IMPLEMENT-EF: A Quality Improvement Initiative to Amplify HFpEF/HFmrEF Awareness

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Background

Heart failure with preserved ejection fraction (HFpEF) and heart failure with mildly reduced ejection fraction (HFmrEF) have less established clinical evidence and treatment guidance compared with other heart failure phenotypes. [1]

To address this gap, the American Heart Association launched IMPLEMENT-EF, a 3-year quality improvement initiative comprising a diverse 40-site collaborative. The initiative aims to improve in-hospital care for patients with HFpEF/HFmrEF by identifying unmet needs, mapping gaps across the patient journey, and defining optimal care models.

Objectives

- Conduct annual process mapping with 40 participating sites over 3 years.
- Identify site-level workflow successes, barriers, and opportunities for improvement.
- Aggregate process mapping findings to inform national dissemination of effective care models and implementation strategies for HFpEF/HFmrEF.

Methods

- A pre-implementation survey was distributed to all 40 sites to assess the current state of HFpEF/HFmrEF care.
- Multidisciplinary teams participated in site-specific process mapping sessions with American Heart Association quality improvement staff.
- Workflows were evaluated from hospital admission through post-discharge follow-up to identify current practices, ideal processes, and implementation barriers.
- Findings from 40 individual site process maps were synthesized into an aggregate process map to identify common successful workflows and barriers.
- Ongoing multi-site collaboration is being used to identify and scale effective implementation strategies.

Aggregate Process Map

1 Patient Identification

Successes:
- Heart Failure Navigator leveraging electronic medical records (EMR) reports
- Consults/triggers for Heart Failure Navigator rounding on patient
- HFpEF screening tool

Barriers:
- Unclear clinical presentation
- Coding delays hinder identification during hospitalization
- Lack of HF Navigator/Coordinator role

2 Evaluation & Treatment

Successes:
- Dedicated order set/care pathway for HFpEF/HFmrEF
- Dedicated pharmacist rounding on patients, providing disease state and medication education
- Medication assistance programs

Barriers:
- Medication not on formulary
- Inconsistent prescribing patterns due to hesitancy for evidence-based therapies
- Cardiology consults inconsistent

3 Follow-up

Successes:
- Pharmacists' follow-up with patients started on new medications/hospital provided cell phone for 24-hour pharmacist availability to prevent readmissions
- Heart Failure Navigator completing follow-up phone calls within 72 hours of discharge
- HRSN assessment visible from inpatient to outpatient

Barriers:
- Lack of staff for addressing HRSNs, medication and symptom management
- Limited cardiology access for hospitals without heart failure clinic
- Lack of standardized HRSN assessment

4 Education

Successes:
- Dedicated heart failure champion to serve as subject matter expert for education
- Virtual nurses provide patient education in patient rooms
- EMR virtual support/education messaging to patients' phones

Barriers:
- No formal process for initial and ongoing HFpEF/HFmrEF education for staff/patients
- Education needed for primary care physicians
- Lack of HFpEF/HFmrEF education materials

Scan to explore participating sites, register for upcoming national education opportunities, and access previous webinars at heart.org/IMPLEMENTEF

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Results

Process mapping identified several workflows associated with optimal HFpEF/HFmrEF care:
- Heart failure champions served as subject matter experts and provided education for clinicians and patients.
- Multidisciplinary teams used EMR-based reports and tools to identify HFpEF/HFmrEF patients and initiate heart failure care pathways.
- Follow-up within 72 hours and again at 30 days after discharge reinforced appointment adherence, medication adherence, fluid monitoring, and symptom management, efforts to reduce readmissions.

Awareness of evidence-based therapies for HFpEF/HFmrEF is increasing; however, key barriers to therapy initiation remain:
- Limited formulary availability
- Provider hesitancy
- Medication access challenges
- Cost-related barriers

Conclusions

Process mapping identified key priorities for improving HFpEF/HFmrEF care across participating sites, including:
- Increasing implementation of evidence-based therapies
- Enhancing clinician and patient education
- Systematically identifying health-related social needs
- Connecting patients with appropriate support services & interventions

IMPLEMENT-EF addresses these priorities through an ongoing learning collaborative, national model-sharing activities, and individualized consultation with participating sites to support local implementation and quality improvement efforts.

Acknowledgements

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References

[1] Redfield MM, Borlaug BA. Heart Failure with Preserved Ejection Fraction: A Review. JAMA. 2023;329(10):827–838. doi:10.1001/jama.2023.2020