Nursing Homes and Medication Management: Strategies for Success-Part 2

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Medication Reconciliation

> Medication reconciliation is the process of comparing a patient's medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. It should be done at every transition of care in which new medications are ordered or existing orders are rewritten.

The Joint Commission. Medication reconciliation. Sentinel event alert, Issue 35.2006. http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/se_35.htm Accessed August 15, 2016

Medication Errors & Discrepancies in Nursing Homes

- 70% of nursing home admissions include at least one medication discrepancy and an average of 3.5 discrepancies per admission from hospital

  Tjia, et al, Medication Discrepancies upon Hospital to Skilled Nursing Facility Transitions. J Gen Intern Med. 2009

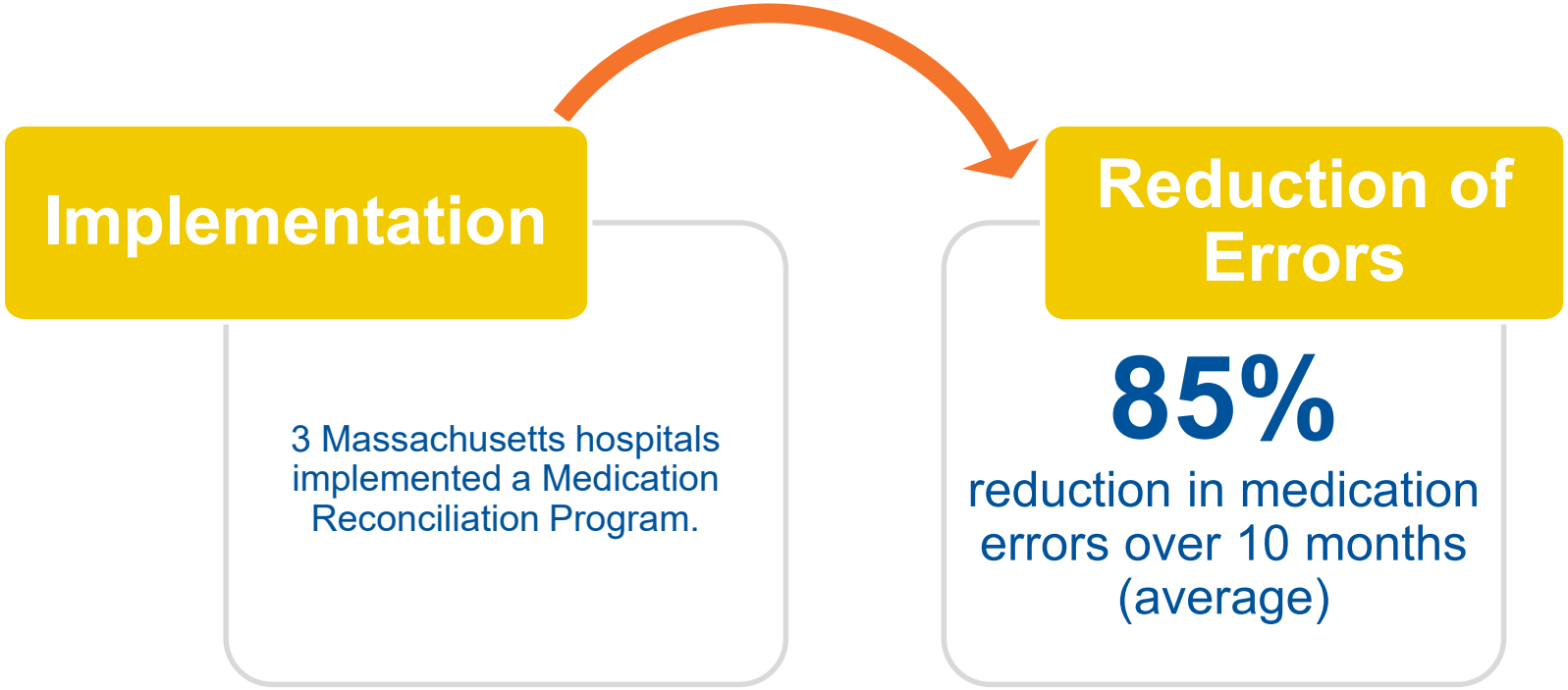
- Up to 90% of nursing home health records contained at least one medication discrepancy

  Tong, et al, Nursing home medication reconciliation: a quality improvement initiative. J Gerontol Nurs. 2017

- A well-run medication reconciliation program improves outcomes
  - A nurse practitioner run standardized medication reconciliation process resulted in a 29.7% decrease in the rate of hospital readmissions within a 30-day period

    Anderson, et al, A nurse practitioner-led medication reconciliation process to reduce hospital readmissions from a skilled nursing facility. J Am Assoc Nurse Pract. 2020

Benefit of Medication Reconciliation Program



The Joint Commission Journal on Quality and Patient Safety. January 2006. (32)1:48

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Preventing and Reducing Adverse Drug Events

The National Action Plan for Adverse Drug Event Prevention:

Anticoagulants, Opioids, Hypoglycemics:

- ✓ **Communication failures**
- ✓ **Suboptimal management systems**
- ✓ **Inadequate access to medication lists and lab results**

"Medication reconciliation as a care transitions strategy is important to reduce potential medication discrepancies."

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Transition of Care

The movement of patients between health care locations, providers, or different levels of care within the same location as their conditions and care needs change.

Coleman, Eric A. Commissioned Paper: Transitional Care Performance Measurement. Performance Measurement Report, Institute of Medicine, 2006. Appendix I, pp. 250-276.

Medication Reconciliation Challenges During Transitions

- Lack of standardized process, clear ownership
- Communication failures
- Coordination gaps
- Non-formulary medications and therapeutic interchanges
- Lack of standardized medication list “source of truth”

A Good Medication History Is Critical for Patient/Resident Safety

- Adverse drug events
  - Definition: injury due to a medication
  - Affect ~10% of patients during hospitalization
  - Affect ~15% of patients after hospital discharge
- Errors in the medication history
  - Account for up to 75% of all potentially harmful medication discrepancies in admission and discharge orders

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Steps involved with Medication Reconciliation

1. **Verification:**
   Taking the Best Possible Medication History (BPMH)
2. **Clarification:**
   Ensuring appropriateness of medications
3. **Reconciliation:**
   Documenting changes to the orders

IHI. Getting Started Kit: Prevent Adverse Drug Events (Medication Reconciliation. How-to Guide.

Verification: Taking the BPMH

BPMH is “the most accurate list of medications the patient should be taking and the list of medications the patient is actually taking prior to admission.”

Society of Hospital Medicine. Marquis Implementation Manual;
A guide for Medications reconciliation quality improvement. September 15, 2011.

Goals of a Good Medication History

- To obtain complete information on the patient's regimen, including the:
  - Name of each medication
  - Formulation (e.g., extended release)
  - Dosage
  - Route
  - Frequency
- To distinguish between what patients are supposed to be on vs. what they actually take

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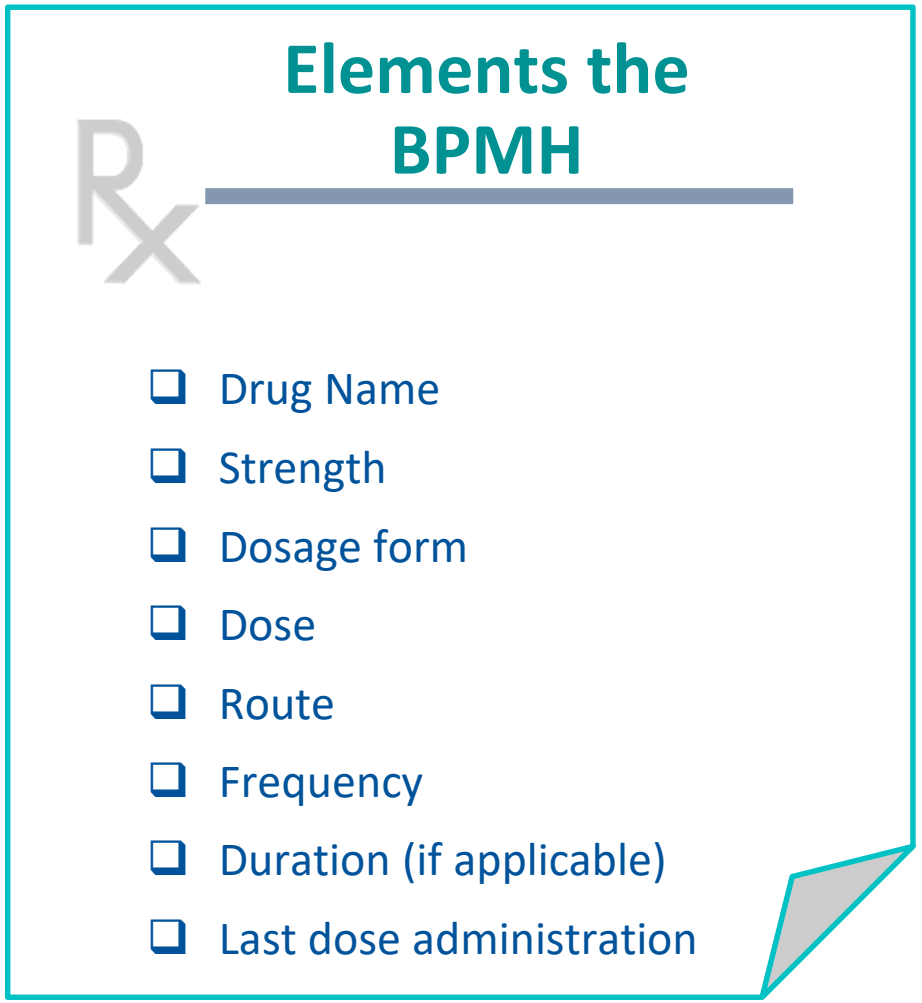
Elements the BPMH



History Also Ideally Includes

- Drug indications
- Any recent changes in the regimen
- Over-the-counter drugs
- Sample medications
- Vitamins, herbals, nutraceuticals, supplements
- When the patient last took each medication
- Allergies and the associated reactions
- Prescriber(s)
- Pharmacy(ies)

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Obtaining the Best Possible Medication History

- Obtaining and comparing existing medication lists
  - Pre-hospital admission med list
    - EHR medication list
    - Community pharmacy – *critical for understanding patterns of adherence*
    - Health Information Exchange list (SureScripts, DrFirst, local RHIO)
  - Hospital discharge medications list
  - Inventory of medications in home
- Patient/family/care partner interview
  - Structured questions

[Tools: MARQUIS, IHI]

Medication History Probes

- Assess when was the last dose of each med
  - *When did you take the last dose of your [warfarin, blood pressure medicine, insulin]?*
- Ask about adherence
  - *Many patients don't take their medicines exactly as they should every day. In the last week, how many days have you missed a dose of one of your medicines?*

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When to Gather Additional Data

- Patient/resident is unsure about medication names, doses, and indications
- Patient/resident cannot explain discrepancies in lists
- Patient/resident doesn't have a list and can't provide medication information from memory
- Sources of information not updated recently
- The missing information is potentially dangerous

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High-Performance Behaviors

Asks the patient open-ended questions about what medications she or he is taking (i.e., doesn't read the list and ask if it is correct)	☐
Uses probing questions to elicit additional information: non-oral meds, non-daily meds, PRN medications, non-prescription meds	☐
Uses other probes to elicit additional medications: common reasons for PRNs, meds for problems in the problem list, meds prescribed by specialists	☐
Asks about adherence	☐
Uses at least two sources of medications, ideally one provided by the patient and one from another "objective" source (e.g., patient's own list and ambulatory EMR med list)	☐
Knows when to stop getting additional sources (e.g., if patient has a list or pill bottles and seems completely reliable and data are not that dissimilar from the other sources, and/or the differences can be explained)	☐
Knows when to get additional sources if available (e.g., if patient is not sure, relying on memory only or cannot resolve discrepancies among the various sources of medication information)	☐
When additional sources are needed, uses available sources first (e.g., pill bottles present). Then obtains pharmacy data. If the medication history is still not clear: obtains outpatient provider lists, pill bottles from home and/or other sources.	☐
Uses resources like Drugs.com to identify loose medications (i.e., for a bag of medications, not in their bottles, provided by a patient)	☐
Returns to patient to review new information, resolve all remaining discrepancies	☐
Gets help from other team members when needed	☐
Educates the patient and/or caregiver of the importance of carrying an accurate and up to date medication list with them	☐

I have a list. Now what?

- The BPMH is used to:
  - Initiate admission orders
  - Compare needs and identify problems at transfer of care
  - Identify needs and potential concerns at discharge.
- BPMH is the critical first step in medication reconciliation

Clarification

Goal:

✓ Identify potentially serious drug related problems

- Discrepancies
- Appropriateness
- Drug interactions
- Therapeutic duplication

Categories of Medication Related Problems (MRPs):

Medication Related Problems

- Unnecessary medications
- Wrong medication
- Dose too low
- Dose too high
- Adverse drug reaction
- Inappropriate adherence
- Needs additional drug therapy

Medication Discrepancies

- Unintended or unexplained/undocumented differences among medication lists across different sites of care. Examples are:
  - Omissions
  - Duplications
  - Dose/frequency/route of administration errors
  - Drug name discrepant/incorrect
- Sometimes discrepancies are differentiated as “intended” or “unintended” – intended discrepancies would have the rationale documented

Reconciliation

- **Composing a single Medication Strategy**
  - Continuing verified medications on BPMH when appropriate during current clinical circumstance
  - Addressing concerns identified during the verification and clarification steps of medication reconciliation

Transmission

- Documenting medication list
- Offering the information for future consideration at transfers of care

Specific Concerns at Discharge

- 3 med lists to reconcile
  - BPMH
  - Active medication orders
  - Home medication list post-discharge
- Self-care post-discharge
  - Disease state education
  - Medication counseling
- Care coordination
  - Primary care providers
  - Specialists
  - Community Pharmacy
  - Essential high risk medication communication elements

Barriers to Medication Reconciliation

- Ownership of the task
  - Perception of added work
- Interprofessional collaboration
- No standardized process
- Patient unable to provide information
- Linking BPMH to each transition of care order process
- Time

Strategies to Implement: Leadership

- Organizational commitment to medication safety
  - Leadership provides framework and resources
  - Accountability
  - Culture of safety with a just and non-punitive error reporting and learning environment
  - Implementation of effective medication safety processes

Strategies to Implement: Logistics

- Personnel
  - Are personnel already doing this job?
  - If not, are personnel available who could be re-allocated to this job?
  - If not, can you hire new personnel?
  - If not, how can you get the resources to do this?

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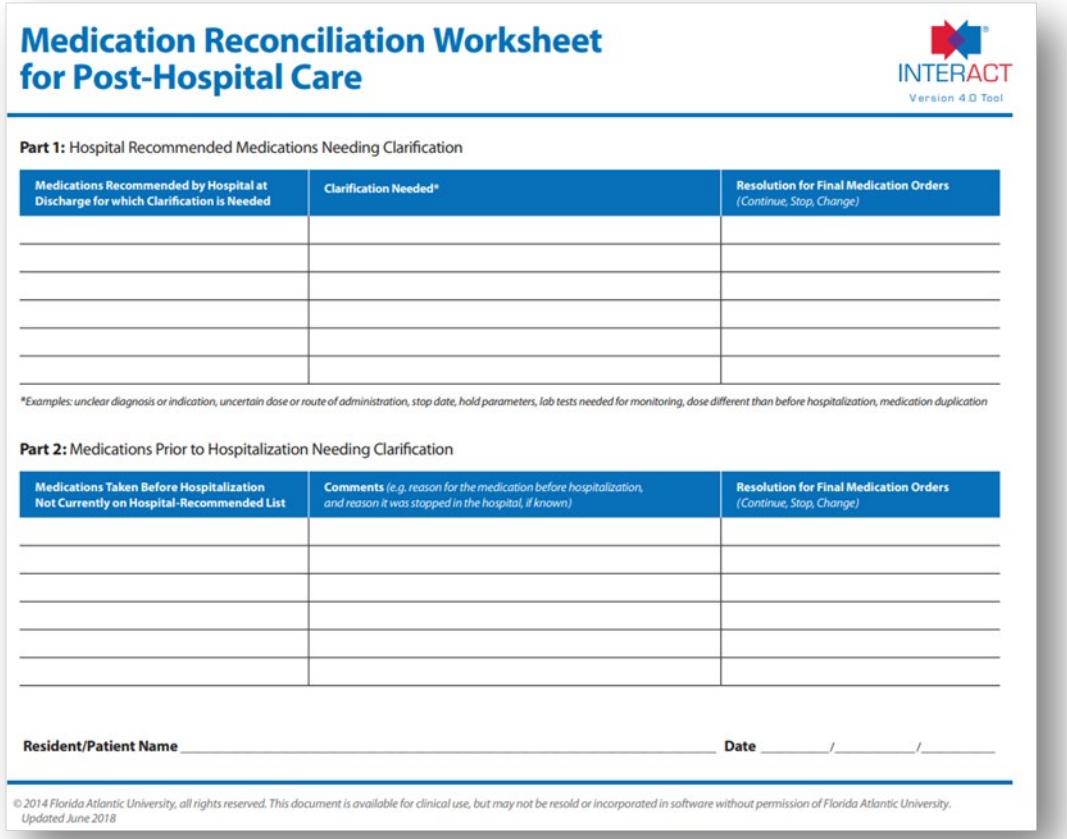
Summary

- Implement an effective medication reconciliation program on patient admission and discharge
- Medication reconciliation consists of verification (BPMH), clarification (med appropriateness), and documentation (documentation of changes and final list)
- Safe medication management requires effective communication on transitions of care

Medication Reconciliation Resources

- Society of Hospital Medicine's MARQUIS Implementation Manual and Med Rec Collaborative
- INTERACT tools and resources
- Institute for Healthcare Improvement Medication Reconciliation Resources to Prevent Adverse Drug Events



Medication Reconciliation Worksheet for Post-Hospital Care

INTERACT Version 4.0 Tool

Part 1: Hospital Recommended Medications Needing Clarification

Medications Recommended by Hospital at Discharge for which Clarification is Needed	Clarification Needed*	Resolution for Final Medication Orders (Continue, Stop, Change)

*Examples: unclear diagnosis or indication, uncertain dose or route of administration, stop date, hold parameters, lab tests needed for monitoring, dose different than before hospitalization, medication duplication

Part 2: Medications Prior to Hospitalization Needing Clarification

Medications Taken Before Hospitalization Not Currently on Hospital-Recommended List	Comments (e.g. reason for the medication before hospitalization, and reason it was stopped in the hospital, if known)	Resolution for Final Medication Orders (Continue, Stop, Change)

Resident/Patient Name _____ Date ____/____/____

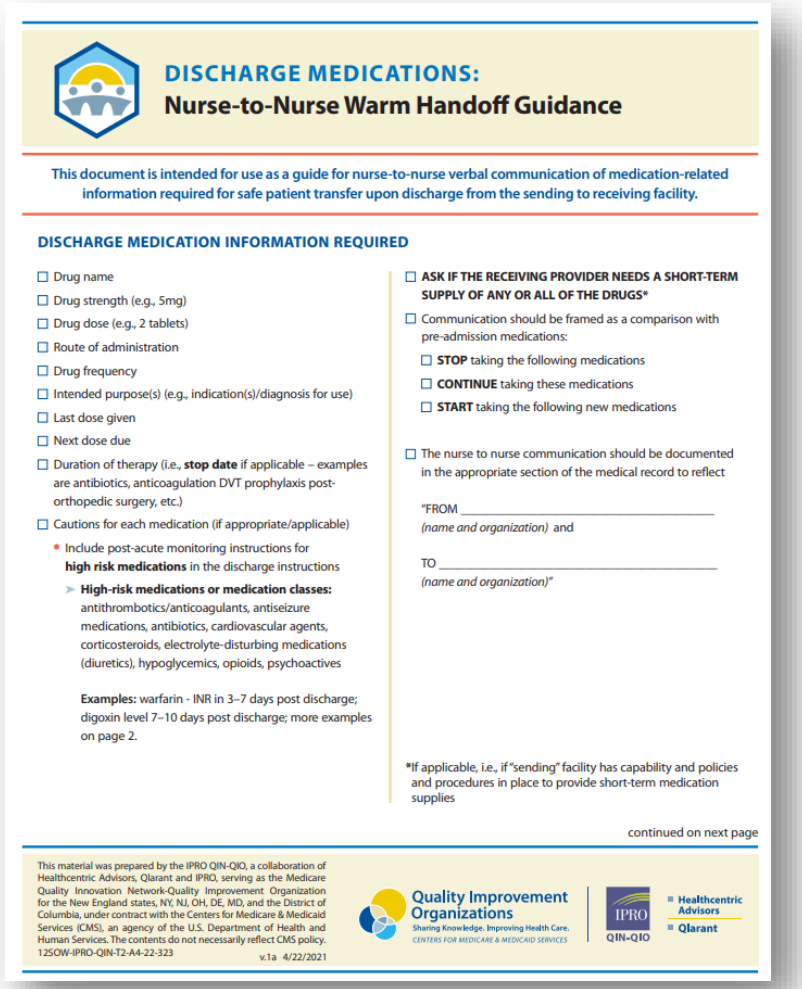
Updated June 2018

Resources for Safe Medication Use

- Be aware of medications that should not be crushed
- http://www.ismp.org/tools/donotcrush.pdf

Drug Product	Active Ingredient(s)	Dosage Form(s)	Reasons/Comments
Abilify MyCite kit	(aripiprazole)	Tablet	Drug-device combination
Absorica	(**ISO**tretinoin)	Capsule	Mucous membrane irritant
Abstral	(fenta**NYL**)	Tablet	Note: Sublingual tablet; do not suck, chew, or swallow whole.
AcipHex	(rabeprazole)	Tablet	Slow-release
AcipHex Sprinkle	(rabeprazole)	Capsule	Slow-release; Note: contents are intended to be sprinkled on food or liquid but should not be chewed or crushed.
Acticlate	(doxycycline hyclate)	Capsule; Tablet	Film-coated; tablet is scored and may be split; Note: 150 mg tablets can be broken into two-thirds or one-third to provide a 100 mg and 50 mg strength, respectively
Actiq	(fenta**NYL**)	Lozenge	Slow-release; Note: this lollipop delivery system requires the patient to slowly allow dissolution. If chewed and swallowed, may result in a lower peak concentration and bioavailability.
Actonel	(risedronate)	Tablet	Irritant; Note: chewed, crushed, or sucked tablets may cause oropharyngeal ulceration.
Actoplus Met Xr	(combination)	Tablet	Slow-release
Adalat CC	(**NIFE**dipine)	Tablet	Slow-release
Adderall XR	(amphetamine salts)	Capsule	Slow-release (a)

Nursing Home Warm Hand-off Across Care Settings



DISCHARGE MEDICATIONS: Nurse-to-Nurse Warm Handoff Guidance

This document is intended for use as a guide for nurse-to-nurse verbal communication of medication-related information required for safe patient transfer upon discharge from the sending to receiving facility.

DISCHARGE MEDICATION INFORMATION REQUIRED

- ☐ Drug name
- ☐ Drug strength (e.g., 5mg)
- ☐ Drug dose (e.g., 2 tablets)
- ☐ Route of administration
- ☐ Drug frequency
- ☐ Intended purpose(s) (e.g., indication(s)/diagnosis for use)
- ☐ Last dose given
- ☐ Next dose due
- ☐ Duration of therapy (i.e., **stop date** if applicable – examples are antibiotics, anticoagulation DVT prophylaxis post-orthopedic surgery, etc.)
- ☐ Cautions for each medication (if appropriate/applicable)
  - Include post-acute monitoring instructions for **high risk medications** in the discharge instructions
    - **High-risk medications or medication classes:** antithrombotics/anticoagulants, antiseizure medications, antibiotics, cardiovascular agents, corticosteroids, electrolyte-disturbing medications (diuretics), hypoglycemics, opioids, psychoactives

      Examples: warfarin - INR in 3–7 days post discharge; digoxin level 7–10 days post discharge; more examples on page 2.

- ☐ **ASK IF THE RECEIVING PROVIDER NEEDS A SHORT-TERM SUPPLY OF ANY OR ALL OF THE DRUGS***
- ☐ Communication should be framed as a comparison with pre-admission medications:
  - ☐ **STOP** taking the following medications
  - ☐ **CONTINUE** taking these medications
  - ☐ **START** taking the following new medications
- ☐ The nurse to nurse communication should be documented in the appropriate section of the medical record to reflect

  "FROM _____
  (name and organization) and

  TO _____
  (name and organization)"

*If applicable, i.e., if "sending" facility has capability and policies and procedures in place to provide short-term medication supplies

continued on next page

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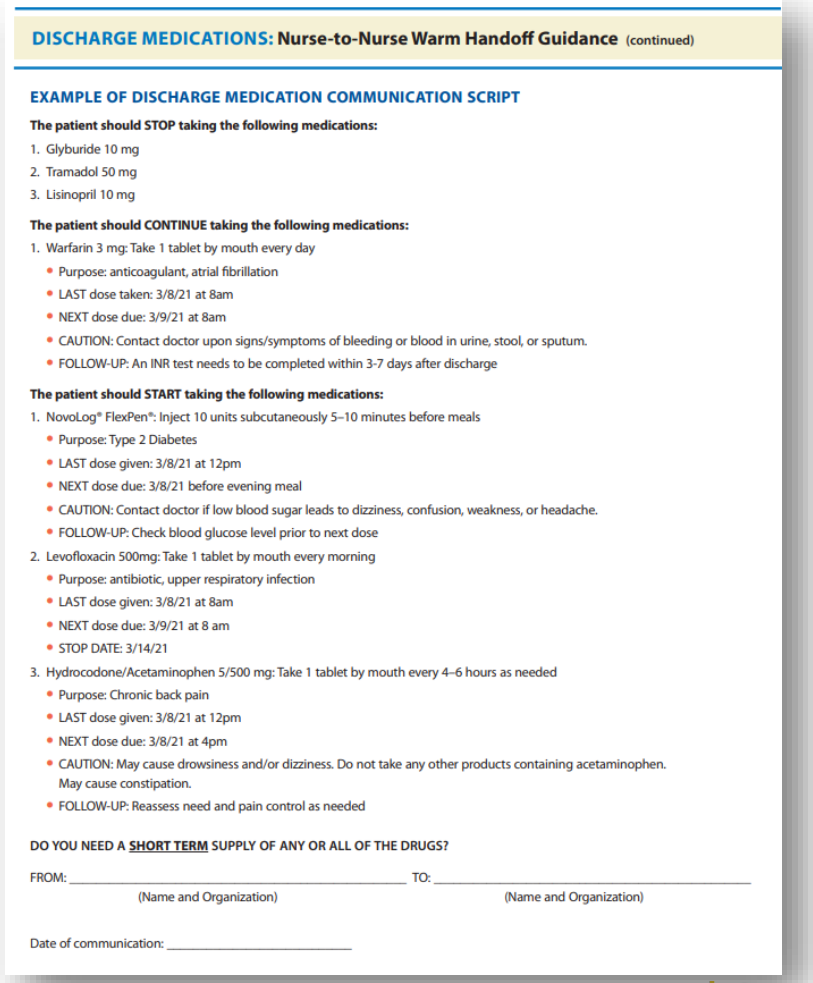

DISCHARGE MEDICATIONS: Nurse-to-Nurse Warm Handoff Guidance (continued)

EXAMPLE OF DISCHARGE MEDICATION COMMUNICATION SCRIPT

The patient should STOP taking the following medications:

1. Glyburide 10 mg
2. Tramadol 50 mg
3. Lisinopril 10 mg

The patient should CONTINUE taking the following medications:

1. Warfarin 3 mg: Take 1 tablet by mouth every day
   - Purpose: anticoagulant, atrial fibrillation
   - LAST dose taken: 3/8/21 at 8am
   - NEXT dose due: 3/9/21 at 8am
   - CAUTION: Contact doctor upon signs/symptoms of bleeding or blood in urine, stool, or sputum.
   - FOLLOW-UP: An INR test needs to be completed within 3-7 days after discharge

The patient should START taking the following medications:

1. NovoLog® FlexPen®: Inject 10 units subcutaneously 5–10 minutes before meals
   - Purpose: Type 2 Diabetes
   - LAST dose given: 3/8/21 at 12pm
   - NEXT dose due: 3/8/21 before evening meal
   - CAUTION: Contact doctor if low blood sugar leads to dizziness, confusion, weakness, or headache.
   - FOLLOW-UP: Check blood glucose level prior to next dose
2. Levofloxacin 500mg: Take 1 tablet by mouth every morning
   - Purpose: antibiotic, upper respiratory infection
   - LAST dose given: 3/8/21 at 8am
   - NEXT dose due: 3/9/21 at 8 am
   - STOP DATE: 3/14/21
3. Hydrocodone/Acetaminophen 5/500 mg: Take 1 tablet by mouth every 4–6 hours as needed
   - Purpose: Chronic back pain
   - LAST dose given: 3/8/21 at 12pm
   - NEXT dose due: 3/8/21 at 4pm
   - CAUTION: May cause drowsiness and/or dizziness. Do not take any other products containing acetaminophen. May cause constipation.
   - FOLLOW-UP: Reassess need and pain control as needed

DO YOU NEED A SHORT TERM SUPPLY OF ANY OR ALL OF THE DRUGS?

FROM: _____ (Name and Organization) TO: _____ (Name and Organization)

Date of communication: _____

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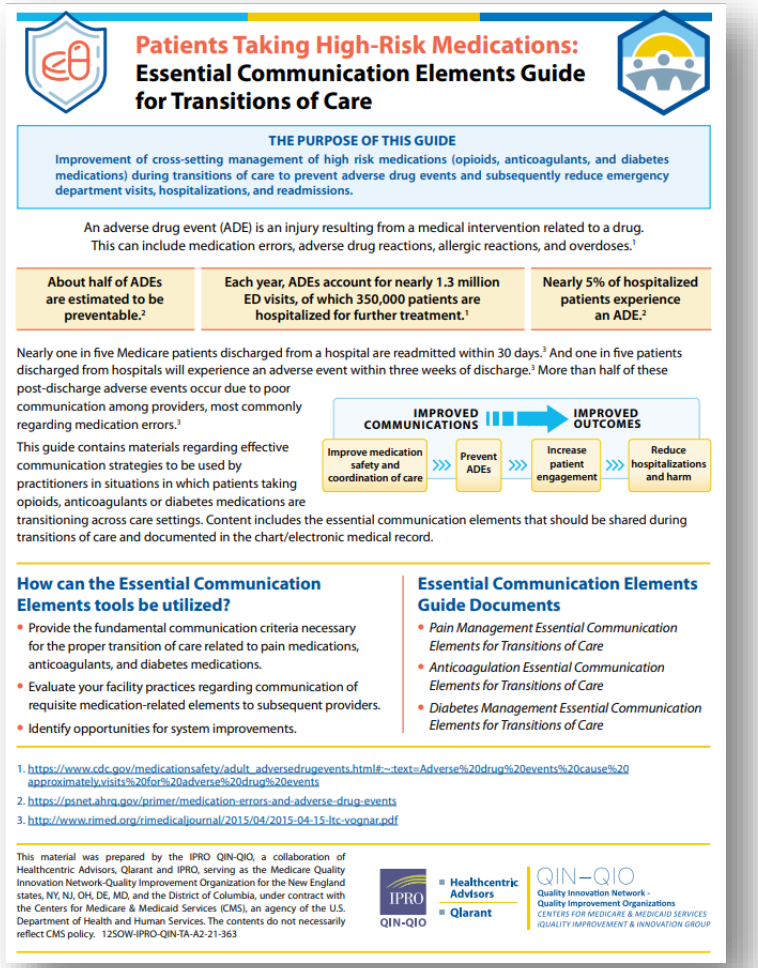
High Risk Medication Essential Communication at Transitions of Care



Patients Taking High-Risk Medications: Essential Communication Elements Guide for Transitions of Care

THE PURPOSE OF THIS GUIDE

Improvement of cross-setting management of high risk medications (opioids, anticoagulants, and diabetes medications) during transitions of care to prevent adverse drug events and subsequently reduce emergency department visits, hospitalizations, and readmissions.

An adverse drug event (ADE) is an injury resulting from a medical intervention related to a drug. This can include medication errors, adverse drug reactions, allergic reactions, and overdoses.[1]

About half of ADEs are estimated to be preventable.[2]	Each year, ADEs account for nearly 1.3 million ED visits, of which 350,000 patients are hospitalized for further treatment.[1]	Nearly 5% of hospitalized patients experience an ADE.[2]

Nearly one in five Medicare patients discharged from a hospital are readmitted within 30 days.[3] And one in five patients discharged from hospitals will experience an adverse event within three weeks of discharge.[3] More than half of these post-discharge adverse events occur due to poor communication among providers, most commonly regarding medication errors.[3]

This guide contains materials regarding effective communication strategies to be used by practitioners in situations in which patients taking opioids, anticoagulants or diabetes medications are transitioning across care settings. Content includes the essential communication elements that should be shared during transitions of care and documented in the chart/electronic medical record.

IMPROVED COMMUNICATIONS → IMPROVED OUTCOMES

Improve medication safety and coordination of care → Prevent ADEs → Increase patient engagement → Reduce hospitalizations and harm

How can the Essential Communication Elements tools be utilized?

- Provide the fundamental communication criteria necessary for the proper transition of care related to pain medications, anticoagulants, and diabetes medications.
- Evaluate your facility practices regarding communication of requisite medication-related elements to subsequent providers.
- Identify opportunities for system improvements.

Essential Communication Elements Guide Documents

- *Pain Management Essential Communication Elements for Transitions of Care*
- *Anticoagulation Essential Communication Elements for Transitions of Care*
- *Diabetes Management Essential Communication Elements for Transitions of Care*

1. https://www.cdc.gov/medicationsafety/adult_adversedrugevents.html#:~:text=Adverse%20drug%20events%20cause%20approximately,visits%20for%20adverse%20drug%20events
2. https://psnet.ahrq.gov/primer/medication-errors-and-adverse-drug-events
3. http://www.rimed.org/rimedicaljournal/2015/04/2015-04-15-ltc-vognar.pdf

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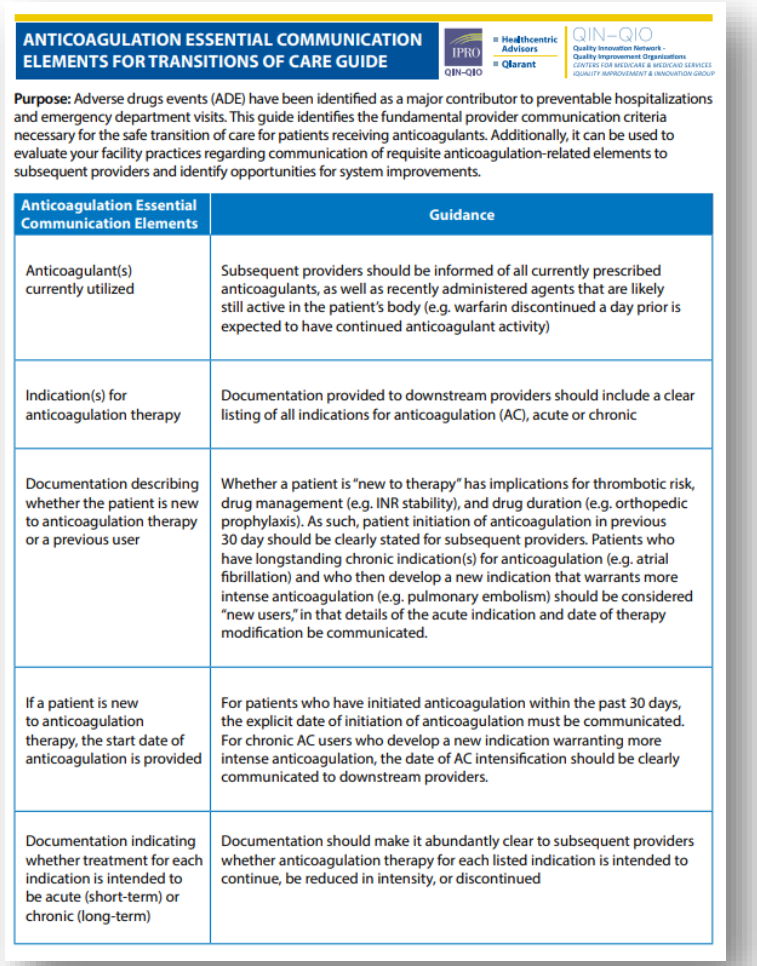
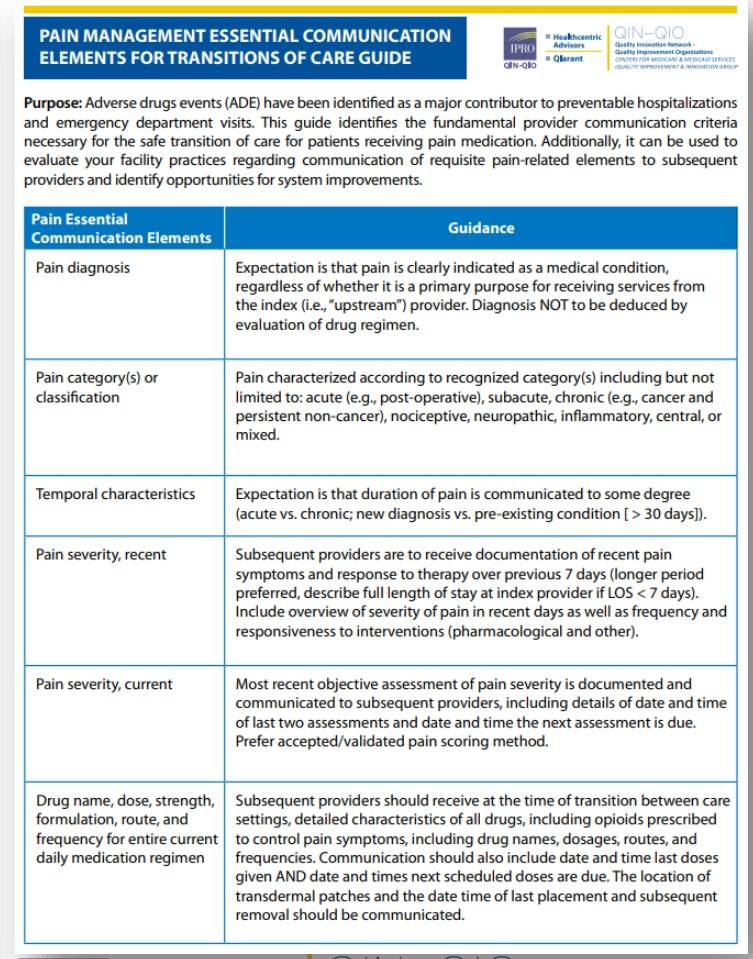


ANTICOAGULATION ESSENTIAL COMMUNICATION ELEMENTS FOR TRANSITIONS OF CARE GUIDE

Purpose: Adverse drugs events (ADE) have been identified as a major contributor to preventable hospitalizations and emergency department visits. This guide identifies the fundamental provider communication criteria necessary for the safe transition of care for patients receiving anticoagulants. Additionally, it can be used to evaluate your facility practices regarding communication of requisite anticoagulation-related elements to subsequent providers and identify opportunities for system improvements.

Anticoagulation Essential Communication Elements	Guidance
Anticoagulant(s) currently utilized	Subsequent providers should be informed of all currently prescribed anticoagulants, as well as recently administered agents that are likely still active in the patient's body (e.g. warfarin discontinued a day prior is expected to have continued anticoagulant activity)
Indication(s) for anticoagulation therapy	Documentation provided to downstream providers should include a clear listing of all indications for anticoagulation (AC), acute or chronic
Documentation describing whether the patient is new to anticoagulation therapy or a previous user	Whether a patient is "new to therapy" has implications for thrombotic risk, drug management (e.g. INR stability), and drug duration (e.g. orthopedic prophylaxis). As such, patient initiation of anticoagulation in previous 30 day should be clearly stated for subsequent providers. Patients who have longstanding chronic indication(s) for anticoagulation (e.g. atrial fibrillation) and who then develop a new indication that warrants more intense anticoagulation (e.g. pulmonary embolism) should be considered "new users," in that details of the acute indication and date of therapy modification be communicated.
If a patient is new to anticoagulation therapy, the start date of anticoagulation is provided	For patients who have initiated anticoagulation within the past 30 days, the explicit date of initiation of anticoagulation must be communicated. For chronic AC users who develop a new indication warranting more intense anticoagulation, the date of AC intensification should be clearly communicated to downstream providers.
Documentation indicating whether treatment for each indication is intended to be acute (short-term) or chronic (long-term)	Documentation should make it abundantly clear to subsequent providers whether anticoagulation therapy for each listed indication is intended to continue, be reduced in intensity, or discontinued



PAIN MANAGEMENT ESSENTIAL COMMUNICATION ELEMENTS FOR TRANSITIONS OF CARE GUIDE

Purpose: Adverse drugs events (ADE) have been identified as a major contributor to preventable hospitalizations and emergency department visits. This guide identifies the fundamental provider communication criteria necessary for the safe transition of care for patients receiving pain medication. Additionally, it can be used to evaluate your facility practices regarding communication of requisite pain-related elements to subsequent providers and identify opportunities for system improvements.

Pain Essential Communication Elements	Guidance
Pain diagnosis	Expectation is that pain is clearly indicated as a medical condition, regardless of whether it is a primary purpose for receiving services from the index (i.e., "upstream") provider. Diagnosis NOT to be deduced by evaluation of drug regimen.
Pain category(s) or classification	Pain characterized according to recognized category(s) including but not limited to: acute (e.g., post-operative), subacute, chronic (e.g., cancer and persistent non-cancer), nociceptive, neuropathic, inflammatory, central, or mixed.
Temporal characteristics	Expectation is that duration of pain is communicated to some degree (acute vs. chronic; new diagnosis vs. pre-existing condition [> 30 days]).
Pain severity, recent	Subsequent providers are to receive documentation of recent pain symptoms and response to therapy over previous 7 days (longer period preferred, describe full length of stay at index provider if LOS < 7 days). Include overview of severity of pain in recent days as well as frequency and responsiveness to interventions (pharmacological and other).
Pain severity, current	Most recent objective assessment of pain severity is documented and communicated to subsequent providers, including details of date and time of last two assessments and date and time the next assessment is due. Prefer accepted/validated pain scoring method.
Drug name, dose, strength, formulation, route, and frequency for entire current daily medication regimen	Subsequent providers should receive at the time of transition between care settings, detailed characteristics of all drugs, including opioids prescribed to control pain symptoms, including drug names, dosages, routes, and frequencies. Communication should also include date and time last doses given AND date and times next scheduled doses are due. The location of transdermal patches and the date time of last placement and subsequent removal should be communicated.

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Nursing Home Warm Hand-off to Pharmacy

Short Stay Nursing Home to Community Pharmacy "Warm Hand-Off" Process

PURPOSE: To establish a nursing home to community pharmacy care coordination process for patients discharged to home on high-risk drugs.

INSTRUCTIONS:

1. ***Identifying the Community Pharmacy***: The name and contact information of the patient's preferred community pharmacy for discharge medications will be obtained by the discharging nurse.

2. ***Nursing Home Discharging Nurse will initiate the High Risk Medication Form (HRMF)***

   LIST OF HIGH-RISK MEDICATIONS: anticoagulants (Coumadin (warfarin), Pradaxa (dabigatran), Eliquis (apixaban), Xarelto (rivaroxaban), Savaysa (edoxaban), Lovenox (enoxaparin), Fragmin (Dalteparin), Arixtra (fondaparinux), heparin, insulins, oral hypoglycemic agents, aspirin, clopidogrel, dual therapy, digoxin, opioids, and cases of polypharmacy (>5 routine meds).

   - The discharging nurse will fax discharge instructions, the discharge medication reconciliation, and the HRMF to preferred community pharmacy.
   - The discharging nurse telephones the pharmacy to confirm fax receipt and to discuss relevant information with the pharmacist (i.e., "warm hand-off"). Relevant information will include discussion of medication list, any necessary follow up due to clinical status, whether patient already has drug in home, and patient's educational needs. If there are any concerns, the prescriber will be notified.

3. ***Role of Community Pharmacist***
   - Once discharge instructions and discharge medication reconciliation are received, medication related problems (MRPs) will be evaluated.
   - The pharmacist will ensure that medications are in-stock or ordered if necessary for next-dose-due date and time. Or, in the case of non-availability of drug, that an alternative drug or other resolution to the problem is achieved.
   - If medication is not picked up **~1 hour prior** to closing on the next-dose-due date, the pharmacy is to call nursing home nurse to verify if patient was discharged. If so, the pharmacy is to call patient using phone number on the discharge instructions to follow-up on pick up of prescription(s). If the patient is unable to be contacted on the day of discharge, the pharmacy will continue to attempt to call the patient daily for pick up and alert the prescriber of prescription delay.
   - Follow-up is to be documented on the HRMF

HIGH-RISK MEDICATION FORM (HRMF)

NAME OF PATIENT:			MEDICAL RECORD NUMBER:	
TO BE COMPLETED PRIOR TO PATIENT DISCHARGE FROM NURSING HOME				
Most recent medication list reviewed? ☐ Yes ☐ No	Most up-to-date discharge summary and discharge instructions reviewed? ☐ Yes ☐ No	Documents available for fax to community pharmacy? ☐ Yes ☐ No		
High risk medication 1:	MRPs identified & resolved, including insurance issues:		Date & time of next dose due upon discharge:	
High risk medication 2:	MRPs identified & resolved, including insurance issues:		Date & time of next dose due upon discharge:	
High risk medication 3:	MRPs identified & resolved, including insurance issues:		Date & time of next dose due upon discharge:	
List any additional high risk medications?	Call community pharmacy to perform "warm hand-off" – list potential issues to be addressed by receiving pharmacist, other issues identified, etc.:			
Name of nurse completing form:	Name of Pharmacy & Fax #:	Date & time of fax to community pharmacy:		
TO BE COMPLETED BY PHARMACY 1 HOUR PRIOR TO CLOSING ON NEXT DOSE DUE DATE				
Did patient pick up prescription for high risk medication(s)? ☐ Yes ☐ No	If no, did pharmacist call the nurse regarding discharge status? ☐ Yes ☐ No	Date & time of call to nurse:	Was patient discharged ☐ Yes ☐ No	
If discharged, did pharmacist call the patient for rx pick-up? ☐ Yes ☐ No	Date & time of call to patient:	Follow-up notes:		

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Sharing Collaboratives

- Next Steps:
  - Identifying and Categorizing challenges
  - Self-paced learning to train staff
  - New roles for pharmacy partners

Thank you!

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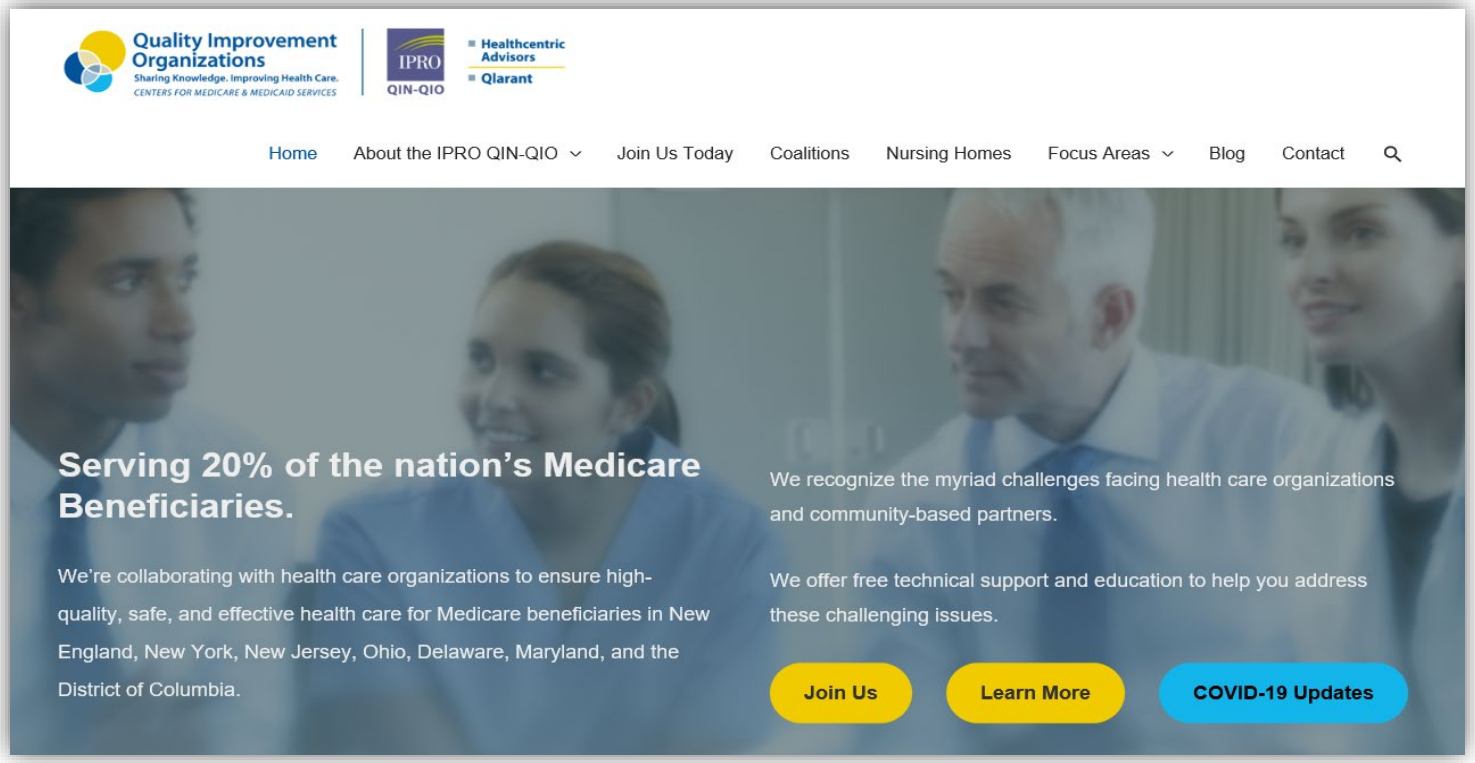

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