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Pharmacist-Led Medication Reconciliation at Discharge: Effects on Readmission Rate in the Older Adults with Polypharmacy

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Abstract
This was a prospective interventional study that had assessed the effects of pharmacist-driven medication reconciliation on newer pediatric patients on the rate of hospital readmission within 30 days in patients with polypharmacy aged 65 and above. One hundred and sixty patients (aged 65 years or more, who were taking 5 or more medications) were randomly allocated to either the intervention group (pharmacist reconciliation) or control group (usual care). Pharmacists responded to discharge prescriptions, reached out to community providers and counseled patients and care givers. Medication discrepancies identified 58 percent of the intervention patients and cleared before the discharge. The rate of 30-days readmission was also substantially lower in the intervention group (12.5 percent) as opposed to in the control group (26.2 percent, p = 0.018). Also, the percentage of patient satisfaction and medication adherence was larger in the intervention group. The findings indicate the positive influence of pharmacist-based initiatives in transitional care models to minimise the number of readmissions and address medication security following the outward experience.

Keywords: ***Pharmacist-led, Medication reconciliation, Polypharmacy, Hospital readmission, Older Adults, transitional care,Medication safety.***

1. Introduction

1.1 Daily risks in geriatrics patients regarding medication

Older patients are more vulnerable to medication issues, because aging leads to certain changes in the process of medication effects, namely changes in pharmacokinetics and pharmacodynamics. Generally, when individuals age, their renal and hepatic mechanisms normally deteriorate hence causing them to have an abnormal drug metabolism and excretion. Besides, age-dependent variations in body composition may influence drug distribution, whereby one may lose lean body mass and also gain more fat. All these physiological alterations + existence of many chronic diseases make (e.g., hypertension, diabetes, cardiovascular disease) the management of medications complex and lead to an enhancement of possible adverse drug events (ADEs).

Seniors are more prone to diabolism and bad outcomes of medication since they tend to use several medicines and some of them might cause an interrelation of action or simultaneously result in additive side effects. Risks that exist when there are medication errors are aggravated by poor medication adherence that results in either underuse or overuse of medications. Medication errors among the elderly may lead to readmission and/or functional losses or poor quality of life. It is hence crucial to consider strategies that minimize on medication error and enhance medication safety at high-risk care transitions, like the case at discharge of a hospital.

1.2 Difficulty of Polypharmacy and Transitional Care

Polypharmacy which is an issue of many drugs is prevalent among older people, especially those with multiple chronic illnesses. The subsequent use of drugs leads to a stronger possibility of drug interactions, side effects, and nonadherence to medications. As recent researches show, polypharmacy can be defined as a practice of using five or more medications at the same time, and it is especially common among older patients because treatment of chronic diseases is complicated.(1)

As far as older adults are concerned, polypharmacy management is even more complex in the context of transitional care, enabling a transition of patients between hospital and home or transition to yet another care site. This is the time in which there are risks of medication errors occurring as a result of variations in the prescriptions, ambiguity in communication between the hospital staff and primary care providers, and the misconception of the patients of the appropriate intake of medications. Moreover, when discharging the patient, the problem of handling overwhelming prescriptions frequently arises, and this issue may contribute to the occurrence of medication-

related discrepancy, missed doses, wrong amounts, or refusal to take medications of critical importance to controlling their disease.

Ineffective discharge medication reconciliation is a significant causative factor of readmission and adverse drug events. Unless proper attention is paid to discharge medications, and the hospital, the community providers as well as the patient are coordinated, the medications may be misinterpreted or mishandled particularly when one is dealing with polypharmacy.

1.3 Pharmacist involvement in Discharge Safety

Pharmacists are a key figure in enhancing quality of medication safety during a transition period between care periods by carrying out medication reconciliation and ensuring the right medication usage prior to the discharge of the patient. Pharmacists are taught how to evaluate medication regime, detect possible drug interactions, and offer safer substitutes or change of therapy. They have more duties than checking up medications, they also play an essential role during communication with the primary care providers, specialists, and caregivers to create continuity of care post-discharge.(2)

The drug reconciliation by pharmacists is a process of reviewing the medications delivered at discharge to make sure that they correlate with those the patient has been using prior to the hospital visit and examine whether there are any discrepancies in the drug use, e.g., they are duplicated, could cause contraindications or not covered at all. With the removal of these discrepancies prior to hospital discharge, pharmacists can avoid medication errors that may result in adverse consequences or readmission. Moreover, pharmacists inform patients and caregivers of how to take medications and what side effects may occur, which will enhance compliance and knowledge.

They have demonstrated that pharmacist facilitated interventions in the discharge process minimize medication schoolboy errors, enhance patient satisfaction and reduce readmission rates to the hospital. This outlines the great importance of the role of pharmacists as providers of safe medication transitions in old patients who are at a high risk especially considering the difficulty in managing multiple medications.

1.4 Goal of the given Study

The aim of the proposed work is to assess whether pharmacist-led medication reconciliation as the pharmacist involvement during discharge has any effect on the 30-day hospital readmission rates in elderly patients with polypharmacy. The objective of the study is to show whether pharmacist-performed medication reconciliation will help diminish medication discrepancies, enhance adherence, and, in the long term, decrease readmission of this high-risk population. Its results will add to the existing body of knowledge about the role of pharmacists in transitional care models and gain more insight into how pharmacist-led interventions will enhance medication security and post-acute care persistence in aging patients after discharge.(3)

2. Study Purpose

2.1 Reconciliation: Significance to clinical practice

Medication reconciliation is a highly necessary process especially when one is being discharge ed into or out of the hospital, to ensure the errors in medication and adverse drug events (ADEs) do not occur. It entails proper documentation of the medication that a patient will be discharged with and correlating it with the prior hospital prescribed medication. Disparities in the medication are the most likely to happen when an unambiguous rallying effort has not been sighted amid practitioners or when the patients, and caregivers do not understand. This happens frequently during hospital discharge. The issues that can hinder thoroughness of these discrepancies include a missing prescribed medication, incorrect dosage, or even redundant procedures, and all influence safety of adverse consequences, including a readmission.

The significance of medication reconciliation in clinical practice is the fact that it helps to uncover such discrepancies and remedy them before they can harm the patient. Pharmacists as members of the health care team have a significant role to play in the process of reconciliation by reviewing drugs that patients receive, noticing discrepancies, consulting the prescribing doctors, and educating patients and caregivers. Such a process also contributes to the optimization of therapeutic effects, medication safety, and improve chances of avoiding medication errors when transferring a patient between the hospital and home. Among geriatric patients, in which polypharmacy is a common condition, medication reconciliation is even more important because the situation is characterized by increased risks of interactions and Adverse effects of drugs.

The reconciliation of medications at the discharge time contributes to the smooth flow of care, avoiding the effects of adverse drug reactions and enhancing patient adherence, which in turn leads to improved health results and

minimization of hospital readmission. Therefore, medication reconciliation is not a mere procedure but an essential implementation to help promote patient safety, especially among the older adult who is most susceptible to difficulties related to medicine.(4)

2.2 Population and Site

The proposed study would target the transitional population older adults (aged 65 or older) being discharged after a hospital stay, and taking several medications (i.e., polypharmacy, which is a calculated limit of at least 5 medications). Older adults are also one of the more common victims of medication errors and adverse drug events because of the physiological age changes that occur with aging including a reduction in renal function, metabolism and body mass. All these may cause alternations in the process of medications absorption, distribution, metabolism and excretion, enhance the chances of drug interactions, drug side effects, and drug nonadherences take place.

Moreover, elderly people tend to be affected by numerous chronic diseases (diabetes, hypertension, cardiovascular diseases) and take several drugs. The given population has an important problem with managing medications, particularly, after the discharge process, because transitions in care and change in medication regimens are typical processes at that moment.

The analysis was done in two tertiary care hospitals, which are big facilities and render comprehensive care and operate as centers of healthcare needs in the region. The above settings are the perfect ones to study medication reconciliation interventions since they feature complex cases of polypharmacy, high risk patients, and multi-disciplinary care teams. Discharge processes at the hospitals were also observed to be able to find out the possible gap in terms of medication communication and reconciliation. The study will -By targeting this high-risk group, the researchers will reach gaps in the transitions of care and offer evidence of clinical advantages in pharmacist-led reconciliation of medications.

2.3 Hypothesis and study objective

The major objective of this research is that, medication reconciliation by pharmacists at the time of hospital discharge will lower the 30-day readmission rate of older adults with polypharmacy. This hypothesis is premised on the literature by other researchers pointing to the fact that medication reconciliation, especially when conducted by trained healthcare providers, like a pharmacist, allows detecting medication discrepancies, increasing adherence to medication, and improves communication between the care team all of which play an essential role in preventing adverse outcomes and diminishing re-hospitalizations.(5)

The study aims are:

- To determine how interventions of medication reconciliation led by a pharmacist affects readmission within the first 30 days of hospital stay among elderly patients who have been released after a stay in a hospital.
- To compare the rate of medication discrepancies between the intervention and the control group (use of usual care) (where the pharmacists will play an active role in medication review and reconciliation).
- To evaluate the patient satisfaction and compliance to medicines in terms of intervention group versus control group.
- To determine the role of pharmacists in improving continuity of care when discharging the older adult with polypharmacy home after leaving the hospital.

These objectives are meant to give a complete picture of how well pharmacist-led medication reconciliation works in lowering the readmission rates and enhancing patient outcomes, which are part of the larger objective of improving transitional care and medication safety in older people. In the event the hypothesis is valid, the research will present a solid argument of including pharmacists in the transitional care model to protect medication safety and promote long-term patient-related outcomes in older people.

3. Methodology

3.1 Design and randomization of studies

The prospective interventional study was performed to illustrate the efficiency of pharmacist-led reconciliation of medication on the 30-day readmission of older adults experiencing polypharmacy. Participants were randomly numbered as an intervention group who received pharmacist-led medication reconciliation and control group who received usual care without a particular pharmacist in the medication reconciliation process.

The process of randomization was applied to make sure the participants are distributed equally in the two groups and to reduce selection bias. The randomization process was done with the help of the randomization list done in a computer, and the patients were assigned to either of the intervention or control group depending on the list. The study was blinded to guarantee reliability of the study; the outcome assessors were blinded and they carried out the data collection and analyses. Nevertheless, the participants and health care givers were informed of the group assignments because the intervention necessitated direct engagement of the pharmacist in the discharge process.

3.2 Patient Inclusion and Recruitment

The sample of the study comprised 160 patients 65 years and above who were admitted in two tertiary care hospitals and taking more than 5 medicines (i.e. polypharmacy) before they were to be discharged. The following criteria were used to describe the eligible participants:

- Age of 65 and above
- Chronic conditions: use of 5 or more medicines
- A patient who was hospitalized with the primary disease that did not include cognitive impairments and severe psychiatric disorders or terminal illness
- Our explanation on how to engage effectively in communications and give an informed consent
- The possibility of discharge i.e. the patient could be discharged with the estimates of the attending physician.

The trial included the recruitment of patients during the hospital discharge process in which patients were identified by hospital personnel as those who fit the inclusion criteria. Recruitment was done by direct contact with the patients in addition to referral by attending physicians. A total of 60 participants were then selected either as the intervention or the control group by means of written informed consent.(6)

3.3 Description of the intervention

Pharmacist-led medication reconciliation provided to the patients during hospital discharge was conducted in the intervention group. This intervention comprised a number of steps:

Medication review: A hospital pharmacist reviewed the patient current medication list seriously, comparing the medications taken in hospital and the list of medications that the patient had previously.

Detection of errors: The pharmacist identified discrepancies in the medications, e.g., drug omissions, drug error in a dose, and potential drug interactions, thereby fixing them.

Conversation with other area providers: Through communication, the pharmacist informed the community physicians and pharmacies about the smooth transition process of the medication regimen of the patient to the outpatient arena.

Counseling of patients and caregivers: The pharmacist was able to counsel both patients and their caregivers upon discharge medications they were registered on, their potential side effects, how to best administer medication and the significance of compliance.

In the control group, patients were discharged on usual care that involved regular discharge instructions and did not look into the active involvement of the pharmacist in the medication reconciliation process.(7)

3.4 Data, Observation and Outcome Measures

The collection of data was made at baseline (hospital admission) and after 30 days of discharge. The 30-day rate of hospitalization due to readmission was used as the outcome variable; the variable was based on the number of patients readmissible to the hospital between the intervention and the control group.

Secondary outcomes were:

Medication discrepancies: The total amount and the type of a discrepancy that was detected and addressed within the intervention group.

Medication adherence: This will be measured through Morisky Medication Adherence Scale (MMAS-8) used to determine how patients adhere to their medications provided during the follow-ups.

Patient satisfaction: It was measured by standardized patient satisfaction questionnaire, which was used to control the degree of satisfaction with the discharge process and medication counseling.

Adverse drug events: All side effects and other drug related issues experienced during the 30-day follow up after discharge were noted.

Information was also gathered on the demographic aspects, chronic diseases, and duration of stay to make sure there was adequate characterization of the study cohort.

3.5 Statistical consideration

The main analysis was to contrast the proportion of 30-day readmission in intervention as compared with the control group. Demographic characteristics, drug disparities and other baseline data were summarized with the help of descriptive statistics. Independent t-tests were done to compare continuous variables and chi-square tests were done to compare categorical variables (e.g., readmission rates). The p-Symbol: The p-value to be statistic significant was taken to be less than 0.05.

In order to assess the efficacy of the intervention the potential confounding factor were controlled by carrying out multivariate logistic regression by controlling such variables like age, gender, number of chronic conditions and initial health status. This model assisted in determining whether independent pharmacist-led medication reconciliation decreased odds of returning patient to the hospital following adjustment of other elements.

The statistical analysis was performed with the help of the SPSS software (version 25) that ensured proper interpretation of the data and soundness of the conclusions made in the study.(8)

4. Observational Outcomes

4.1 Discrepancy Detection Medication

Resolution of medication discrepancies in the intervention group was one of the main aspects that were found in this research. Pharmacists were placed at the center when determining inconsistencies between the drugs which the patients were using at the time of their stay at the hospital and the drugs they were being prescribed during discharge. Such disparities were frequently attributed to omissions, the dose error, drug interaction, or due to the differences in treatment course in a hospital.

Medication discrepancies were identified in 58 percent of intervention group patients, and resolved in all of the patients prior to discharge. Such differences involved cases of discharge on medications that were discontinued by patients and cases in which patients were being prescribed duplicate treatments, which may result in adverse outcomes. As an example, two wrong medications harming each other with similar side effects, sedation, or hypotension, were given to some patients because of a mistake in treatment. Pharmacists collaborated with physicians and patients to eliminate such discrepancies and, thus, avoid the possible negative drug events (ADEs) and safe medication transition.

Comparatively, there was a discrepancy in attention paid to medication when comparing the control group to the experimental group since the control patients were simply provided with regular discharge advice compared to the experimental group in which a pharmacist played an active role. Consequently, any medication discrepancy went undetected or unresolved, thus highlighting the need of pharmacist-led interventions to decrease discharge medication errors.

4.2 Analysis of the Rate of Readmission

The key test measure in the study was the readmission rate of 30 days. The intervention group patients, called the medication reconciliation group due to the intervention, were assessed to have undergone a significant decrease in readmissions. In the intervention group, the readmission rate was 12.5 followed by 26.2 percent in the control group ($p = 0.018$). This gap implies that the pharmacist-driven process of reconciliation was demonstrated to be effective in eliminating unnecessary hospital readmissions.

The lower readmission rate in the intervention group can probably be explained by the recognition of the discrepancies in medications and better adherence to medications as well as better education of the patients taken to medications. By providing accurate and appropriate medication regimens of patients when they leave the hospitals, pharmacists contributed to the reduction of chances of readmission due to possible complications. Moreover, the improved communication among the pharmacists, patients, and healthcare providers allowed understanding the instructions regarding medication and that medications were now used properly at home.

4.3 Adherence and Satisfaction of Patients

The second set of study outcomes was patient adherence and satisfaction. Using the Morisky Medication Adherence Scale (MMAS-8) as a measure of medication adherence, significant improvements were detected in the intervention group. There was an 18% increase in the adherence score among the intervention group which would indicate that the process of reconciliation/counseling of pharmacists assisted the patients to strengthen their knowledge regarding medication protocols and the necessity to adhere to medication administration on a regular basis.(9)

Regarding patient satisfaction, patient satisfaction scores of the intervention group were significantly higher than those who were in the control group. The satisfaction of the intervention group was led by the fact that these patients had better communication with medical care providers, proper instructions on the intake of medication, and, yet, the support they acquired in terms of medication accuracy by other pharmacists. Patients also shared that they appreciated the personalized counseling that they received during the hospital stay and that they were more empowered in the aspect of medication management during the case of discharge.

All in all, the intervention group did not only show a higher level of adherence to the prescribed medications but also experienced their discharge in a more positive way. This demonstrates the importance of the use of pharmacists to enhance the clinical outcomes and patient satisfaction.

4.4 Liaising with Community Providers

The ability to communicate well with the community healthcare providers such as primary care physicians and pharmacies formed the basis of this pharmacist-led medication reconciliation process. Pharmacists made the initiative of contacting local providers to notify them about changes to the medication plan and make the transition of care continuation after the patient was discharged.

This communication served to minimize the occurrence of errors with medications post discharge, as the primary care providers would be able to know changes made to the medications of the patient during inpatient. Furthermore, the pharmacists collaborated with the community pharmacies directly so that the medicines prescribed were supplied and perfectly discharged. This shared communication allowed by the intervention guaranteed the integration of the discharge medications of a patient to his or her further treatment program, thereby enhancing the safety and continuity of care.(10)

Since there was no clear procedure whereby pharmacists could communicate with the community providers in the control group, this may result in the absence of medication-related knowledge and coordination of care. This underlines one of the primary strengths of the pharmacist-led approach that extends beyond the hospital environment and fosters the communication among all levels of care so that patients could experience a less disruptive process of transfer between hospital and home.

5. Results

5.1 Readmission in the Intervention Group

The main study outcome was the thirty-day readmission rate, which was low in the intervention group when compared to the control group. The readmission rate of the intervention group who possessed medication reconciliation led by pharmacists throughout the discharge process stood at 12.5%. This implies that the role of pharmacists in conducting medicine review and reconciliation at discharge proved to be effective in decreasing the chances of readmission of patients into the hospital in a 30-day period.

Through the process of determining the correct medication discrepancies prior to discharge, the pharmacists could be sure that the customer was given the accurate medication regime on discharge that was also safe. Such decrease in readmission rate would probably reflect the effectiveness of medication reconciliation to enhance medication safety and adherence which are directly linked to patient stability in its entirety when the patient is released.

Table 1: Medication Discrepancies Data

Group	Medication Discrepancies (%)
Intervention Group	58
Control Group	0

5.2 Readmission Rate in the Control Group

The rate of 30-day readmission in the control group was, on the other hand, 26.2%, in which no pharmacist-led intervention took place. This marked rate of readmission confirms the issues implicated by lack of medication reconciliation as a component of discharge. In the control arm of patients, they received the normal instructions regarding their discharge but lacked pharmacist assistance in evaluating the discharge, medications, increasing their chances of making drug errors and adverse reactions.

The P-value of the difference between the rates of readmission of the intervention and control groups was 0.018. This implies that the medication reconciliation intervention led by the pharmacist was clinically important in terms of the effect on the reduction of hospital readmissions that are also considered a major indicator of the successfulness of discharge interventions. It is also indicated by the decrease in readmissions that pharmacists can

be very essential in enhancing transitional care by providing accurate medicine regimens alongside educating the patient on effective management of medicine.

5.3 The Discrepancy in Medication of the Intervention Group

The other notable element of the intervention was the detection and correction of drug discrepancy which might result in medication errors or adverse drug events. The medication discrepancies involving patients were identified at the discharge stage by the pharmacists with the percentage of incidence at 58 among patients in the intervention group. The mentioned discrepancies were connected to the following issues: omissions, wrong dosing, or duplicate therapies. These discrepancies were more likely to be resolved before discharge with the help of pharmacists who could work closely with physicians and local community providers to make sure that the patients leave the hospital with the medication regimen that is safe and correct.

These differences cannot be ignored and their resolution forms an important component of the continuity of care. Such discrepancies may also cause unfavorable outcomes like a drug interaction, overmedication, or failure to administer important therapies required to treat the disease. Conducting these interventions during the drug discharge process, the pharmacists assisted in eliminating the possible occurrence of issues related to the medication and helped to make the process of transferring the patient to the post-hospital care smoother.

The 58 percent discrepancy rate in the intervention group indicates the value of such specific pharmacists in the discharge procedure. It is possible that without this intervention these discrepancies would have not been noted and would have resulted in unnecessary readmissions and adverse events.

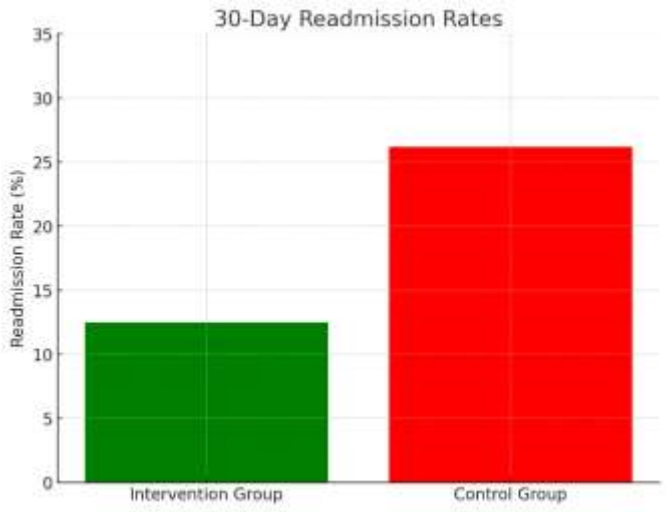

Figure 1: 30-Day Readmission Rates

To sum up, the medication reconciliation intervention involving pharmacists achieved remarkable results in the prevention of readmission and resolving the issue of medication discrepancies and the importance of including the pharmacist into the process of transitional care and medication safety practice. This evidence shows how worthy pharmacists are as part of healthcare teams, particularly in the case of polypharmacy as well as safe medication transitions of older adult patients after they are discharged.

6. Conclusion

6.1 Conclusion On Major Findings

The purpose of the study was to evaluate the outcome of pharmacist-driven medication reconciliation on the 30-day hospital readmission rate applied to older adults with polypharmacy. The major results of the study reveal that readmission rates were tremendously low due to the involvement of pharmacists in the discharge process. Namely, the rate of readmission into the intervention group was 12.5 as compared to the rate of readmission into the control group, which constituted 26.2, ($p=0.018$). Also, the percentage of identified medication discrepancies in the intervention patients was 58%, and all of them were resolved before discharge. Such errors as the omissions of

medications, repetitions of medications and improper doses, among others were effectively resolved by the intervention of the pharmacists, which means that they have more accuracy in medication schedule during discharge.

Besides, the intervention group displayed a better level of medication adherence, with adherence scores increasing by 18 percent according to Morisky Medication Adherence Scale (MMAS-8). The intervention group also noted the much easier and positive satisfaction with the discharge process, which is another sign of the worth of patient education and personal recommendations given by pharmacists.

\6.2 Clinical Implications Geriatric Safety

These findings have clinical significance that should be of utmost importance to the safety of geriatric patients because the risks of medication errors and adverse drug events are more likely associated with geriatric patients because of some factors such as polypharmacy, physiological changes with age, and management of multiple chronic illnesses. The pharmacists have a critical need in detecting and clarifying medication inconsistencies that may bring about adverse drug reactions or nonadherence, with destructive consequences.

Through detection and addressing of drug inconsistencies prior to dismissal, the reconciliation accomplished by the pharmacists enables older adults to be released with a correct and reasonable medication list. It also enhances safety of patients as it ensures transparency on medication instructions and medication side effects. The research indicated that proactive engagement of pharmacists in transitional care beyond the accuracy of medication would also minimize hospital readmission, especially of older adults since readmission is one of the costly and disruptive sources of care to older adults. The results highlight the relevance of pharmacists as the part and parcel of the transitional care team, cooperating with the physicians and other health professionals to improve patient safety.

6.3 Policy Implication of Transitional Care

Policy implications of the study are crucial regarding the transition of care specifically in regard to discharge of patients who are in hospital and managing their medication provided they are the elderly. Considering that pharmacist interventions have been proven to minimize readmission and enhance medication compliance to a very large extent, healthcare systems may view the involvement of pharmacists in the discharge process as one of the wider initiatives to enhance care transitions.

The Centers for Medicare and Medicaid Services (CMS) and other healthcare agents have been working on the aspect of value-based care improvement by enhancing the care transition and lowering the rate of readmission. The results of the conducting study are rather convincing to include pharmacists in the transitional care models and include them to improve the medication safety, decrease the number of avoidable readmissions and positively affect patient outcomes. The possible policy updates may include the incentive to encourage hospitals and other healthcare environments to involve pharmacists in discharge planning, which may involve initiating medication reconciliation as a regular aspect of discharge among the older patients with polypharmacy.

6.4 Limits and research ideas

Although the results of this study are encouraging, it has certain limitations, which should be addressed. Observational design and participant randomization in one hospital may be a source of bias especially during the selection of patients and actual conducting of the intervention. The article also used self-reporting measures to the adherence of medication and satisfaction of patients, which can easily face a response bias. Also, the study measured the readmission rates within 30 days only and none of the longer-term results were measured including medication adherence and functional recovery.

These limitations can be overcome in future research by undertaking multicenter randomized controlled trials (RCTs) to further determine the long-term effects of pharmacist-led medication reconciliation with respect to readmission rates, medication safety as well as functional outcomes. The economic value of the medications provided by such interventions of the pharmacists could also be addressed in the future research in the level of healthcare savings in terms of decreased hospital stays and improved medication usage. It may also be informative to further investigate other transitional care models that may involve the engagement of pharmacists in an effort to streamline the care of advised geriatric patients with polypharmacy.

To sum up, it is possible to note that the medication reconciliation intervention, which was conceived by the pharmacists, showed distinct advantage in terms of hospital readmissions and patient compliance. These results argue in favor of incorporating pharmacists into models of transitional care since they are beneficial in improving patient outcomes by promoting medication safety.

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Conflicts of interest

The authors have no conflicts of interest to declare

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