early progress in areas where baseline performance revealed significant opportunity, including increased cardiac-specific care plan utilization and sustained strength in advance care planning documentation. Adoption of structured caregiver education tools, including the Green/Yellow/Red monitoring framework and the NPHI Patient and Caregiver Guide, improved consistency of teaching and clinician confidence, while patient self-management outcomes remain an area for future evaluation.

Collectively, these early indicators suggest that the structural and educational interventions introduced through the Advanced Cardiac–Heart Failure Pathway have positioned the organization to meaningfully evaluate clinical and utilization outcomes over time. Future analyses will focus on quantifying the impact of this model on rehospitalization, earlier hospice engagement, and palliative care access across the continuum (Table).

DISCUSSION

The transformation of Samaritan's Advanced Cardiac–Heart Failure pathway occurred within a national landscape where heart failure has become one of the most complex and consequential conditions in serious illness care. Research has consistently demonstrated that patients living with advanced heart failure face substantial symptom burden, complex treatment regimens, and fragmented care during the final stages of illness. Studies show that heart failure is now the leading cause of hospitalization among adults over 65, with 25% experiencing readmission within 30 days.[7] While acute care guidelines and transition-of-care frameworks provide a foundation for heart failure management, their impact depends on consistent implementation across postacute, community-based, and hospice settings. Integrated models that align cardiology, palliative care, and hospice services have demonstrated improvements in continuity, symptom burden, and goal-concordant care for patients with advanced heart failure.[8,9] These gaps underscore a critical need for models that bridge acute care, community-based services, and end-of-life care with clarity, consistency, and expertise.

Despite the intensity of symptoms, including dyspnea, fatigue, edema, and anxiety, heart-failure patients receive less timely palliative or hospice care compared with patients with cancer or other terminal conditions.[7] Multiple systematic reviews and integrative analyses affirm that palliative care interventions improve quality of life, reduce symptom burden, enhance caregiver preparedness, and may even reduce health care utilization among patients with chronic heart failure.[10,11] These benefits extend beyond the patient to include improved caregiver coping and reduced emotional distress. Caregivers of individuals with heart failure shoulder complex responsibilities such as medication management, monitoring for fluid overload, and managing advanced therapies like LVADs and inotrope infusions often without adequate support.[12,13]

Integrated care models that unify cardiology, palliative care, hospice, and primary care show promise in improving transitions between hospital and community settings. Coordinated heart failure palliative pathways enhance continuity, reduce avoidable hospital use, and support alignment of care with patient goals.[9] Similarly, system redesign, not isolated interventions, is necessary to address persistent gaps and build scalable models of care for advanced cardiac disease.[14]

Specific to device-supported patients, emerging literature documents the need for structured protocols and interdisciplinary planning for LVAD management at the end of life. Case series and clinical reviews emphasize that hospice programs can safely manage LVAD patients when supported by standardized workflows, communication pathways, and staff training.[15]

Our findings contribute to this growing body of work by demonstrating that a community-based organization can create a standardized, evidence-aligned, and interprofessional cardiac pathway that spans hospice, palliative medicine, primary care at home, care navigation, and bereavement services. The implementation of AHA-aligned algorithms, structured communication handoffs, education systems, and governance processes shows that high-acuity cardiac care can be delivered safely and predictably outside the hospital setting. Notably, the transformation did not depend on the presence of specialized cardiac units or advanced technologies; rather, it emerged from the integration of clinical disciplines, shared language, and consistent processes. Our journey offers a replicable framework for organizations seeking to strengthen their cardiac programs while meeting the growing complexity of the patients they serve.

TABLE. Selected Process and Early Outcome Measures After Implementation of the Samaritan Advanced Cardiac–Heart Failure Pathway

Measure Domain	Metric	Baseline (Preimplementation)	Postimplementation[a]	Alignment to AHA Standards/Notes
Program governance	Interprofessional cardiac governance structure	Not established	Established	AIM Committee formed to meet AHA program management standards
Program governance	Structured complex care review for high-acuity HF patients	Ad hoc	Standardized	Required for LVAD, inotrope, and advanced therapy cases
Clinical practice and documentation	Cardiac-specific care plan utilization	Low/inconsistent	Increased/standardized	Integrated into hospice and palliative documentation
Clinical practice and documentation	Completion of cardiac-focused intake elements	Variable	Consistent	Includes NYHA class, device status, therapies
Education and workforce readiness	HF onboarding and annual education completion	0.1%	80%	Tracked through LMS
Education and workforce readiness	Availability of LVAD and advanced therapy education	Not available	Available	Discipline-specific pathways
Patient and caregiver education	Use of Green/Yellow/Red framework	Not standardized	Standardized	Supports symptom escalation education
Patient and caregiver education	Readiness-to-learn assessment documentation	Inconsistent	Routine	Aligns with caregiver preparedness standards
Early outcome indicators	Clinician-reported confidence managing advanced HF	Variable	Improved	Based on internal feedback
Early outcome indicators	Organizational readiness for AHA certification	Criteria not met	Certification achieved	AHA certification awarded October 2025

AHA, American Heart Association; HF, heart failure; LMS, learning management system; LVAD, left ventricular assist device; NYHA, New York Heart Association.
[a]Postimplementation measures reflect early data collected after pathway implementation and before full longitudinal outcome analysis. Measures are reported descriptively in alignment with quality improvement methodology.

LESSONS LEARNED

Several lessons from this implementation hold relevance for other hospice and palliative care programs. First, governance and standardization emerged as foundational elements of effective advanced heart failure care. Early experiences with advanced therapies, including LVADs and inotrope support, demonstrated that clinical commitment alone is insufficient without structured processes, clear accountability, and shared workflows.

Second, interdisciplinary education and competency-building must be system-wide rather than siloed. Nurses, physicians, advanced practice providers, social workers, chaplains, aides, and access teams each contribute to the heart failure care trajectory, and collective confidence across disciplines is directly linked to patient safety and care consistency. Third, early and ongoing caregiver education is indispensable. Heart failure caregiving requires continuous monitoring and complex decision-making, and tools such as the Green/Yellow/Red monitoring system and the NPHI Patient/Caregiver Guide support caregiver self-efficacy, preparedness, and resilience.

Finally, the development of a truly coordinated pathway required deliberate examination and reframing of long-held assumptions regarding the compatibility of advanced cardiac therapies with hospice and palliative care. Replacing these assumptions with evidence-based, patient-centered practices enabled more timely referrals, clearer communication, and improved alignment of care with patient goals.

This work also highlights broader system-level implications. Hospital partners increasingly rely on community-based organizations capable of managing advanced heart failure patients after discharge to reduce avoidable readmissions and support shared quality outcomes. Patients benefit from consistent education, clear expectations, and seamless transitions across settings, while caregivers require reliable communication, anticipatory guidance, and emotional support.[13] Hospice and palliative care programs must continue to evolve their models to meet the growing clinical complexity of the populations they serve. Certification processes, when used as structured quality frameworks, can accelerate this evolution by providing clarity, accountability, and alignment with national standards.

CONCLUSION

Redesigning cardiac care across the serious illness continuum represents more than completion of a certification process; it reflects an organizational commitment to patients, caregivers, and health system partners. Through the development of a unified, evidence-informed pathway supported by education, governance, and interdisciplinary collaboration, fragmented processes were transformed into a coordinated model capable of addressing the complex needs of individuals living with advanced heart failure.

As the population of patients with advanced heart failure continues to grow, so does the urgency for serious illness programs to adapt. The transformation described in this article demonstrates that community-based organizations can develop scalable pathways grounded in best evidence, prepare teams to deliver high-acuity cardiac care, and build the systems required to sustain excellence over time. Meaningful change begins with critical examination of existing processes, willingness to learn from early challenges, and commitment to designing care experiences that are consistent, coordinated, and aligned with patient and caregiver goals.

This work may inform other hospice and palliative care organizations seeking to strengthen advanced heart failure care. By committing to standardization, interdisciplinary collaboration, caregiver support, and evidence-informed practice, hospice and palliative organizations can redefine what it means to care for patients with advanced heart failure. This work demonstrates a scalable approach to delivering advanced heart failure care across the serious illness continuum.

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