ALLIANT HEALTH SOLUTIONS | HQIC Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

HQIC Patient Safety:

Welcome!

- All lines are muted, so please ask your questions in the Chat panel.
- For technical issues, chat to “All Panelists.”
- Please actively participate in polling questions that pop up on the lower right-hand side of your screen near the end of the presentation.

We will get started shortly!

The Anticoagulation Forum

Jennifer Massey, PharmD
Alliant Health Solutions

Carol Snowden, RN, BSN
Alabama Hospital Association

March 22, 2022

ALLIANT HEALTH SOLUTIONS

HQIC
Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

Making Health Care Better *Together*

COLLABORATORS:

Alabama Hospital Association
Alliant Health Solutions
Comagine Health
Georgia Hospital Association
KFMC Health Improvement Partners
Konza

Hospital Quality Improvement

Welcome from all of us!

ALABAMA HOSPITAL ASSOCIATION

ALLIANT HEALTH SOLUTIONS

Comagine Health

GHA Georgia Hospital Association

kfmc HEALTH IMPROVEMENT PARTNERS

KONZA

Adverse Drug Event Co-Leads

Carol Snowden, RN, BSN
Carol has over 20 years of experience in clinical nursing and quality improvement. She joined the Alabama Hospital Association as the quality director in March 2021.

Contact: csnowden@alaha.org

Jennifer Massey, PharmD
Jennifer has 15 years of health care experience, including clinical pharmacy in the acute care hospital setting and various roles at Alliant Health Solutions working on the CMS contract for the Quality Innovation Network-Quality Improvement Organization (QIN-QIO). She currently serves as the SME for Opioids and Adverse Drug Events for HQIC.

Contact: Jennifer.Massey@allianthealth.org

Darren Triller, PharmD

Darren Triller, PharmD, is director of strategic initiatives at the Anticoagulation Forum. He is a clinical pharmacist with over 30 years of experience in drug safety and quality improvement. Prior to joining Anticoagulation Forum, he spent 10 years as a senior program director for IPRO, the CMS-designated QIN-QIO for New York State. In that capacity, he created and led the New York State Anticoagulation Coalition, a multi-disciplinary collaborative of over 150 anticoagulation service providers, government agencies and professional organizations. Through the coalition, he conceptualized and led the publication of a pivotal paper, *Features of electronic health records necessary for the delivery of optimized anticoagulant therapy: consensus of the EHR Task Force of the New York State Anticoagulation Coalition* (Annals of Pharmacotherapy, 2015). He also led the design and dissemination of the Management of Anticoagulation in the Peri-Procedural Period app (MAPPP), currently available on both Apple and Android smartphone platforms.

Anticoagulation FORUM

Celebrating 30 Years

Always Learning. Forever Leading.

Anticoagulation Forum

Resources to Advance the Safety and Quality of Anticoagulant-Related Care

March 2022

Anticoagulation FORUM | ANTICOAGULATION Centers of Excellence

ALLIANT HEALTH SOLUTIONS | HQIC Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

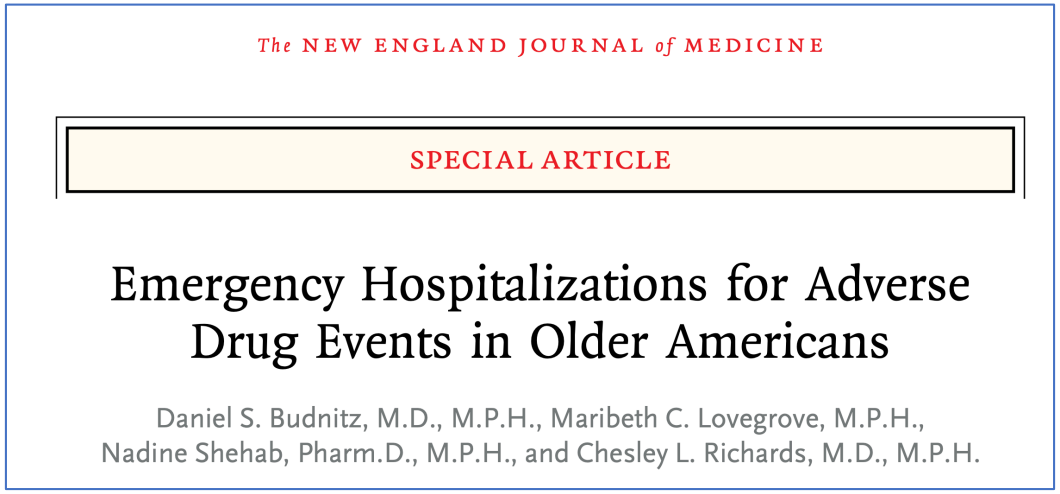
Agenda

- Welcome & Introductions
- Perspective on anticoagulation-related harms
- About the Anticoagulation Forum
- Review of available resources
- Opportunities for engagement
- Q&A

Perspective on Anticoagulation-Related Harms

- Class of drugs most frequently associated with adverse drug events (ADEs) prompting emergency department visits and hospitalization
- Errors and avoidable harms are common in acute and residential facilities
- Care transitions are risk-prone
- Quality measures and administrative oversight requirements are suboptimal
- Use of anticoagulants and complexity of regimens is increasing
- Organized services improve care, but are not widespread

NEJM 2011



The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Emergency Hospitalizations for Adverse Drug Events in Older Americans

Daniel S. Budnitz, M.D., M.P.H., Maribeth C. Lovegrove, M.P.H., Nadine Shehab, Pharm.D., M.P.H., and Chesley L. Richards, M.D., M.P.H.

Four medications or medication classes were implicated alone or in combination in 67.0% (95% CI, 60.0 to 74.1) of hospitalizations: warfarin (33.3%), insulins (13.9%), oral antiplatelet agents (13.3%), and oral hypoglycemic agents (10.7%).

NEJM 2011

Table 4. National Estimates of Medications Commonly Implicated in Emergency Hospitalizations for Adverse Drug Events in Older U.S. Adults, 2007–2009.*

Medication	Annual National Estimate of Hospitalizations (N=99,628)		Proportion of Emergency Department Visits Resulting in Hospitalization
	no.	*% (95% CI)*	%
Most commonly implicated medications†			
Warfarin	33,171	33.3 (28.0–38.5)	46.2
Insulins	13,854	13.9 (9.8–18.0)	40.6
Oral antiplatelet agents	13,263‡	13.3 (7.5–19.1)	41.5
Oral hypoglycemic agents	10,656	10.7 (8.1–13.3)	51.8
Opioid analgesics	4,778	4.8 (3.5–6.1)	32.4
Antibiotics	4,205	4.2 (2.9–5.5)	18.3

JAMA 2021

Original Investigation

October 5, 2021

US Emergency Department Visits Attributed to Medication Harms, 2017-2019

Daniel S. Budnitz, MD, MPH[1]; Nadine Shehab, PharmD, MPH[1,2]; Maribeth C. Lovegrove, MPH[1]; et al

In this cross-sectional nationally representative sample that included 60 US EDs between 2017 and 2019, annual estimates of the most frequent medication types and intents of use associated with ED visits attributed to medication harms (adverse events) were therapeutic use of anticoagulants (4.5/1000 population) and diabetes agents (1.8/1000 population) for patients aged 65 years or older; therapeutic use of anticoagulants (0.6/1000 population) and diabetes agents (0.8/1000 population) for patients aged 45 to 64 years; nontherapeutic use of benzodiazepines (1.0/1000 population) and prescription opioids (0.7/1000 population) for patients aged 25 to 44 years; and unsupervised medication exposures (2.2/1000 population) and therapeutic use of antibiotics (1.4/1000 population) for children younger than 5 years.

JAMA 2021

Drug product[b]	ED visits for medication harms overall		Proportion of ED visits for medication harms attributed to therapeutic use, nationally weighted, % (95% CI)[c,e]	ED visits for medication harms overall, estimated annual ED visits per 1000 individuals (95% CI)[c,f]
	No. of cases[a]	Nationally weighted, % (95% CI)[c,d]		
Patients aged ≥65 y				
Warfarin	5706	20.7 (17.9-23.5)	99.8 (99.7-100.0)	2.5 (1.4-3.6)
Insulin	3146	11.1 (9.0-13.2)	99.3 (98.9-99.7)	1.3 (1.0-1.7)
Clopidogrel	3057	10.9 (7.8-14.0)	99.8 (99.6-100.0)	1.3 (0.5-2.2)[g]
Apixaban	2507	8 (6.0-10.1)	99.8 (99.6-100.0)	1.0 (0.4-1.6)
Rivaroxaban	1764	6.3 (5.0-7.5)	99.9 (99.8-100.0)	0.8 (0.4-1.2)
Metformin	729	3.0 (2.4-3.6)	98.8 (97.6-100.0)	0.4 (0.2-0.5)
Aspirin	621	2.6 (0.6-4.6)[g]	97.8 (96.4-99.2)	0.3 (0.1-0.5)[g]
Lisinopril	639	2.4 (1.8-3.1)	96.7 (94.9-98.6)	0.3 (0.2-0.4)
Glipizide	445	1.7 (1.3-2.1)	99.9 (99.7-100.0)	0.2 (0.1-0.3)
Oxycodone	370	1.4 (1.0-1.7)	69.2 (62.6-75.8)	0.2 (0.1-0.2)

Perspective on Anticoagulation-Related Harms

- Class of drugs most frequently associated with adverse drug events (ADEs) prompting emergency department visits and hospitalization
- Errors and avoidable harms are common in acute and residential facilities
- Care transitions are risk-prone
- Quality measures and administrative oversight requirements are suboptimal
- Use of anticoagulants and complexity of regimens is increasing
- Organized services improve care, but are not widespread

Increasing Complexity

- Four unique DOACs
- Expanding indications for AC use (e.g., PAD)
- Expanding use of implanted devices (valves, LVAD, LAAODs)
- Complex patient characteristics (obesity, dialysis, etc.)
- Multiple reversal agents, strategies
- COVID
- Exploding and evolving medical evidence/guidance

ANTICOAGULATION STEWARDSHIP:
EVIDENCE OF IMPACT

Anticoagulation FORUM

Anticoagulants are essential yet high-risk medications. Anticoagulation-related errors and inappropriate use result in devastating bleeding and thrombotic events. Dedicated anticoagulation management programs have been shown to improve the quality and safety of anticoagulant use and improve clinical outcomes. (All findings presented are statistically significant).

Inappropriate DOAC Dosing:

Quality Gap

- **1 in 3** DOAC doses inappropriate[1-3]
- Under–dosing
  - ↑ risk CV hospitalization **(26%)**[4]
  - ↑ stroke / systemic embolism **(22%)**[4]
  - ↑ death **(24%)**[5]
  - No reduction in bleeding[5]
- Over–dosing
  - **2X** mortality[4]
  - ↑ stroke **(26%)**[5]
  - ↑ major bleeding **(30-100%)**[5]

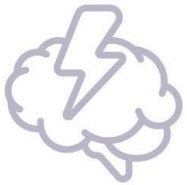
Stewardship Impact

- **93%** of DOAC doses appropriate in outpatients[6]
- **44%-58%** improvement in hospital dosing errors[7,8]
- **43%** ↓ in major bleeding[9]
- **53%** ↓ in death[9]

Suboptimal DOAC Adherence:

Quality Gap

- **33%** of patients on DOACs for atrial fibrillation are non-adherent resulting in a **40%** ↑ rate of strokes[10]



Stewardship Impact

- **91%-97%** adherence rates achieved[11,12]

Inappropriate Aspirin – Anticoagulant Combination:

Quality Gap

- **34%-50%** of patients on anticoagulant therapy use aspirin without a clear indication[13,14]
- Inappropriate aspirin users had
  - **2x** as many cardiac events[14]
  - **56%** ↑ bleeding–related ED visits[15]
  - **70%** ↑ major beeding events[16]
  - No reduction in thrombosis through addition of aspirin[13-17]

Stewardship Impact

- **34%-87%** ↓ in inappropriate aspirin use among anticoagulated patients[18,19]

Suboptimal Warfarin Control:

Quality Gap

- TTR **>65%** needed to derive any benefit from warfarin
- Yet, **2/3** of warfarin patients have a mean TTR of only **54%**[21,25]
- These patients are at **3x** ↑ risk for strokes and **2x** ↑ risk for major bleeding[21-25]

Stewardship Impact

- ↑ TTR to **70%**[26]
- **39%** ↓ in supratherapeutic INRs[27]
- **31%** ↓ in bleeding, thromboembolism, and mortality[26,27]
- **45%** ↓ in hospital LOS[28]
- **79%** ↓ in anticoagulation–related admissions[28]
- **$11** net ROI for every $1 invested[28]

Bleeding Management and Utilization of Clotting Factors and Antidotes:

Quality Gap

- Major bleeding events from anticoagulants carry a mortality rate of up to **20%** within 30 days [29,30]
- Reversal strategies are costly at **$4,000 to $50,000** per episode[31]
- **56%** of orders for reversal agents are inappropriate[30,32]

Stewardship Impact

- **95%** ↓ of inappropriate prescribing[33]
- **45%** ↓ in blood factor administration[34]
- **$4 million** annual cost savings[34]

Suboptimal Management of Heparin-Induced Thrombocytopenia:

Quality Gap

- HIT is a rare **(≤1%)** but potentially devastating disease[35]
- Up to **64%** of HIT patients experience thromboembolic complications requiring treatment with alternate anticoagulants[35]
- HIT tests are innappropriate **50%-75%** of the time [31,36,37]
- HIT can ↑ costs by **$20,000** and length of stay by **16** days[38]

Stewardship Impact

- **42%** ↓ in suspected HIT[39]
- **79%** ↓ in adjudicated HIT[39]
- **91%** ↓ in HIT with thrombosis[39]
- **64%** ↓ in inappropriate lab tests[40]

Anticoagulation FORUM | ANTICOAGULATION Centers of Excellence

ALLIANT HEALTH SOLUTIONS | HQIC Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

The Joint Commission National Patient Safety Goal for Anticoagulation

R³ Report | Requirement, Rationale, Reference

A complimentary publication of TheJoint Commission — Issue 19, Dec. 7, 2018

Published for Joint Commission-accredited organizations and interested health care professionals, *R3 Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, *R3 Report* goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement. *R3 Report* may be reproduced if credited to The Joint Commission. Sign up for email delivery.

National Patient Safety Goal for anticoagulant therapy

Effective July 1, 2019, eight new elements of performance will be applicable to all Joint Commission-accredited hospitals, critical access hospitals, nursing care centers, and medical centers (accredited under the ambulatory health care program). These new requirements are at NPSG.03.05.01 in the "National Patient Safety Goals" chapter.

For years, this NPSG has played an important role in improving the safety of patients receiving anticoagulation therapy. However, there has been a rise in adverse drug events associated with direct oral anticoagulants (DOACs), and The Joint Commission believes that relevant updates to this NPSG to address DOACs may help reverse that trend.

About the Anticoagulation Forum

- Largest nonprofit organization of anticoagulation specialists in North America
- Mission
  - Improve the quality of care for patients on antithrombotic medications
  - Educate and empower current healthcare providers
  - Advance the training of future experts
  - Advocate for clinical best practices
  - Promote Inclusion, Diversity, Equity and Allyship (IDEA)

Unique Organizational Design

- Multidisciplinary by design–physicians, pharmacists, nurses
- Active board of nationally recognized experts
- Free membership
- Free continuing education credits
- All resources free of charge except the conference and bootcamp events

Available Resources

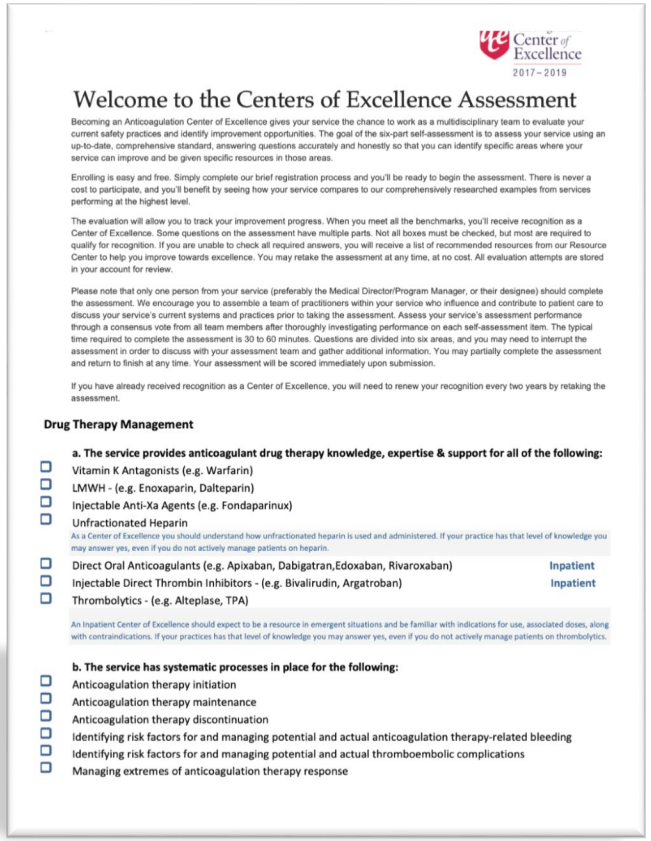
- Website and membership
- Anticoagulation Centers of Excellence
- Anticoagulation Stewardship

Website and Membership

- Expert guidance documents
- Order sets
- Live and enduring webinars/educational programs (with free CE)
- Searchable Resource Center and topical Rapid Resources
- Dynamic literature website and Rapid Recaps
- Newsletter

Anticoagulation Centers of Excellence (ACE)

- Free self-assessment measuring excellence in anticoagulation practices
- Pass the assessment and become a “Center of Excellence” with three-year recognition
- Free to enroll & assessment serves as a roadmap to implementing best practices
- Over 150 practices have been recognized as a “Center of Excellence”
- Once you become an ACE practice, you’re invited to join the “Innovation Circle” every-other-month discussion group & list-serve tackling cutting-edge topics, sharing resources & engaging in QI projects



Center of Excellence
2017–2019

Welcome to the Centers of Excellence Assessment

Becoming an Anticoagulation Center of Excellence gives your service the chance to work as a multidisciplinary team to evaluate your current safety practices and identify improvement opportunities. The goal of the six-part self-assessment is to assess your service using an up-to-date, comprehensive standard, answering questions accurately and honestly so that you can identify specific areas where your service can improve and be given specific resources in those areas.

Enrolling is easy and free. Simply complete our brief registration process and you'll be ready to begin the assessment. There is never a cost to participate, and you'll benefit by seeing how your service compares to our comprehensively researched examples from services performing at the highest level.

The evaluation will allow you to track your improvement progress. When you meet all the benchmarks, you'll receive recognition as a Center of Excellence. Some questions on the assessment have multiple parts. Not all boxes must be checked, but most are required to qualify for recognition. If you are unable to check all required answers, you will receive a list of recommended resources from our Resource Center to help you improve towards excellence. You may retake the assessment at any time, at no cost. All evaluation attempts are stored in your account for review.

Please note that only one person from your service (preferably the Medical Director/Program Manager, or their designee) should complete the assessment. We encourage you to assemble a team of practitioners within your service who influence and contribute to patient care to discuss your service's current systems and practices prior to taking the assessment. Assess your service's assessment performance through a consensus vote from all team members after thoroughly investigating performance on each self-assessment item. The typical time required to complete the assessment is 30 to 60 minutes. Questions are divided into six areas, and you may need to interrupt the assessment in order to discuss with your assessment team and gather additional information. You may partially complete the assessment and return to finish at any time. Your assessment will be scored immediately upon submission.

If you have already received recognition as a Center of Excellence, you will need to renew your recognition every two years by retaking the assessment.

Drug Therapy Management

a. The service provides anticoagulant drug therapy knowledge, expertise & support for all of the following:

- ☐ Vitamin K Antagonists (e.g. Warfarin)
- ☐ LMWH - (e.g. Enoxaparin, Dalteparin)
- ☐ Injectable Anti-Xa Agents (e.g. Fondaparinux)
- ☐ Unfractionated Heparin

As a Center of Excellence you should understand how unfractionated heparin is used and administered. If your practice has that level of knowledge you may answer yes, even if you do not actively manage patients on heparin.

- ☐ Direct Oral Anticoagulants (e.g. Apixaban, Dabigatran,Edoxaban, Rivaroxaban) Inpatient
- ☐ Injectable Direct Thrombin Inhibitors - (e.g. Bivalirudin, Argatroban) Inpatient
- ☐ Thrombolytics - (e.g. Alteplase, TPA)

An Inpatient Center of Excellence should expect to be a resource in emergent situations and be familiar with indications for use, associated doses, along with contraindications. If your practices has that level of knowledge you may answer yes, even if you do not actively manage patients on thrombolytics.

b. The service has systematic processes in place for the following:

- ☐ Anticoagulation therapy initiation
- ☐ Anticoagulation therapy maintenance
- ☐ Anticoagulation therapy discontinuation
- ☐ Identifying risk factors for and managing potential and actual anticoagulation therapy-related bleeding
- ☐ Identifying risk factors for and managing potential and actual thromboembolic complications
- ☐ Managing extremes of anticoagulation therapy response

[Download a PDF of assessment]

Anticoagulation FORUM | ANTICOAGULATION Centers of Excellence

ALLIANT HEALTH SOLUTIONS | HQIC Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

Anticoagulation Stewardship

Anticoagulation FORUM | ANTICOAGULATION Centers of Excellence

ALLIANT HEALTH SOLUTIONS | HQIC Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

ANTICOAGULATION STEWARDSHIP:
A NATIONAL MOVEMENT

Anticoagulation FORUM

HHS has called for Anticoagulation Stewardship Model Advancement

The US Department of Health and Human Services' National Action Plan for Adverse Drug Event Prevention identified anticoagulants as a drug class warranting systematic improvements to prevent drug-related harm, stating:

"Federal partners should lead efforts to promote the concept of 'anticoagulation stewardship' to reduce anticoagulant ADE burden." [1]

Other agencies and organizations have also prioritized anticoagulation safety and quality

The Centers for Disease Control and Prevention *have Identified Anticoagulants as the Most Frequent Contributors to Emergency Department Visits and Hospitalization*	***The Food and Drug Administration*** *has Funded the Development of Anticoagulation Stewardship Model*	***The Veterans Health Administration*** *has Implemented National Standards for Anticoagulation Management*	***The Joint Commission*** *has Expanded the National Patient Safety Goals for Anticoagulation Management*	***The National Quality Forum*** *is Developing a Playbook to Guide Stewardship Implementation*
Studies by the CDC have shown anticoagulants to be the drug class most frequently associated with adverse drug events causing ED visits and hospitalizations, particularly among the elderly, and many are considered preventable.[2-5]	The FDA contracted with the Anticoagulation Forum to develop the Core Elements of Anticoagulation Stewardship Programs Guide.[6]	"It is VHA policy that every VA medical facility must maintain a centralized evidence-based anticoagulation management program. The program must provide coordinated processes and procedures ensuring Veterans are appropriately treated and monitored, to ensure safety of anticoagulation therapy through transitions of care."[7,8]	National Patient Safety Goal 03.05.01 was updated in 2018 to reduce avoidable patient harms related to suboptimal anticoagulant use, including care transitions, peri-procedural management, bleeding management, and other key aspects of patient care.[9]	NQF has partnered with Anticoagulation Forum to develop a comprehensive guide on implementation of Anticoagulation Stewardship in hospitals.

The Anticoagulation Forum welcomes your support in advancing Anticoagulation Stewardship across care settings.

Anticoagulation Stewardship

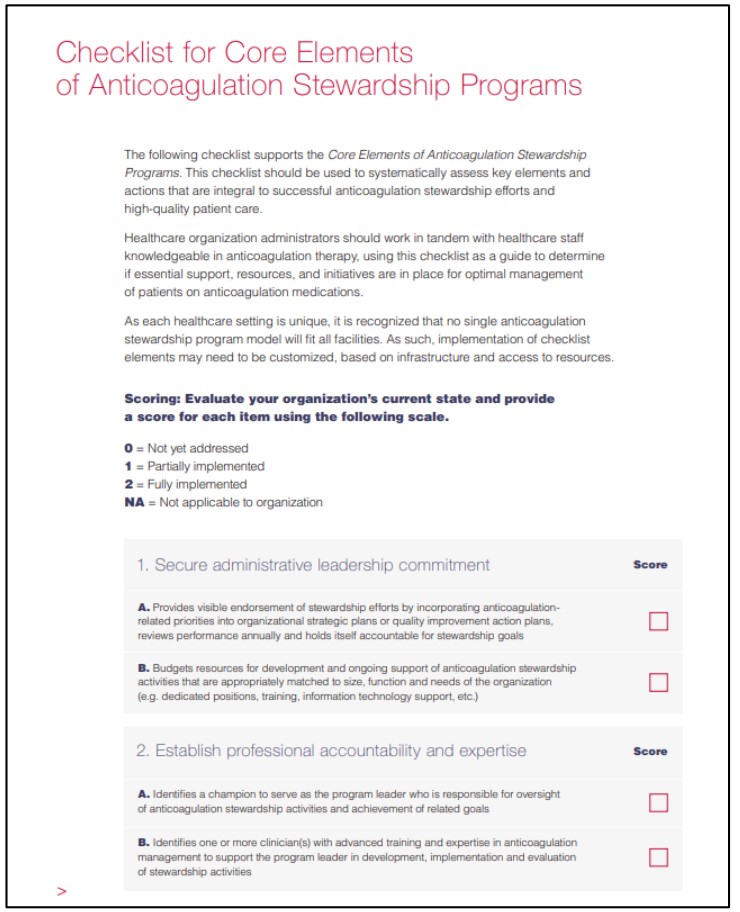
- Strategic initiative to "move the needle"
- Goal to improve the safety and quality of patient care and reduce adverse drug events associated with anticoagulants
- One-year project funded by FDA
- Developed:
  - Core Elements of Anticoagulation Stewardship Programs Guide
  - Checklist for hospitals to assess level of stewardship implementation
  - Administrative Oversight Gap Analysis

Access at: https://acforum.org/web/education-stewardship.php

Anticoagulation Stewardship Checklist

- Used to systematically assess key elements and actions that are integral to successful stewardship efforts & high-quality patient care

- Guide to determine if essential support, resources, and initiatives are in place for optional management of patients on anticoagulant medications



Checklist for Core Elements
of Anticoagulation Stewardship Programs

The following checklist supports the *Core Elements of Anticoagulation Stewardship Programs*. This checklist should be used to systematically assess key elements and actions that are integral to successful anticoagulation stewardship efforts and high-quality patient care.

Healthcare organization administrators should work in tandem with healthcare staff knowledgeable in anticoagulation therapy, using this checklist as a guide to determine if essential support, resources, and initiatives are in place for optimal management of patients on anticoagulation medications.

As each healthcare setting is unique, it is recognized that no single anticoagulation stewardship program model will fit all facilities. As such, implementation of checklist elements may need to be customized, based on infrastructure and access to resources.

Scoring: Evaluate your organization's current state and provide a score for each item using the following scale.

0 = Not yet addressed
1 = Partially implemented
2 = Fully implemented
NA = Not applicable to organization

1. Secure administrative leadership commitment	Score
A. Provides visible endorsement of stewardship efforts by incorporating anticoagulation-related priorities into organizational strategic plans or quality improvement action plans, reviews performance annually and holds itself accountable for stewardship goals	☐
B. Budgets resources for development and ongoing support of anticoagulation stewardship activities that are appropriately matched to size, function and needs of the organization (e.g. dedicated positions, training, information technology support, etc.)	☐

2. Establish professional accountability and expertise	Score
A. Identifies a champion to serve as the program leader who is responsible for oversight of anticoagulation stewardship activities and achievement of related goals	☐
B. Identifies one or more clinician(s) with advanced training and expertise in anticoagulation management to support the program leader in development, implementation and evaluation of stewardship activities	☐

>

Anticoagulation FORUM | ANTICOAGULATION Centers of Excellence

ALLIANT HEALTH SOLUTIONS | HQIC Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

CORE ELEMENTS OF ANTICOAGULATION STEWARDSHIP

Secure administrative leadership commitment: Dedicating necessary human, financial, and technology resources

Establish professional accountability and expertise: Appointing a single leader responsible for program outcomes, supported by at least one clinician with expertise in anticoagulation management

Engage multidisciplinary support: Involving key specialists and disciplines to obtain perspective from all domains of the care delivery system

Perform data collection, tracking, and analysis: Defining the population, objectively evaluating performance, and guiding decision-making

Implement systematic care: Implementing sustainable, efficient, evidence-based action(s) at the system level to assure the safety and quality of anticoagulation management

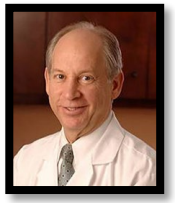
Facilitate transitions of care: Creating systems to optimize communication and ensure safe transitions between care settings

Advance education, comprehension, and competency: Assuring that clinicians, patients, and others have the knowledge and skills necessary to optimize outcomes

The MIDAS Program

- Mentored Implementation & Dissemination of Anticoagulation Stewardship (MIDAS)
- Demonstrate feasibility of Core Elements of Anticoagulation Stewardship Programs
- Two-year project funded by FDA
  - Year 1 – Mentorship program at five hospitals
  - Year 2 – Develop and disseminate Implementation Playbook
- Implementation Playbook will provide guidance and resources for hospitals to independently establish a stewardship program

Project Leadership



Jack Ansell, MD, MACP

Geoff Barnes, MD, MSC, FACC, FAHA, FSVM
University of Michigan

Andy Bland, MD, MSc
Base Camp Health

Allison Burnett, PharmD, PhC, CACP
University of New Mexico

Nathan Clark, PharmD, BCPS, FCCP
Kaiser Permanente Colorado

Steve Deitelzweig, MD, MMM, SFHM, FACP, FACC
Ochsner Medical Center

David Garcia, MD
University of Washington

Scott Kaatz, DO, MSc, FACP, SFHM
Henry Ford Hospital

Darren Triller, PharmD
Anticoagulation Forum

Dan Witt, PharmD, BCPS, FCCP
University of Utah College of Pharmacy

Anticoagulation FORUM | ANTICOAGULATION Centers of Excellence

ALLIANT HEALTH SOLUTIONS | HQIC Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

Hospital Sites

The Brooklyn Hospital Center
Brooklyn, NY

CHRISTUS ST. Vincent Regional Medical Center
Santa Fe, NM

University of Alabama at Birmingham
Birmingham, AL

Ochsner Medical Center
New Orleans, LA

University of California, San Francisco
Moffit- Long Hospital
San Francisco, CA

Implementation Playbook

- Under development by the National Quality Forum (available Sept 2022)
- Leverages familiar and successful antimicrobial stewardship model
- Provides guidance and resources for hospitals to institute an anticoagulation stewardship program, without individual mentorship
- Developed by a large team of multidisciplinary subject matter experts
- Disseminated through AC Forum's 12,000+ members and partner organizations upon completion

Opportunities for Engagement

- Membership and newsletter
- Live and recorded webinars as source of CE for clinicians
- Send staff to boot camp and conferences
- Pursue Center of Excellence Status
- Initiate stewardship program
- Share new ideas for collaboration

Ask and Offer

- Ask: A single high-level clinician to join the AC Forum from each hospital.
- Offer: AC Forum will do a presentation on a topic of PSO interest in the future.

Thank you for Your Valuable Input

For more information on resources and opportunities to improve the quality and safety of anticoagulation management, contact Darren Triller: dtriller@acforum.org

Questions?

Email us at HospitalQuality@allianthealth.org or call us at 678-527-3681.

ALLIANT HEALTH SOLUTIONS | HQIC Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

HQIC Goals

Behavioral Health Outcomes & Opioid Misuse

- ✓ Promote opioid best practices
- ✓ Decrease high dose opioid prescribing and opioid adverse events in all settings
- ✓ Increase access to behavioral health services

Patient Safety

- ✓ Reduce risky medication combinations
- ✓ Reduce adverse drug events
- ✓ Reduce *C. diff* in all settings

Quality of Care Transitions

- ✓ Convene community coalitions
- ✓ Identify and promote optical care for super utilizers
- ✓ Reduce community-based adverse drug events

ALLIANT HEALTH SOLUTIONS | HQIC Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

Making Health Care Better *Together*

COLLABORATORS:

Alabama Hospital Association
Alliant Health Solutions
Comagine Health
Georgia Hospital Association
KFMC Health Improvement Partners
Konza

Hospital Quality Improvement

@AlliantQIO

@AlliantQIO

Alliant Health Solutions

AlliantQIO

Thank you for joining us!
How did we do today?

This material was prepared by Alliant Health Solutions (AHS), the Hospital Quality Improvement Contractor (HQIC) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this document do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication No. 12SOW-AHSQIN-QIO TO3 - HQIC--1680-03/14/22

ALLIANT HEALTH SOLUTIONS | HQIC Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP