



Advancing High Performance Health

# ASPIRE

Accelerating System Progress with  
Implementation Research and Education

White Paper

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## *Improving Care Transitions for Patients with Venous Thromboembolism (VTE)*

For more information on this research, contact:  
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This publication is intended for formulary decision makers, population health decision makers, and/or similar entities.

# Improving Care Transitions for Patients with Venous Thromboembolism (VTE)



## Executive Summary

Together with a team of national experts, AMGA recruited six member healthcare organizations (HCOs) for an implementation study to help improve the quality of care for patients with venous thromboembolism (VTE), including deep vein thrombosis (DVT) and pulmonary embolism (PE).

Leveraging quality improvement and implementation science strategies, participating organizations developed and implemented a variety of interventions over 12 months to improve care for people with VTE during transitions of care between the hospital, the emergency department (ED), and the ambulatory setting.

### Objective

To use a learning health system\* and implementation science-informed approach to assess interventions designed to improve VTE care transitions in six AMGA member organizations.

An environmental scan was conducted by each organization, and specific needs fell into 5 domains:

1. Improve Relationships and Communications among Providers
2. Centralize and Standardize Protocols/Care Pathways
3. Safe Prescribing and Management of Anticoagulants
4. Patient Engagement and Education Activities
5. Restructure/Redesign Care Processes

### Outcomes:

- Improvement in follow-up within 7 days of an index VTE diagnosis with an overall average relative improvement of 33.3%,  $p < 0.0001$ . Follow-up included any contact with the patient including an ambulatory care visit or a phone call from a clinical pharmacist, video visit, or electronic communication.<sup>2</sup>
- Improvement in reducing hospitalizations and ED visits, in which a VTE diagnosis was present, within 45 days of index VTE diagnosis across all settings, with an overall average relative reduction of 18.7%,  $p = 0.033$ .<sup>2</sup>
- Hospital admissions and emergency visits for VTE-related adverse drug-events were tracked with a non-significant change from baseline to post-intervention,  $p = 0.528$ .<sup>2</sup>

Two combinations of interventions were associated with improving 7-day follow up after a VTE episode:

- Safe prescribing and management of anticoagulants (provider and patient education; 30-day starter packs; post diagnosis/discharge follow-up processes in place) and standardized protocols (EHR integration of VTE processes including dosing and treatment, tracking and monitoring of patients)<sup>2</sup>

or

- Safe prescribing and management of anticoagulants (provider and patient education; 30-day starter packs; post diagnosis/discharge follow-up processes in place), and improved care team communication (timely, accurate, and frequent communication), and redesign care processes (expanding anticoagulant clinic access for patients prescribed DOACs)<sup>2</sup>

The following five case studies describe the specific care gaps addressed by each AMGA member organization, providing details on their respective interventions, developed resources, and the outcomes attained.<sup>†</sup>

\*A learning health system is one in which internal data and experience are systematically integrated with external evidence, and that knowledge is put into practice to improve care.<sup>1</sup>

<sup>†</sup>One organization's case study is not included due to pending approval.

DOAC = direct oral anticoagulant.

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# Summary of Study Activities at Each of the Six Participating Healthcare Organizations

## 1. North Mississippi Health Services, Tupelo, MS

### ***Comprehensive care during care transitions***

Joining AMGA's VTE Care Transitions Study was a way for North Mississippi Health Services (NMHS) clinics in Tupelo, MS, to create a comprehensive, sustainable, and scalable program to ensure safe care transitions for patients diagnosed with VTE. NMHS introduced a comprehensive program, *VTE Care Connections*, to enhance the management of patients diagnosed with VTE. The program operates through a patient registry that identifies patients with a VTE diagnosis across hospital discharges, emergency departments, and primary care settings, ensuring consistent and ongoing monitoring of patient care.

### **Identification of Needs and Intervention Planning**

The Relational Coordination (RC) Survey was employed to improve relationships and communication among providers. It was administered at baseline to gain insight into the relationships within and among eight workgroups involved in care transitions for patients with VTE including the anticoagulation clinic, ED, outpatient clinics, hospitalists, inpatient case management, home care, population health, and rehab and skilled nursing. The clinical pharmacist lead for the study then met with each workgroup to discuss the results and brainstorm ideas for improvement which were then implemented and re-tested.

The workgroups narrowed down ideas generated from their brainstorming sessions and further refined them to define interventions to be implemented as part of *VTE Care Connections*. Following the intervention period, the survey was administered again, and responses were compared to those from the pre-intervention survey. Several solutions were identified during the workgroup meetings including interventions that were developed and implemented, which in turn led to positive clinical and process outcomes.

### **Interventions**

Clinical pharmacists located in the Family Medicine Clinic now receive a daily list of patients who are diagnosed with VTE and prescribed an anticoagulant. This information is merged into Epic. The registry has enabled comprehensive, continuous monitoring, and oversight. Additionally, this information can now be accessed by a patient's primary care provider. Within 72 hours of discharge or diagnosis (in primary care), patients are contacted by clinical pharmacists to verify the patient has the prescribed anticoagulant in-hand, understands the importance of taking the medication as directed, and has scheduled a follow-up visit with their primary care provider.

Structured data fields were added to the patient record in Epic to document information collected by the pharmacist during the follow-up phone call, including medication access, comprehension of discharge instructions, patient education documentation, and follow-up appointments. Epic now fosters transparency of detailed information with primary care providers and has been programmed to issue auto-reminders to primary care physicians and clinical pharmacists in the anticoagulation clinic (ACC) at crucial decision junctures, such as 3-, 6-, and 12-months post-medication initiation. All forms were developed as flow sheets that could be copied and edited into the next encounter.



*VTE Care Connections* employs innovative strategies to ensure patients have the anticoagulant in hand at discharge, including meds-to-beds initiatives and direct oral anticoagulant (DOAC) "starter packs" that contain 30 days of medication. To reduce other barriers to taking medications as directed, *VTE Care Connections* uses test claims to ascertain insurance coverage and cost estimates before medications are prescribed, and patient assistance programs are leveraged when financial support is needed.

The program also includes review of orders at discharge to identify and correct any errors in dosing and provides education and training for prescribers when errors occur. To initiate this review, a notification is sent to the clinical pharmacist when a DOAC is ordered. If changes need to be made, the pharmacist has prior approval from the Pharmacy and Therapeutics (P&T) committee to make certain changes per protocols. To prevent future errors, the pharmacist contacts the prescriber to provide education. Finally, *VTE Care Connections* expanded access to prescribing consultation for prescribers by clinical pharmacists.

## Results

*VTE Care Connections* demonstrated impressive results. Before the study, NMHS estimated that 5% of patients on DOACs were referred to the ACC. After the implementation of *VTE Care Connections*, this rose to 95%, due in part to the automation of the referral process in Epic for patients newly diagnosed with VTE to the ACC from the hospital, ED, and primary care. At the same time, the number of patients with DOACs in-hand upon discharge after a new VTE diagnosis in the hospital or ED increased from 0% to 33%. Nearly 100% (98%) of patients discharged from all settings received a follow-up phone call from the clinical pharmacist, a significant relative improvement rate of 79.2% over the baseline average of 54.7%. The percentage of patients who had a readmission or ED visit within 45 days post-discharge went from 7.3% at baseline to 6.6% post-intervention, a relative improvement rate of 9.6%. NMHS improved communication and relationship scores in every domain on the follow-up RC survey.

## Resources created during the study

Patient Assessment 	
+ New Reading	
	Last Filled Value
	
<b>Patient Assessment</b>	
Does patient know which medication is the anticoagulant?	Yes <<
Does patient have medication?	Yes <<
How many days of therapy missed since discharge/last encounter?	0 <<
Is this new therapy?	Yes <<
Does the patient know how long to take the medication?	Yes <<
Does the patient know what symptoms to report to provider?	Yes <<
How satisfied is patient with the communication provided by their provider about their diagnosis, drug therapy, and tests required?	Satisfied <<
Does patient have follow-up appointment with PCP?	No <<
Concurrent antiplatelet therapy?	Aspirin <<
Has pt been admitted to an ER or hospital since last communication with patient?	Yes <<
<b>Patient Education Checklist</b>	
Pt given contact number for AC Clinic Pharmacist:	Yes <<
Pt instructed when to de-escalate therapy:	Yes <<
Pt given instructions on anticoagulant:	Appropriate dosing and what to do about missed doses; Side effects to manage and report; What to do when having invasive procedures; Other drugs and over-the-counter products that can interact with my anti-clotting drug; Expected costs; Remind other providers of care you take anticoagulant/ bracelets/health app; Dietary recommendations; Activities to avoid
<b>OTHER</b>	
Time spent (minutes):	5 <<

## 2. Allegheny Health Network, Pittsburgh, PA

### ***Improving communication and coordination between the hospital and primary care***

Allegheny Health Network (AHN), including Forbes Hospital and Premier Medical Associates, joined the VTE Care Transitions Study to learn about how implementation science can improve transitions of care for patients with VTE.

During the study, AHN worked to improve communication and coordination between inpatient nursing, a Premier clinical pharmacist, and Premier case managers to improve handoffs from the hospital to primary care during transitions from the hospital and ED to home. To do this, the Premier-based clinical pharmacy hired a hospital-based coordinator who identified patients in the hospital and ED who have been diagnosed with VTE and coordinated the transitions of care.

The coordinator visits all patients in the hospital and ED with newly diagnosed VTE who are identified daily through a report produced using CarePort, a care coordination software. The coordinator puts information about each patient diagnosed with VTE into a spreadsheet that is used to track Premier patients. The coordinator enters the patient's name, medications, and demographic information into a spreadsheet that creates a task that sends an alert to staff on the Premier case management and pharmacy teams. Information in the spreadsheet is accessible to everyone involved in care transitions. The spreadsheet is also used to track prescribing errors and the clinical pharmacist provides education to prescribers when needed.

Once an alert is sent out, a clinical pharmacist reviews the information for each patient and calls the patient within 48 hours of discharge. The Premier Pharmacy Manager also calls all patients a few days after the first call to make sure there are no issues with obtaining medication.

AHN also created a short patient education video that features their providers and provides information on the causes of VTE, the seriousness of the diagnosis, the importance of taking medication as prescribed, side effects and length of treatment, and next steps for care.

The coordinator uses the video to provide education to patients and their families in the hospital and ED during a face-to-face visit prior to discharge. During this visit, the coordinator presents the patient education video using a QR code and employs “teach back” to ensure they understand the education. If for some reason the patient is unavailable when the coordinator goes into the room, the coordinator leaves the QR code so that the patient can watch the video on their own. When the coordinator isn't available (on nights and weekends), another nurse visits patients to provide the education.

### **Qualitative Insights**

A hospitalist reported that the most impact has been to follow-up:

“Knowing staff are following up with patients post-discharge to address any challenges creates a safety net not just with VTE but other conditions as well.”

A pharmacist also reported that they noticed an impact. When she called patients post-discharge, they had a better understanding of what they were supposed to do, and this was especially true for the patients discharged from the ED who historically understood less than those discharged from the hospital.

In both these examples, AHN has helped several high-risk patients with a new VTE diagnosis, who needed a higher level of medical management, obtain their medication.

## Results

Among Premier patients with VTE who were discharged from Forbes hospital, 95.1% (n=39) received follow-up within 7 days. When compared with the baseline rate (45.9%; n=50), this was a relative improvement of 107%.

## Resources created during the study

### 1. Follow-up Tracking Form

Patient First Name	Patient Information				Discharge Date	Care Coordinators			Interdisciplinary Care Team		SDOH/Care Gaps Addressed		7 Day Follow Up Apt	30 Day Follow Up Apt
	Patient Last Name	DOB	PCP	Medication and Dosage at Discharge		First Education Call	Create Note and Task	Schedule 7 and 30 Day FUP	Review Note/Task For Care Gaps	Complete FUP Call Prior to Apt	Yes	N/A	Date	Date
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
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						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

2. Patient video – AHN also created a patient-facing video, available upon request.

### 3. Henry Ford Health, Detroit, MI

#### ***Creating safer care transitions from the ED to home***

The VTE Care Transitions study was conducted in the largest hospital in the Henry Ford Health (HFH) system in Detroit, MI. The hospital has 877 licensed beds and operates a large medical residency training program. The hospital's ED is staffed by the Henry Ford Medical Group (HFMG).

HFH identified the need to improve care transitions for insured patients with a VTE diagnosis who were discharged from the ED but were not part of the HFMG. To address this, they devised a new process specifically for newly diagnosed VTE patients, facilitating their transition from the ED to the HFH Anticoagulation Service.

Post-discharge follow-up encounters for all patients were conducted by the Anticoagulation Service pharmacists through telephone consultations that were initiated after receiving a referral from the ED. They also established clear pathways for follow-up care after ED discharge, ensuring improved communication and coordination between the ED and the Anticoagulation Service. To facilitate the referral process, HFMG created educational resources to guide ED clinicians on locating and completing the referral form.

HFH uses guidelines in the EHR to help their prescribers select agents appropriate for the patient's clinical picture in terms of other disease states and concomitant medications. During the study, they incorporated consults into their workflow to provide guidance when selecting alternative medications that fit the patient's clinical profile, considering other diseases and medications.

Collaboration with the outpatient pharmacy is an important aspect of HFH's efforts. They worked closely with the pharmacy to ensure patients had access to prescribed medications before discharge. The outpatient pharmacy ran a test claim to determine insurance coverage and medication cost, and when necessary, they applied coupons or vouchers to alleviate financial burdens on patients.

HFH's Anticoagulation Service became a model for effective and patient-centered care transitions for patients outside of the HFMG. Due to the resulting confidence that the ED clinicians have in the new process for safely discharging patients from the ED on DOACs, they plan to expand the work by focusing on identifying low-risk patients who are currently held overnight for observation in the hospital and instead discharge them home from the ED.

One challenge that arose was finding a physician to assume responsibility for these patients until a warm handoff to their primary care provider (PCP) could be made. To overcome this hurdle, the Anticoagulation Service identified two physicians willing to take temporary responsibility for the patients until a warm handoff could occur, and pharmacists informed the outside providers about the patients' status and the need for follow-up care.

By the end of data collection, all insured patients outside of the HFMG who were discharged from the ED were referred to the Anticoagulation Service, received follow-up care until a warm handoff was made to their PCP, and were discharged with medication in-hand.



## 4. Independence Health System (formerly Excela Health), Greensburg, PA

### ***Providing DOACs in primary care settings***

Independence Health System (referred to as Excela in this article), located just outside of Pittsburgh, is a network of integrated multispecialty practices with >300 physicians, three hospitals, and many ancillary services. At the time of the study, Excela had 25 primary care practices located throughout Westmoreland County.

During the VTE Care Transitions study, Excela implemented several improvements to streamline VTE management including follow-up phone calls from a clinical pharmacist, enhanced content of discharge summaries for both patients and clinicians, all to ensure patients have their anticoagulant medication.

A key intervention was the creation of a process to streamline management when VTE is diagnosed in the ambulatory setting. DOAC starter packs were made available onsite to 25 providers in 20 clinics, making it convenient for clinicians to provide immediate care to patients after diagnosis and ensure that patients have their medication in-hand before leaving the clinic.

When a patient is diagnosed with a VTE in primary care practice, a DOAC starter pack is dispensed to the patient and the clinical pharmacist is notified. This alerts the pharmacist to restock the starter pack and reach out to the patient to provide a follow-up call.

Excela dispenses a one-time, one-month supply of DOAC, allowing patients to leave with their medication in-hand. DOACs are now stocked in the cabinets of the ED. If the patient needs medication during a time when the outpatient pharmacy is closed (e.g., evenings or holidays), the ED provides the medication to the patient, and the outpatient pharmacy bills the medication on the back end. The outpatient pharmacy is also able to adjudicate the free trial. A VTE Treatment Map was created for initiating anticoagulation, utilizing the test claim procedure with the employee pharmacy as well as the starter packs. (See **Resources**.)

The clinical pharmacist collaborated with Cerner, the IT department, and system architects to create additional fields in the EHR for patients diagnosed with VTE who are prescribed an anticoagulant. The fields are now required to be completed by the discharging clinician. This enabled the creation of a patient registry now used for follow-up, helps to guide the anticoagulant ordering process, and ensures appropriate documentation, including reasons for not prescribing anticoagulation if applicable. (See **Resources**.)

Before the study, Excela patients received an overwhelming amount of information related to VTE at discharge. This workflow facilitated improvements to the discharge summaries for patients through streamlining the information on the summary to be specific to the diagnosis and anticoagulant. It also enables providers in the ambulatory setting to easily identify their patients who are discharged on an anticoagulant.

Patient education is now also provided prior to inpatient and ED discharge using educational videos provided by Cerner. The videos serve as a cost-effective alternative to hiring additional staff to provide education and critical information to patients regardless of the setting of care and is available 24 hours per day, 7 days per week.

## Results

Twenty-six patients were diagnosed and transitioned home on a DOAC directly out of the ambulatory setting during the study. All patients now leave the ambulatory settings with DOACs in-hand. Among the patients discharged from all areas (hospital, ED, ambulatory), the proportion returning to the ED or hospital within 45 days of discharge was reduced from 12% to 8.8%, a relative improvement of 26.7%. Follow-up within 7 days among all patients diagnosed with VTE went from 75.4% to 83.5%, a relative improvement of 10.7%.

## Resources created during the study

### 1. Added documentation into the EHR for VTE

Revised workflow:

- “Is an anticoagulant ordered for DVT or PE?” if yes, it opens up another area.
- Based on the responses, it automatically generates the order which is then auto populated.
- If they select no, an anticoagulant is not ordered, then they must give a reason (e.g., there’s a concurrent GI bleed).

Physician Discharge Instructions - BUILD, FMHFIFTYTHREE

\*Performed on: 09/15/2022 1230 EDT

**Physician Discharge Instructions**

Does the patient have a diagnosis of AMI/Acute Coronary Syndrome, Stroke/TIA, Heart Failure, DVT or PE on discharge?

Yes  
 No

Yes  
 No

Yes, Systolic  No  
 Yes, Diastolic

Yes  
 No

Yes  
 No

Yes  
 No

Yes  
 No

Is there documented moderate to severe left ventricular systolic dysfunction and/or ejection (LVEF) less than or = 40?

Yes  
 No

Left Ventricular Ejection Fraction (LVEF) %

Inpatient Discharge Instructi... X List

Font Size [Rich Text Editor Icons]

**This Is Your Medications List**

- DOAC

	What	How Much	When	Instructions	Last Dose	Next Dose
<b>NEW</b>	DOAC	1 Tab Oral	Every day			

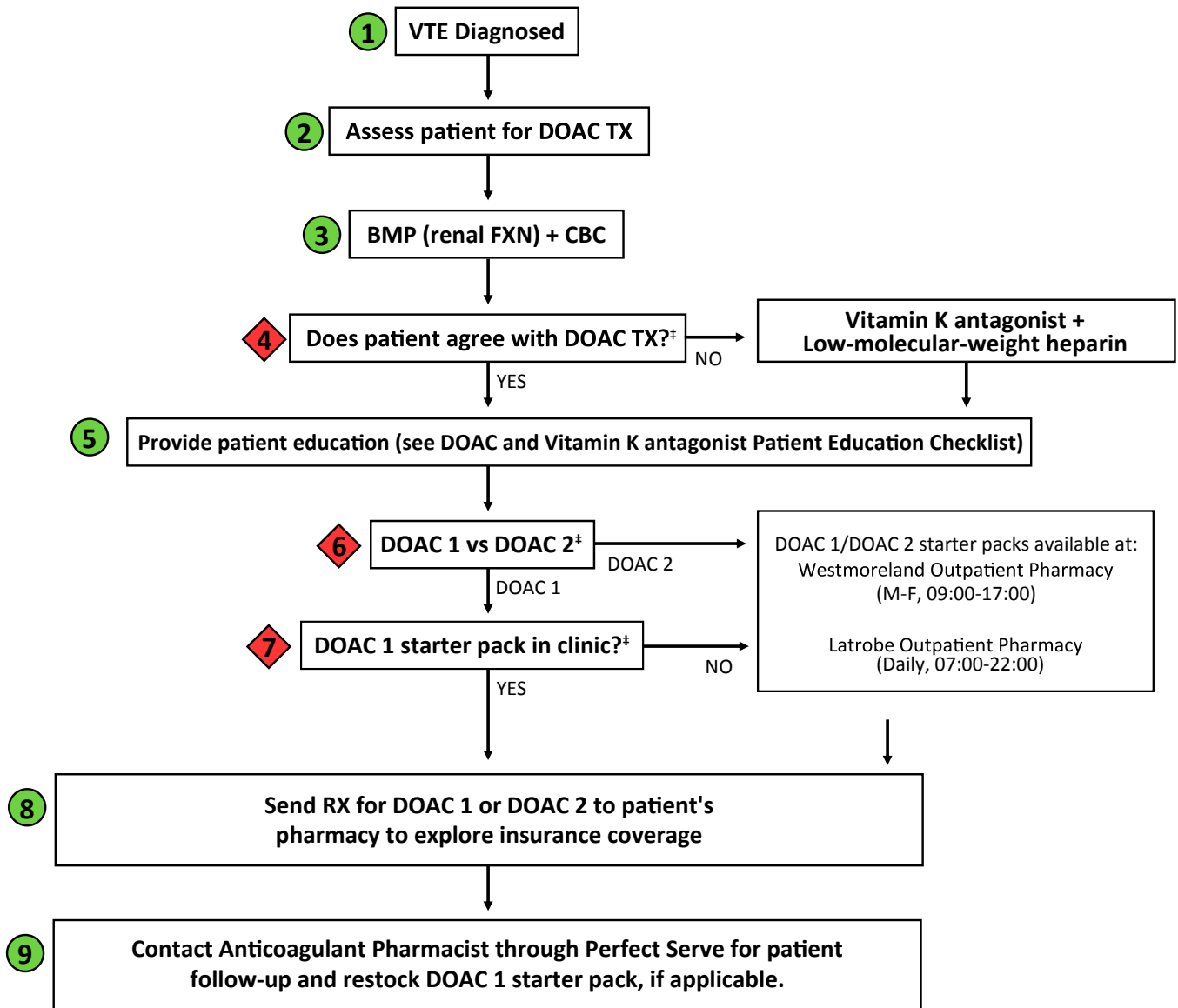
**Stop taking these medications**

- Vitamin K antagonist

	What	How Much	When	Comments
<b>STOP TAKING</b>	Vitamin K antagonist	1 Tab Oral	Every day	

## 2. Outpatient treatment map

### VTE Outpatient Management Algorithm



VTE Outpatient Management Algorithm v2 6.121.22

‡Decision point.

## 5. Beth Israel Lahey Health, Burlington, MA

### *Improving patient education for VTE*

Beth Israel Lahey Health (Lahey) is a 335-bed, academic, level I trauma center with an active Thrombosis Program and Pulmonary Embolism Response team that serves patients from the greater Boston, MA, area as well as from Southern Maine and Southern New Hampshire. The system cares for approximately 1,300 patients with DVT or PE each year in the inpatient or ED setting. This study was led by the clinical pharmacist for an ACC located within cardiology.

### Identification of Needs and Intervention Planning

The Relational Coordination (RC) Survey was employed to improve relationships and communication between providers. It was administered at baseline to gain insight into the relationships within and among eight workgroups involved in care transitions for patients with VTE including the anticoagulation clinic, ED pharmacists, ED physicians, outpatient clinics, hospitalists, vascular medicine, home health, nursing, population health, and case management. The clinical pharmacist lead for the study then met with each workgroup to discuss the results and brainstorm ideas for improvement which were then implemented and re-tested. The workgroups narrowed down ideas generated from their brainstorming sessions and further refined them to define interventions to be implemented.

Several solutions were identified during the workgroup meetings including interventions that were developed and implemented and in turn led to positive clinical and process outcomes. A key focus was improving discharge planning. The ACC worked with hospital medicine to revise the workflow and notify the ACC of patients with VTE before discharge. This enabled patient education and the development of a follow-up plan before discharge. The ACC is now a resource for the case managers, who previously felt isolated when they have questions about high-risk discharges. In return, the ACC now contacts the case management team when they need information for discharge planning.

Changes were made in the ED prescribing protocols which include the way anticoagulants are dispensed at discharge. Lahey now provides the first month's supply of medication to patients through a meds-to-beds program. Additionally, DOACs are now dispensed by outpatient pharmacy during operating hours (except for 2:00 am – 7:00 am, when there is no pharmacist on duty in the ER). The staff in the ED also reported opportunities for improvement in communication with the Vascular Medicine Service, and they are now actively exploring ways to improve.

### Additional Interventions

Lahey created an auto-referral in Epic that prompts all providers to refer their patient to the ACC when they prescribe a Starter Pack or DOAC for treatment of an acute VTE. The workflow changes also allow for referral of patients outside of the system to the ACC, where they are followed for up to a month, until a warm handoff can be made to their non-network provider. The alert in Epic also notifies providers that they need to enroll patients in the ACC if they place an ambulatory order for a DOAC.

Patients who are referred are entered into DAWN AC, a safety monitoring software, which is interfaced to the Epic EHR. Information is entered into DAWN AC including clinical history, medication details, indications, and dosing and the software verifies the dosage and raises alerts for potential contraindications or medication interactions. During the study, DAWN AC was enhanced, adding alerts specifically for patients prescribed a DOAC. Daily reports were generated to proactively identify potential adverse drug events in real-time which helped to promptly address and manage patient safety concerns.

Patient education materials were developed in-house, including a patient checklist. (See **Resources**.)

To improve the education provided to prescribers, Lahey implemented several measures. They established a dedicated phone/pager service that allows prescribers to easily contact a pharmacist for assistance prescribing anticoagulation. It's available on weekdays, 7:00 am – 5:00 pm. Additionally, the team created educational materials to acquaint providers with available resources such as clinical pharmacists and the ACC. These materials also offer guidance on how to enroll patients into the clinic.

Additionally, the clinical pharmacist working in cardiology plays a significant role in co-managing patients on anticoagulation and is readily available to discuss complex cases. She assists providers to enroll high-risk patients in the ACC. Educational efforts have also been extended to the pharmacy department, cardiology department, and AC nurses, through “lunch and learn” sessions.

### Qualitative Insights

Patients seem very satisfied with the education and help finding and navigating the prescription fill.

Coordination pertaining to care transitions between the ACC and the other workgroups has increased. An example, the ACC helped a pharmacist in the ED to get anticoagulation for patient that required pre-authorization, which could not be done by the ED pharmacists but could be done by the ACC.

One champion, a cardiologist, reported that they are now catching prescribing errors such as poorly or inappropriately dosed patients before patients go out the door. The new referral process is going well and they are enrolling more patients on DOACs into the ACC clinic.

### Results

The proportion of patients who received a follow-up phone call by a clinical pharmacist or meeting with their primary care provider within 7 days of discharge has gone from 34.7% to 42.9%, a relative improvement of 23.6%.

Average communication scores between workgroups went from 3.4 at baseline to 3.6 at follow-up, a relative improvement of 5.9%, and relationships went from 4.0 at baseline to 4.3 at follow-up, a relative improvement of 7.5%.

### Resources created during the study

## Can the patient take their MEDS?

**E**ngage in shared decision making

**M**edication reconciliation

**P**rescriptions available

**O**ut of pocket costs assessed

**W**e discuss compliance

**E**ducate

**R**eview of follow up care



In order to be successful with your new anticoagulant medication, it is important that you work together with your providers to ensure safe and effective care.

Use the following checklist to confirm that you are ready to start taking your MEDS:

**M** My medications are affordable and ready for pick up.

- ✓ Prescription has been sent to my preferred pharmacy.
- ✓ Pharmacy has the medication in stock.
- ✓ The out-of-pocket cost is affordable to me.

**E** Education about the medication has been provided to me.

- ✓ I know why I have been prescribed this medication.
- ✓ I know how and when to take the medication(s).
- ✓ I am aware of the potential side effects.

**D** Discussed my available resources.

- ✓ I know who to call if I have any further questions.

**S** Scheduled follow up appointments.

- ✓ I have an upcoming appointment with \_\_\_\_\_ on \_\_\_\_\_.

## About AMGA's ASPIRE Program

Accelerating System Progress with Implementation Research and Education (ASPIRE) is a new AMGA program designed to facilitate change, using methods grounded in implementation science to increase the widespread adoption of evidence-based practice. Each ASPIRE project is led by a multidisciplinary team of national experts in clinical and operational healthcare management, implementation science, and population health. Members participating in ASPIRE projects receive individualized support from advisors in guideline and measure development, as well as design and implementation of internal workflow processes. AMGA's research and analytics team conducts rigorous evaluations for each ASPIRE project to document changes in workflow and communication and to disseminate successful approaches to other AMGA members. For more information, contact [research@amga.org](mailto:research@amga.org).

## About AMGA

AMGA is a trade association leading the transformation of healthcare in America. Representing multispecialty medical groups and integrated systems of care, we advocate, educate, innovate, and empower our members to deliver the next level of high performance health. AMGA is the national voice promoting awareness of our members' recognized excellence in the delivery of coordinated, high-quality, high-value care. Over 177,000 physicians practice in our member organizations, delivering care to more than one in three Americans.

**References:** **1.** About Learning Health Systems. [Ahrq.gov](https://www.ahrq.gov/learning-health-systems/about.html). Published 2019. Accessed March 13, 2024. <https://www.ahrq.gov/learning-health-systems/about.html>. **2.** Data on file. 2023 AMGA.



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