Cardiovascular Round Table

ESC Guidelines implementation in the real-world setting: How data, clinical paths and technological tools support clinicians and patients

Group 3:

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ESC Guidelines implementation in the real-world setting:

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- MAIN barrier: access to GOOD data, especially in the REAL-WORLD
  - No homogenous data – 'spotty data' in some communities (not all Nordic countries)
  - 2 speeds:
    - Registries in academic hospitals and less in smaller/non-academic hospitals
    - Knowledge of the guidelines (junior staff versus senior staff)
- Data/technology is gamechanger though - BENCHMARKING:
  - INCENTIVE towards the HCP/care facility
  - Towards the patient (is my goal achieved)
- FUTURE: HCP with AI support
  - Rapidly summarize patient chart and check versus the guideline (UPDATES)
  - NLP translation towards the patient
  - To help adoption in medical community: it should come from a certified community (Qualification needed)

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- **DATA as incentive to improve care**
  - Immediate feedback on how the centers are doing
  - BUT: Access to the information is critical
  - What are the barriers to collect data and implement this benchmarking (money, …)?
    - Financial incentive if they reach the goal, especially important for the small hospitals – elements to implement at local level
  - EMRs – to implement guideline-directed pop-ups to advise or trigger when patients are not achieving goals

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CARE PATHWAY

- Post-discharge care – GPs – what is the gap – how to improve quality outcomes post discharge?
    - Clear discharge letter
    - HC system/payors
    - MDT play role – nurse/clinical pharmacist
    - Patient

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PROMINENT ROLE PATIENT

- AF – turn around – **patients** prominent rôle in early identification
  - Smart watches can offer an advantage
  - Patients want to achieve goals and they should know what there goals are (data to be shared with patients)
    - Role of the MDT (HCP, nurse, clinical pharmacist) to help them understand their treatment goals
    - Yet! You need an electronic « thing » to make a patient think of it. Because patients forget post visit. We need to help them remember the goal
    - Responsibility of the MDT to provide info to patients at right time (not in acute phase)
    - Care pathway implementation

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- **2 speeds:** Academic environment versus non-academic/private difference in strictness towards guidelines implementation– same for patients in academic versus private patients
  - Number of staff
  - Small hospitals do not participate in registries – have less data available to do quality of care checks
    - Question of money
  - Knowledge guidelines: Less follow-up of guideline updates – chatbots will help
    - RW patients are treated by more junior HCPs → chatbots will helps
    - Training
    - What has changed in guidelines
    - Quality of care

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- **Why are recommended treatments/medications not applied/used – what are the common themes about the why**
  - Common theme: no incentive
  - Data can provide that incentive - need for immediate feedback on how the centers are doing
  - Data of quality of care
  - Registries and benchmarking (HF example in Denmark)
  - What are the barriers in other countries to implement this benchmarking (money, …)
  - EMRs – to implement guideline-directed pop-ups to advise or trigger when patients are not achieving goals
  - Access to information is critical
- Gap when patient is discharched – GPs?

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  - What are the barriers in other countries to collect data and implement this benchmarking (money, …)?
  - EMRs – to implement guideline-directed pop-ups to advise or trigger when patients are not achieving goals
  - Financial incentive if they reach the goal, especially important for the small hospitals – elements to implement at local level
    - Discussion on how these incentives can be implemented
- Post-discharge care – GPs – what is the gap – how to improve quality outcomes post discharge?
  - Clear discharge letter
  - HC system/payors

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