

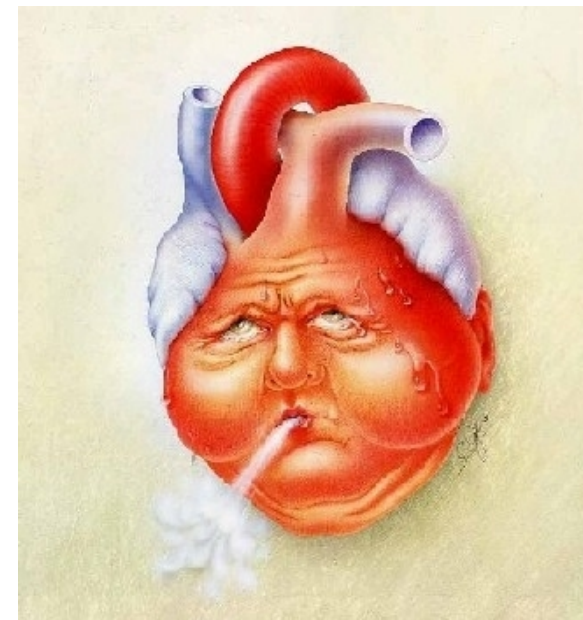
# Implementation of a Guideline Directed Medical Therapy Discharge Checklist for Heart Failure Patients to Reduce Readmission Rates.

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## PROBLEM STATEMENT

- ❖ Decompensated heart failure patients are not being prescribed proper guideline directed medical therapy (GDMT) at discharge, resulting in frequent readmissions and decreased quality of life.
- ❖ The 30-day readmission rate for acute on chronic heart failure with a reduced ejection fraction (HFrEF) exacerbation at this facility is 25%, compared to the national benchmark of 18.2%

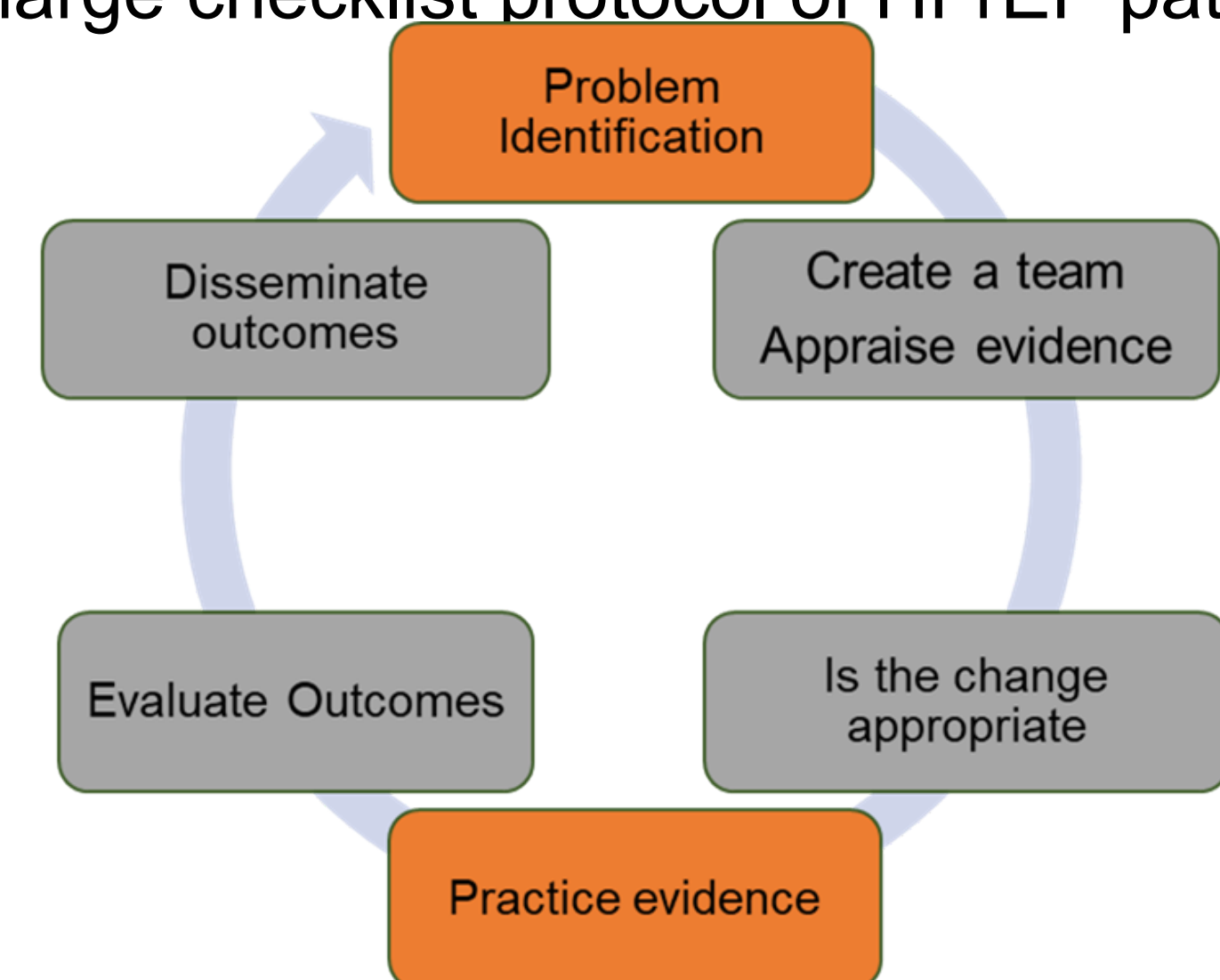


## PROJECT PURPOSE

- ❖ Develop a discharge checklist protocol to implement the "Get with the Guidelines" Heart Failure Program to reduce 30-day readmission rates.
- ❖ Increase awareness and adherence to the "Get With the Guidelines" quality measures to improve patient outcomes and reduce 30-day readmission rates.
- ❖ PICOT: In adult patients with a diagnosis of decompensated HFrEF, does implementation of a standardized discharge checklist protocol, using the "Get with the Guidelines"-Heart Failure program, reduce readmission rates over 30 days when compared to current practice?

### MODEL/NURSING THEORY

- ❖ The Iowa Model of Evidenced-Based Practice (IMEBP) was used to provide the structure for implementation of a GDMT discharge checklist protocol of HFrEF patients



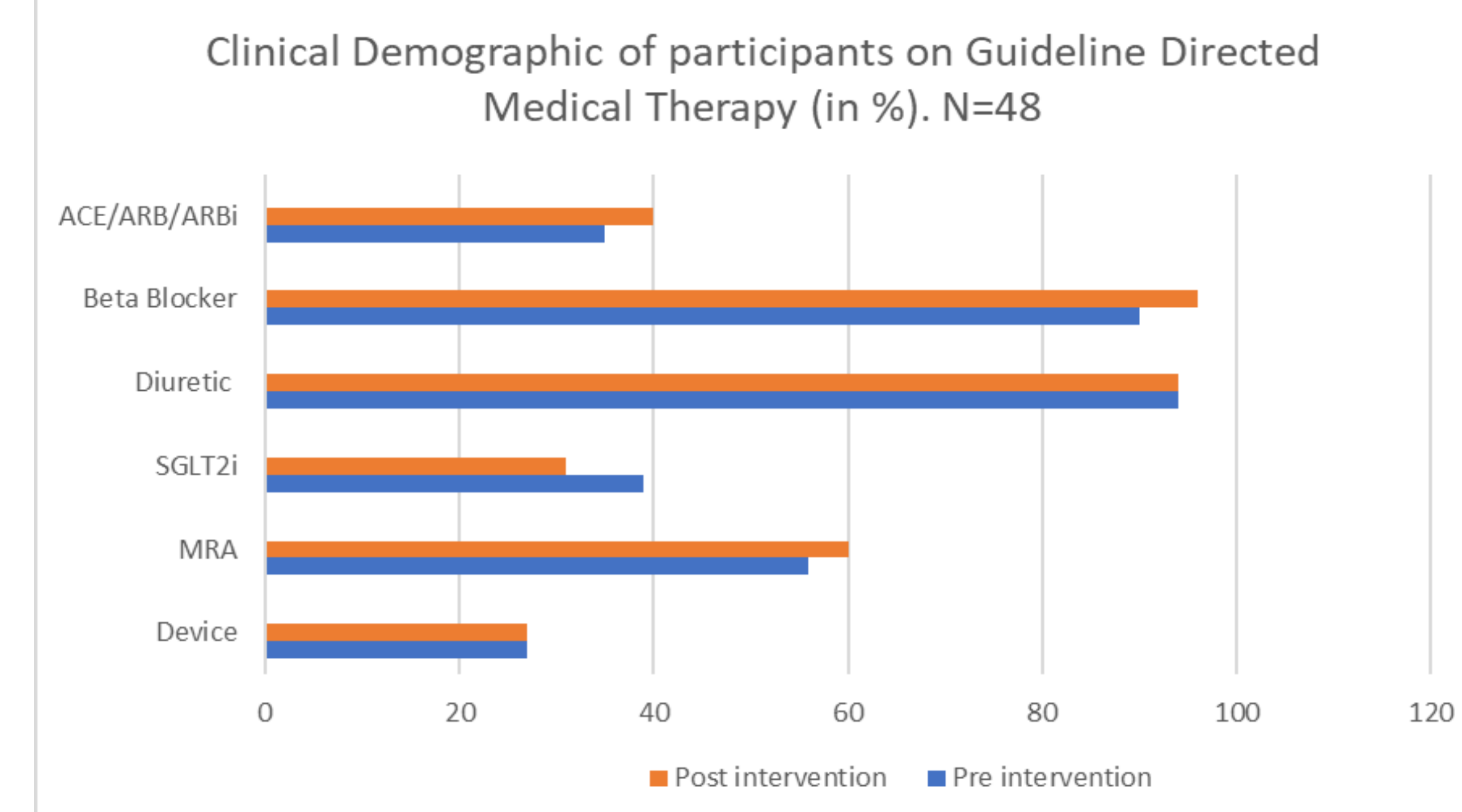
Adapted From: (Schaffer et al., 2013)

## METHODS

- ❖ **Participants:** Adults with acute on chronic HFrEF admitted to the project site facility.
- ❖ **Setting** The project was implemented at a community hospital in Central Florida.
- ❖ **Instruments/Tools** Readmission rates were measured pre and post implementation of discharge checklist.

Figure 1. Clinical Demographics

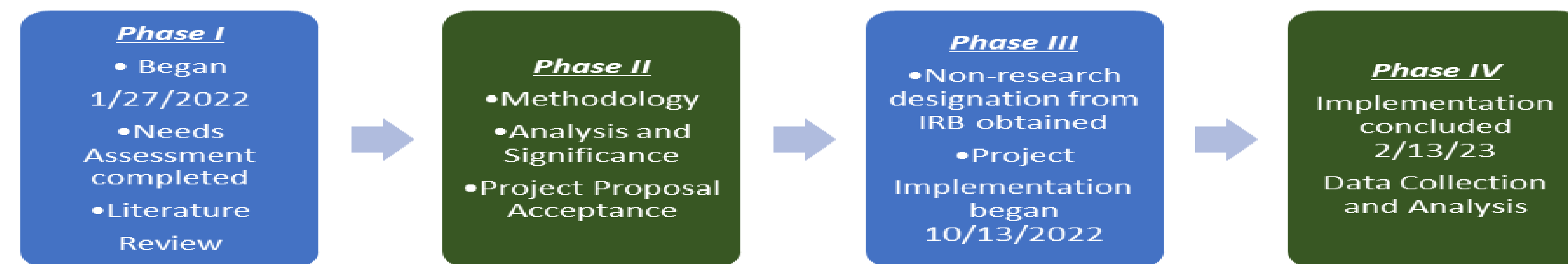
Figure 1: *Participants on GDMT*



## INTERVENTION AND DATA COLLECTION

- ❖ Educated key stakeholders on problem significance.
- ❖ Obtained baseline thirty-day admission data.
- ❖ Educated hospitalists and staff on revised discharge checklist and reviewed AHA Guideline Directed Medical Therapy recommendations.
- ❖ Implemented the checklist: Added to physical chart and added "Treatment Team Sticky Note" to the EHR to communicate to MDT that checklist to be utilized at discharge.
- ❖ Statistics: t-test (continuous) & Chi-square (categorical)
- ❖ Appraised post-intervention results with hospital staff

Figure 2: *Project Timeline*



## RESULTS

- ❖ Post intervention, the days to readmission went from 6 days to 18 days ( $p = <0.0001$ ).
- ❖ The thirty-day readmission rate for the number of patients included in the project was reduced by 26%.

Figure 3: *Heart Failure: 30 Days Readmission Rates for number of patients included in project*

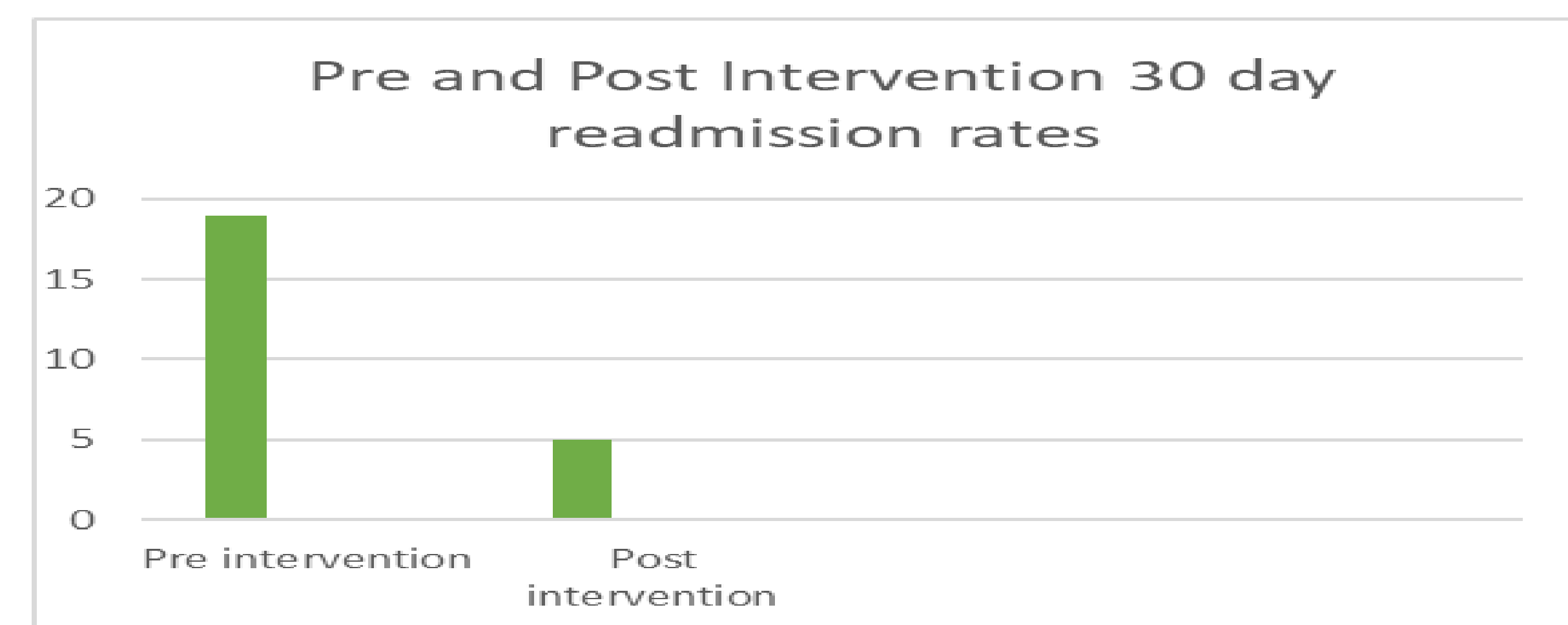


Table 1. Demographic and Clinical Variables

Variable	Pre checklist use	Post checklist use	P value
<b>No. (%) of patients</b>			
Female	26(54)	20(42)	0.3763
Nonsmokers	36(75)	38(79)	0.8162
<b>GDMT</b>			
ACE/ARB/ARNI	17(35)	19(40)	0.7389
Beta Blocker	43(90)	46(96)	0.7505
Diuretic	45(94)	45(94)	1.0000
SGLT2i	14(39)	15(31)	0.4795
MRA	27(56)	29(60)	0.7893
<b>Mean (SD)</b>			
Age, years	56.2(14.5)	58.4(15.1)	0.4684
EF (in %)	20.1(6.8)	22(6.2)	0.1172
Days to readmit	6(16.2)	18(7.8)	<0.0001
30 day readmit (#pts)	19(5.1)	5(2.1)	<0.0001

## LIMITATIONS

- ❖ Limitations include: one single intervention that encompassed multiple guideline directed therapies. Financial constraints due to cost of some newer guideline directed therapies can lead to non-compliance through no fault of the patient. Ongoing studies regarding individual guideline directed therapies.
- ❖ Further study is needed to determine if utilization of the checklist will have long term effects on readmission rates

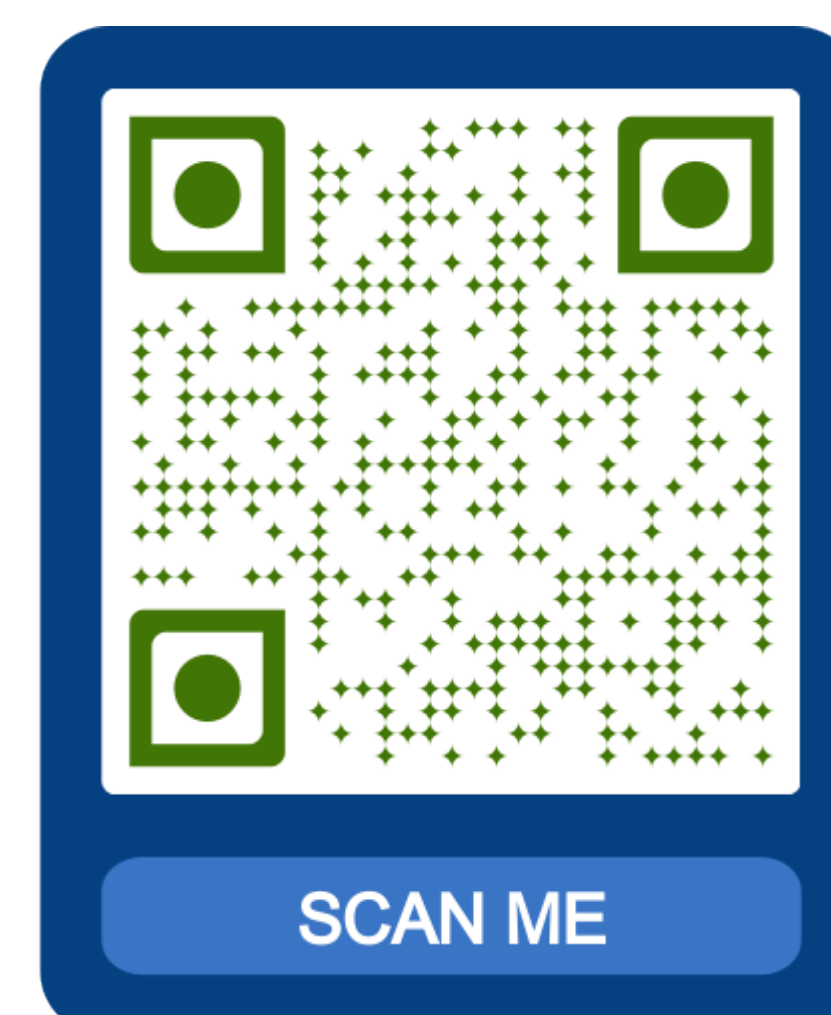
## IMPLICATIONS

- ❖ Utilization of the discharge checklist decreased 30-day readmission rates in adult patients with acute on chronic HFrEF by 26%.
- ❖ The reduction of readmissions of heart failure patients was clinically significant, but not statistically significant due to the small sample size.
- ❖ The results of the successful implementation of a standardized DC process for HF patients directly address a gap in the literature for need for further study.
- ❖ Involvement in process improvement by advanced practice nursing adds tremendous value to patient care.

## SUSTAINABILITY

- ❖ The checklist is concise, easy to interpret, and required little training among hospitalists and heart failure nurse navigator.
- ❖ The checklist can be updated for future AHA guideline recommendations by the APP along with the heart failure nurse navigator. Collaboration with the discharge team can reinforce compliance with the checklist.

Please scan for references



# Utilization of discharge checklist did decrease readmission rates for heart failure patients.