A patient satisfaction study based on the results of the Consumer Quality Index

The outpatient clinic for Neurology in the University Medical Centre Groningen

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Abstract

Introduction

Patient satisfaction is an important pillar in quality of care. In Dutch health care settings, patient satisfaction is measured using the Consumer Quality Index (CQ-index). For outpatient clinics, it is an almost completely quantitative questionnaire, supplemented with two qualitative questions. CQ-index questionnaires give insight in two things: what patients consider important and what their experiences are with care. Managers and professionals encounter problems, because from the results from the CQ-index it is difficult to conclude where specific problems have their origin. This study focuses on exploring and improving patient satisfaction of the outpatient clinic for neurology in the University Medical Centre Groningen (UMCG) using the 2015 CQ-index results as starting point.

Methodology

The study had an explorative character. The research question was worded: *How can patient satisfaction on an outpatient clinic be improved, following the results of the Consumer Quality-index of an outpatient clinic performed in 2015?* For finding answers to the research question, a qualitative approach was used. The study consisted of four parts: 1) analysing the CQ-index data, provided by the UMCG, to gain starting points for part two, three and four of the study; 2) two focus groups with patients of the outpatient clinic for Neurology in the UMCG who visited the outpatient clinic within the last six months; 3) interviews with five employees of the outpatient clinic for neurology in the UMCG; 4) from the CQ-index data, the high performing outpatient clinic for Neurology of all academic hospitals in the Netherlands are found: interviews have been done with four employees of the outpatient clinic for Neurology in the Radboudumc Nijmegen. In this – so called – positive deviance method, Radboudumc is the positive deviant. Focus groups and interviews are structured according to the Appreciative Inquiry framework. Data-analysis was performed using Atlas TI.

Results

The CQ-index was completely filled in by 109 patients of the outpatient clinic, a response rate of 27.4%. On average, the outpatient clinic scores a 7.8 on a scale of one to ten, somewhat lower compared to the benchmark average (8.1). Strong points are accessibility and interpersonal conduct by physicians. Important bottlenecks in patient satisfaction are provision of information, information about medication and after care. Focus groups generate comparable results. Patients say they want more and better written information, information about medication and side effects, being able to register at the reception as well as the reception pole and employees to be more proactive. Employees of the outpatient clinic in the UMCG think patient satisfaction can be improved by putting brochures in the waiting room and all consultations room and give clear information so patients do not leave the outpatient clinic with uncertainty. The positive deviant is involving patients when making new written information and focusses on patient centred care. They said

this contributed to their high patient satisfaction scores. Thereby, they will start with a patient advisory board, just for the outpatient clinic.

Discussion

CQ-index results painted the same picture as focus groups and interviews with employees: biggest improvements can be made regarding provision of information and after care. These themes have low experience and high importance scores at the CQ-index 2015. Also, patients and employees find it to be important things, that can be improved easily. Brochures regarding diseases, diagnoses and treatment have to be available at all times. These brochures already exist. When the outpatient clinic wants to make their own brochures or other written means of communication like letters, it is highly recommended the outpatient clinic for neurology in the UMCG consults with patients about the content. Proper and explicit information regarding medication and side effect is important as well. A more proactive attitude of employees is desired. Also, hiring a host for the outpatient clinic and setting up a patient advisory board is advisable.

Samenvatting

Inleiding

Patiënttevredenheid is een belangrijke pijler in de kwaliteit van zorg. In Nederlandse gezondheidszorginstellingen wordt de Consumer Quality Index (CQ-index) gebruikt om de tevredenheid van patiënten te meten. Voor poliklinieken bestaat er een vrijwel volledig kwantitatieve vragenlijst, aangevuld met twee kwalitatieve vragen. CQ-index vragenlijsten geven inzicht in twee zaken: wat patiënten belangrijk vinden en wat hun ervaringen zijn met de zorg. Alleen, managers en professionals ondervinden problemen met het interpreteren van de resultaten van de CQ-index, omdat het moeilijk te bepalen is waar aangetoonde problemen hun oorsprong hebben. Dit onderzoek richt zich op het onderzoeken en verbeteren van de patiënttevredenheid op de polikliniek neurologie in het UMCG, met de resultaten van de CQ-index 2015 als uitgangspunt.

Methode

Dit onderzoek had een exploratief karakter. Voor het vinden van de antwoorden op de onderzoeksvragen is een kwalitatieve benadering gebruikt. Het onderzoek bestond uit vier delen: 1) het analyseren van de CQ-index data, aangeleverd door het UMCG, om aanknopingspunten te krijgen voor stap twee, drie en vier; 2) twee focusgroepen met patiënten die maximaal een half jaar voor de focusgroepen de polikliniek neurologie hebben bezocht; 3) interviews met vijf medewerkers van de polikliniek neurologie in het UMCG; 4) uit de CQ-index is de best presterende polikliniek neurologie van alle academische centra in Nederland gevonden: interviews zijn gedaan met vier medewerkers van de polikliniek neurologie in het Radboudumc. In deze – zogenaamde – positive deviance methode, is het Radboudumc de positieve deviant. Focusgroepen en interviews zijn gestructureerd aan de hand van het Appreciative Inquiry framework. Data-analyse is gedaan met behulp van het computerprogramma Atlas TI.

Resultaten

De CQ-index werd volledig ingevuld door 109 patiënten van de polikliniek, een respons van 27,4%. Gemiddeld scoort de polikliniek een 7,8 op een schaal van een tot tien, lager in vergelijking met de NFU Benchmark (8,1). Sterke punten zijn de toegankelijkheid en de bejegening door artsen. Belangrijke knelpunten in de tevredenheid van de patiënt zijn verstrekken van informatie door medewerkers van de polikliniek, informatie over medicatie en nazorg. Focus groepen genereerden vergelijkbare resultaten. Patiënten zeggen dat ze meer en betere schriftelijke informatie, informatie over medicatie en bijwerkingen willen, zich kunnen zich registreren bij de receptie, evenals de aanmeld uil en dat medewerkers pro-actiever moeten zijn. Medewerkers van de polikliniek denken dat patiënttevredenheid verbeterd kan worden door het beschikbaar hebben van brochures in wachtkamer en behandelkamers, het houden van een dubbel systeem voor aanmelden en het verschaffen van duidelijkere informatie zodat patiënten niet met onzekerheid de polikliniek verlaten. De positive deviant betrekt patiënten wanneer ze nieuwe schriftelijke informatie

maken en leggen ze de focus op patiëntgerichte zorg. Daarnaast beginnen ze met een patiënten adviesraad, alleen voor de polikliniek.

Discussie

De CQ-index schetste grotendeels hetzelfde beeld als de focusgroepen en interviews met medewerkers: grootste verbeteringen kunnen worden gemaakt met betrekking tot verstrekken van informatie en nazorg. Deze thema's hebben lage ervarings- en hoge belangscores. Daarnaast vinden zowel patiënten als medewerkers het belangrijke aspecten die relatief eenvoudig verbeterd zouden kunnen worden. Folders ten aanzien van diagnose, ziekte en behandeling moeten te allen tijde beschikbaar zijn. Hiervoor kunnen reeds bestaande folders gebruikt worden. Als de polikliniek zelf haar schriftelijke informatie wil maken (bijv. brieven), is het zeer aan te bevelen om hier patiënten bij te betrekken. Daarnaast is goede en expliciete informatie ten aanzien van medicatie en bijwerkingen belangrijk. Een meer proactieve houding van medewerkers is gewenst. Ook is het aannemen van een gastheer voor de polikliniek en het opzetten van een patiënten adviesraad zeer aan te raden.

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1. Introduction

Quality of care is a well-known concept and has gained more and more attention over the last years. There are several definitions of quality of care. An often cited one is the one from the Institute of Medicine (IOM) (1, 2): "Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge how care is provided have to reflect appropriate use of the most current knowledge about scientific, clinical, technical, interpersonal, manual, cognitive, and organization and management elements of health care." Based on this definition the IOM drafted six dimensions of quality: care should be safe, effective, efficient, timely, equitable and patient centred (1, 2). The last of these six dimensions, patient centeredness, is defined as: "the system of care should revolve around the patient, respect patient preferences, and put the patient in control." (1) To improve quality of care all dimensions should be improved, thus also the patient centeredness. According to Donabedian in The Lichfield Lecture (3), customers (patients) are able to say what healthcare outcomes are to be pursued, what risks are to be accepted and what costs are realistic in return for a certain improvement in health state. Each patient has a different value of importance of living longer, self-image and -worth and function (e.g. physical, economic or social). From this follows that patients at least participate in defining the quality of care, because they specify the goals it should meet (3).

The Dutch Health Care Inspectorate (Inspectie voor de Gezondheidszorg, IGZ) announced earlier in 2016 they will start using layman inspectors in the form of patients to assess the delivered quality of care in, for example, hospitals (4). This announcement points out the importance of the opinion of patients, even for the Dutch Health Care Inspectorate.

1.1 Patient satisfaction

Apparent from the previous section, patient centeredness is an important factor in quality of care, and getting more important. This is why taking patient satisfaction into account when assessing the quality of care is crucial. It is often covered in literature, as it is a key concept for evaluating and improving health care (5). That is why this section will delve deeper into patient satisfaction, its determinants, how it can be measured and methodological considerations.

Patient satisfaction can be described as the reaction of a patient to certain aspects of his experience with received health care (6). This means, patients appraise health care as well as providers and health insurers, but from their own perspective (6, 7). Motivations to survey and measure patient satisfaction include the fact that it is a predictor to health-related behaviour and adherence to therapy (6, 8) and whether patients are willing to recommend the health care provider to other patients (6, 7). Furthermore, patient satisfaction is useful for appraising communication and interpersonal conduct. Patients are, after all, the first and best source of accurate information concerning clarity of explanations, helpfulness of information and

barriers to obtain care (6, 9). Despite the fact that many studies have discussed patient satisfaction, it still is a difficult matter to figure out (10).

Actual consultation with the physician is the most important determinant of the patient's opinion about the outpatient clinic (11). Adequate communication by physicians towards their patients is decisive to reaching good patient satisfaction scores (11). Factors that cause patient dissatisfaction are length of waiting time, poor communication and provision of information, poor reachability and patients not being included in the decision making process regarding their treatment (11). Other determinants for patient (dis)satisfaction are the outcome of a treatment and the kindness of nurses and physicians (6).

Various background characteristics influence whether or not a patient is satisfied with received care. For example: older patients and patients with lower educational levels seem to be more satisfied compared to younger and highly educated patients (6, 11). Psychosocial determinants also have a role, in the way that patients could report greater satisfaction than they actually experience because they think being negative about their received health care may have negative consequences regarding their treatment (6, 12). This emphasizes the importance of anonymizing the process of gathering data when doing study regarding patient satisfaction.

1.1.1 Measuring patient satisfaction

Patient satisfaction can be measured in different ways. There is no single broadly used method for measuring it (11). A systematic literature review from 2008 summarized studies (n=35) with different designs for measuring patient satisfaction in outpatient clinics in Europe (11). Most studies had a cross-sectional design (51%) and used a questionnaire to collect data (54%). In almost 20% of cases, interviews were used to assess patient satisfaction. The remaining cases used a mixed-method approach.

From another systematic literature review summarizing solely English-written studies in patient satisfaction (13), a few methodological considerations to assess patient satisfaction can be derived. The most important for this study will be discussed here. Impersonal methods (e.g. digital) result in more criticism and lower reported satisfaction because the anonymity of respondents is not compromised and there is no pressure for socially acceptable responding, but face-to-face (or telephone) interviews generate higher responses. Also, problems exist with obtaining usable responses from elderly, severely ill, cognitively impaired and aphasic people. On-site surveys cause an under-representation of patients who less frequently use health care in outpatient populations. The literature review states qualitative approaches provide more in-depth information, in contrast to the quantitative approaches. If resources permit it, a mixed approach may be the best option (13).

1.1.2 Positive deviance

The approaches described in paragraph 1.1.1 are deficit-based: focus lies on identifying negative results or accidents from the past, and learning from these. Effectiveness is limited as only two out of three projects with these kinds of methods achieve satisfactory results and feasible change (14, 15). Improving quality in health care can sometimes even lead to unforeseen consequences (16). For example: when successfully assessing one issue, it is not uncommon it causes new problems elsewhere. 'This can cause people to lose faith in the project.' (16) Another method that can be used to improve certain aspects of patient satisfaction is positive deviance. This chapter will include definitions and concepts which go along with positive deviance and how it can be used in practice.

Positive deviance is a method that can be used for identifying and learning from other departments or hospitals on a certain quality aspect. Positive deviance is a framework based on the assumption that problems can be solved using solutions that already exist (14, 17, 18). So called 'positive deviants' are being studied, because under similar conditions, they have found a way to manage problems where others struggle (14, 19).

For positive deviance in health care, a four-stage process for adopting the approach has been proposed by Bradley et al. (figure 1) (17). The four stages are: 1) identify the positive deviants using a widely ratified, routinely collected data; 2) use qualitative methods to generate hypotheses (or recommendations) about how positive deviants succeed; 3) test the hypotheses within larger, more representable samples; 4) finally, implement the successful practices widely (14).

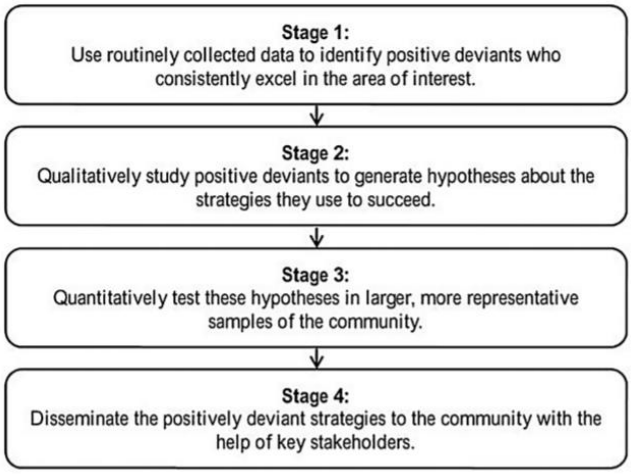

Figure 1: The stages in the positive deviance process for health care organizations (17).

1.1.3 Consumer Quality Index

In various Dutch health care settings, e.g. hospitals, youth healthcare and home care, patient satisfaction with received care is measured using the Consumer Quality index (CQ-index). The CQ-index is a standardized set of questions for the measurement of experiences of patients (the consumers) with care. CQ-indexes consist of several interconnecting questionnaires and associated guidelines for data collection, data-analysis and reporting of the results (20). By implementing and executing the CQ-index, quality of care from the patients perspective can be identified. The CQ-Index questionnaires are developed by NIVEL, the Dutch institute for health services research. It is based on the American questionnaire systematic Consumer Assessment of Healthcare Providers and Systems (CHAPS) and the Dutch Quality Of care Through the patient's Eyes questionnaire (QUOTE, also developed by NIVEL) (21).

The CQ-index questionnaires give insight in two things: what patients consider important and what their experiences are with care. Results are used to evaluate and improve quality of care. The gathered information is meant for patients (to help them choose a health care provider), health insurers (to help them purchase qualitative good care), managers and professionals (to help them improve their service and care), the health care inspectorate and the Dutch Ministry of Health, Welfare and Sport (20).

Managers and professionals encounter problems, because from the results from the CQ-index it is difficult to conclude where specific problems have their origin. The questionnaire is in fact standardized and CQ-index questionnaires are for different parts of care (mostly) consistent. This means it is difficult to use the results for quality improvement for a certain hospital or department of a hospital. Research has shown that among employees of hospitals, additional qualitative information and better feedback is needed: employees want feedback on question level instead of composite scores, because it is easier to interpret (22).

The CQ-index for outpatient hospital care (Vragenlijst Poliklinische Ziekenhuiszorg), for instance, consists of seventy questions, of which two are qualitative (23). The fact that there are only a few qualitative questions is corresponding with the finding health care professionals desire more qualitative information from the CQ-index (24).

1.2 University Medical Centre Groningen

One of the hospitals that encounter problems with the interpretation of the CQ-index results is The University Medical Centre Groningen (UMCG). It is one of the largest hospitals in the Netherlands and the largest employer in the Northern three provinces of the Netherlands (Groningen, Friesland and Drenthe). Over ten thousand employees work in patient care and academic research. Patients come to the UMCG for basic healthcare, but also for high specialized care (including diagnosis and treatment) (25). The UMCG has 32 outpatient clinics. An outpatient clinic, or outpatient department, is a ward in a hospital where people are seen for a medical consultation or treatment by a physician, without admission to the hospital (26). One of the 32 outpatient clinics in the UMCG is for Neurology. The outpatient clinic consists of six sections comprising the most common diseases: general outpatient clinic, outpatient clinic for movement disorders, outpatient clinic for children, outpatient clinic for Multiple sclerosis, outpatient clinic for Neuromuscular disorders and outpatient clinic for traumatology. The outpatient clinic for children is not in the scope of this study.

Professionals in the outpatient clinic for Neurology in the UMCG experience the same problems with CQ-index as stated earlier: they do not know how to deal with the results of the CQ-index and how to use these results to improve their outpatient clinic. Therefore, in the following chapter the outcomes of the most recent CQ-index of this outpatient clinic, performed in 2015, will be addressed. This study will focus on translating these results towards concrete recommendations, to enable quality improvement in the outpatient clinic of Neurology in the University Medical Centre Groningen. The results of this study can be used as an example for other outpatient clinics or hospitals for translating the results of their CQ-index to help them assure quality improvement.

2. Research question

As stated before, the outpatient clinic for neurology in the UMCG has difficulties with how the results of the CQ-index can be used to improve patient satisfaction. Therefore this study will focus on how patient satisfaction at the outpatient clinic can be improved, using the results of the CQ-index of 2015. To establish this, the following research question has been drawn up:

Main question:

How can patient satisfaction on an outpatient clinic be improved, following the results of the Consumer Quality-index of an outpatient clinic performed in 2015?

To help find a well-founded answer to the main research question, it will be broken down into four sub questions. The first sub question refers to the results of the CQ-index for the outpatient clinic for neurology in the UMCG, over 2015. The second sub question focuses on opinions of patients about the bottlenecks derived from the CQ-index. The third sub question focuses on opinions of employees of the outpatient clinic for Neurology in the UMCG. This is an important step because for making a valid assessment of patient satisfaction, opinions of both actor groups should be included (27). The fourth and last question regards the opinion of employees of another outpatient clinic, that has high patient satisfaction scores according the CQ-Index.

Sub questions:

1. What are the results of the CQ-index for the outpatient clinic of neurology in the UMCG?
2. How do patients of the outpatient clinic for Neurology in the UMCG think the bottlenecks in patient satisfaction, found with the CQ-index, could be eliminated?
3. How do employees of the outpatient clinic for Neurology in the UMCG think the bottlenecks in patient satisfaction, found with the CQ-index, could be eliminated?
4. How can knowledge of improving and maintaining high patient satisfaction of another, high performing outpatient clinic for Neurology (based on the results of CQ-index), be used to improve patient satisfaction in the outpatient clinic for Neurology in the UMCG?

3. Research methods

The study was executed from July 2016 to September 2016. It took place at the outpatient clinic for Neurology the University Medical Centre Groningen and another high performing outpatient clinic for Neurology in another academic hospital, Radboud University Medical Centre in Nijmegen (Radboudumc).

The study had explorative character. For finding answers to the research questions, a qualitative approach has been used. This approach is preferred, because research (sub)questions focused on exploring experiences and perspectives of people (28, 29). In addition, it was a suitable research design for producing scientific knowledge on a subject on which is little scientific information (30).

The study consisted of four parts, one for each sub question. The first one consisted of analysing the CQ-index data, provided by the UMCG, to gain starting points for part two, three and four of the study (answering sub question 1). The second part consisted of two focus groups with patients of the outpatient clinic for Neurology in the UMCG (answering sub question 2). Where first two parts focused on the opinions of patients regarding their satisfaction with the outpatient clinic, the third and fourth part focused on employees: part three regarded interviews with five employees of the outpatient clinic for neurology in the UMCG (answering sub question 3). The fourth part regarded interviews with four employees of the high performing outpatient clinic for Neurology in the Radboudumc, Nijmegen (answering sub question 4). These last two parts focused on opinions of medical professionals on gaining and maintaining high patient satisfaction. All parts will be further explained throughout the rest of this chapter.

3.1 Summary of used methods

In the table 3.1, the research methods, population and data-analysis methods that have been used to answer the research questions are summarized.

Table 3.1: Brief overview of used methods for gathering and analysing the data

Research question	Data collection	Population	Data-analysis
1	CQ-Index data	Patients (and family caregivers) of all outpatient clinics in the Netherlands	CQ-Index data has already been analyzed
2	Semi-structured focus group discussion	Patients (and family caregivers) of outpatient clinic for Neurology in the UMCG	According to the six steps described by Plochg et al (30). Atlas TI will be used for transcribing and coding.
3	Semi-structured one-on-one interviews	Employees of outpatient clinic for Neurology in the UMCG	According to the six steps described by Plochg et al (30). Atlas TI will be used for transcribing and coding.
4	Semi-structured one-on-one interviews	Employees of positive deviant (= outpatient clinic for Neurology in Radboudumc)	According to the six steps described by Plochg et al (30). Atlas TI will be used for transcribing and coding.

3.2 Part one: The CQ-index data

In this part, the methods used in the first part of the study will be further elaborated. This part regarded the describing of the CQ-Index results of the outpatient clinic for neurology in the UMCG, gathered in 2015. For this part of the study, access to the results was granted by the UMCG. Results were accessible via an online platform (www.mediquest.nl/cerium).

3.2.1 Research design

The CQ-Index questionnaires for outpatient hospital care ('Vragenlijst Poliklinische Ziekenhuiszorg') (23) were sent to patients of all academic hospitals in the Netherlands and to all outpatient departments in the UMCG. A total of 26,338 questionnaires have been sent in 2015. Of this total amount, 398 questionnaires were sent to random patients (and/or family caregivers) who visited the outpatient clinic for neurology within half a year before sending the questionnaires. This is done via an independent research company, MediQuest (31). As stated before, the CQ-index for outpatient hospital care consisted of 70 questions: two of these questions were qualitative questions. Here, respondents could indicate in words what weak points they experienced in the outpatient clinic and whether or not they would give the outpatient clinic a compliment about something. The rest of the questions (68) were quantitative. They measured the following dimensions of patient satisfaction: accessibility, reception at the outpatient clinic, waiting time at the outpatient clinic, interior of the outpatient clinic, interpersonal conduct by the physician, information and communication given by the physician, interpersonal conduct by a (possible) other care giver, information and communication given by the (possible) other care giver, collaboration at the outpatient clinic, involvement of the patient, and after care. Hereafter, respondents were asked to rank the outpatient clinic from 0 (= very bad) to 10 (=excellent). At the end, respondents were asked to fill in some background variables: gender, age, level of education, state of health, chronic diseases, country of birth (of themselves and their parents) and spoken language at home.

3.3 Part two: focus groups

As stated earlier, the second part of the study consisted of focus groups with patients that visited the outpatient clinic. In the following paragraphs, the design used for data gathering, the research population (and recruitment), used measuring instrument and data-analysis will be described.

3.3.1 Research design

Focus groups are group interviews, conducted by an experienced moderator. Focus groups usually are homogenously composited groups with minimal four to maximal twelve participants. They have an interactive conversation and deliver information from their personal experience about focused topics regarding the subject of the study (28). A semi-structured approach will be used, structured according to the Appreciative Inquiry method. This will be described later in the paragraph '3.3.4 Instrument: focus group script'. The topics in the focus group script were the topics on which the outpatient clinic for Neurology in the UMCG performed good and bad, according to the results of the CQ-index of 2015.

Focus groups are an often used method to gain information about how patients experience their disease and delivery of health care. The biggest advantages of this method were that it is relatively cheap and straightforward method to generate (focused) qualitative data (28). Also, interviewees could provide historical information regarding the subject and it allowed the researcher to have control over the questioning during execution of the focus group (29). Furthermore, participants could interact with each other, this resulted in more in depth information regarding opinions of participants (28). This is amplified by the fact that respondents in focus groups interacted with each other and can understand and strengthen perspectives of others. This generated unique insights that may not be collected otherwise, for example in one-on-one interviews (32). It was important that the moderator was experienced in the field of focus groups. Less experienced moderators tend to make it more a sequence of individual interviews, instead of motivating the participants to start a group conversation (33). This is why an experienced moderator has been asked to conduct the focus groups, preventing potential bias. This moderator was an employee of the UMCG, with experience regarding focus group due to the function she is in. Next to the moderator, an observer (= lead investigator) was present to assure coverage of all topics, operate recording materials and observe non-verbal communication (28).

The ideal amount of focus groups depends on the nature of data collection. In addition, data saturation had to be taken in account: when focus groups deliver no new data, there is no purpose in performing another focus group (28). Taking the previous into account accompanied by the amount of time and resources available for execution of the study, two focus groups were performed. Plan was to make sure each focus group consisted of approximately six people, (former) patients and family caregivers. More information about the participants can be found in paragraph '4.3.2 Research population'.

3.3.2 Research population

For this part of the study, target population regarded (former) patients and family caregivers that have visited the outpatient clinic for Neurology in the UMCG between March and June of 2016, are eighteen years or older and are mentally competent. It was chosen to include the family caregivers as well because in some cases they fill in the CQ-index when the patient they take care of is incapable of doing it themselves (23). Therefore, it is important to include their opinions too. Family caregivers can speak on behalf of, or support patients during the focus groups. A recent period of four months (between March and June of 2016) is chosen to make sure enough participation of patients will be accomplished and the visit to the outpatient clinic has not been too long ago: maximum of half a year, just like in the CQ-index. This was done to prevent participants not being able to recall their experience well enough. This may cause recall bias. Furthermore, patients and family caregivers are eligible when they speak the Dutch language and are not in a complaint procedure. The latter to prevent these patients to use the focus groups as a platform to express their complaints.

Patients and their family caregivers will be selected via a so called purposeful sample (=not at random). This means selecting patients on purpose, because they have a certain affinity with the subject (28). In this case, patients (and their family caregivers) of the outpatient clinic for neurology in the UMCG.

3.3.3 Recruitment

Recruitment took place in July of 2016. Respondents have been contacted via a letter announcing they could be contacted about participating in a focus group, 117 letters have been sent. The letter also contained information about the purpose of the study, focus groups and privacy. This letter can be found in appendix A. A few days later the researcher called the patients who got a letter and asked if they wanted to participate in one of the focus groups. This prevents delay due to waiting for a response when, for example, contact was made solely in writing. The first phone calls were made during the day (between 11 a.m. and 5 p.m.) Not all patients who got a letter answered the phone the first time. Second attempts were made in evening hours (between 6 and 9 p.m.). Third attempts were made one week after the first attempt. To the patients not reached in the recruitment period - that took 8 days - a letter was sent to inform them their participation in the study was no longer needed, it can be found in appendix B. This regarded 50 patients. When a patient agreed to participate (n=12) in a focus group, an information letter was sent with practical information (time, date, location and directions) and further information about the purpose of the focus group. This letter can be found in appendix C. All sent letters had the corporate identity of the UMCG to ensure patients the hospital was the sender.

3.3.4 Instrument: focus group script

For the focus groups, a semi-structured script was drafted. It can be found in appendix D. The purpose of the focus groups is to gain qualitative data on the satisfaction of patients at the outpatient clinic for Neurology in the UMCG. The focus group will be recorded in order to enable a reliable transcription for the analysis. Before commencing the focus groups, the researcher asked participants to fill in a questionnaire regarding back ground variables, this questionnaire van be found in appendix E.

The focus group script was built according to the Appreciative Inquiry (AI) method. AI is a framework (both theoretical and participatory) that can be used to engage groups and cross boundaries with a positive approach (34, 35). This makes it an ideal tool for setting up focus groups. AI is based on the 4-D cycle, which consists of four parts (35, 36). It can be found in figure 2.

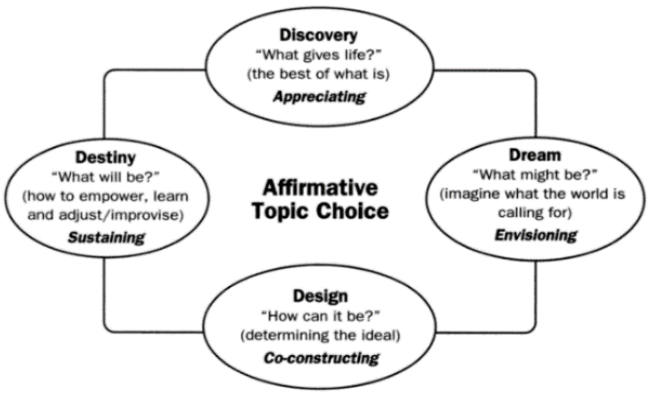

Figure 2: The 4-D cycle of Appreciative Inquiry (35)

Step 1 in AI is Discovery, in which participants recalled the strong points of the outpatient clinic for neurology. The second and third step are Dream and Design. For this study, both were combined to dream about and design the ideal outpatient clinic. The fourth step is Destiny. In this last step, the ideal outpatient clinic was looked at from a realistic perspective and respondents are asked to think about what has to be done to be able to create the ideal outpatient clinic. Where possible, focus group-questions and topics were based on the results of the CQ-Index for outpatient hospital care performed in 2015 at the outpatient clinic for Neurology in the UMCG. Strong points and bottlenecks in patient satisfaction, as stated earlier, have been included in a topic list, together with general questions about the experience of patient and their family caregivers. When deemed necessary, the moderator gave a short introduction when a new topic will be addressed. These introductions were also a part of the focus group script.

At the end, the moderator asked the participants if there were any important subjects they feel were not, or not properly, covered during the focus groups session. Hereafter, the session has been closed by the moderator. The estimated time of the focus groups was ninety minutes.

Focus groups are often supplemented with other research methods, to validate the gained information (28). In this case interviews with employees of the outpatient clinic for Neurology in the UMCG (chapter 3.4) and interviews with employees of the 'positive deviant': the outpatient clinic for Neurology in Radboud UMC in Nijmegen (chapter 3.5).

3.4 Part three: interviews with employees of the outpatient clinic for Neurology in the UMCG

The third phase of the study regarded interviews with employees of the outpatient clinic for Neurology in the UMCG. In the following paragraphs research design, population and the measuring instrument will be further explained.

3.4.1 Research design

The most used form of data gathering in qualitative research is interviewing (29). A semi-structured one-on-one approach is chosen. It is semi-structured because questions are open, but topics of the CQ-index are part of the interview protocol, what can be found in appendix F.

Interviews are held with employees of the outpatient clinic for neurology, to get information about the perception of the employees regarding patient satisfaction and how they think patient satisfaction could be improved. In addition and as stated before, including all actor groups is important when trying to achieve change or make improvements (27). In this case: patients and employees of the outpatient clinic for neurology in the UMCG.

In contrast with the focus groups, interviews have been performed by the lead investigator. Experience with moderating is less important with one-on-one interviews, compared to focus groups (30). Furthermore, using the lead investigator as interviewer is an advantage because it allowed the use of correct and relevant terminology and jargon, without the need to define this to a third party interviewer (32). Any potential bias originating from the lead investigator being the interviewer is reduced by using a semi-structured interview protocol (32). This makes sure the interviews remained focused on the chosen topics and all these topics were covered in all interviews.

3.4.2 Research population

The research population consisted of five employees of the outpatient clinic for neurology in the UMCG. To get different inputs, people in different functions have been approached to cooperate: physicians (two neurologist), paramedics (one nurse and one nurse practitioner) and one front desk attendant. All employees have direct contact with patients. Interviews took place at the UMCG . This means there is no travel distance for the respondents, so chance of getting enough participation is higher (30). Interviews took place in a private room, the only way interviews could be disturbed was when a pager or mobile phone went off.

Respondents were recruited by asking the head of the outpatient clinic to propose some employees for interviews. This choice has been made because this person has the best view of which employees could contribute to the subject of the study.

3.4.3 Instrument: interview protocol

For this part of the study, an interview protocol has been used. The interview protocol for this part can be found in appendix F. Before starting the interview function at the outpatient clinic has been noted. Furthermore, the main activities, contact with patients and the concept of patient satisfaction have been briefly discussed. The rest of the interview was structured just like the focus groups with AI, because AI is based on the assumption every organization has some strengths that can be the starting point of positive changes (35). The questions, however, in the 4-D's were slightly different from those in the focus groups to adjust them to employees instead of patients. Therefore, this will be explained below.

In the interview protocol, the Discover-phase also focused on the strong points of the outpatient clinic regarding patient satisfaction. In this case, they are supplemented with what caused this high satisfaction and what has been done (actively) to remain high patient satisfaction. The Dream and Design phases in the interview protocol have been combined, just like in the focus groups. The questions in these phases were the same: dreaming and designing the ideal outpatient clinic. The destiny phase was the same as in the focus groups.

At the end, the interviewer asked whether or not every subject has been covered properly according to the interviewee or if any important subjects have not been discussed. Hereafter, the interview has been ended. The estimated time for the one-on-one interviews was approximately thirty minutes.

3.5 Part four: Positive deviance

The fourth part of the study consisted of interviews with employees of the outpatient clinic for neurology that has the highest scores in the CQ-index of 2015: the outpatient clinic for neurology in the Radboud UMC (Radboudumc) in Nijmegen. In the following paragraphs research design, population and the instrument will be further explained.

3.5.1 Research design

For this part, the positive deviance method was used. As stated earlier, positive deviance is a method that can be used for identifying and learning from other departments or hospitals on a certain quality aspect. The positive deviance method is based on the assumption that problems can be solved using solutions that already exist (14, 17). For positive deviance in health care, a four-stage process for adopting the approach has been proposed by Bradley et al. It can be found in figure 1 (17).

In this case, step 1, the routinely collected data to identify positive deviants, was the data gathered with the CQ-index in 2015. Based on these findings, the outpatient clinic for Neurology in the Radboudumc has been asked to act as positive deviant, because they have the highest patient satisfaction scores of all outpatient clinics for Neurology in academic hospitals in the Netherlands. Views of employees of this outpatient clinic on reaching optimal patient satisfaction have been inquired. For this part of the study one-on-one face-to-face interviews have been conducted, because this part involves individual views and opinions of employees of a high performing outpatient clinic (28). Just like the interviews at the UMCG, these interviews have been performed by the lead investigator. Ideally, step 3 and 4 are performed as well (see figure 1). Regarding the time available, the choice was made to just perform step 1 and 2.

3.5.2 Research population

For this part of the study, the target population were all employees of the outpatient clinic for Neurology in the Radboudumc. To get different inputs (just like in the UMCG), people in different functions have been approached to cooperate: physicians (two neurologist), paramedics (one nurse and one nurse practitioner) and one front desk attendant. All employees have direct contact with patients. In this part, data collection took place at the Radboudumc in Nijmegen. This means there was no travel distance for the respondents, so chance of getting enough participation is higher (30).

Respondents were recruited by asking the contact person at the Radboudumc to propose some employees of the outpatient clinic for Neurology in that hospital for interviews. This contact person has the best view of which employees could contribute to the subject of the study.

3.5.3 Instrument: interview protocol

For this part of the study, an interview protocol has been used. The construction of this protocol and the way of conducting the interviews will be further explained. The interview protocol for this part can be found in appendix G. Before starting the interview, function at the outpatient clinic has been noted. Furthermore, the main activities, contact with patients and the concept of patient satisfaction has been briefly discussed. The rest of the interview was structured just like the interviews at the UMCG, with AI, because AI is based on the assumption every organization has some strengths that can be the starting point of positive changes (35). The questions in the 4-D's were much alike those in the interviews with employees of the outpatient clinic for Neurology in the UMCG. However, there were some slight differences because in this case, emphasis was on the positive points rather than potential weak points or points for improvement. The intention was, after all, to use the strengths of the outpatient clinic for Neurology in the Radboudumc to improve the outpatient clinic in the UMCG. Constraints in patient satisfaction, however, will be briefly addressed. The differences will be further elaborated on below.

In the interview protocol, the Discover-phase also focused on the strong points of the outpatient clinic regarding patient satisfaction. In this case, it was supplemented with what could have caused high satisfaction scores and what has been done (actively) to remain high patient satisfaction. This was the same as in the other interview protocol. The Discover-phase however, was supplemented with the question regarding what has been done to get at the current point of patient satisfaction. Constraints in patient satisfaction of the outpatient clinic in the UMCG have been added, to help get specific answers for the UMCG. The Dream and Design phases were combined in the interview protocol, just like in the interviews at the UMCG. The questions in these phases were the same: dreaming and designing the ideal outpatient clinic. Does the positive deviant have wishes to achieve the perfect outpatient clinic? The last part, destiny, the question was about what should be done to get here and who should be involved to obtain this.

At the end, the interviewer asked whether or not every subject has been covered properly according to the interviewee, if any important subjects have not been discussed and if the interviewee had any more concrete tips for the UMCG. Hereafter, the interview was been ended. The estimated time for the one-on-one interviews was approximately thirty minutes.

3.6 Data-analysis

Data-analysis in the qualitative parts of this study was the same. Data of the CQ-index was already analysed. The data-analysis procedures will be described in this paragraph.

Because this study will generated a lot of qualitative data, a structured approach of analysing the data was desired. That is why analysis was performed according to the six steps that have been described by Plogch et al. (30), to make the analyzation of the huge amount of data so systemized, ordered, transparent and assessable as possible.

The first step was to order and prepare research material for analysis. This has mainly a practical character. It consisted of transcribing the audio and sorting data gathered in the focus groups and individual one-on-one interviews. The second step was to get a global view of the research material. The researcher read the gathered materials in a global manner, to get a general impression about the quality of the materials in light of answering the research questions. The third part regarded the start of the detailed analysis: during this step, this first round of coding the transcribed materials has been performed. The main goal of coding was to organise data in fragments of text, before giving them meaning in a next stage. The transcribed data has been coded and analysed in Atlas TI, a computer programme built for analysing qualitative data (37). After this, the deepening of the detailed analysis took place. The codes used in the this second round of coding were nine themes of the CQ-index: accessibility, the reception, interior of the outpatient clinic, waiting(time) at the outpatient clinic, interpersonal conduct, information & communication, collaboration by employees, patient participation and after care. These subjects are the names of the chapters and sections in the results and discussion parts of this study. This ensured a structured way of presenting the results and the recommendations in the discussion. In the seconds round of coding, the researcher also indicated if the theme emerged spontaneously or when specifically asked about (only in the focus groups). Themes mentioned spontaneously could indicate importance to patients (and family caregivers) (38). For employees of the UMCG, strong and weak points have been coded and how employees think these could be (further) improved. For employees of the positive deviant, recommendations regarding the nine themes of the CQ-index have been coded. In the fifth step, a meaningful way of presenting the results had to be found. For example, results can be presented per theme (cross-case) or respondent (within case) (30). In this case, results are presented cross-case. The final step was to interpret the analysis as a whole: by comparing the results of the study against the original problem, the research questions and relevant literature, answers are found to what the results mean in light of the situation of the outpatient clinic for Neurology in the UMCG.

4. Results

4.1 CQ-Index results

The most recently performed CQ-index is from the year 2015. The CQ-index for outpatient hospital care (23) was distributed to patients from the outpatient clinic for Neurology in the UMCG. It measures a total of 17 constructs, also named quality dimensions. The questionnaire was completed by 109 patients, a response rate of 27.4%. This is equal to the overall hospital response rate (27.5%). In this chapter the results, positive scores and potential bottlenecks in patient satisfaction will be discussed.

On average, the outpatient clinic scores a 7.8 on a scale of one to ten and 48.1% of all respondents would recommend it to family members. Compared to other outpatient clinics for Neurology in academic hospitals in the Netherlands, the outpatient clinic in the UMCG scores somewhat below average (=8.1). The national benchmark can be found in figure 3.

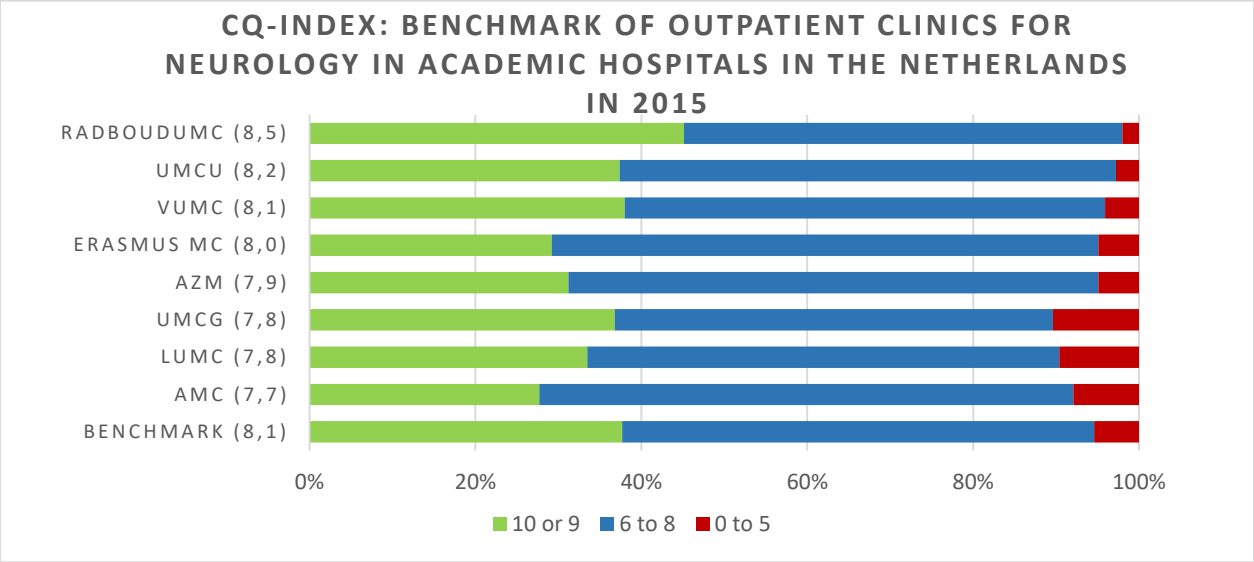

Figure 3: the benchmark of all outpatient clinics for Neurology in the Netherlands in 2015. On overall rating, the outpatient clinic for Neurology in the UMCG ranks 6th out of 8 with a 7.8 (On a scale of 1 to 10. Red = 1 - 5; blue = 6 – 8; green = 9 or 10).

The outpatient clinic for Neurology in the UMCG scores good on accessibility, as can be seen in table 4.1. Respondents said the outpatient clinic is easy to find within the hospital and it is easy to reach by telephone during working hours. It also performs well on interpersonal conduct by the medical professionals. Respondents state they feel taken seriously and listened to.

A bottleneck in patient satisfaction is provision of information to patients: Almost 40% of the respondents said they did not get any information from caregivers about possible side effects of their treatment. Additionally, more than 80% of respondents indicated they did not get any information about their rights as a patient (e.g. a second opinion or access to their own medical records) and close to 30% said

they had no influence on the treatment they were getting. Furthermore, the outpatient clinic scored low on the matter of after care. Respondents said in almost 30% of cases they do not get any or enough information about the effects of their condition or illness on their daily life (for example: physical activity, work and necessary aids). Also, if they encountered problems after visiting the outpatient clinic, they did not know who to contact (in over 25% of all cases). Finally, 92% of the respondents said they were not kept informed about how long they had to wait before it was their turn.

In the results of the CQ-index, experience scores and importance of the item can be found. In table 4.1 can be seen that the provision of information by the physician, after care and information about received medication have low experience scores but high importance. This means these items should have a high priority in improvement projects.

Table 4.1: CQ-index items, ranked on experience score and importance. Low being below average, high above average

Item	Experience score	Importance
Provision of information by the physician	Low	High
After care	Low	High
Information about medication	Low	High
Provision of information by (second) caregiver	Low	Low
Patient participation	Low	Low
Interior of the outpatient clinic	High	Low
Reception at the outpatient clinic	High	Low
Accessibility	High	Low
Waiting times at the outpatient clinic	High	Low
Interpersonal conduct by the (second) caregiver	High	High
Interpersonal conduct by the physician	High	High
Communication by the (second) caregiver	High	High
Communication by the physician	High	High
Collaboration	High	High

In short, the outpatient clinic for Neurology in the UMCG scored slightly below average in the national benchmark of outpatient clinics for Neurology in academic hospitals. Strong points were accessibility and interpersonal conduct by doctors. Weaknesses, or bottlenecks in patient satisfaction, were provision of information by (second) caregiver, patient participation, provision of information by the physician, information about medication and after care. The last three being important factors of patient satisfaction.

4.2 Results of the focus groups

In this paragraph, the results of the focus groups will be described. First, the research population will be described. Hereafter the actual results of the focus groups will be presented, broken down into the nine subjects: accessibility, the reception, interior of the outpatient clinic, waiting(time) at the outpatient clinic, interpersonal conduct, information & communication, collaboration by employees, patient participation and after care. These subjects are based on the CQ-index for outpatient clinics. A summary of the results can be found in table 4.2

Table 4.2: Positive, negative and mixed opinions of participants of focus groups regarding CQ-index subjects

CQ-index subject	Positive	Negative	Mixed[1]
Accessibility	• Findability within hospital • Quick contact via direct telephone line of outpatient clinic	• Long waiting time when calling through main desk of hospital	
Reception	• Front desk personnel	• Occupation of the front desk (s)*	• Registration pole
Interior of the outpatient clinic	• Free coffee[2] (s)	• Separation between waiting room and administrative personnel working behind a wall (s) • Decoration (s)	
Waiting(times) at outpatient clinic	• Waiting times are short; patients are understanding when they have to wait • Being summoned for the appointment	• Available reading materials (s)	
Interpersonal conduct	• Employees take their time (s) • Being able to ask questions (s) • Expertise of employees (s) • Employees show empathy • Employees listen attentively		
Information and communication	• Not face-to-face contact • Verbal information	• Proactive attitude from employees (s) • Brochures	• Received letters
Collaboration between employees	• Consultation with supervisor	• Collaboration with other departments (s)	• Variety of physicians (s)
Patient participation		• Medication: be more open to other medicine (s)	• Making a new appointment (s)
After care	• Written feedback after consult (s)	• Information about medication • Getting clear information	• Guidance by a medical professional (s)

*(s) = spontaneously mentioned
1: on these subjects, opinions were divided during the focus groups
2: machine was hard to find

4.2.1 Research population

In total, of 117 potential identified focus group participants, 67 were reached by phone. Of this amount 12 (former) patients agreed to participate. Others did not want to participate for unknown reasons. Two said they would bring a family caregiver. Two (former) patients had to cancel participation. One due to health related reasons, the other due to unknown reasons. One did not show at the meeting, making the total amount of participants 11 (9 patients, 2 family care givers). Information regarding the participants can be found in table 4.3. Six of the participants were men and 9 were (or are) a patient at the outpatient clinic. The average age was 60.5 years old, ranging from 35 to 78.

Table 4.3: Background variables of participants of the focus groups

N (%)		11 (100)
Gender	Men	6 (54.5)
	Women	5 (45.5)
Highest completed education	Low educated[1]	3 (28)
	Secondary educated[2]	4 (36)
	Higher educated[3]	4 (36)
Role during visit	Patient	9 (82)
	Family caregiver	2 (18)

1: No education, lower education, LBO, VMBO, MAVO

2: MBO, HAVO, VWO

3: HBO, WO

4.2.2 Accessibility

Two themes regarding accessibility of the outpatient clinic of neurology were mentioned: the findability within the hospital and the opportunity to call and e-mail the outpatient clinic (or physicians) when necessary.

When asked about the findability within the hospital, one participant said it was easy to find when first visiting the outpatient clinic. When asked specifically about telephone contact with the outpatient clinic, different opinions arose. Some participants said it took way too long to get someone of the outpatient clinic on the phone. One respondent said: "*It takes a lot of time, it can take hours on the phone to reach them.*" By asking more questions, it appeared that these participants called the outpatient clinic through the main desk of the UMCG. Evidently, this call transfer takes too much time according to some participants. Other participants said they got the direct telephone number of the outpatient clinic. They either found it on received letters or on the website of the UMCG. Calling directly via the outpatient clinic was way quicker, according to participants: "*When using the direct telephone number, you'll quickly have someone on the phone.*" Finally, when asked about contact via e-mail, one respondent said he thought this was possible because once he received an e-mail from his neurologist.

4.2.3 Reception

Regarding the reception of the outpatient clinic, three themes were mentioned: occupation of the reception, personnel at the reception and the registration pole.

From the last quote, the consistency between the registration pole and the next theme – occupation of the reception – can be seen. Regarding the occupation of the front desk, spontaneous remarks made: patients said there should be at least one employee manning the reception. When asked about the current situation, respondents said the outpatient clinic lacks atmosphere due to the poor occupation of the reception: "*When you left the outpatient clinic, in earlier days, lots of people sat there. Now, there is not much happening, I find that very unfortunate. We do not have a person to contact."*

Participants were very positive about the personnel manning the reception of the outpatient clinic, one mentioned when asked about the personnel: "*They are very friendly, understanding and most of all very calm. They took their time with us."* Furthermore participants stated personnel at the reception thinks along with the patients, which is perceived as pleasant.

Regarding the registration pole (an automated registration system, patients have to scan a barcode when arriving at the outpatient clinic) opinions were divided. When asked about the registration pole, some reactions were positive: "*I think the new scan-system is ideal. You can scan your barcode on your letter and you are registered. I find it to be quite simple."* Two participants said they did not like the registration pole. Mainly because they found it impersonal and difficult to use. One participant stated: "*The one who knows*

how it works will scan its barcode and takes a seat. But I think for the ones who do not know how it works, a back-up should be available, a permanent occupation of the reception." Other participants agreed with this statement.

4.2.4 Interior of the outpatient clinic

Regarding the interior of the outpatient clinic, three themes with a practical character were discussed: coffee machine, separation of employees and waiting room and the decoration of the outpatient clinic.

The fact that visitors of the outpatient clinic have the possibility to get free coffee out of a coffee machine was mentioned spontaneously by one participant. Other participants agreed it is nice to be able to get a free cup of coffee. One person added that the machine was difficult to find, because it is located around the corner in a hallway.

Another participant spontaneously stated she wants a separation between the waiting room and the personnel working behind the reception. To be clear, this is administrative personnel, not the personnel manning the reception. She said: "*Behind the wall people are working, they are talking. You can hear their conversations. They did not say anything wrong, just small talk between colleagues, but I do not want to hear that. I annoys me."* Later she added that she did not hear any sensitive information about patients but that she could imagine this could happen.

The last theme concerns the decoration of the outpatient clinic. Two participants spontaneously mentioned this topic. They said it looks too dull, old and incoherent. When asked, one participant mentions the monitors with general information on the ceiling. He states: '*The content is very poor. Now it gives actualities and weather information, while I think: on these screens you can promote yourself'* When asked how the outpatient clinic could use these screens participants said it could be used to give information about the department, research and other relevant information for patients.

4.2.5 Waiting(time) at the outpatient clinic

Concerning the waiting(time) at the outpatient clinic, three themes were discussed: available reading materials, timeliness, and being summoned for the appointment.

One participant spontaneously said he wanted to change something about the available reading materials at the outpatient clinic. He stated the reading materials are outdated and target group orientated: "*I cannot find anything I like. I think there has to be more choice in available reading materials. Now reading materials with art, clothing; the 'Margriet' and 'Libelle'. Sometimes I see children in the waiting room, something like a 'Donald Duck' or how do they call it these days? Personally I like magazines about engineering, or a computer or auto magazine. But also up to date, because what I see now is pretty outdated."* Some participants had to travel a great distance to get to the outpatient clinic and are sometimes way too early: *"Something to pass the time would be pleasant."* Other participants agreed and when asked they say they like to read actualities, like a newspaper. Furthermore participants are asked whether or not they want digital reading materials. However they preferred something tangible, like a magazine.

Participants were satisfied with the timeliness at the outpatient clinic: they stated waiting times are short and the outpatient clinic functions efficient. When a participant had to wait for a brief period of time (e.g. 10 minutes), he was very understanding of the fact a prior appointment could take some more time.

When asked about the course of events of getting from the waiting room to the appointment, participants were positive. They stated patients are picked up at the waiting room by the physician or nurse: "*They introduce themselves and give you a hand. That does not happen everywhere. Now one knows who he is dealing with."*

4.2.6 Interpersonal conduct

Five themes regarding interpersonal conduct were discussed: whether or not the employees take their time during a consult, being able to ask questions, expertise of employees, empathy of employees and whether or not employees listen attentively

Different participants spontaneously said employees of the outpatient clinic took their time during a consult. They valued this as very positive: "*He took a lot of time for me. This made me feel very good. I was taken seriously when I panicked"*

One respondent spontaneously said he was able to ask questions and that physicians listened to his questions, he valued this as very pleasant. Another participant agreed with him. Later, after further questioning, the same participant said a special meeting was organized for him and his family, so they could ask all their questions. He appreciated this very much.

Also, a spontaneous remark was made about the expertise of the employees: "*The physicians that work here know what they are doing. I find that very important*".

This is consistent with what other participants stated about the empathy shown by employees of the outpatient clinic. According to participants, employees have a good sense of what their patients feel, for example one participant stated: "*They did not ask me if I was anxious. I appreciated this because it did not put me on the wrong track*" Another participant stated something similar: "*The physicians sensed I was anxious, they came with new ideas causing me to feel reassured. I experienced this as very positive.*"

Participants were also very positive regarding the fact employees listened to them. They stated patients are listened to and are being heard: "*One is being listened to, that is important. A physician has to listen. Not just think and form an opinion in advance"*

4.2.7 Information & communication

Information and communication was most discussed in both focus groups, five themes can be found in the transcripts: received letters, proactive attitude of employees, other contact (not face-to-face), brochures, explanation.

The next theme, the proactive attitude of employees of the outpatient clinic, is consistent with the theme about the information regarding patients' medication (in 'After care'). When asked what should be prioritized to improve patient satisfaction at the outpatient clinic, two participants stated they wanted a more proactive attitude from their physician: "*I think they should be more proactive, and not leave everything to you."* This quote regarded the information the participant got about medicine he took.

Regarding the received letters, not many remarks were made. One respondent found it a matter of course and said: "*I think it is normal. I cannot say whether it is positive or negative. This is how it should be, I think.*" Another participant had one point of improvement for the appointment letters: "*put in the name of the person you have an appointment with, this is lacking sometimes.*"

Participants also got their information through other ways of communications: not face-to-face. Not face-to-face contact is all the contact for which the patients does not have to be at the outpatient clinic, for example via telephone or e-mail. This way of communicating was positively assessed by participants. One participant said: "*I got a call every time I had an increase in the dose of my medicine, or in between just to ask how I was doing. I found this very pleasant and it gave a confident feeling.*" In addition, another participant said if something can be done over the phone, it should be done over the phone.

When asked about brochures, participants were unanimous: information about diagnosis and diseases is very limited when it comes to brochures. Sometimes participants did not get a brochure and if they did, they could not find any information in it regarding their disease or the diagnosis they just got. One participant stated: "*Regarding the brochures: I could not get any relevant information out of it. So, if it gave me more information, no.*" Participants did get tangible information about the (physical) examinations they

would get. Another participant added brochures are mostly focused on the logistics that come with diagnosis and treatment.

Explanation (verbal information) given by employees of the outpatient clinic however, was positively assessed by the participants: "*During the consult and the examination everything was explained in a clear way. I found that to be very efficient.*" Most participants agreed. One participant said one time he did not get a proper explanation, but the next time everything was set straight and explained well.

4.2.8 Collaboration by employees

Regarding the collaboration by employees at the outpatient clinic, three themes were mentioned: variety of physicians, collaboration with other departments and consultation with supervisor.

The first theme, variety of physicians, concerns the different physicians one patient meets during different consults. Two participants spontaneously mentioned they appreciated the fact they did not have a regular physician. The main reason was that a fresh pair of eyes at their situation caused another view and other opinions about their disease or medicine: "*Due to the variety of physicians we can realize that another physician looks from another perspective to the same patient. This can result in a change in medication choice."* After asking around if other participants felt the same, it appeared opinions were divided. Others preferred seeing the same physician every visit.

One participant made a spontaneous remark regarding the collaboration with other departments. He got conflicting information about his condition and treatment. This was experienced as confusing and caused uncertainty.

Participants found it ensuring that the neurologists in training consulted their supervisor on a regular basis: "*They walked away for a brief moment, in the event of ambiguities. To consult their supervisor, in another room. This made sure one always gets a well-founded answer."* Another participant added a supervisor could give a more conclusive answer than a neurologist in training, so she appreciated them consulting a supervisor when necessary.

4.2.9 Patient participation

Patient participation existed of two themes: medication and making a new appointment. Initial mentioning of both themes was spontaneous.

Participants wanted physicians and other medical specialists at the outpatient clinic to be more open to new medicine, in particular when a patients came forward with a medicine: "*I thought they were a bit rigid in the first and old medication. They did not think with us regarding new medicine."*

Making a new appointment was mentioned spontaneously by one participant, followed by a discussion. The first, spontaneous, remark is made with concern to the fact that an appointment is always made with a reason, for example: work: The participant stated the following: "*I always try to make an appointment when I do not have to work. A moment that fits me, and my employer … But what sometimes happens to me it that I get a letter two or three months in advance with the notification: 'we planned a new date for your appointment.' Without consulting me.*" When asked around it gets clear patients do not have the possibility to make a new appointment at the reception, when they leave the outpatient clinic. When they approach personnel at the reception about a new appointment, the response one participant got was: "*You will get a letter*." Another participant is fine with the current manner of making appointments. He says there is always the option to call the outpatient clinic to make an appointment that suits his agenda.

4.2.10 After care

Regarding after care performed by employees of the outpatient clinic, four themes were discussed: guidance by a medical professional after visiting the outpatient clinic, written feedback after consult, information about medication, and clear information.

The first time guidance by a medical professional after a visit of the outpatient clinic was mentioned (in both focus groups) was spontaneous. One participant valued guidance as very positive. He said he got a clear schedule of increase and decrease of his medicine. In the other focus group, the lack of guidance was pointed out, for example when a patient leaves the outpatient clinic after a diagnosis: "*When you leave the physician, and the diagnosis is clear, a nurse should be available afterwards to have a relaxed conversation about what you just have heard*."

One participant spontaneously told about the feedback he got after he visited the outpatient clinic. He got a written report of his consult. When asked around, others said they would also welcome a report like this, on paper or digital. One participant said: "*What you were just talking about, the feedback on paper or digital, I would really appreciate that. So you can read it in your own time, with someone else."*

Two participants made a remark about the information they received with respect to their medication. They both stated they did not get enough information about any side effects. In addition, one stated he had to inform himself about the medication he was getting, possible alternatives and new

developments. He got his information from the internet: "*I prefer they look at the new developments and come forward with it, not that I as layman have to find out myself."*

Participants stated clear information is important, otherwise they leave the outpatient clinic in uncertainty. This was mentioned in both focus groups. "*I got a spray, because when he is out for more than five minutes his life is in danger. So now I have that spray on me, but I have so many questions left: can I leave him alone? Or the spray is at home and he is not. Where should I pay attention to?"* This participant said a brochure with information could make information more clear and help take away a great deal of uncertainty.

4.3 Results of the interviews at the UMCG

In this section, the results of interviews with employees at the outpatient clinic for neurology in the UMCG will be described. For this part, five interviews were performed: two neurologists, two nurses and one front desk attendant have been interviewed regarding their view on patient satisfaction at the outpatient clinic they work at. Average time of the interviews was 22:42 minutes, varying from 17:08 minutes to 29:11 minutes.

First, the remarks made by employees concerning what they think is important to patients will be described. Next, the subjects of the CQ-index will be outlined. Emphasis in this part lies on the themes with lower scores in the CQ-index 2015 and high importance, namely: information and communication (oral and on paper) and after care. Other results will be discussed briefly. A summary of the results can be found in table 4.4

Table 4.4: Perceptions of emplyees regarding patient satisfaction at the outpatient clinic and ideas for improvement regarding CQ-index subjects of employees of the outpatient clinic for neurology in the UMCG

CQ-index subject	Positive	Negative	Mixed[1]	Ideas for improving patient satisfaction
Accessibility		• Located at first floor	• Reachability by phone	
Reception			• Registration pole	• Keep a double registration system
Interior of the outpatient clinic	• Facilities of the outpatient clinic	• Small and outdated rooms		• More minor procedures at outpatient clinic
Waiting(times) at outpatient clinic	• Waiting times			• Communicate (extra) waiting times to patients, e.g. via a TV-screen
Interpersonal conduct	• Employees take their time with patients • Patient appreciate knowledge and capabilities			
Information and communication	• Oral information • Information giving by MS department	• Information on paper		• Put standard brochures in all consultation rooms • Use brochures compiled by e.g. patient organizations
Collaboration between employees		• Patients do not have their own specialist		• Give the physicians in specialist training personal consultation hours
Patient participation				• More responsibilities in the hand of patients • Patients want more digital systems
After care	• Information giving by MS department	• Provision of information about medication • Sometimes patients do not know where they stand		• Give clear information about logistics • Set up a room for patients where they can talk about their situation

1: on these subjects, perceptions were different during different interviews

4.3.1 Information and communication

This theme regarded the provision of information, oral and on paper, given by employees of the outpatient clinic. Opinions from employees about patient satisfaction and ideas concerning improving patient satisfaction regarding this topic will be described.

Employees are unanimous about the performance of the outpatient clinic in providing patients with proper information: oral information giving is good while information available on paper, e.g. brochures, is inadequate. One interviewee said: "*The correspondence towards patients can be improved, this can be done easily. Make a booklet or brochure: 'you are visiting the outpatient clinic for neurology.' Write what they can expect and what they have to prepare themselves, e.g. a medication list. Currently this is written in a letter, this is less clear. Moreover, a letter is lost easily. I think this is an area we can improve."* Concerning letters sent by the outpatient clinic, an employee said that sometimes the letters are not good enough or too long: "*Sometimes I read one of our letters and think: 'well..' I see quite a story. And for new patients we have to put in an appendix as well."* On this topic, employees think it could be a valuable idea to involve both patients and employees in the drafting of new letters.

Written information is in a lot of cases not findable, outdated or not available. One interviewee specified: "*Provision of information to patients is very limited. There are some brochures hanging on a wall or sitting in a rack, behind a curtain. You want to offer more things, information for patients, so it is easier to find."* When asked what the ideal situation would be, one interviewee stated: "*That standard brochures are put at your consultation room, so I can say to a patient: 'I told you, you have this or that disease, here is a brochure.' Not a piece of paper dating from 1973 that has been copied for the 800th time. Just a rack with some standard brochures with URL's that is being restocked every time. Give that to patients immediately so they can read it at home or find information on the internet using the URL's from the brochure. We do not have that now*."

The situation as described above is better organized at the outpatient clinic's sub department for Multiple Sclerosis (MS). They have a carousel with different brochures regarding MS. "*We are the only ones who have something like this, a carousel with different brochures. I restock it myself when it is empty."* When asked how they would like to make sure this kind of information gets accessible at other specialisms at the outpatient clinic, an interviewee said: "*We could use the brochures compiled by the patient organizations or the Dutch association for Neurology and pay more attention to make sure these brochures are always available."*

4.3.2 After care

After care concerns the care and guidance and information given by employees of the outpatient clinic to a patient and family caregivers after a consult or other visit at the outpatient clinic. Opinions from employees about patient satisfaction and ideas concerning improving patient satisfaction regarding this topic will be described.

After care is for a great part giving of information and being clear to patients, according to an interviewee: "*I think patients do not know where they stand when they have been here and need further medical examination or have to get a result of an medical examination but do not know when that is going to happen. This is something we can improve."* Clear information with respect to logistics at the outpatient clinic could help make sure patients know where they stand when they leave the outpatient clinic.

As stated in the chapter '4.3.2 Information and communication', the outpatient clinic's sub department for MS has a carousel with brochures regarding different topics. This carrousel also contains brochures about medication and side effects. An interviewee stated on this topic: "*I think this is already pretty good, but it can always be better"*. At other specialisms, these brochures are not available. According to employees, this could be improved by using existing brochures.

When asked how after care could be improved, an idea came up. This idea regarded setting up a room for patients in which they can tell their own story: "*A room where, for example, once a week someone takes place to who they can talk to. So they can share their experiences."* According to the interviewee, this '*someone*' could also be a patient with the same condition.

4.3.3 Strong and weak points in patient satisfaction: other CQ-index themes

In this section, the remaining CQ-index themes will be discussed. These themes are: accessibility, reception at the outpatient clinic, interior of the outpatient clinic, waiting times, interpersonal conduct, collaboration between employees and patient participation. Opinions from employees about patient satisfaction and ideas concerning improving patient satisfaction regarding these topics will be described briefly.

Regarding accessibility of the outpatient clinic, employees find it remarkable the outpatient clinic for neurology is not on the ground floor. One interviewee said: "*We are situated at the first floor and our patients are in general the ones with the most mobility problems. I find that peculiar."* Another stated: "*We are situated at the first floor, people in a wheelchair or who come in with an ambulance have to use the elevator. This could be improved during the reorganisation of the outpatient clinic."* About the accessibility by phone, opinions are divided. One employee stated: "*Some patients complain about the reachability of the outpatient clinic via the telephone, it is often not reachable."* Another interviewee stated: "*If patients have questions, they can call or e-mail me or my colleague. It think patients appreciate they can contact us quickly by phone or e-mail.*"

About the reception at the outpatient clinic, most remarks concerned the registration pole that has been installed to automate the registration process. Some patients were displeased and did not know how it worked, according to an employee: "*They were very negative, especially the elderly patients. Younger patients just went 'bleep' and sat down."* According to another employee, the registration pole has positive and negative aspects: "*I can see immediately when a patient is signed in, so I can pick them up more quickly. But the system of signing in and getting a number is not patient friendly, that is why we pick them up ourselves."* A third employee said: "*It is difficult. On the one hand, you want to use more technologies like this, on the other hand we have a lot of elderly patients with dementia. They do not know how to use it. That is why we will always have to keep a double system."*

Regarding the interior of the outpatient clinic, different subjects were mentioned by the employees. They think patients are positive about the facilities of the outpatient clinic, e.g. the coffee machine with free coffee and a wheelchair-accessible toilet. Furthermore they think patients are positive about the fact collecting blood for testing can take place at the outpatient clinic, instead of at the vaccination centre at the other side of the hospital. A interviewee states more minor procedures like this could take place at the outpatient clinic, instead of elsewhere in the hospital: "*I would like to see more minor procedures like this at the outpatient clinic, e.g. an ECG. To offer more service at the outpatient clinic."* They think patients are less positive about the small and outdated rooms and the fact that colours are pale like: "*I want a bit more ambiance in the uninviting rooms. A little bit more colour. There is little colour, I think."*

Interviewed employees think patients are satisfied with the amount of time they have to wait for an appointment: "*Patients have practically no waiting time at our outpatient clinic, I think that is something they appreciate very much."* When patients do have to wait they say they do not mind, according to employees. Furthermore, employees find it important that when patients do have to wait longer, the delay time should be communicated: "*When a patient has to wait longer, as a consultation holder you are responsible for letting know you are delayed. I think patients can appreciate that."* When the idea of putting waiting times on television screens was put forward by the interviewer, employees are positive: "*I notice people appreciate it when they have to wait for another fifteen minutes, we let them know. So I think: maybe it is a good idea to work with a screen like that."*

According to all interviewed employees, patients are satisfied with the interpersonal conduct by neurologists, assistants and front desk personnel. One interviewee said: "*I think people like it we take time for our patients. For both new and revisiting patients. I think we take more time with our patients compared to general hospitals, I think patients really appreciate that."* And: "*I think patients appreciate the knowledge and capabilities we have, and that we deploy these differently compared to general hospitals which they are familiar with."*

Regarding collaboration between employees, one topic was discussed: the fact patients do not have a regular specialist they see when they visit the outpatient clinic. Interviewees think patients do not like this: "*I think that can be something patients are less satisfied about, that it is possible that the specialist they see can differ each visit."* According to an employee this could be prevented by giving the physicians in specialist training personal consultation hours: "*Personal consultation hours for physicians in specialist training need to be arranged. This can easily be done. From day one up and including year six personal consultation hours with their own patients. Also for the patients, to make sure they have the same doctor they are going to see every time."*

Regarding patient participation, interviewed employees would like to see more responsibilities in the hands of patients. One interviewee stated when the ideal outpatient clinic was being discussed: "*People should get more responsibilities. That more responsibilities are given to patients. A patient who can handle it, that goes without saying."* When asked about it, employees say these responsibilities could be incorporated in a digital (online) system: "*I think that is what patients want these days. I could imagine patients getting their own personal USB-stick, plugs it in my computer and that I can access it."*

According to interviewed employees, regarding all subjects nothing structural is done to maintain or improve patient satisfaction. Action is taken when a patient files a complaint or when periodical research, e.g. the CQ-index, shows a substandard result. These actions however, are on an ad hoc basis. When asked employees say both employees and patients (and family caregivers) could be involved in change and improvement projects. However, they do not think opinions of patients are useful on work content related issues: "*Customer is king, but I also think from my own work process. In unkind words: the patient visits the outpatient clinic for half an hour. I sit here every day, sometimes for eight or nine hours.*"

4.4 Results of interviews at the positive deviant

In this section, the results of interviews with employees at the positive deviant, the outpatient clinic for neurology in the Radboudumc, will be described. For this part, four interviews were performed: one neurologist, one nurses, one manager care outpatient clinic neurology and support team and one front desk attendant have been interviewed regarding their view on patient satisfaction at the outpatient clinic they work at. Average time of the interviews was 25:15 minutes, varying from 15:37 minutes to 34:43 minutes.

First, the remarks made by employees concerning what they think is important to patients will be described. Next, the themes of the CQ-index will be outlined. Focus lies on how patient satisfaction can be improved, according to the employees of the Radboudumc. Emphasis in this part lies on the themes with lower scores in the CQ-index 2015 and high importance, namely: information and communication (oral and on paper) and after care. Other results will be discussed briefly. A summary of the results can be found in table 4.5.

Table 4.5: Ideas for improving patient satisfaction of employees of the positive deviant (outpatient clinic for neurology in the Radboudumc) regarding CQ-index subjects on different themes

CQ-index subject	Theme	How to improve patient satisfaction
Accessibility	-	-
Reception	• Registration pole	• Let patients choose where they want to register: front desk or registration pole • Hire (voluntary) hosts for the outpatient clinic • Let patients know they are being noticed when entering the outpatient clinic
Interior of the outpatient clinic	• Boundary conditions of health care	• Free cup of coffee • Music in the waiting room • Good chairs • "*It has to be a friendly space*"
Waiting(times) at outpatient clinic	• Decreasing access times	• Temporarily increase capacity • Monitor access times and put up graphs to make sure everybody is aware of current situation • Waiting times on TV-screens in waiting room
	• Letting patients know how long they have to wait	• Make sure all consultation holders use it consistently
Interpersonal conduct	• Asking personal questions	• Look further than just the disease. Hear what is important to patients
Information and communication	• Information on paper	• Ask patients for input when developing (new) brochures and letters • Explore the use of digital communication tools like 'Face Talk'
	• Oral information	
Collaboration between employees	• Same specialist every visit'	• Divide physicians in specialist training into service blocks • Realise a patient is not at the outpatient clinic for fun, he can be nervous
	• Mind-set of personnel	
Patient participation	• Let patients make their own decisions	• Empower self-management as much as possible. Look at what is possible with patients and family caregivers
After care	• Information about medication and side effects	• Be explicit when talking about side effects of prescribed medication

4.4.1 Information and communication

This theme regarded the provision of information, oral and on paper, given by employees of the positive deviant. Opinions from employees of the positive deviant about patient satisfaction and ideas concerning improving patient satisfaction regarding this topic will be described.

"*Patients find it important they get the information they need and that is applicable to their situation."* This was stated by an employee during one of the interviews. What patients find important information differs per patient. It was difficult for the interviewee to elaborate further on this topic.

Regarding the improvement of brochures, the outpatient clinic for neurology in the Radboudumc asks patients to help them. One employee said: "*We worked together with patients to see what was the best way to adapt our written information. Coincidentally, this was a patient who worked in communications, so that was convenient. Together with us he looked at our brochures, and where and how they could be improved."* When asked whether or not this is worth repeating when necessary, the employee said: "*Yes, for sure!*"

The next step for the positive deviant is to build a good working (digital) communication system allowing information to be shared quickly via a computer, telephone or even, when desirable, face-to-face at a patient's home. Especially digital ways of communication were discussed comprehensively with employees of the positive deviant: "*I consider 'Face Talk' to be very important. We get a lot of people who do not live in the near vicinity, sometimes you do not have to see them face-to-face. We just started with a pilot to try and stimulate this … when a patients says he finds it pleasant to discuss a result of a medical examination via 'Face Talk' we can do that, when appropriate. When necessary we can always schedule an face-to-face appointment. It saves a drive to our hospital, which is environmental friendly. Also, for the patient is just costs fifteen minutes"* And: "*I would like to make more use of it. For example, that a physician, when he makes a new appointment for a periodical check, he thinks: is this possible via 'Face Talk' or telephone?"*

4.4.2 After care

After care concerns the care and guidance and information given by employees of the outpatient clinic to a patient and family caregivers after a consult or other visit at the outpatient clinic. Opinions from employees of the positive about improving patient satisfaction on this topic will be described.

According to employees of the positive deviant, information regarding medication and their side effects could be improved. This is also an occurring problem at their outpatient clinic for neurology in the UMCG, according to their employees and patients. Interviewees at the positive deviant do not have a concrete idea how this could be improved: "*One should not sum up the whole story from the package insert. However, some medicine do have some typical side effects. I learned that you have to mention those very explicitly."* For example, the employee said: "*One should not say: you can get nauseous when using this medicine, or a dry mouth or dizzy.' No, one should say clearly to a patient: 'now we are going to talk about the side effects of this medication.' Because when we ask patients later whether or not they heard something about the side effects of the medication and physicians only talked about medication, they say: 'no, we heard nothing about it.'"* This is the positive deviant's way of dealing with this problem, being explicit regarding side effects of prescribed medication.

4.4.3 Improving the other CQ-index themes

In this section, the remaining relevant CQ-index themes will be discussed. These themes are: reception at the outpatient clinic, interior of the outpatient clinic, waiting times, interpersonal conduct, collaboration between employees and patient participation. Opinions from employees of the positive deviant about patient satisfaction and ideas concerning improving patient satisfaction regarding these topics will be described briefly.

Regarding reception at the outpatient clinic, multiple subjects were discussed. The outpatient clinic is the Radboudumc is equipped with a registration pole. Employees say they paid a lot of thought to the installation of the pole: "*We thought about it, it is not patient friendly but on the other hand is it very convenient. So patients get to choose: they can go to the front desk and register themselves or they use the registration pole."* Another measure to assist patients with (among other things) the use of the registration pole is hiring hosts for various dayparts. These hosts are volunteers: "*It is not yet in the system of humans, when you do not pay attention you walk right past it. So quite a few dayparts we have a volunteer to help impart patients with things like this, but also keep their eyes and ears open in the waiting room to see if someone has been waiting for a long time."* In addition to these activities, the host is responsible for keeping the waiting room tidy and answering questions of patients. Finally, according to an employee, it is very important to let patients know you have noticed them enter the outpatient clinic. Especially now the

registration pole is installed: "*Say 'good morning' when they enter, even though we have the registration pole where they can register themselves … Welcome the people."*

With concern to the interior of the outpatient clinic, the interior of the waiting room was discussed during the interviews. According to an employee, the boundary conditions of heath care can make something to a success: "*A patients hopes a doctor does his work appropriately, I think a patient is convinced a doctor does his work appropriately, but the boundary conditions make it to a success."* In this case, boundary conditions are whether or not a patient can get a free cup of coffee, music in the waiting room, better chairs: the overall atmosphere. "*It has to be a friendly space."*

Regarding waiting times, two themes were discussed: access times and the waiting room. Access times at the positive deviant used to be a problem. Nine years ago, the access time after a referral, e.g. from another hospital, was ten weeks. It has been brought back to the situation now: four weeks. This has been done by starting with temporary consulting hours in the evening, to eliminate the cue. Thereby, monitoring access times was an important tool: "*For us it was very useful to monitor, especially in the past. We put up graphs about the access times, from the last twenty weeks. People could see the lines and saw that access times were increasing. This was easy, because now everybody knew an extra consult had to be planned."* In the waiting room, the outpatient clinic in the Radboudumc uses an screen on which waiting times are shown: "*When people are sitting in the waiting room and a previous appointment takes longer, the estimated time is put on a screen."* However, this system does not always work properly because sometimes the consultation holder forgets to call the front desk with the message they need more time.

With respect to interpersonal conduct, employees of the positive deviant are very much aware of the personal situation of patients: "*I ask questions about the personal situation of patients, just like my colleagues. We try to focus on hearing what is important to the patient."* This is also a topic patients are satisfied about, according to employees of the positive deviant: "*I think patients are satisfied about the patient centred care … Together with the patient we look at what is currently going on in their lives. Not so much their disease, but more: who is the patient as a person and what is important in your life."*

Regarding the collaboration between employees, having the same specialist during different visits was discussed. At the positive deviant, patients see, as much as possible, the same specialist. The physicians in specialist training have service blocks: "*Of course, when a patient cannot wait for three weeks for a result of a medical examination we have to see what is possible. But the idea remains: when you see a new patient for the first time, you will see that patient back. And if that same patient gets a referral a year later, we try to get him an appointment with the same doctor."* Also, the positive deviant tries to deliver care at patients' homes. This requires good communications with other care givers: "*It can be at a patient's home, because that is also a wish, to do that more often. Not to deliver all the care at the outpatient clinic, but if it is*

desirable go to a home or care facility and sit down with the patient, care givers, specialist geriatric medicine and the family."

Concerning patient participation, employees of the positive deviant try to help patients to make their own decisions and empower self-management. In this group of patients however, that could be difficult: "*We try to do that as much as possible. However, sometimes with patients with Parkinson's disease it is a bit difficult because they are not always capable to manage themselves. But even then we look with patients, or family caregivers, at what is possible."* The outpatient clinic also has a digital information system, called 'Mijn Radboud': "*We are now very busy with 'Mijn Radboud'. They (patients) can log in and see more and more data themselves. That is what we stimulate, we want a bit more responsibility of our patients, and not dependency."*

At the positive deviant, personnel speaks in their regular meetings about patient satisfaction: "*Also we speak about the experience of patients. This can be meeting of nurses, that we have among ourselves."* Thereby, projects have been done to improve patient satisfaction. These projects focused on what was important to patients: "*Recently, a project regarding patient preferences has been performed. This project showed that patient find self-management important. Also collaboration between employees and information – e.g. about medication – are important topics."* This project involved a mixed group of patients and caregivers: "*This makes sure everybody is actively concerned with how we can reach and maintain the best situation for the patient. It is not a project group with just care givers, but also with patients, relatives and people from primary care."*

The Radboudumc has a central Patient Advisory Board. The outpatient clinic for neurology in the Radboudumc is starting up their own Patient Advisory Board, just like some other outpatient clinics in the hospital: "*Now we do it irregularly, asking patients: how did you like it? What did you miss? What went well? But we are going to use Patient Advisory Board very specifically for questions like this. Of course we hope it contains people who are critical and are able to think along with us."*

5. Discussion

The focus of this study was on exploring and improving patient satisfaction of the outpatient clinic for neurology in response to the 2015 CQ-index results. In this chapter, the research question will be answered. Furthermore, results will be evaluated and recommendations will be done. Next, strengths and limitations will be described and the 2016 CQ-index results will be discussed. Finally, recommendations for the UMCG and further research will be done .

5.1 Answering the research question

The research question was: *How can patient satisfaction on an outpatient clinic be improved, following the results of the Consumer Quality-index of an outpatient clinic performed in 2015?* Four sub-questions were drawn up to help answer this question: 1) What are the results of the CQ-index for the outpatient clinic of neurology in the UMCG?; 2) How do patients of the outpatient clinic for Neurology in the UMCG think the bottlenecks in patient satisfaction, found with the CQ-index, could be eliminated?; 3) How do employees of the outpatient clinic for Neurology in the UMCG think the bottlenecks in patient satisfaction, found with the CQ-index, could be eliminated?; 4) How can knowledge of improving and maintaining high patient satisfaction of another, high performing outpatient clinic for Neurology (based on the results of CQ-index), be used to improve patient satisfaction in the outpatient clinic for Neurology in the UMCG? The research questions will be answered by highlighting the two topics that were discussed widely than others: 1) information and communication and 2) after care. Others will be discussed briefly. All conclusions and recommendations can be found in a table in appendix H, divided per CQ-index theme: accessibility, reception, interior of the outpatient clinic, waiting(time) at the outpatient clinic, interpersonal conduct, information & communication, collaboration by employees, patient participation and after care.

5.1.1 Information & communication

The CQ-index scores in 2015 were high on communication and low on provision of information (both oral and on paper). Participants of the focus groups gave the same impression of their experience with the outpatient clinic: they were positive regarding communication (face-to-face, via telephone and e-mail) and negative regarding the written information they got. Employees of the outpatient clinic had the same impression of the satisfaction of the visitors of the outpatient clinic.

Patient satisfaction on this topic can be improved by making sure brochures are available for all types of medical examinations, diagnosis and treatments patients could encounter when visiting the outpatient clinic. These brochures have to be given to patients when they leave the outpatient clinic or as an appendix from a letter for e.g. an appointment for a medical examination. This ensures patients can read this information in the comfort of their own home. Other research has shown patients' recollection regarding

medical information is often poor, in particular when a patient is older (39). Older patients are not uncommon at the outpatient clinic for neurology, written information can help these patients recollect.

Another idea to improve written information and thus improve patient satisfaction, is to ask patients for input on this topic. The positive deviant has done this and was satisfied with the results. Patients can give input regarding the content of letters and brochures. In another setting, but also with patients with a chronic disease – just like the patients at the outpatient clinic for neurology, input of patients was used to help develop written information (40). In this case, it regarded drafting a guidebook for patients with osteoarthritis. Researchers provided members of two groups of users with a summary of results from qualitative research into people's experiences of living with chronic pain. These summaries were used to structure group meetings, which were organized to help find information needed for the guidebook (40). The outpatient clinic for neurology in the UMCG could use the same approach when asking patients to help them.

5.1.2 After care

After care (and information about medication) scored low on the 2015 CQ-index. Participants of focus groups gave the same impression of their experience with the outpatient clinic. Guidance by a physician after e.g. a change in medication was good, but provision information regarding medication and side effects were insufficient.

These problems can be solved by giving clear information to patients when they leave the outpatient clinic. This can be done by arranging that patients can talk to someone, e.g. after they got a diagnosis. This could be an nurse or an experienced patient. Hereby, written information is also important (same recommendations as in '5.1.6 Information & communication').

The positive deviant recognized these problems with provision of information regarding medication and side effects. They stimulate their consultation holders to be very explicit towards patients when they talk about side effects of prescribed medication. Another method to enhance patients' recollection of provided information regarding medication is to use recall-promoting techniques such as summarizing the consult or giving written information (41). Both methods can be easily stimulated by the outpatient clinic in the UMCG to their employees in a periodical staff meeting.

5.1.3 Answers regarding the other CQ-index aspects

Accessibility scores were high at the 2015 CQ-index. This means, participants who filled in the CQ-index 2015 were content with the way they could reach and access the outpatient clinic. In focus groups, participants said are content with both the physical accessibility as the accessibility by phone. The only remark made by patients was that when they call via the main desk of the UMCG, it takes a long time before they get to speak with the person they want. This also came forward in the interviews with employees. Situations like this can be prevented easily by telling patients they have to call directly to the outpatient clinic. Employees can refer to the website or letters. Here, the direct telephone number of the outpatient clinic can be found.

Regarding the reception at the outpatient clinic, the scores at the 2015 CQ-index were high. However, some patients in the focus groups were critical regarding the registration pole that was installed at the outpatient clinic. They found it difficult to use and missed explanation. Others, generally younger participants, found is easy to use. Employees of the outpatient clinic in the UMCG and the Radboudumc endorsed this finding. A proposal for improving patient satisfaction at this topic is to let people visiting the outpatient clinic choose how they want to register themselves: at the reception or the registration pole. Prerequisite for this is that always at least one person is manning the front desk. In this way, people who know how the registration pole works will keep using it, others will go to the front desk. Another idea, put up by the positive deviant, is to hire (voluntary) hosts to help patients register themselves. For the outpatient clinic in the UMCG this could be a good idea for the peak times to relieve pressure on front desk personnel. These hosts could also perform other tasks, like keeping the waiting room tidy and assisting patients by answering various questions.

Concerning the interior of the outpatient clinic, CQ-index scores in 2015 were high. This contradicted with things that came forward in the focus groups. In general, patients were negative regarding the interior. Only the fact they could free coffee and tea was brought up as a positive point. This was also put forward in interviews with both employees of the outpatient clinic for neurology in the UMCG as in the Radboudumc, as a point patients consider to be important. Patients were negative regarding the dull decoration of the outpatient clinic and the fact administrative personnel can be heard talking by patients when they wait in the waiting room. The first point, the decoration, was also brought up by employees of the outpatient clinics in both hospitals. They stated this could be improved by creating more ambiance in the rooms, instead of the situation now. Important however, is not to jeopardize functionality. Another idea is to play background music in the waiting rooms. According to literature, this could help lessen patients' anxiety (42).

Patients do not like the fact administrative personnel can be heard when they wait in the waiting room. Employees are aware they can be heard taking, and try to keep this in mind. To get a more definite

solution for this problem, the room where the administrative personnel works could be shut off from the outpatient clinic or another work location could be found.

According to the CQ-index of 2015, patients are satisfied about the waiting times at the outpatient clinic. This is also shown by the results of the focus groups. Patients find the timeliness and course of events at the outpatient clinic good. However a remark was made regarding the available reading materials. These are outdated and target group orientated. Focus of the reading materials is at elderly patients, but the outpatient clinic also has younger visitors. Regularly updating and widening the genres of the reading materials can improve satisfaction at this point. Patients are not notified when they have to wait longer than expected, according to the CQ-index 2015. The positive deviant uses television screens to let people waiting in the waiting room know when waiting times increase. The physician that needs more time with a previous patient calls to the front desk and they put it up on the screen. Similar systems, like a time tracker, are proven to be effective in Emergency Departments (43). This is another setting compared to an outpatient clinic, but the underlying idea is the same: "wait times of uncertain length feel longer than certain ones" (44). So, communicating waiting times could be a nice addition to the waiting room of the outpatient clinic in the UMCG.

Following from the CQ-index 2015, the outpatient clinic has high scores regarding interpersonal conduct from both the physician as a second caregiver. In the focus groups, patients were positive as well on this topic. This is also what employees hear from patients. No concrete recommendations were done to further improve patient satisfaction on this topic. Important is to remain aware impersonal conduct is one of the most crucial factors in patient satisfaction.

Regarding collaboration by employees, the CQ-index scores in 2015 were high. Overall, patients in focus groups gave the same impression: they were satisfied with the way employees of the outpatient clinic worked together. One topic was discussed in the focus groups, interviews with employees of the outpatient clinic for neurology in the UMCG and at the Radboudumc: the fact patients see different physicians during different visits. Patients were divided regarding this topic: some found it to have added value because another set of eyes could help improve their situation, others wanted to see the same physician every time. Literature shows patients prefer seeing the same physician or a small team of physicians when they are seen over time on a regular basis (45). Employees at the outpatient clinic in the UMCG stated they thought patients want the same physician every time. The outpatient clinic at the positive deviant uses service blocks for they physicians in training. This means physicians in training have fixed consultation hours on which their own patients can be planned. This could also be an idea for the outpatient clinic, to improve patient satisfaction. It has support among the employees, because the same idea has been put forward by one of the interviewees.

Regarding patient participation, the outpatient clinic got low scores on the CQ-index of 2015. In the focus groups, patients complained they are not able to make a next appointment by themselves. They would like to get more control over when an appointment takes place, so they can coordinate it with other obligations.

Employees of the outpatient clinic also want to see more responsibilities in the patients' hands. However, they focused on medical responsibilities: give patients access to a digital system where they can see and fill in personal data, e.g. the medication they take. This could help accelerate processes at the outpatient clinic. The positive deviant also encourages self-management as much as possible. They have a digital system ('Mijn Radboud') where patients can log in and see their own personal data. This would be a great idea for the outpatient clinic for neurology in the UMCG, to enhance patient participation. However, this is a hospital-wide case: the outpatient clinic cannot set up an own digital system, independent from the hospital.

5.2 Strengths and limitations

In this part, the strengths and limitations of this study will be discussed. This explorative qualitative way of assessing patient satisfaction by asking patients, employees and a positive deviant for recommendations after a CQ-index result has not been performed before. Positive deviance has been used in other settings (14), but not in the combination used in this study. More about positive deviance van be read in '5.2.1 Positive deviance'. By combining the research methods used, the researcher had the possibility to gather and compare data that otherwise would not be combined with each other. This contributed to the strength of the study and its results.

To make sure all topics, positive and negative, in focus groups and interviews were covered, the 4D's of AI were used to set up the focus groups script and interview protocol. This offered a theoretical and practical framework that could be used to identify specific needs (positive and negative) (34), in this case of the UMCG and its patients. This helped keep focus on positive aspects when that was being discussed, instead of shifting to the negative easily. Because both the focus groups and interviews were semi-structured, conversations stayed on topic, but there was enough room for input of participants. Therefore, both AI and the fact focus groups and interviews were semi-structured contributed to the strength of this study.

Focus group interviews generated reliable results, because despite some cancellations enough participation was generated and participants were selected randomly. Compared to individual interviews, in focus groups the moderator has less control over the course of events and could pay less attention to some individuals (28). To prevent this as much as possible, two experienced moderators were used to lead the focus groups (different moderator for every focus group). During different meetings, the researcher and moderators discussed purpose of the study, so this was clear before starting focus groups and both moderators discussed the same subjects with participants. In studies like this one, it is important the visit to the outpatient clinic was not too long ago, so participants of focus groups could remember events that occurred more accurate. This was ensured as much as possible by recruiting patients who visited the outpatient clinic for a maximum of six months ago before starting the focus groups.

Interviewees in the UMCG and Radboudumc were approached by the manager of their respective outpatient clinic. This saved valuable time, because the manager's access to employees is easier compared to the researcher's. The answers given, however, are not considered to be social desirable, because at the beginning of each interview it was explicitly mentioned information shared was confidential and will be processed anonymously. Interviews were conducted by the researcher and the manager was not present before, during or after the interviews. Two interviews were disrupted by a pager and a telephone. This could have been prevented by asking interviewees to turn off their pager or phone, but these interviewees needed to be reachable, so being disrupted this way was unavoidable. The disturbance did not affect the progress of

the interview greatly, because the interviewer reminded the interviewee what he was saying. Interviews could proceed quickly.

This patient satisfaction study focused on the outpatient clinic for neurology in the UMCG. This means, recommendations are specifically for this outpatient clinic in this hospital. However, if another outpatient clinic encounters the same problems for e.g. information & communications or after care, they could learn from the findings of this study.

5.2.1 The CQ-index

The CQ- 2015 has been used for starting points for the focus groups, interviews and positive deviance. In general, the focus groups with patients generated the same results of CQ-index of 2015 regarding the satisfaction of patients. Only regarding the interior of the outpatient clinic, patients in focus groups were more critical compared to the picture outlined by the results of the CQ-index. This can be caused by the way questions were asked, or one participant making a negative remark encouraging others to do the same. The fact remains that this are experiences of patients they shared when asked. The rest of the CQ-index themes created the same picture as focus groups.

During the execution of this study, the CQ-index results of 2016 are released. They differ from the one of 2015. The largest differences and consequences of these differences are discussed below.

On average, the outpatient clinic scores an 8.1 on a scale of one to ten. Compared to other outpatient clinics for Neurology in academic hospitals in the Netherlands, the outpatient clinic in the UMCG still scores somewhat below average (=8.2), but less compared to 2015. The 2016 national benchmark can be found in figure 4.

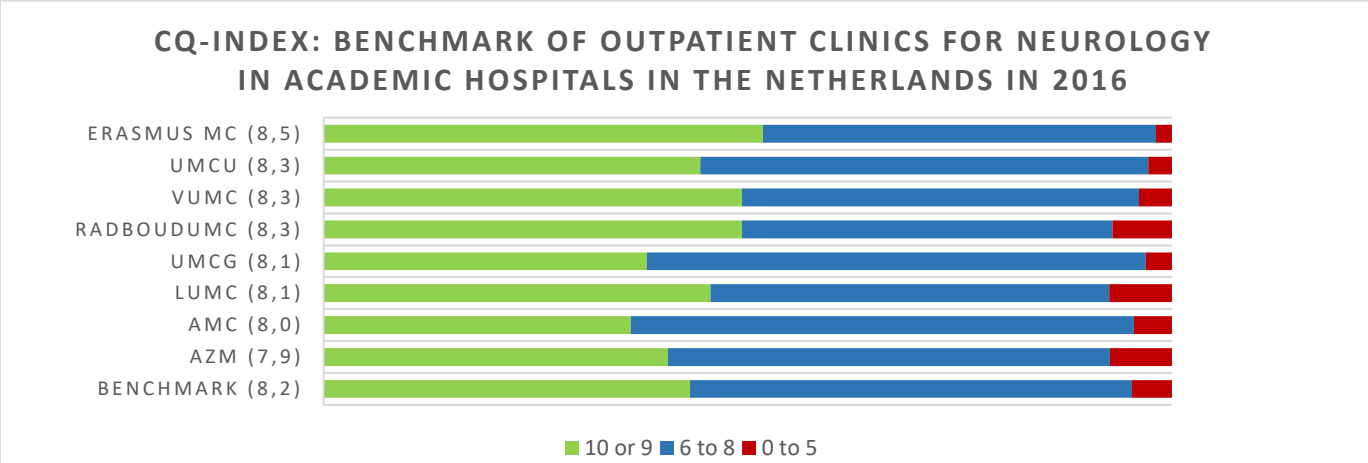

Figure 4: the benchmark of all outpatient clinics for Neurology in the Netherlands in 2016. On overall rating, the outpatient clinic for Neurology in the UMCG ranks 5th out of 8 with a 8.1 (On a scale of 1 to 10. Red = 1 - 5; blue = 6 – 8; green = 9 or 10).

When a positive deviance study is started and the CQ-index 2016 is used in step 1, the Erasmus MC turns up to be the positive deviant. The outpatient clinic for Neurology in the Radboudumc scores lower on most topics compared to 2015, UMCG scored higher on most topics. The outpatient clinic for Neurology in the UMCG still has low satisfaction scores on provision of information and after care, so findings and recommendation done after the CQ-index of 2015 stay intact.

After seeing the differences in the CQ-index results, management of the outpatient clinic has been asked if any actions were taken regarding the CQ-index of 2015 which may have caused the increase in satisfaction scores. It turned out no concrete actions were taken, only awareness by giving attention to the CQ-index themes. This and normal variation could have caused CQ-index scores to be higher in 2016.

The CQ-index is a proper tool for comparing hospitals and hospital departments concerning patient satisfaction, because it gives a lot of information about different patient satisfaction related topics. When actual improvements need to be made, it provides insufficient information. For detailed information regarding patient satisfaction and concrete recommendations, focus groups with patients, employees and the positive deviance method are good additions. These qualitative method generates detailed data that the CQ-index cannot generate. Down sides of these qualitative methods is that they are time consuming. However, when CQ-index scores are lower than desired it is advisable to put time and effort in finding out the underlying problems. The CQ-index alone provides to little information to find these answers.

5.2.2 Positive deviance

In this part of the report, special attention should go out to one of the method used: positive deviance. This method has not yet been used in a similar setting like this one, so it is desirable for further research to go in to the value of this method in this kind of research. Therefore in this paragraph, the experience of the researcher with positive deviance will be discussed.

Regarding positive deviance, not all four steps (14, 17) have been performed. Ideally, testing gathered hypotheses within larger, more representable samples (step 3) and implementing the successful practices widely (step 4) are performed as well. Concerning the time available, it was omitted in this study. This does not devaluate current findings, but an extra step could have been made. Thereby, in other studies in health care settings where positive deviance was used, only step one and two were performed as well (46-48). In table 2 in Baxter et al. (14) can be seen that way more studies used positive deviance, but did not perform all the four steps.

In this study, positive deviance was a valuable addition to more common methods of measuring patient satisfaction, e.g. the CQ-index and focus groups. The positive deviant in this study, Radboudumc in Nijmegen, experienced it to be a compliment that the UMCG asked for their collaboration. They gave a

lot of useful information to help improve recommendations and make them more practical with concrete examples.

Summarizing, positive deviance could help improve patient satisfaction and overall healthcare, due to the sharing of information. Hospitals and other healthcare institutions should not reinvent the wheel, but make use of knowledge of others. However, more studies have to be performed in which all four steps are gone through. That is why more research is needed regarding positive deviance is needed in which all four steps are gone through.

5.4 Recommendations

In this section two type of recommendations will be done: practical recommendations and recommendations for further research. First, practical recommendations for the outpatient clinic for Neurology in the UMCG will be given. These recommendations can also be used by other, similar, outpatient clinics.

5.4.1 Practical recommendations for the outpatient clinic for Neurology in the UMCG

All improvements and ideas mentioned earlier (section 5.1) could help improve patient satisfaction at the outpatient clinic for neurology in the UMCG. However, on some themes improvement projects could have higher impact on patient satisfaction because satisfaction scores are lower or are of higher importance. This regards the information and communication and after care, in which communication and provision of proper information also plays an important role. These themes have low experience and high importance scores at the CQ-index 2015. Also, patients and employees find it to be important things, that can be relatively easy improved. The first step that has to be made is to make sure brochures are available at all times. Brochures regarding most neurological diseases, diagnosis and treatment already exist at patient federations and the Dutch Association for Neurology. These brochures can be ordered and put in racks in the waiting room and consultation rooms. When the outpatient clinic wants to make their own brochures or other written means of communication like letters, it is highly recommended they consult with patients about the content.

Not just written communication regarding medication is important. Verbal information is important as well and has to be very explicit. Patients indicated they had to find out themselves what the effects were of their medication and what alternatives were. A more proactive attitude of employees is desired. Thereby, most common side effects have to be communicated explicitly to patients to make sure they understand what kind of effects their medication could have. Employees prescribing medicine should be encouraged by the management of the department to put more emphasis on this part on provision of information, because it had low importance scores and high importance.

It is important to make sure patients feel welcome at the outpatient clinic and are assisted when needed. At busy moments, this is difficult for just one front desk attendant. The outpatient clinic at the positive deviant uses voluntary hosts at these busy moments, to assist patients and help keep the waiting room tidy. The UMCG already has issued vacancy for a voluntary functions like this. It is advisable the outpatient clinic for neurology benefits from this situation and makes sure they get one or more of these volunteers.

Finally, it is advisable to set up a patient advisory board for the outpatient clinic, just like the positive deviant. Among other things, the patient advisory groups of different departments in the Radboudumc help reviewing patient information products (49). Using a patient advisory board, makes sure voices of patients are heard regularly, contributing to improvement of and maintaining high patient satisfaction.

5.4.2 Recommendations for further research

Also for further research, a few recommendations can be made. This study used the CQ-index as starting points to gain recommendations from patient, employees and a positive deviant. This is an ad hoc way of research: only when CQ-index scores are unsatisfying, further research takes place in terms of focus groups. A standardized set of questions, more detailed than the CQ-index, could be developed and distributed among patients. These questionnaires can focus on specific CQ-index themes, e.g. after care. When the CQ-index scores are bad on this topic, another 'after care questionnaire' could be distributed to get more detailed information and recommendations. This prevents having to set up and analysing qualitative research, which is very time consuming.

As stated before, in this study, only step one and two of positive deviance are performed. To test if these recommendations found in these steps are good enough, the findings in this study have to be used in further research and tested in a larger, more representative samples of the population (17). Furthermore, positive deviance is not commonly used in this part of health care. However, both the positive deviant as the UMCG were positive regarding this method, which makes it advisable to use positive deviance more often as a tool for improvement.

The results of this study can be used in other outpatient clinics and in other hospitals with the same problems as the outpatient clinic for Neurology in the UMCG. Thereby, it offers starting points for further research regarding patient satisfaction.

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Appendices

Appendix A: First information letter

Betreft: Medewerking aan onderzoek

Geachte mevrouw/mijnheer,

Onlangs heeft u een afspraak gehad op de polikliniek van afdeling neurologie in het Universitair Medisch Centrum Groningen. Wij zijn benieuwd naar uw ervaringen van dit bezoek. Met deze brief willen wij u informeren over een onderzoek waarmee wij hopen deze ervaringen te verzamelen, te analyseren en te gebruiken voor het eventueel aanbrengen van verbeteringen. In deze brief staat het doel en de eventuele voor- of nadelen van deelname aan onderzoek vermeld.

Mocht u na het lezen van deze informatie nog vragen hebben, dan kunt u deze stellen aan de onderzoeker (contactgegevens staan onder aan de brief).

Doel van het onderzoek

Het doel van dit onderzoek is te weten komen wat de ervaring is van patiënten met de gang van zaken op de polikliniek neurologie. Door u te vragen naar uw mening kunnen deze meegenomen worden in verbeteringen en veranderingen op de polikliniek. Hierdoor kan de zorg zoals u ervaart beter worden.

Waarom meedoen?

Door mee te doen met dit onderzoek, kunt u een bijdrage leveren aan dit wetenschappelijk onderzoek. Door mee te doen ondervindt u geen risico's. Met uw hulp kan er meer inzicht komen in dit onderwerp en kan de manier waarop zorg wordt geleverd beter aansluiten bij uw wensen.

Wat u kunt verwachten

Het onderzoek bestaat uit een focusgroep discussie waarin u gevraagd uw ervaringen te delen en in discussie te gaan met vijf anderen die, net als u, recent de polikliniek neurologie hebben bezocht. De focusgroepen zullen worden geleid door twee personen. De focusgroep discussie vindt plaats in het UMCG en zal ongeveer anderhalf uur duren.

Tijdens de focusgroepen zal een geluidsopname gemaakt worden zodat later de gesproken tekst uitgetypt kan worden voor het onderzoek. Deze geluidsopname wordt na het onderzoek vernietigd. Namen en persoonlijke gegevens zullen niet gebruikt worden in het onderzoek. Uw privacy wordt gerespecteerd.

Wat gebeurt er als u niet mee wilt doen?

Het deelnemen aan dit onderzoek is volledig vrijwillig. Als u niet mee wilt doen, hoeft u daarvoor geen reden op te geven. Als u kiest om niet mee te doen, heeft dit geen enkele invloed op uw eventuele verdere behandeling/begeleiding. Daarnaast als u toestemming geeft, kunt u zich altijd bedenken en stoppen met het onderzoek.

Wat gebeurt er met uw gegevens?

Bij het gebruiken van de onderzoeksgegevens wordt de Wet Bescherming Persoonsgegevens nageleefd. De gegevens die verzameld worden zullen vertrouwelijk behandeld worden en anoniem worden verwerkt.

Wilt u nog iets weten?

Met deze brief hopen wij u voldoende geïnformeerd te hebben over het onderzoek. Uw medewerking wordt bijzonder op prijs gesteld. Binnen een paar werkdagen zal de onderzoeker u telefonisch benaderen om te vragen of u wilt meewerken of niet. Dan kan ook een afspraak gemaakt worden.

Mocht u nog vragen hebben, kunt u deze altijd stellen. Hiervoor kunt u contact opnemen met Thom Ronde, onderzoeker van dit project (xxxxx@umcg.nl)

Met collegiale groeten,

J.J. de Vries, neuroloog, chef de policlinique

neurodegeneratieve aandoeningen

Thom Ronde

Masterstudent Gezondheidswetenschappen

Appendix B: Letter to not reached (former) patients

Betreft: brief medewerking aan wetenschappelijk onderzoek

Geachte mevrouw/mijnheer,

Recent heeft u van ons een brief ontvangen waarin werd aangekondigd dat u telefonisch benaderd zou kunnen worden met betrekking tot medewerking aan een wetenschappelijk onderzoek. We hebben geprobeerd u vorige week te bereiken maar helaas is dit niet gelukt.

Op dit moment is er voldoende medewerking van andere bezoekers van de polikliniek neurologie. Uw medewerking is daarom niet meer nodig. Via deze brief willen wij u daarom op de hoogte stellen dat er geen contact meer met u zal worden gezocht.

We willen u bedanken voor uw interesse door het lezen van de brief.

Met collegiale groeten,

J.J. de Vries, neuroloog, chef de policlinique
neurodegeneratieve aandoeningen

Thom Ronde,
Masterstudent Gezondheidswetenschappen

Appendix C: Second information letter

Geachte mevrouw/meneer […],

In aansluiting op het telefoongesprek dat u onlangs met één van ons heeft gehad, nodigen wij u graag uit voor een focusgroep op **donderdag/woensdag 11/17 augustus a.s.**
Tijdens deze bijeenkomst willen we met u praten over uw ervaring met uw bezoek aan de polikliniek neurologie in het UMCG.

Om een goed beeld te krijgen hoe patiënten hun bezoek aan de polikliniek neurologie hebben ervaren, zouden we graag uw ervaringen horen in een focusgroep.

Tijdens de focusgroep gaan twee gespreksleiders met u en ongeveer acht tot tien andere (ex)patiënten (en eventueel mantelzorgers) over verschillende onderwerpen in gesprek. U kunt daarbij denken aan uw ervaringen in het onderzoekstraject rondom het stellen van de diagnose, de informatie die u kreeg ten aanzien van uw behandeling, de manier waarop u door de verschillende medewerkers (baliemedewerkers, verpleegkundig specialisten, physician assistents (PA's) en artsen) bent bejegend. Door van u te horen wat goed ging, wat er mogelijk beter kan, kunnen wij de behandeling en (na)zorg op de polikliniek in het UMCG verbeteren.

De gesprekken die met u en de andere (ex)patiënten worden gevoerd, worden schriftelijk vastgelegd. In het verslag worden geen namen genoemd. Wat u vertelt is dus niet naar u te herleiden. Er worden ook geluidsopnamen gemaakt om achteraf precies na te gaan wat er is gezegd. De geluidsopnamen zijn bedoeld voor intern gebruik.

U bent **vanaf 13.00/13.15 uur** van harte welkom in de leeszaal van de afdeling Neurologie (ruimtenummer 34.4.014). Bewegwijzering vanaf ingang Zuid (hoofdingang) en vanaf ingang Noord is aanwezig.
Voor u (en evt. uw begeleider(s)) staan in deze ruimte thee en koffie klaar.
Om **13.15/13.30 uur** start de spiegelbijeenkomst.
Na de bijeenkomt is er gelegenheid om met ons, de medewerkers van het behandelteam borstkanker, onder het genot van een kopje koffie of thee na te praten.
Om **14.45/15.00 uur** is de bijeenkomst afgelopen.

Het is belangrijk voor ons om te weten hoe u uw behandeling heeft ervaren. Wij stellen uw deelname dan ook erg op prijs.
Heeft u nog vragen over de focusgroep van 11/17 augustus a.s. over uw ervaring met de polikliniek neurologie, dan kunt u contact opnemen met Thom Ronde (bereikbaar op maandag t/m donderdag tijdens kantooruren, via telefoonnummer […] of […]@umcg.nl), bij voorkeur per e-mail vanwege afwezigheid tussen 23 juli en 6 augustus. Na deze periode zal, bij vragen, contact worden opgenomen.

Met vriendelijke groet,

J.J. de Vries, neuroloog, chef de policlinique
neurodegeneratieve aandoeningen

Thom Ronde
Masterstudent Gezondheidswetenschappen

Appendix D: Focus group script

Hoe ervaren patiënten hun bezoek(en) aan de polikliniek Neurologie?

Datum en tijd:

……

……..

Locatie:

……

……

Gespreksleider:

……

……..

Verslaglegger:

……

……...

Opmerkingen:

……

……

.....

Rol van de onderzoekers:

Gespreksleider: introduceert de studie / het onderzoek, leidt de discussie en motiveert de deelnemers om (mee) te praten.

Verslaglegger: verantwoordelijk voor **geluidsopnames**, houdt een **veldverslag** bij waarin het proces, de interacties, de sfeer en de van de FGD worden bijgehouden. Probeer vast te leggen wie wat zegt.

Voorafgaand

Zorg dat je het onderzoek hebt geïntroduceerd en de FGD-procedures hebt uitgelegd aan de hand van het informatieblad. Zorg er voor dat alle deelnemers de instemmingsverklaring en de algemene vragenlijst hebben ingevuld.

Introductie

Gespreksleider: "In het kader van het afstuderen van mijn master Gezondheidswetenschappen willen we met u een discussie voeren over uw ervaring met polikliniek neurologie in het UMCG. Het gaat hierbij om uw mening en de dingen die u ervaart. Er zijn dus geen goede of foute antwoorden.

Ik wijs er nogmaals met nadruk op, dat de informatie die u verstrekt hoogst vertrouwelijk behandeld zal worden. Dit betekent dat alleen ik en iedereen hier aanwezig weet wat hier besproken wordt. Graag vraag ik dan ook aan alle aanwezigen om op een vertrouwelijke manier om te gaan met wat hier besproken wordt. De gegevens uit dit interview zullen worden verwerkt zonder dat er namen worden gebruikt. Informatie zal ook nooit doorgegeven worden aan derden.

Om er zeker van te zijn dat alles dat wordt besproken goed wordt overgenomen zou ik de discussie graag opnemen. Gaat u hiermee akkoord?

Zijn er nog verdere vragen voor we beginnen?

Introducerende vragen

Gespreksleider: "Voordat we beginnen wil ik jullie vragen om je voor te stellen aan de groep".
Ga iedereen bij langs en vraag elke deelnemer individueel om zichzelf te introduceren door de volgende vragen te stellen:

- Wat is uw voornaam? Leeftijd?
- Kent u andere deelnemers in deze groep? Wie? Hoe kent u hen?

Discover

- Wat vindt u het allerbeste aan de zorg die u kreeg op de polikliniek Neurologie in het UMCG?
    - Doorvragen
        - Heel goed. Zijn er nog meer dingen?
        - Weet iemand anders nog andere dingen?
        - Voorbeelden uit de CQ-Index:
            - Toegankelijkheid (makkelijke te vinden en (telefonisch) te bereiken)
            - Bejegening (door bijvoorbeeld de arts)

Dream & Design: De perfecte polikliniek

Gespreksleider: "Stel u voor: geld speelt geen enkele rol en jullie zijn de baas op de polikliniek Neurologie, wat zouden jullie dan doen om deze polikliniek Neurologie te maken tot 'de ideale polikliniek Neurologie'?

- Zijn er bijvoorbeeld ook onderwerpen waarvan u denkt dat het beter kan?
    - Doorvragen
        - Oké, heel goed. Zijn er nog meer dingen?
        - Weet iemand anders nog andere dingen?
        - Voorbeelden uit CQ-Index?
            - Ontvangst aan de balie
            - Bejegening door de arts
            - Informatievoorziening (bijv. over medicatie, rechten als patiënt)
            - Nazorg (bijv. contact na bezoek, vervolgstappen na evt. diagnose)
            - Wachttijden in de wachtkamer
        - Op welke manier zou dit beter/anders kunnen?
            - Oké, en zou iemand anders een andere manier weten?
- Als u deze punten een bepaalde prioriteit zou mogen geven, welke zou dan de hoogste en welke de laagste prioriteit krijgen?
    - Waarom?

Destiny

<u>Gespreksleider:</u> "Zojuist hebben we het gehad over hoe 'de ideale polikliniek Neurologie' er volgens jullie uitziet."

- Wat moet er volgens jullie gebeuren om ervoor te zorgen dat deze zaken gerealiseerd kunnen worden?
    - Doorvragen
        - Oké, heel goed. Zijn er nog meer dingen?
        - Weet iemand anders nog andere dingen?
- Wie zouden daar bij betrokken moeten worden?
    - Medewerkers polikliniek?
    - Patiënten?
    - Mantelzorgers?

Afronden van de FGD:

Gespreksleider: "We hebben heel veel verschillende onderwerpen besproken, die allemaal te maken hebben met uw ervaring met uw bezoek aan de polikliniek. Ik wil jullie vragen of er nog belangrijke dingen zijn die met deze onderwerpen te maken hebben waarvan jullie het gevoel hebben dat we het nog niet hebben besproken, en die jullie toch graag willen delen in deze discussie?"

Gespreksleider: "Ik zou nu graag de discussie willen afronden. Hoe hebben jullie de discussie ervaren?"

Gespreksleider/verslaglegger: bedank de deelnemers voor hun deelname.

Tijdsschema focusgroep discussie	
Introductie en voorstelrondje	10 minuten
Discover	20 minuten
Dream & Design: De perfecte polikliniek	35 minuten
Destiny	15 minuten
Aanvullende dingen vanuit deelnemers en afsluiting	10 minuten

Appendix E: Questionnaire before starting focus group

Vragenlijst voorafgaand aan focusgroep

Leeftijd: ……

Geslacht:
- Man
- Vrouw

Hoogst genoten opleiding:
- Geen opleiding
- Lager onderwijs (basisschool, speciaal basisonderwijs)
- Lager of voorbereidend beroepsonderwijs (zoals: LBO, VMBO)
- Middelbaar Algemeen Voortgezet Onderwijs (MAVO)
- Middelbaar Beroepsonderwijs (MBO)
- Hoger algemeen en voorbereidend wetenschappelijk onderwijs (HAVO, VWO)
- Hoger Beroepsonderwijs (HBO)
- Wetenschappelijk Onderwijs (Universiteit)
- Anders, namelijk: . . . . .

In welke rol bezocht u de polikliniek?
- Patiënt
- Mantelzorger

Waarvoor bezocht u de polikliniek neurologie?

……
……
……
……
……

Appendix F: Interview protocol employees UMCG

Interviewprotocol Medewerkers

Datum interview:

Tijd interview:

Mijn naam is Thom Ronde, in het kader van het afstuderen van mijn master Gezondheidswetenschappen wil ik u een aantal vragen stellen over patiënttevredenheid op uw polikliniek en hoe dit in uw ogen wordt gewaarborgd. Het gaat hierbij om de indruk die u krijgt over de tevredenheid van de patiënt.

Wanneer ik u vraag naar uw mening, gaat het uitdrukkelijk om uw persoonlijke mening. Er zijn dus geen goede of foute antwoorden.

Ik wijs er nogmaals met nadruk op, dat de informatie die u verstrekt hoogst vertrouwelijk behandeld zal worden. Dit betekent dat alleen ik weet welke antwoorden u gegeven heeft. De gegevens uit dit interview zullen worden verwerkt zonder dat er namen worden gebruikt. Informatie zal ook nooit doorgegeven worden aan derden.

Het interview duurt ongeveer een half uur

- Als eerste begin ik met een algemene introductie
- Daarna wil ik het met u hebben over sterke punten van uw polikliniek
- En als laatste wil ik het graag met u hebben over de ideale polikliniek en hoe deze in uw ogen tot stand kan komen

Om er zeker van te zijn dat ik uw antwoorden goed overneem zou ik het gesprek graag opnemen. Na het transcriberen van de opname, wordt de opname vernietigd. Gaat u hiermee akkoord?

Heeft u nog vragen voor we beginnen?

Geslacht:

Leeftijd:

Functie:

U bent werkzaam op de polikliniek Neurologie in het Radboud UMC/UMCG. Wat zijn uw voornaamste werkzaamheden?

- Op welke manier komt u in contact met patiënten?
- Wat verstaat u onder patiënttevredenheid?

Discover

Waarop denkt u dat uw polikliniek goed scoort op het gebied van patiënttevredenheid?

- Uit CQ-Index:
    - Ontvangst aan de balie
    - Bejegening door de arts
    - Informatievoorziening (bijv. over medicatie, rechten als patiënt)
    - Nazorg (bijv. contact na bezoek, vervolgstappen na evt. diagnose)
- Hoe komt dat denkt u?
- Wat wordt er op deze polikliniek (actief) gedaan om dat zo te houden?

Dream & Design

Stel u voor: geld speelt geen enkele rol en u had het volledig voor het zeggen op uw polikliniek, wat zou u dan doen om deze polikliniek Neurologie te maken tot ‘de ideale polikliniek Neurologie’? Hierbij zou ik u willen vragen patiënttevredenheid in uw achterhoofd te houden.

- Zijn er bijvoorbeeld ook onderwerpen waarvan u denkt dat het beter kan?
    - Zo ja, welke?
        - Wachttijden in de wachtkamer
    - Op welke manier zou dit beter/anders kunnen?
- Als u deze punten een bepaalde prioriteit zou mogen geven, welke zou dan de hoogste en welke de laagste prioriteit krijgen?
    - Waarom?

Destiny

Zojuist hebben we het gehad over hoe ‘de ideale polikliniek Neurologie’ er volgens u uitziet.

- Wat moet er volgens u gebeuren om ervoor te zorgen dat deze zaken daadwerkelijk worden geïmplementeerd?
- Wie zouden daar bij betrokken moeten worden?
    - Medewerkers polikliniek?
    - Patiënten?
    - Mantelzorgers?

Zijn er verdere zaken die u met mij wil delen met betrekking tot de eerder besproken onderwerpen?

Heeft u nog opmerkingen of vragen met betrekking tot dit interview?

Dan wil ik u bedanken voor deelname aan het onderzoek.

Eindtijd interview:

Appendix G: Interview protocol employees positive deviant: Radboudumc

Interviewprotocol positive deviant

Datum interview:

Tijd interview:

Mijn naam is Thom Ronde, in het kader van het afstuderen van mijn master Gezondheidswetenschappen wil ik u een aantal vragen stellen over patiënttevredenheid op uw polikliniek en hoe dit in uw ogen wordt gewaarborgd. Het gaat hierbij om de indruk die u krijgt over de tevredenheid van de patiënt.

Wanneer ik u vraag naar uw mening, gaat het uitdrukkelijk om uw persoonlijke mening. Er zijn dus geen goede of foute antwoorden.

Ik wijs er nogmaals met nadruk op, dat de informatie die u verstrekt hoogst vertrouwelijk behandeld zal worden. Dit betekent dat alleen ik weet welke antwoorden u gegeven heeft. De gegevens uit dit interview zullen worden verwerkt zonder dat er namen worden gebruikt. Informatie zal ook nooit doorgegeven worden aan derden.

Het interview duurt ongeveer een half uur

- Als eerste begin ik met een algemene introductie
- Daarna wil ik het met u hebben over sterke punten van uw polikliniek
- En als laatste wil ik het graag met u hebben over de ideale polikliniek en hoe deze in uw ogen tot stand kan komen

Om er zeker van te zijn dat ik uw antwoorden goed overneem zou ik het gesprek graag opnemen. Na het transcriberen van de opname, wordt de opname vernietigd. Gaat u hiermee akkoord?

Heeft u nog vragen voor we beginnen?

Geslacht:

Leeftijd:

Functie:

U bent werkzaam op de polikliniek Neurologie in het Radboud UMC/UMCG. Wat zijn uw voornaamste werkzaamheden?

- Op welke manier komt u in contact met patiënten?
- Wat verstaat u onder patiënttevredenheid?

Discover

Waarop denkt u dat uw polikliniek goed scoort op het gebied van patiënttevredenheid?

- Hoe komt dat denkt u?
- Deze polikliniek scoort op verscheidene (onderstaande) punten goed op het gebied van patiënten ervaringen. Het UMCG scoort hier aanzienlijk minder op. Wat heeft u gedaan om die goede score te verkrijgen?:
    - Ontvangst aan de balie (welkom voelen, baliemedewerker)
    - Bejegening door de arts (serieus nemen, aandachtig, genoeg tijd)
    - Informatievoorziening (bijv. over medicatie, rechten als patiënt)
    - Communicatie (uitleg en vragen stellen)
    - Inrichting (aankleding)
    - Samenwerking (tegenstrijdige info? Aansluiten van behandelingen, verwijzing)
    - Inspraak patiënt
    - Nazorg (bijv. contact na bezoek, vervolgstappen na evt. diagnose)
- Wat wordt er op deze polikliniek (actief) gedaan om dat zo te houden?
    - Welke processen liggen daar aan ten grondslag?

Dream & Design

Deze polikliniek scoort natuurlijk al hoog op patiënttevredenheid. Maar stel u voor: geld speelt geen enkele rol en u had het volledig voor het zeggen op uw polikliniek, wat zou u dan doen om deze polikliniek Neurologie te maken tot ‘de ideale polikliniek Neurologie’? Hierbij zou ik u willen vragen patiënttevredenheid in uw achterhoofd te houden.

- Zijn er bijvoorbeeld ook onderwerpen waarvan u denkt dat het beter kan?
    - Zo ja, welke?
        - Wachttijden in de wachtkamer
        - Nazorg
    - Hoe zou dit beter/anders kunnen?
- Als u deze punten een bepaalde prioriteit zou mogen geven, welke zou dan de hoogste en welke de laagste prioriteit krijgen?
    - Waarom?

Destiny

Zojuist hebben we het gehad over hoe ‘de ideale polikliniek Neurologie’ er volgens u uitziet.

- Wat moet er volgens u gebeuren om ervoor te zorgen dat deze zaken daadwerkelijk worden geïmplementeerd?
- Wie zouden daar bij betrokken moeten worden?
    - Medewerkers polikliniek?
    - Patiënten? → gebeurt dit al?
    - Mantelzorgers?

Zijn er verdere zaken die u met mij wil delen met betrekking tot de eerder besproken onderwerpen?

Heeft u nog opmerkingen of vragen met betrekking tot dit interview?

Dan wil ik u bedanken voor deelname aan het onderzoek.

Appendix H: Table with conclusions and recommendations

Overall conclusions and recommendations regarding CQ-index subjects

CQ-index subject	Conclusions	Recommendations
Accessibility	• High CQ-index scores • When calling the outpatient clinic via main desk of the UMCG, it takes a long time to get the right person on the phone	• Inform patients the need to call directly to the outpatient clinic, refer to website for phone number
Reception	• High CQ-index scores • Some patients, especially elderly, found the registration pole difficult to use	• Let people choose how the want to register when they visit: via front desk or registration pole • Hire (voluntary) hosts for peak hours
Interior of the outpatient clinic	• High CQ-index scores, contradicted in focus groups • Decoration is dull • Patients can hear administrative personnel talk, they do not like this	• Create more ambiance by adding colors or other decorations at walls, however it is important not to jeopardize functionality • Keep in mind to talk more softly. Create a separate room, that could be shut off for the administrative personnel
Waiting(times) at outpatient clinic	• Good CQ-index scores • Reading materials are outdated and target group orientated • Patients are not notified when they need to wait longer than expected	• Regularly update and widen genres of the available reading materials • Use TV-screens to communicate waiting times
Interpersonal conduct	• High CQ-index scores, participants of focus groups patients had no remarks	• -
Information and communication	• High CQ-index scores on communication, low on provision of information • Communication was good and the amount of written information was poor	• To improve the amount of written information given, brochures should be available at all times and given to patients after a visit • Ask patients for input by creating new brochures
Collaboration between employees	• High CQ-index scores • Patients see different physicians during different visits: some liked it, others did not	• Create service blocks for specialists in training, this was also put forward by the positive deviant and employees of the outpatient clinic in the UMCG
Patient participation	• Low CQ-index scores • Patients are not able to make their own appointment • Employees want more responsibilities in patients' hands	• Give patients access to a digital system where they can see and fill in personal data, e.g. the medication they take; they could also make appointments here (hospital wide case)
After care	• Low CQ-index scores • Guidance by physician was good • Provision of information regarding medication and side effects was poor	• Give clear information when patients leave the outpatient clinic • Stimulate consultation holders to be very explicit towards patients when

they talk about side effects of prescribed medication