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.

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.

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 (3 [14.9%] vs 23 [14.7%]) This was similar for visits to GPs after discharge.

But based on patient feedback ...

“During your hospitalization, did you meet with a professional to talk about your medications?”
- MRA only: 143 patients: 33% “YES”
- MRA and MRd: 156 patients: 43% “YES”
p=0.083

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?”
- MRA only: 143 patients: 44% “YES”
- MRA and MRd: 29 patients: 34% “YES”
p=0.001

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.

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