



Original Research

# Pharmacists' barriers and facilitators on implementing a post-discharge home visit

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## Abstract

**Background:** Introducing a post-discharge community pharmacist home visit can secure continuity of care and prevent drug-related problems. Currently, this type of pharmaceutical care is not standard practice and implementation is challenging. Mapping the factors influencing the implementation of this new form of care is crucial to ensure successful embedding.

**Objective:** To explore which barriers and facilitators influence community pharmacists' adoption of a post-discharge home visit.

**Methods:** A mixed methods study was conducted with community pharmacists who had recently participated in a study that evaluated the effectiveness of a post-discharge home visit in identifying drug-related problems. Four focus groups were held guided by a topic guide based on the framework of Greenhalgh et al. After the focus groups, major barriers and facilitators were formulated into statements and presented to all participants in a scoring list to rank for relevance and feasibility in daily practice.

**Results:** Twenty-two of the eligible 26 pharmacists participated in the focus groups. Twenty pharmacists (91%) returned the scoring list containing 21 statements. Most of these statements were perceived as both relevant and feasible by the responding pharmacists. A small number scored high on relevance but low on feasibility, making these potential important barriers to overcome for broad implementation. These were

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the necessity of dedicated time for performing pharmaceutical care, implementing the home visit in pharmacists' daily routine and an adequate reimbursement fee for the home visit.

**Conclusions:** The key to successful implementation of a post-discharge home visit may lay in two facilitators which are partly interrelated: changing daily routine and reimbursement. Reimbursement will be a strong incentive, but additional efforts will be needed to reprioritize daily routines.

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**Keywords:** Community pharmacy; Mixed method research; Home visit; Continuity of care; Implementation research

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## Background

Hospital discharge is a transition moment prone to medication errors due to the involvement of multiple healthcare providers across the different healthcare settings.<sup>1,2</sup> This increases the complexity of coordination and communication during discharge risking loss of important information.<sup>3</sup> Community pharmacists have shown that they can play an important role in securing the continuity of care.<sup>4</sup> A possible strategy for an increased pharmacist utilization post-discharge is a home visit. The HomeCoMe (Home-based Community pharmacist-led Medication management) intervention is a post-discharge follow-up home visit by community pharmacists designed to prevent drug-related problems post-discharge.<sup>5</sup> HomeCoMe addressed several limitations described in previous studies, eg by the use of hospital-initiated home visit planning, communicating up-to-date medication information to community pharmacists and intensive collaboration between patients' own community pharmacists and general practitioner.<sup>6,7</sup>

However, home visits are still relatively new for pharmacists and introducing a home based intervention as usual pharmaceutical care can be challenging. The performing community pharmacists need specific skills for this intervention since it differs from their routine care. Additionally, since patients differ, every home visit requires a tailored approach from the pharmacist. This challenges standardization and increases the sensitivity to features of the local context and the performer of the home visit.<sup>8</sup> These organizational and logistical difficulties may hamper the broad implementation of home-based interventions.<sup>9</sup> Therefore, extensive mapping of the factors influencing implementation can contribute to successful future embedding in routine care.<sup>10,11</sup>

The evaluation of a home based intervention (HomeCoMe) in the Netherlands presents an opportunity to comprehensively map its imple-

mentation barriers and facilitators.<sup>5</sup> Earlier studies of post-discharge home visits by pharmacists predominantly focused on its effectiveness to improve patient outcomes or the cost-effectiveness, scarcely reporting factors for successful implementation.<sup>7,12,13</sup> Elucidating these factors can also facilitate the design of other future pharmaceutical care interventions.

Therefore, the objective of this study was to explore which barriers and facilitators influence community pharmacists' adoption of a post-discharge home visit.

## Material and methods

### *Study setting and population*

A mixed methods study was conducted consisting of focus groups, followed by individual scoring of major barriers and facilitators obtained from these focus groups. This approach enabled the scoring of all barriers and facilitators reported in the individual focus groups. Community pharmacists who had performed post-discharge home visits within the HomeCoMe study participated in this study.<sup>5</sup> Data was collected between March 2015 and January 2016.

### *Focus group procedures*

Four focus groups were held with four to seven participants per group. All focus groups were chaired by the same moderator (EK) and guided by a topic guide ensuring similar data collection procedures across all four discussions<sup>14</sup> (Appendix 1). EK had a high degree of moderator involvement by leading the focus groups. Moreover, she created a permissive environment that nurtures different points of view without pressure to reach consensus and encouraged group members to respond to one another's ideas and comments. Furthermore, an implementation expert (AvD) attended all meetings and he had a low

Table 1  
The main components of the Greenhalgh framework

Greenhalgh component	Description
Innovation	Addresses the innovation itself, eg the relative advantage in effectiveness of the intervention or its complexity
Adopter	Addresses the adopters of the innovation, eg their motivation to adopt the innovation or their skills to perform it
Communication and influence	Addresses the internal influences that help spread the innovation, eg the impact of opinion leaders or the support of key individuals (champions)
Outer context	Addresses the external influences on the organizations decision to adopt the innovation, eg comparable organizations or policymakers
Implementation process	Addresses the transition from considering an innovation to routinely performing it, eg by focusing on leadership and management and feedback and adaptation
System readiness	Addresses the amenability of a specific innovation in the organization, eg by focusing on the innovation-system fit and dedicated time and resources
System antecedents	Addresses the structure, the absorptive capacity for new knowledge and the receptive context for change of the organization where the innovation will be implemented
Linkages	Addresses the links between different components of the model in the design and implementation stage, eg between innovators and potential users

degree of moderator involvement. He was an extra listener to the group discussion and stimulated discussion when necessary. Finally, all focus groups were audio-taped and a student researcher (TS) recorded time and took additional notes on, for example, non-verbal communication. TS had no degree of moderator involvement and did not participate in the discussion.

#### Data collection

The theoretical basis for this study was the conceptual framework of Greenhalgh et al to ensure the gathering of all essential information and to enhance the interpretability of the study findings.<sup>15,16</sup> The Greenhalgh framework was chosen based on its operational construct which provided step-by-step guidance for completing implementation research. It also addresses the needed organization and community levels (Socio Ecological Framework (SOF) levels, as defined by Tabak et al) fitting in with the primary research question.<sup>16</sup> Furthermore, this framework is broadly applied in many primary healthcare disciplines including pharmacy practice.<sup>17,18</sup>

The Greenhalgh framework addresses eight components and was the basis for the topic guide<sup>15</sup> (Table 1). As the participating individual community pharmacists were expected to lack specific knowledge on more comprehensive components such as *System antecedents* and *Linkages in design and implementation stages*, these components were excluded from the topic guide. A previous study also excluded these components.<sup>18</sup>

The major barriers and facilitators identified in the focus groups were formulated into statements and presented to all participating pharmacists in an online scoring list. This list aimed to (1) verify whether the participating pharmacists could identify themselves with the relevance of the stated barrier/facilitator across all focus groups and (2) score each barrier/facilitator on feasibility in daily practice. The pharmacists were asked to rank each statement on both *relevance* and *feasibility in daily practice* using a 5-point Likert scale, from 1 (highly irrelevant/very infeasible) to 5 (highly relevant/very feasible).

#### Data coding and analysis

First, all audio logs were transcribed verbatim and imported in NVivo version 10 software. Privacy-sensitive information, eg names of the participating pharmacists and pharmacies, was removed from the transcripts and replaced by codes to ensure anonymity. The audio logs and transcripts were stored on a password-protected hard disc only accessible to the principle researcher (HE). Second, one researcher (TS) identified and coded text elements within the transcripts using an inductive (data-driven) approach in an iterative process. Next, the principal researcher (HE) reviewed the coded transcripts. Discrepancies were resolved through discussion and, if necessary, a third researcher (EK) was consulted to reach consensus. Finally, all coded barriers and facilitators identified in the four focus group manuscripts were linked to the

components of the Greenhalgh framework by one researcher (HE) and checked by two researchers (EK, AvD). Possible discrepancies were resolved through discussion.

The mean scores on *relevance* and *feasibility in daily practice* of the online scoring list are presented in a scatter plot and grouped per component of the Greenhalgh framework.

## Results

### General characteristics

Twenty-six pharmacists had performed post-discharge home visits as part of the HomeCoMe study and were eligible for inclusion.<sup>5</sup> Four pharmacists were excluded because they had changed jobs. The remaining 22 pharmacists accepted the invitation.

Overall the pharmacists had a mean of 17.6 (range 2–31, SD 8.4) years of working experience in the community pharmacy setting and the majority (68.2%) of the pharmacists were female. They performed a mean of 5.4 (range 0–23, SD 5.6) home visits per pharmacist during the study period of approximately 1 year. The inclusion was based on availability of patients discharged from the 2 included wards (neurology and pulmonology disease) to a specific community pharmacy. One pharmacist did not perform any home visits but had been responsible for the planning and preparation of the home visits during the study period.

### Focus group outcomes

Most themes mentioned by the pharmacists could be classified in the *Innovation* component of the Greenhalgh framework followed by the *Adopter* and *Implementation process* components. The major themes and illustrative quotes per component are described in more detail below.

#### Innovation

Pharmacists valued the intervention as effective in solving patients' drug-related problems.

*"... I identified major issues and had to collect medication at the patients' home which should not be used post-discharge. Yes, I've experienced that a couple of times."*

By visiting patients' homes pharmacists gained valuable insight in patients' individual lifestyle and living conditions.

*"Yes, you get additional information, off course! [...] You get an overall picture of how patients store their medicines at home, for example."*

The intervention was also seen as a possibility to improve patients' knowledge, as pharmacists were often struck by patient's lack of disease and medication awareness and knowledge. The social interaction between pharmacist and patient was seen as a positive contribution towards an improved patient-provider relationship.

*"You develop a bond with the patient."*

The technical support in the form of the provided HomeCoMe protocol was assessed as supportive but pharmacists also mentioned it sometimes disturbed the conversation, eg due to the need of making notes.

*"A protocol gives you something to hold on to, something to fall back on if you lose track."*

*"I was struggling to keep the conversation going when I was trying to adhere to the protocol."*

Furthermore, pharmacists mentioned that the preparation of patients at hospital discharge on the upcoming intervention reduced the perceived complexity of performing the intervention. Patients were already informed what to expect from the post-discharge home visit which resulted in well-prepared patients who were not surprised when they received the telephone call to schedule an appointment.

*"I think it is important the patient has already been informed about the home visit at hospital discharge."*

The study protocol expected that pharmacists visited the patient within a week after hospital discharge. Some pharmacist felt that their agenda was dictated by the hospital.

*"In your mind you've got to have some flexibility like: right now a patient is discharged and apparently I have to be ready. [...] My schedule is determined by someone within the hospital who decides that a patient can go home. That always evokes some sort of aversion."*

Finally, support of the local organizations management was considered as important as that could either be facilitating or hindering for the implementation of the home visit.

*"Yes I do like it [the intervention], but if the organization's management thinks that other activities are more important, well ..., so yes management definitely plays an important role here."*

### Adopter

The majority of the pharmacists enjoyed performing the visits, this was especially the case in visits where drug-related problems could be resolved or prevented.

*“I really enjoyed performing the home visits, it was a positive experience for me. So, that substantially lowers the threshold for me if I have to do it again.”*

Pharmacists saw themselves as the designated performer and felt that their experience in pharmacotherapy was sufficient for the post-discharge home visit.

*“You have to be a pharmacist to interpret lab values for instance, and to see the bigger picture.”*

However, they would like to improve themselves in communication skills to be able to make the home visits more effective and structured.

*“Yes, some communication skills. In my case, I thought it was quite hard. You are not used to it, usually you’re working with a computer and managing pharmacy technicians and all of a sudden you have to perform consultations as a practitioner.”*

### Implementation process

The pharmacists considered the collaboration in a multidisciplinary team with other healthcare professionals as an important facilitator, eg the general practitioner, homecare services and the in-hospital specialist.

*“If you formulate treatment goals that differ from those of the GP, this could lead to miscommunication. It is important to align them.”*

*“... also contact with the specialist might be useful I think, that you provide some feedback information.”*

Furthermore, pharmacists stressed the importance of dedicated resources or funding in the form of a reimbursement for their performances.

*“Our preference in daily activities is indeed for the ones you get paid for.”*

Next, the pharmacists gave feedback on adapting the patient selection to possibly enhance the effect of the intervention, eg by only selecting patients with polypharmacy, non-adherent patients, elderly or patients who went through a life changing event (eg stroke).

*“Especially, I have the multiple drug users in mind. It is known that an increased number of drugs leads to poor adherence. It can be beneficial to explain*

*once more that a specific disorder is treated with four different drugs.”*

*“A drug-naïve patient who needs to use five drugs after discharge, yes, for this patient it [the intervention] can be really meaningful.”*

Also logistic improvements were suggested. For instance, deploying an in-hospital pharmacy assistant responsible for the patient selection process or implementing a pre-visit telephone screening to assess the necessity for a home visit.

*“That could be particularly useful, to screen for patients at risk.”*

### System readiness

Pharmacists stated that they currently spent most of their time on logistics and pharmacy management which conflicts with delivering pharmaceutical care interventions. They mentioned that the intervention itself was time-consuming particularly because it also required time for preparation and finalizing.

*“Well, that’s because it [the intervention] doesn’t match with our daily activities due to the pressure of work and all the other things that are expected from you. Which is odd because this [the intervention] is what we are supposed to do.”*

*“Our daily activities are quite centered around logistics and drug handling. In a way we have to separate that [from pharmaceutical care].”*

*“Well, I’m thinking of restructuring the pharmacy. [...] Deploying a pharmacy manager for instance.”*

### Communication and influence

Pharmacists appreciated the meetings and training sessions that were organized to facilitate the project. This gave them the opportunity to discuss possible practical problems and gave them adequate time to adapt their daily planning. Finally, ongoing support and follow-up during the project from the project coordinator (HE) and the outpatient pharmacist responsible for the planning and preparation of the home visits was seen as an important facilitator.

*“When he [project coordinator] started the project, he prepared it very well with up to three meetings with all the pharmacists.”*

*“They [project coordinators] kept us on our toes, like: “you need to call the patient”, “did you call the patient already?” or “where is the recording device?”. That went really well.”*

### Outer context

The discussion on the external influences on the organization's decision to adopt the home visit focused on the role of health insurance companies and patients' informal carers. Insurance companies were considered as a barrier especially because the lack of a reimbursement fee.

*“Well, if I'm completely honest, if health insurance companies are not willing to reimburse our activities by simply stating that these are part of usual care, than I think it will fade out.”*

Informal carers could be involved more if patients were not completely capable of taking care of himself, for instance when terminally ill.

*“... sometimes a partner has also a role in the medication management of the patient and then it is very useful [to include them]”*

### Ranking of major themes: Results of the online scoring list

Twenty-one barriers/facilitators (indicated **a–u**) were presented in the form of an online scoring list to all participating pharmacists (Appendix 2). Two participants did not respond due to long term absence resulting in a response rate of 91% ( $n = 20$ ).

Twenty out of the 21 barriers/facilitators were scored as relevant (mean score  $> 3$ ) and 18 were scored as feasible in daily practice (mean score  $> 3$ , Fig. 1). Five were scored as highly relevant and highly feasible (mean score  $> 4$ ). Four of these were linked to the *Innovation* component; the ability of the home visit to signal and solve drug-related problem (**a**), improving the patient-pharmacist relationship (**d**), the support with a protocol (**e**) and informing the patient at discharge about the home visit (**f**). The fifth one was linked to the *Adopter* component and addressed pharmacists' need for sufficient knowledge on pharmacotherapy (**i**).

Next, two barriers/facilitators scored high on relevance (mean score  $> 4$ ), but low on feasibility (mean score  $\leq 3$ ), which will potentially make them important bottlenecks for implementation. The first was the necessity for a reimbursement fee (**t**, *Outer context*) and the second was the readiness of the community pharmacy to implement this pharmaceutical care intervention in the daily routine (**o**, *System readiness*).

The pharmacists doubted the feasibility of visiting patients at home compared to patients visiting the pharmacy (**b**, *Innovation*, mean

score  $< 3$ ). Finally, pharmacists scored the presence of an informal carer/family member during the home visit as neutral (**u**, *Outer context*, mean score  $\approx 3$ ). They commented that it could be relevant in specific situations, but it was not seen as a necessity and they stated that it will involve challenges for daily practice.

### Discussion

This study identified numerous barriers and facilitators for the pharmacists' adoption of a post-discharge pharmacist home visit. The most relevant and perceived as feasible were the inter-professional collaboration in primary and secondary care and the community pharmacists' skills in communication and pharmacotherapy, whereas potential barriers were a reimbursement fee and adopting of the home visit into the current daily routine of the community pharmacist.

Traditionally, community pharmacists have been predominantly responsible for the provision of product-related services, eg medicine dispensing and medicine compounding. Although these elements are still embedded in their usual activities, pharmacists evolve towards pharmaceutical care services, such as medication therapy management and prescribing of medication.<sup>19,20</sup> Performing a home visit is another example of these services. This study showed that the participating pharmacists recognized the importance of a post-discharge home visit and saw themselves as the designated performer of such a visit. This new form of pharmaceutical care could become routine care if the identified barriers are properly addressed. An important facilitator for implementation is the existence of adequate reimbursement models in order to ensure that this intervention can be embedded in the daily activities of the pharmacist as recognized by the participating pharmacists. A recent review evaluating preventive pharmacy-delivered interventions on smoking, alcohol and weight control highlighted that relevance of reimbursement for broad dissemination of these services.<sup>21</sup> However, pharmacists are still predominantly reimbursed for dispensing and not for delivering pharmaceutical care.<sup>22</sup> Part of the problem could lie within the limited evidence for pharmaceutical care interventions reducing adverse clinical outcomes. This results in health insurance companies being reluctant to change traditional reimbursement models. There are examples illustrating that this barrier can

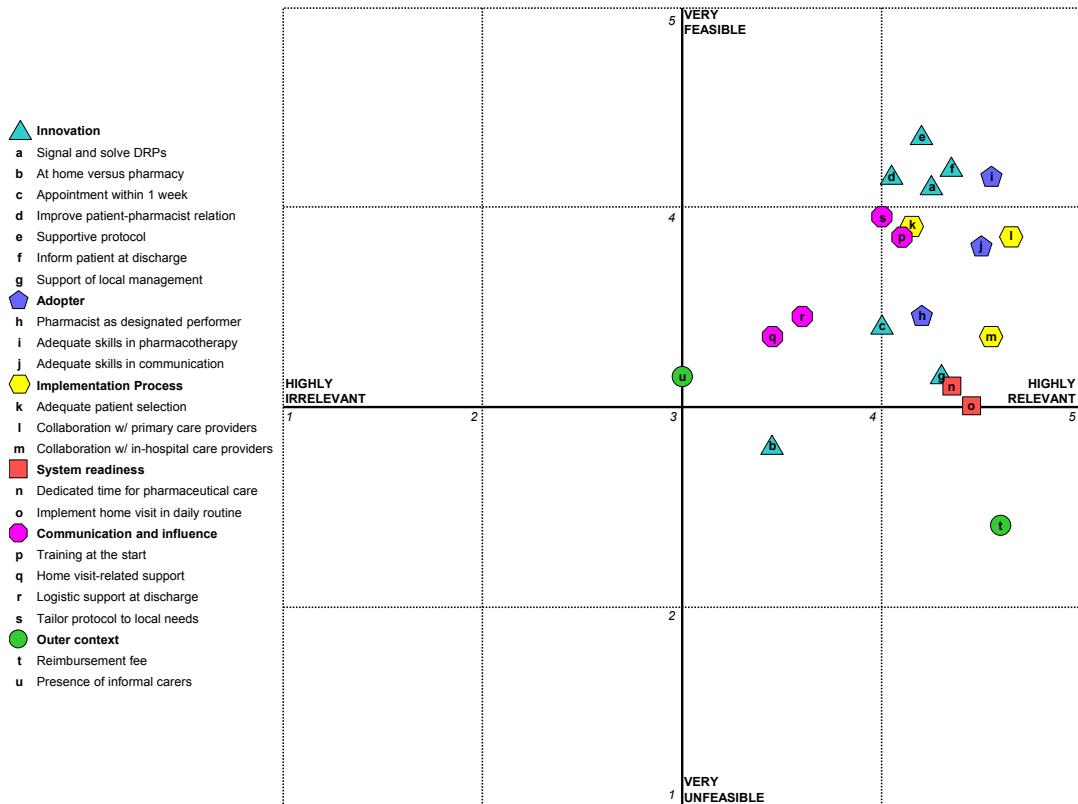


Fig. 1. Scatter plot linking the mean relevance and feasibility scores of the participating pharmacists ( $n = 20$ ) on the statements based on the major barriers/facilitators, grouped by the components of the Greenhalgh framework.

become a facilitator once reimbursement is in place, the Australian home medicine review (HMR) has become a well-established and government-funded program for community pharmacists.<sup>23</sup>

Although the participating pharmacists were motivated to perform the home visits and mentioned the importance of implementing the intervention in their daily routine, they struggled with finding the required time. Similar findings have been reported in earlier studies.<sup>24,25</sup> Pharmacists saw the advantages of a home visit for identifying and solving drug-related problems and building a pharmacist-patient relationship. However, they ranked a home visit as less relevant and less feasible than a patient visiting the pharmacy. The pharmacists' explanation for this was that performing a home visit is more time-consuming and therefore more difficult to implement. Furthermore, the intervention protocol prescribed that the appointment should take place within 1 week post-hospital discharge. A limited timeframe was previously reported as a

barrier and possibly adds to reported lower feasibility.<sup>26</sup> Previous work showed that although community pharmacists realize that their focus should be on pharmaceutical care, in reality it is still mainly dispensing-based.<sup>27</sup> A possible strategy to address this barrier is that pharmacists need to reprioritize their daily routine to fulfill their role as healthcare providers, for instance by delegating management and logistics. The compatibility with usual care may be even further improved by incorporating the views and suggestions of the potential performing pharmacists into the intervention, as complex interventions benefit from a certain degree of tailoring to local context.<sup>8,21</sup>

Provision of pharmaceutical care also implies a more extensive collaboration with other healthcare providers. The pharmacists acknowledged the importance of a close interprofessional collaboration and ranked it as feasible from their local perspective. On a national level the current cooperation between pharmacists and GPs in the Netherlands is relatively good, but internationally

this might be different. Evidence from the Australian HMR suggests that previous positive encounters and trust are important factors for collaborating with general practitioners.<sup>23,28</sup> Other related and relevant facilitators according to the participating pharmacists are their communication skills and knowledge in pharmacotherapy. Pharmacists need to ensure that these skills and knowledge are sufficient, not only to perform the intervention itself, but also to be a proper discussion partner for the physician. The pharmacists stated that they could improve these skills enabling them to limit consultation time and maybe even improve the effectiveness of the intervention by asking adequate (follow-up) questions. The relevance of proper communication skills is further demonstrated by the fact that patient counseling by pharmacists leads to increased medication adherence and decreased patient confusion and insecurity.<sup>29</sup> Therefore, to maximize the benefits of these pharmacist home visits, training for the pharmacist in communication skills is crucial.

#### *Strengths and limitations*

An important strength of this study was the participation of all eligible pharmacists who performed the intervention in the focus groups. Next, the use of the conceptual framework of Greenhalgh et al structured and improved the generalizability of the identified barriers and facilitators. The additional online scoring list provided valuable information on the *relevance* and *feasibility in daily practice* through the eyes of practicing pharmacists. An additional strength was that the principal investigator (HE) of the original HomeCoMe study deliberately did not participate in the focus groups, because his presence might lead to pharmacists moderating their criticism. Furthermore, the pharmacists were told that they should feel free to express any experienced barriers.

A limitation of this is that the same 20 pharmacists were used for the follow-up scoring of the most important barriers, possibly limiting its generalizability. However, by performing this additional scoring method the gathered data across the different focus groups could be verified amongst all participants. A second limitation of this study is that it did not incorporate the views of patients and/or physicians. This information may also be important for future implementation.

#### **Conclusion**

This study focused on the barriers and facilitators that influenced pharmacists' adoption of a post-discharge home visit. Community pharmacists need to make sure that their skills in communication and pharmacotherapy are adequate. Furthermore, extensive collaboration with other healthcare providers in primary and secondary care and tailoring of the intervention to the local context may further increase adoption in daily clinical practice. The key to successful implementation, however, may lay in two facilitators which are partly interrelated: changing daily routine and reimbursement. Reimbursement will be a strong incentive, but additional efforts will be needed to reprioritize daily routines for instance by delegating management and logistic activities.

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## Appendix 1

### Topic guide for the focus groups

O = opening question initiating a new topic

F = follow-up questions asked by moderator to start the discussion, if necessary

#### 1. Introduction

O: What is your name, how long have you been working as a pharmacist, how long within the Zorggroep Almere, how many visits have you performed?

#### 2. Exchange of experiences

*All of you experienced performing the post-discharge home visits. We are gathered here today to exchange and discuss your experiences. Let us discuss these one by one.*

O: What are your experiences with the home visits thus far?

F: What went well? Can you identify some success factors?

F: What went wrong? Can you identify some barriers?

F: Why do you think that you were successful and your colleague experienced difficulties? What could be the cause of that? Can you mention some important factors?

F: What are crucial aspects for succeeding with these home visits? Can you mention some setting-related factors? Can you mention some individual pharmacist factors?

F: Did you enjoy performing these home visits? Why did you like it? Why didn't you like it?

#### 3. Skills and support

*As a pharmacist you need a specific skill set to perform these home visits.*

O: Do you think that you were sufficiently skilled?

F: If yes; which skills do you think are necessary? If not; which skills did you lack? What do you need to improve those?

O: What are your thoughts on the provided support?

F: Can you mention some important parts of the support that you have received? What kind of support did you miss? What kind of support was unnecessary? Why?

#### 4. Innovation and adopter

*Hospital discharge implies a risk for the patient. There are several ways of supporting these patients.*

O: What are your thoughts on performing post-discharge home visits to support these patients?

F: Would this be the best way for every discharged patient? Who will benefit most and who will not? What is an alternative way of supporting these patients? Or is post-discharge support not relevant at all?

F: What are (dis)advantages of these home visits as compared to usual care?

F: How did the patients experience these home visits?

O: There are several healthcare providers who could perform these home visits, what is your role as a community pharmacist?

F: Why? Or would you use the pharmacist more selectively? How and why would you do that?

#### 5. Implementation and system readiness

O: What is the way to implement these home visits into the daily practice?

F: Which tools would you need for that? Which patients would you target?

O: Is the current community pharmacy ready for these home visits?

F: What would you change? Why would you change that? How does that affect the current home visit protocol?

#### 6. Communication and external context

*As a pharmacist you need to make choices when your day are busy. After the project phase these home visits might end up as usual care.*

O: Without the "compulsory" character of the project, would you still perform these home visits?

F: Do you think that these home visits are important?

F: What are possible external factors that influence your decision (e.g. professional guidelines, reimbursement, management)?

#### 7. Summary and conclusion

*The moderator summarizes all subjects.*

O: Do you have something to add? What did we miss?

**Appendix 2****Statements based on the major barriers and facilitators included in the online scoring list**

- a) The home visit should enable pharmacists to identify and solve drug-related problems
- b) The appointment should take place at the patients home (not in the pharmacy or by telephone)
- c) The appointment should take place within 1 week post-discharge
- d) The home visit should contribute to the patient-provider relationship
- e) There should be a protocol to perform the home visit
- f) Patients should be prepared at discharge for the pharmacist visiting their home
- g) Local management should support the pharmacists in performing the home visits
- h) The pharmacist should perform the home visit himself (so not pharmacy technicians for example)
- i) The pharmacist should have sufficient skills on pharmacotherapy to be able to perform the home visit
- j) The pharmacist should have sufficient skills on communication to be able to perform the home visit
- k) Only patients who would benefit most from the home visit should be selected
- l) Primary care providers (e.g. general practitioner, home health care team) should be prepared to collaborate with the pharmacist
- m) Secondary care providers (e.g. specialist) should be prepared to collaborate with the pharmacist
- n) The pharmacist should make time for delivering pharmaceutical care
- o) The home visit should fit in pharmacists' daily routine
- p) Pharmacists should be trained on the content and performing the home visits in advance
- q) There should be support with respect to content when pharmacists need that as a result of a home visit
- r) Logistic support should be available for the pharmacist at hospital discharge
- s) Pharmacists should be allowed to tailor the protocol to the local circumstances
- t) Health insurance companies should offer a reasonable reimbursement fee for the home visit
- u) An informal carer should be present during the home visit