PHARMACIST-LED MEDICATION RECONCILIATION AT DISCHARGE SHALL NOT BE SUFFICIENT TO REDUCE UNPLANNED HEALTHCARE UTILIZATION: HEAR THE PATIENT EXPERIENCE!

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N° 4CPS-035

Background and Importance

Older patients often experience adverse drug events (ADEs) after discharge → may lead to unplanned readmission.

Pharmacist-led Medication Reconciliation at discharge (MRd) has been shown to reduce medication errors that lead to ADE.

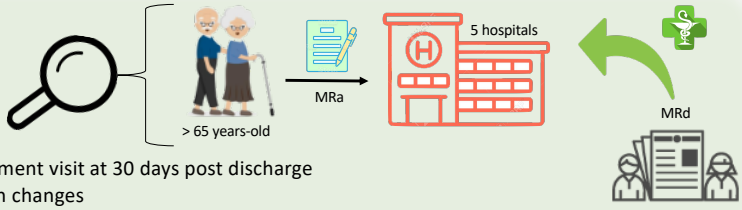
Aim and Objectives

Main objective → To evaluate the MRd's effect provided to patients aged > 65 on their unplanned rehospitalization for ADEs within 30 days.

Secondary objective → To assess impact of pharmacist's presence on patients' experience and knowledge of their treatment.

Materials and Methods

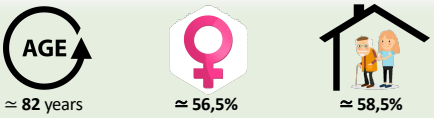
- Observational multicenter prospective study (pragmatic approach)
- In medical and rehabilitation wards in 5 hospitals in Brittany, France.
- Included patients → > 65 years-old who received MR at admission (MRa).
- Intervention → Pharmacist-led MRd.



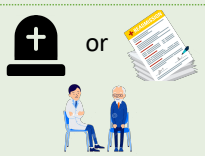
Primary endpoint : % of death / unplanned rehospitalisations / emergency department visit at 30 days post discharge
Secondary endpoints : patient's perception of discharge/knowledge of medication changes

Results

We included overall **377 patients**, divided into a **control group** (« MRa only », n=156) and an **intervention group** (« MRa and MRd », n=221). Both were comparable.



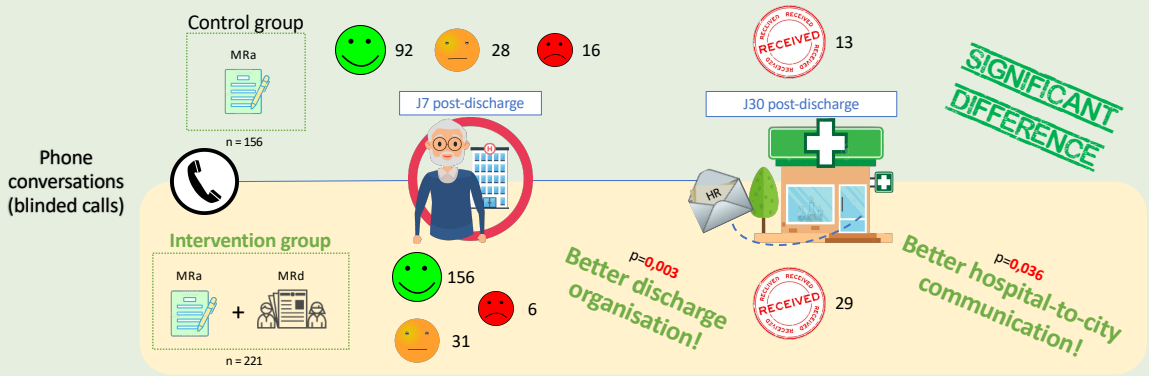
Unplanned healthcare utilization
-
Number of post-discharge visits to the General Practitioner (GP)



NO SIGNIFICANT DIFFERENCE

In the intervention group, at J30 post-discharge, **there was no significantly different % of death, unplanned rehospitalization and/or emergency visit related to ADE** (20 [9%] vs 9 [5,8%]) **or other interventions** (33 [14,9%] vs 23 [14,7%])
This was similar for visits to GPs after discharge.

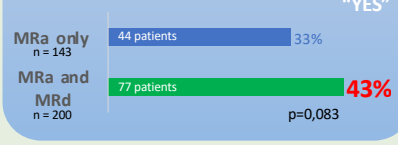
But based on patient feedback ...



SIGNIFICANT DIFFERENCE

For the intervention group, discharge from hospital seemed **well organized (80,8 vs 67,6%)** and **community pharmacist had received information** about their hospital stay at J30 post-discharge more frequently **(47,5 vs 27,7%)**.

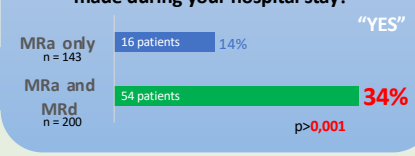
"During your hospitalization, did you meet with a professional to talk about your medications?"



In the intervention group, patients' memory of **the pharmaceutical interview** about their medication with a healthcare professional were better.
Better information for the discharge!

Patients who received MRa and MRd significantly **obtained more information about medication changes** during hospitalisation at discharge.
Better link between patient and healthcare team!

"At the end of your hospitalization, were you given a document (other than a prescription) setting out your medication and the changes made during your hospital stay?"



Conclusion and Relevance

- Our pragmatic study **didn't give the evidence for usefulness of MRd** on healthcare utilization at J30 post-discharge on patients over 65 years-old.
- **MRd significantly improved the patient's experience** on seamless care after discharge.
- **A better integration of pharmacists** in care services is necessary to improve the process, and the best time for the patient's interview remains unclear.
- Study bias: all patients received a MRa, which necessarily improved the baseline of the control group → **Impact of conciliation at the patient's entry!**
- **Further studies are needed** to better understand this positive impact on drug care pathways.

Acknowledgements

Authors acknowledge the French Ministry of Health for financial support, and everyone who worked on the CONPARMED study (NCT04018781).