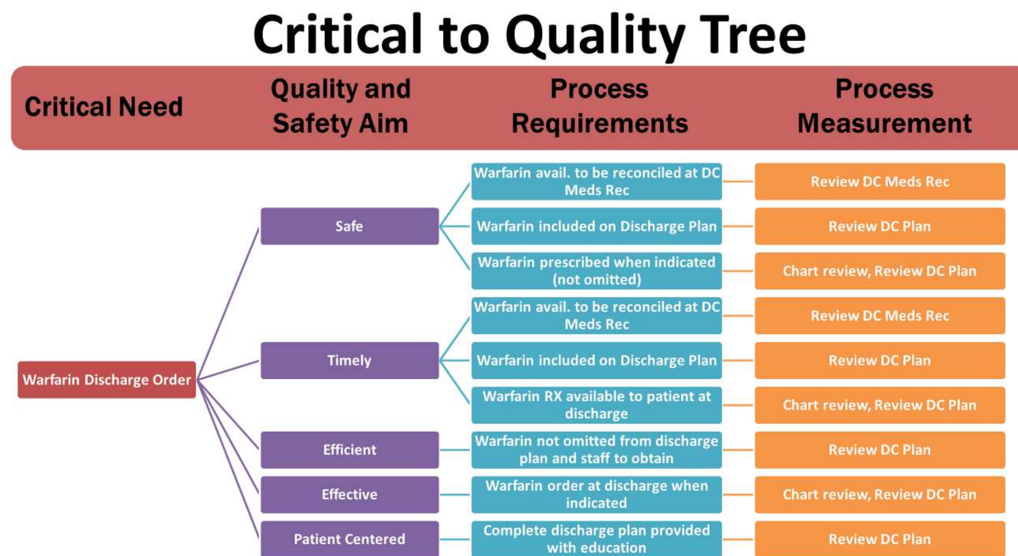
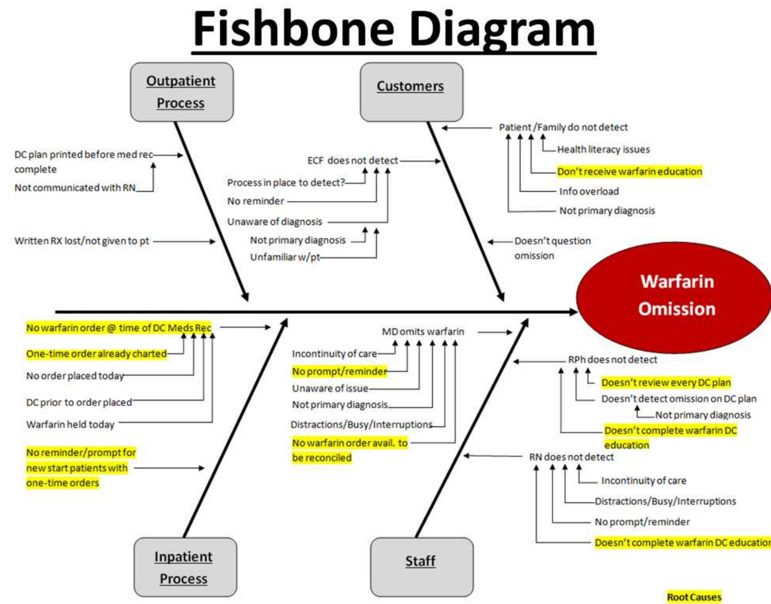
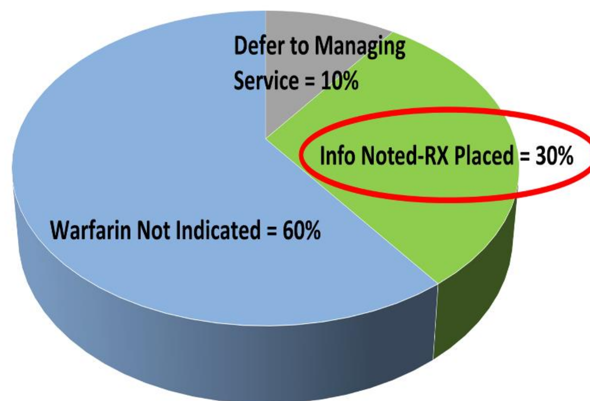


Supplemental Figure 1. Critical to quality tree was used to determine process requirements and measurements that aligned with quality and safety aims to meet the critical need of a warfarin discharge order. Abbreviations: Avail-available, DC-discharge, Meds-Medication, Rec-Reconciliation, RX-prescription



Supplemental Figure 2. Fishbone diagram was used to determine customer, outpatient process, staff, and inpatient process contributing factors for warfarin omission. Identified contributing factors are highlighted in yellow. Abbreviations: DC-Discharge, ECF-Extended Care Facility, Info-Information, MD-physician, Med-Medication, Rec-reconciliation, RN-Registered Nurse, RPh-Registered Pharmacist, RX-prescription, w/pt-with patient



Supplemental Figure 3. Warfarin order was subsequently placed following the alert on 30% (12/40) of patients, warfarin was not indicated at discharge in 60% (24/40) of patients, and alert was deferred in 10% (4/40) of patients.

The Control Plan

Step	Measures	Data Collection	Data Display	Special Cause Response	Person Responsible
FINAL Alert Response	Provider final alert response / month	Warfarin Alert Report	Pie chart	Individual retraining and follow-up	Supervisor, Medication Safety Director, Clinical Informatics
Warfarin Omissions	Warfarin omissions/ week Target = 0%	Warfarin Alert Report w/Chart Audit	Control Chart	Individual retraining and follow-up	Supervisor, Medication Safety Director, Clinical Informatics
FINAL Alert Response "Will Place RX"	# of final alert response "Will Place RX" / week (warfarin omissions prevented)	Warfarin Alert Report			Supervisor, Medication Safety

Supplemental Figure 4. Screenshot of control plan used to monitor and sustain results. Data monitored included number of alerts, warfarin omissions, and final alert responses of "will place Rx".