The intervention

The final intervention comprised patient information the day before discharge (preparing information for the discharge counseling), medication reconciliation, discussion with physician, patient counseling at discharge, medication report to primary care physician, and phone follow-up to patient three days after discharge. In the following, each part of the intervention is described in detail.

Patient information the day before discharge

The day before discharge, the pharmacist visited and informed the patient about the planned discharge counseling. The pharmacist provided the patient with a short leaflet explaining the purpose and course of the counseling. The pharmacist explained that the counseling would be based on the patient’s needs and encouraged the patient to think about any questions he/she might have regarding medication, illness, or other concerns about being discharged. The leaflet included a few lines for the patient to write down questions.

Medication reconciliation

Prior to the discharge, the pharmacist conducted a medication reconciliation. When necessary, the pharmacist consulted a clinical pharmacist. Based on the medication reconciliation, the pharmacist prepared a draft version of the patient’s discharge report.

Discussion with responsible physician

Based on the medication reconciliation and the prepared discharge report, the pharmacist consulted the physician responsible for the patient. If the pharmacist had found any discrepancies that could not be solved by consulting a clinical pharmacist, the pharmacist presented and discussed these with the physician until a clarification was reached. Further, the pharmacist made sure that the physician had prepared prescriptions on any new medications, removed prescriptions for discontinued medications, and, when relevant, ensured correct reimbursement for new prescription medications.

Patient counseling at discharge

Based on the medication reconciliation and physician counseling, the pharmacist conducted a 15 minute discharge counseling with the patient. If the patient had prepared questions or expressed any needs for discussing specific topics, these were prioritized. Otherwise, the pharmacist went
through the patient’s medication list and explained the reasons for any medication changes, such as changed doses, new medications, and discontinued medications. Further, when relevant, the pharmaconomist covered items such as drug administration, treatment duration, and specific side effects. At the end of the counseling, the pharmaconomist provided the patient with the updated medication list and a written summary of the counseling for the patient to take with him/her back home. The summary included a direct phone number to the pharmaconomist in case the patient should think of any questions regarding his/her medical treatment following discharge. If the patient was discharged prior to a weekend, the pharmaconomist provided the patient with new medication for 2-3 days, until the patient had the opportunity to pick up the medication at a community pharmacy.

**Medication report to primary care physician**

Following the patient counseling, the pharmaconomist finished the patient’s discharge report and made a separate medication report to the patient’s primary care physician. The medication report included a short description of the patient’s current medication and any medication adjustments made during hospitalization.

**Phone follow-up to patient three days after discharge**

Three days after discharge, the pharmaconomist made a phone follow-up to the patient. The pharmaconomist asked if the patient had experienced any medication-related problems or had any questions concerning his/her medication, giving the patient the opportunity to discuss these with the pharmaconomist.