

**2007 ASHP Summer Meeting
P27D**

Category: Quality Assurance / Medication-Use Safety

Type: Descriptive Report

Title: Pharmacist facilitated discharge: a prospective study of medication reconciliation and telephone follow-up interventions

Purpose: Medical inpatients frequently experience medication changes during hospitalization. This increases the risk for potential medication related errors at discharge. These errors may cause adverse events that result in increased readmission costs, as well as increased morbidity and mortality. In an effort to minimize such errors, JCAHO now requires medication reconciliation at discharge. We describe a pharmacist-facilitated discharge process designed both to identify and resolve medication discrepancies prior to discharge and to assist patients in managing medication-related problems that arise during the transition from hospital to home.

Methods: A clinical pharmacist participated in multidisciplinary discharge rounds for selected general medicine services at a large Midwestern academic medical center. The pharmacist screened patients for inclusion using the following criteria: discharge to home, prescribed > 5 medications with at least one high risk medicine, English speaking, and active telephone service. They then identified and communicated discharge medication discrepancies to clinicians for reconciliation, counseled patients and families, provided a reconciled medication list to subsequent providers, and contacted patients by phone within 72 hours after discharge and at 30 days to identify and address post-discharge medication-related problems. All interventions were documented, including number and type of discrepancies, the medications involved, any post-discharge medication-related problems, and the follow-up actions taken.

Results: Over a 10 month period, 958 of the 1122 patients (85%) who were discharged home were screened. 721 (75%) of the screened patients met inclusion criteria. Patient interviews were conducted in 477 of the 721 (66.2%) patients to assess current medication use. 34% (248/721) of eligible patients were counseled at discharge. Time constraints, weekend/evening discharges, and lack of notification of discharge were the most common reasons for failure to counsel. A total of 486 discrepancies were identified and resolved in 63% of patients counseled, with an average of 3 discrepancies per patient. The most common discrepancies were missing medications (41.2%), failure to discontinue unnecessary or inactive medications (23.7%), and wrong dose/frequency (16.3%). Medication discrepancies occurred most frequently with the following therapeutic classes: cardiovascular, analgesic, endocrine, antimicrobial, and gastric acid suppression. Follow-up phone calls within 72 hours and at 30 days were completed respectively in 24% (59/248) and 8.5% (21/248) of patients counseled at discharge. A total of 123 post discharge problems were identified and resolved by the clinical pharmacist.

Conclusion: Medication discrepancies at discharge were disturbingly common. Implementation of a pharmacist facilitated discharge process increased recognition and resolution of these errors. Follow-up telephone calls both enabled pharmacists to reinforce discharge instructions and promoted early recognition and resolution of post-discharge medication-related problems.

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