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Letter to the editor

Comment to: What are the problems, information needs and objectives of community pharmacists? A mixed method approach

Dear editor,

Brühwiler *et al*. addresses significant health systems gaps in communications and transitions of care when patients follow up at community pharmacies following discharge from hospitals.[1] The authors also report on needs and perceptions of community pharmacists in their role to guide optimal patient care. While the authors aptly highlight the need for improvement in care, tangible actions that providers, community pharmacists, and institutions can adopt to accomplish this goal are not fully elaborated. Here, we furnish a few plausible strategies:

(1) Bridging communication and leveraging emerging technological avenues. Despite medication reconciliation efforts in hospitals, medication errors still occur following discharge.[2] These errors are attributed in part to communication barriers such as inaccessibility of discharge providers, and can lead to increased readmissions, morbidity and mortality.[1] As such, discharging providers must ensure that they actively engage and communicate with community pharmacists.[3] Ensuring easy and reliable access to hospital providers and patient information on discharge by building relationships with local hospitals, and establishing secure next-generation technological systems for bridging communication between community pharmacists and hospital providers should be pursued. For example, the authors note that in their current health system, general practitioners automatically receive discharge summaries. Next steps may be to link community pharmacists to these documents, which may note reasoning behind medication changes.

(2) Medication reconciliation and interventions by clinical pharmacists. Numerous studies involving pharmacist-led medication reconciliation demonstrated reduction of medication discrepancies at patient discharge. Furthermore, as the authors have suggested, pharmaceutical interventions by clinical pharmacists during hospitalizations lead to reduced intervention by community pharmacists after patient discharge.[4] Facilitating verbal communication between community and hospital pharmacists, may optimize medication reconciliation. We recommend an active role for clinical pharmacists during hospital admission and discharge medication reconciliation, and hospital stay.

(3) Enriching cross-discipline collaboration and competency. Securing collaborative relationships and cultivating a culture of cross communication between hospital providers and community pharmacists may help community pharmacists provide optimal patient care following discharges. Additionally, targeted educational outreach programs may inform both disciplines of overlapping guidelines and best practices. Interdisciplinary conferences, small-group meetings, and email forums may also help cultivate closer partnership between community pharmacists and hospital providers. We believe that such venues for discourse may help raise awareness of challenges and barriers faced by both disciplines and practice domains, and lead to development of tangible solutions.

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Authors' reply

Dear Editor,

We appreciated reading the letter to the editor concerning our publication "Hospital discharge: What are the problems, information needs and objectives of community pharmacists? A mixed method approach".[1]

Our publication focusses on current problems that community pharmacists face with discharged patients. One of our aims was to evaluate if pharmacists see any benefit from transferring information from the hospital to

community. We agree that this is only one possibility – among many others that you stated – to optimise hospital discharge. Some of the strategies named in the letter, like collaborative relationships or the technical development, were also brought up by study participants. But we did not aim to give an overview of different optimisation strategies, like other authors did.[2]

This publication was a preparatory work. In our following project (not yet published), we aimed to evaluate the benefit of a pragmatic in-hospital service. The service comprised an in-hospital prescription check by the clinical pharmacist and an enhanced information transfer to the community pharmacist.

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