Medication review / reconciliation post-discharge
Differences

• Guidelines (Denmark, Netherlands)
• Reimbursement (UK, Netherlands, France)
• Involved health-care professionals (clinical/community pharmacists)
• Information exchange systems (Netherlands, Denmark, Belgium, Spain, France)
Patient identification and selection

• Patient selection → high-risk patients (old AND young, more than 3 drugs and 1 chronic condition)
  – Lot of changes in medication plan during hospitalization
  – Admission due to DRP
  – Risk medication
  – Patients with low health literacy/ cognitive impairment
  – Medication discrepancies identified at admission (by medication reconciliation)

• Identification of patients
  – By clinical pharmacist in hospital (1-2 days before discharge)
  – Screening tool in combination with conversation with patient
  – Referral for medication review by HP to CP
RECONCILIATION AND REVIEW: WHO, WHEN, ELEMENTS
Barriers / Facilitators

AFTER DISCHARGE PHARMACEUTICAL SERVICES HURDLES – HOW TO FIGHT THEM

- Attitude (Pharmacist’s, GP’s, patient’s, hospital’s
- Patient satisfaction
- Leading coordinator
- Collaboration across all settings
- Team work
- Legal and policy structure
- E-information sharing (@)
- PR
- Pharmacist Associations exercising pressure
- Reimbursement
- Training on Medication Review
- Clinical data
- Training (pharmacotherapeutic skills, communication skills)
- Time
- Funding
- Competition with other Health professionals