Medication review / reconciliation post-discharge

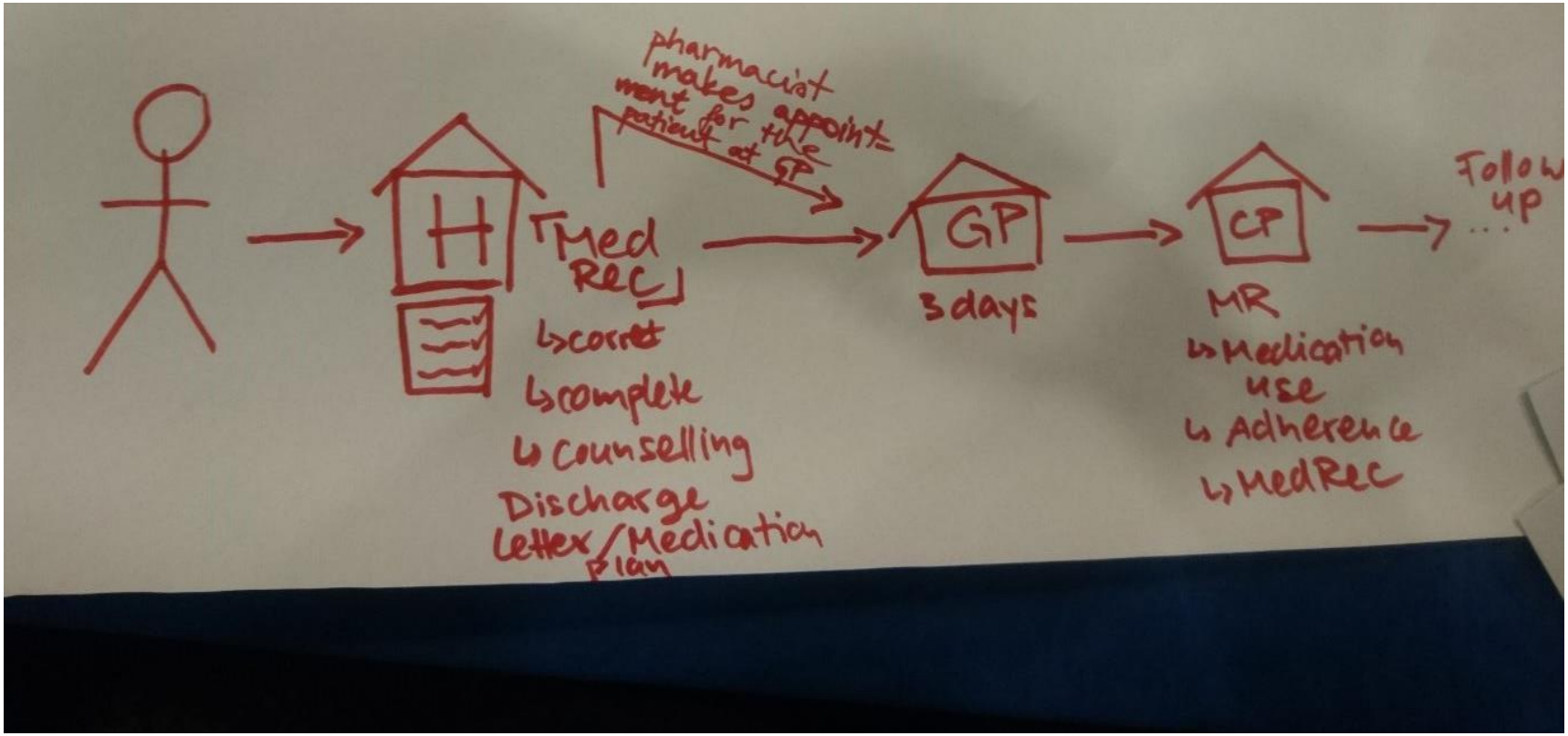
Differences

- 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 impairement
  - 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

RECONCILATION 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 exercing pressure
- Reimbursement
- Training on Medication Review
- clinical data
- Training (pharmacotherapeutic skills, communication skills)
- Time
- Funding
- Competition with other Health professionals