

## Abstract 16

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**Title:** Bringing Science to the Bedside- GDMT NOW not later

### Background:

Guideline driven medical therapies (GDMT), vetted through current clinical trials and peer reviewed by internationally recognized bodies are not expediently or consistently incorporated into clinical practice for hospitals or providers. Hospital administrators are anticipating their physician leaders and providers will be “in the know” and immediately responsive to the most current guidelines and guideline updates. Physicians are frequently operating from a position of a personalized care plan for their patients, which dates back to training or practice or clinical gestalt. This established a variable approach to patient care in the hospital as different as provider, or patient presentation. Operationalization of current clinical practice guidelines, and standardized care paths are not frequently evidenced in hospitals apart from a directed approach or an extremely integrated system of requirements, such as in accreditation.

### Methods:

In 2014 a navigated approach with a cohort of 57 hospitals varying in size/structure and location, was created. This process educated hospital teams using monthly conferences, documentation review and data analysis to foster compliance with 279 required Acute Coronary Syndrome (ACS) processes, of which the preponderance were Class I Level of Evidence (LOE): A GDMTs. Through the required gap analysis, it was determined ***none*** of the hospitals utilized a risk stratification process for ACS determination, nor were they able to demonstrate compliance with the 2007 guideline for Door to ECG (D2ECG) and shown to a provider within 10 minutes; used to rule out ACS, for example. Also despite the advent, hospital purchase, and use of more sensitive laboratory assays supporting the 99th percentile, they continued to use grey zone (an expired 2008 NACB guideline) which included indeterminate ranges for troponin results no longer supported.

### Results:

After only 12 months, **97% of the 57** hospitals were compliant with ***all Class I LOE:A Acute Coronary Syndrome GDMTs***. Earlier recognition of ACS; by conforming to D2ECG processes, they lowered ST Elevated Myocardial Infarction (STEMI) timeline measures, and reduced mortality as well as length of stay (LOS) on a variety of fronts. **90% of the 57** hospitals removed outdated greyzone for troponin measures and reduced their risk for missed Myocardial Infarction (AMI) by up to 8%.

**Conclusion:**

By using a navigated approach to support GDMT operationalization with hospital administrators and their teams, and by providing data analysis, as well as strategic problem solving facilitated a proven approach to incorporate GDMTs into actual practice more quickly than ever before.