Patient evaluations of mental health service provision: implications for performance improvement and mental healthcare service evaluation

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Patient evaluations of mental health service provision: Implications for performance improvement and mental healthcare service evaluation

by

Jeffrey Joseph Angera

A dissertation submitted to the graduate faculty in partial fulfillment of the requirements for the degree of DOCTOR OF PHILOSOPHY

Major: Human Development and Family Studies (Marriage and Family Therapy)

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1997

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ABSTRACT

The researchers explored methods of performance improvement at a hospital outpatient mental health clinic utilizing a qualitative patient evaluation. The study evaluated patient experiences receiving mental health services at a county hospital. Areas explored include: 1) mental health patient experiences interfacing with providers and ancillary services in the system, 2) patient suggestions for improvement, and 3) patient reactions to participating in a qualitative evaluation. The study examined all facets of service provision except confidential information expressed within the confines of the provider/patient relationship. The two primary data collection procedures included focus group discussions with patients only and focus groups with patients and an interdisciplinary team of clinic staff. Five central domains emerged from the qualitative data analysis: 1) positive and negative evaluative information, 2) factors influencing communication flow, 3) factors influencing patient dignity, 4) structural/procedural and interpersonal solutions, and 5) the interventive value of the focus group evaluation process. Implications from this study support the need for mental health organizations to conduct in-depth customer research to assess the patient perspective before designing performance efforts. In addition, the study suggests family therapists apply their systems training, clinical skills, and qualitative methods to facilitate such evaluations.
CHAPTER 1

INTRODUCTION

*The single best validated principle in the literature on management of change is that the people who will have to live with the results of change need to be deeply involved in designing and implementing new processes.*

*Unfortunately they rarely are.*

—Backer, 1995, 352

One of the central themes addressed in the ever changing healthcare industry is development of methods to improve the provision of health and mental healthcare (Batalden & Stoltz, 1993; JCAHO, 1992; Keill & Johnson, 1994; Laffel & Blumenthal, 1989). Initially, individual providers (physician, mental health practitioner) were responsible for maintaining exemplary levels of quality service provision. As trends established to develop outside means of accountability, the responsibility for quality shifted to the institutions in which healthcare services were provided (Kazandijian, 1995). This initially manifested itself as minimum standards of healthcare provision and later developed into system wide methods to monitor the quality of healthcare services provided. In time the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (formerly the Joint Commission on Accreditation of Hospitals) developed and served as the accreditation body determining if individual institutions achieved satisfactory levels of quality.
The early manifestations of what may be called the systematic quality movement took the form of standardization of care. Professional guidelines for healthcare provision were developed with corresponding methods to monitor these guidelines. As healthcare evolved, emphasis shifted from minimum standards to optimal levels of care. These efforts took the form of quality assurance programs. The primary focus of these efforts surrounded the operationalization of satisfactory standards of performance. Emphasis was placed on outcome. If satisfactory outcomes were not realized, efforts were made to "root out" the problem. Individuals were identified and made accountable for unacceptable levels of service/job performance.

Following the trends of business and industry, the Joint Commission recognized that quality must be examined in terms of process and not merely outcome (Laffel & Blumenthal, 1989). This shift represented a movement from individual focus to improving organizational systems and processes (Keill & Johnson, 1994). Largely, influenced by the work of W. Edward Deming and J. M. Juran, models of improving processes related to "core functions" identified by JCAHO took shape (Gaucher & Coffey, 1993). The most recent expression of this quality movement is represented by Performance Improvement.

As indicated in the JCAHO standards put forth in the 1996 re-accreditation manual, Performance Improvement (PI) is the cornerstone of all core functions identified for healthcare organizations. The re-accreditation manual details general components necessary for all PI efforts subsumed under the five standards: planning, design, measurement assess, and improvement. As in any large-scale organizational quality
endeavor, the success of PI hinges largely upon careful attention paid primarily to the planning and design phase. This coupled with the commitment of leadership and the involvement of the constituent parties will increase the likelihood of quality efforts which manifest themselves as better patient care, increased satisfaction of employees, and improved performance (Leebov & Ersoz, 1991). In essence, performance improvement that makes a difference.

In reviewing the standards relevant to performance improvement, it is evident that JCAHO urges each organization to establish systematic PI processes that will address the subtle nuances of that particular institution. However, little attention is given to the planning and design phase to systematically guide each individual organization in its performance improvement endeavors. Further, methods of using patient evaluations and suggestions for improvement are not specifically defined. Recently healthcare organizations have begun to develop methods to assess patient’s experiences (JCAHO, 1995), but models must continue to be refined (Lehr & Strosberg, 1991).

**Purpose of the Study**

The following project attempted to develop a greater understanding of the provision of outpatient mental health in a small Midwestern urban hospital. The focus of the project involved attending to patient evaluations and solution generation to inform the planning and design phases of future interdepartmental performance improvement projects. This study utilized a limited number of focus groups with patient stakeholders. The larger project involved taking the evaluation data generated from patients to an
interdepartmental staff group and eventually to a conjoint patient/staff focus group. The study examined the function of providing outpatient mental health services and the associated processes required to fulfill this function. Results yielded information "grounded in the experience" of the patient (Glaser & Strauss, 1967) which will increase the likelihood future quality improvement efforts are aligned with patient experiences of the system.

**Collaborative Project Introduction**

The research was a collaborative project involving two doctoral students working together to learn about quality improvement in a mental healthcare organization. Two distinct yet complementary research agendas were guiding the inquiry. The primary researcher agenda explored patient evaluations of service provision and generated suggestions for improvement. Correspondingly, the co-researcher agenda explored staff evaluations of service provision and generated suggestions for improvement (Kerber, 1997). These agendas were recursive and interdependent.

The collaborative project involved both staff and patient participation. The researchers conducted focus groups over a period of six months. During the first month and a half of the study, three staff only focus groups were conducted in parallel sequence with four patient only focus groups (see Figure 1). At the conclusion of the staff and patient only focus groups, the groups merged to form conjoint patient/staff focus groups. In addition to the focus groups two individual interviews were conducted by the primary researcher.
Figure 1. Collaborative Project Overview
Participant expertise was accessed primarily through transcripts derived from audio taped interviews. Following qualitative methodology (Creswell, 1994; Gummesson, 1991; Lincoln & Guba, 1985; Tesch, 1990) data were collected and analyzed in a recursive and emergent fashion. Both researchers worked independently as well as collaboratively with several observers throughout data collection and analysis. At several stages during the interview process researchers extrapolated themes from the transcripts and shared the themes with the participants and auditors for critique and refinement. In their final form, themes reflect both cultural issues and pragmatic suggestions for consideration when designing and implementing performance improvement.

Research Questions Posed by the Study

Based on rationale discussed in the literature and the researcher’s native knowledge of the system, the following questions drive the inquiry. The questions are broad to encourage the exploratory nature of the evaluation (Creswell, 1994; Fetterman, 1989).

- What are patient perceptions/evaluations of their experiences receiving mental health services?
- What are patient suggestions for change in the system?
- What are mental health patient’s perceptions of focus group evaluations? Are focus group evaluations interventive?
- How can patient and staff participants be combined in the process of informing the improvement of performance in the system?
CHAPTER 2

REVIEW OF RELEVANT LITERATURE

History of the Quality Movement in Healthcare

In the late 19th century and early 20th century the seminal efforts to create a quality standard in healthcare emerged. The American College of Surgeons was founded in 1913 to begin the movement to standardize healthcare. This foundation was driven by the work of Dr. Ernest Codman and Dr. Edward Martin. These physicians suggested that standardization of hospital equipment and care would result in the best methods of treatment for patients as well as giving the public some method of distinguishing institutions committed to maintaining the standards of healthcare (Luce, Bindman, & Lee, 1994; Roberts, Coale, & Redman, 1987). In essence, standardization equated with quality in this early stage of the evolution of healthcare.

Though the wisdom of these practitioners laid the groundwork for the future, the College of Surgeons experienced difficulty initiating the process of standardization. Fortunately, John Bowman, the director of the College obtained a grant from the Carnegie foundation to the launch the first standardization program (Roberts et al., 1987). As a result, in 1917, the Committees on Standards from every state convened in Chicago and laid out the guidelines for hospital standardization. As an outgrowth of this conference the College of Surgeons established the “Minimum Standards” from which hospitals were scrutinized to meet the criteria for accreditation. These five standards included:

1. Organizing hospital medical staffs;
2. Limiting staff membership to well-educated, competent, and licensed physicians and surgeons;

3. Framing rules and regulations to ensure regular staff meetings and clinical review;

4. Keeping medical records that included the history, physical examination, and laboratory results; and

5. Establishing supervised diagnostic and treatment facilities such as clinical laboratories and radiology departments (Roberts et al., 1987).

By 1950, the American College of Surgeons had expanded its scope considerably but was having a difficult time sustaining the financial burdens associated with accreditation. To overcome this difficulty, in 1951, the College merged with the American College of Physicians, the American Hospital Association, the American Medical Association, and the Canadian Medical Association to form the Joint Commission on Accreditation of Hospitals (Roberts et al., 1987).

In 1966 a shift occurred in the Joint Commission emphasis moving from a minimal standard of care to development of an optimal level of care (Donabedian, 1966). Rationale for this transformation was based on the notion that the majority of hospitals in the country had achieved and were maintaining the minimum standards and the standards were not motivating hospitals to excel in service care provision given the available technology. Consequently, in 1970, the guidelines evolved from the one page “Minimum Standards” to a 152 page manual emphasizing optimal achievement (Roberts et al., 1987). Further, given the Joint Commissions experience and expertise, their mission of voluntary
accreditation expanded to include other types of health and health related organizations (Luce et al., 1994). These other health related organizations included ambulatory care, hospice, and community mental health (Luce et al., 1994).

In the early 1970's the Joint commission standards evolved to what was known as quality assurance standards. These included a systematic review of procedures and the development of objective and valid criteria for measuring the quality of care provided (Roberts et al., 1987). Thus, the advent of the outcome emphasis. However, as noted by Roberts et al.:

Despite this quality assurance focus, most relevant hospital activities consisted of formal audit studies. In too many cases, these studies become paper exercises conducted to meet Joint Commission standards. Because of this, the quality assurance effort was compromised and failed to effect the desired intent. Preoccupation with the audit requirement rather than quality care had left hospitals at the periphery of meaningful quality assurance activities. (p. 940)

To address the limitations in the quality assurance method, the Joint Commission moved to broaden the scope of quality assessment and improvement programs. Utilizing continuous quality methods derived in industry (Goonan & Jordan, 1992; Laffel & Blumenthal, 1989), the Joint Commission advocated a multidisciplinary approach in its 1988 Agenda for Change. The goal involved challenging the organization of improvement within departments to that of more interdepartmental efforts, from improving individuals
to improving organizational systems and processes (Keill & Johnson, 1994). This transition, patterned after industry, characterized the latest manifestation of the quality initiative, performance improvement.

**Performance Improvement**

Underscoring the importance of quality efforts, JCAHO devoted one chapter of the hospital re-accreditation manual solely to defining expectations for performance improvement. As stated in the manual:

A hospital’s performance of important functions significantly affects its patient outcomes, the costs to achieve these outcomes, and the perceptions of its patients and their families about the quality and value of its services. The goal of improving organization performance is to continuously improve patient health outcomes. (JCAHO Accreditation Manual, 1996, p. 239)

The accreditation manual dictates certain standards that each healthcare organization must address over a period of time to demonstrate necessary attention to performance improvement efforts. The standards fall under the following five categories: plan, design, measure, assess, and improve. Further, under each standard, substandards are detailed illustrating the necessary components to address each standard. At the time of three year review, an accreditation team assesses each organization's efforts on a five point rating scale in relation to each standard and substandard.
To address the planning standard, each organization must demonstrate a coordinated, systematic hospitalwide approach to performance improvement (Manual, 1996). The primary emphasis is to move beyond departmental lines and promote collaboration between parts of the system that interface to accomplish core functions of service for the organization. The manual suggests that these joint efforts break from the traditional improvement methods which organized themselves around predefined structures (i.e. specific departments or isolated units) to focus on functions (groups of core processes) and altering variance associated with these functions.

In improving performance the Joint Commission refers to the design standard as the determination if current processes can be incrementally altered or if hospital objectives and methods require redesign. The Joint Commission suggests that when considering designing a new process the following components must be considered: "the organizations' mission, vision, and strategic plan; data about organizational activities relevant to the process; current knowledge about the process, and organizational resources" (JCAHO, 1995, p. 32).

The measurement standard and substandards emphasize the necessity for the collection of accurate data to develop an understanding of the processes under analysis. The Joint Commission cites healthcare organizations requirements to demonstrate effectiveness and efficiency by collection of valid and reliable data (JCAHO, 1995). The difficulty with this standard is operationalizing constructs in such a manner to allow
sensitivity to changes which make a difference to end users and other customers in the system rather than merely performance improvement on paper.

The assessment standards involve the translation of data into information promoting decision making regarding identification and prioritization of actions. Typically, assessment involves determining what factors contribute to the current process, sources of variation, and points of breakdown. The Joint Commission indicates intensive process assessment should result in identifying opportunities for improvement (JCAHO, 1995).

Improvement standards are designed to focus actions to foster improved quality based on previous measurement and assessment. This involves identifying the appropriate stakeholders to be a part of the improvement effort and organizing them around aspects of the process that require attention. Further, this standard begs the question of whether incremental improvement is appropriate or if process redesign is indicated (JCAHO, 1995).

In examining the above standards, one observes a number of limitations. First, the standards are written in such a manner to focus on the necessity of a systematic, collaborative effort of performance improvement throughout the hospital. The focus of the standards clearly is on the measurement and assessment phases of the improvement effort (15 substandards under measurement, 12 substandards under assessment; one under plan, none under design and one under improve). However, one may question how these measurement and assessment activities are informed. It is this author's perspective that
little attention is given to adequately address the complexity of each function under study. Greater systemic understanding is necessary to plan and design performance improvement measures that make a difference to patients whom the service is ultimately organized around, as well as other stakeholders in the system. In essence, regardless of the precision of measurement and assessment of data, if the scope of study does not represent the complexity of the system and adequately assess patient evaluations, the organization is merely addressing performance improvement on paper, not that which will make a marked difference to patients and hospital staff.

Second, the underlying theme of performance improvement is to develop superior service to meet the needs of patients. Though, some efforts to improve performance may involve technical processes and necessitate professional knowledge (which patients likely would not have), only recently (JCAHO, 1995) have models begun to emerge to incorporate the patient in the improvement endeavor. This suggests patient experiences receiving services of identified functions must be sought to drive improvement efforts. In its extreme form, patients might serve in some capacity on the performance improvement teams.

Some would argue that developing information gathered through satisfaction surveys/questionnaires attempts to elicit patient information. Though these indices provide necessary information, questionnaires do not capture the Joint Commissions shift from outcome to outcome and process. As such, the following study adds necessary and crucial steps to the performance improvement endeavor. This included a two-fold effort
to better inform the process. First, more in-depth measures were taken to inform the performance improvement process adding a step prior to the "plan and design" phases. This step involved examining patients interface with an adult outpatient mental health system. Inquiry into patient's experience included eliciting their experiences when interfacing with providers and ancillary services in the mental health clinic. In addition, this exploration of the patient perspective sought to generate suggestions for improvement. From this data internal stakeholders were identified and organized in groups with patients to cross-fertilize information to create a positive feedback loop.

**Patient Involvement in Quality Improvement**

The underlying focus in almost all quality related literature involves improving healthcare to better meet the needs of patients. Borrowing from industrial quality trends, healthcare organizations are defining quality as a continuous effort by members of an organization to first meet the needs and expectations of patients and then other customers in the system (Laffel & Blumenthal, 1989). This suggests a dialogue between customers and suppliers of healthcare must be open and carefully maintained to foster relationships that promote longevity and loyalty (Berwick, 1989). This goes beyond the simple recognition of the patient as the recipient of the product. Rather, it begs concerted effort to address the needs of patients, understand their experiences, and understand the factors that influence their decision to chose one healthcare organization over another. As stated by Lehr and Strosberg:
Quality is a customer determination, not an engineering determination, not a marketing determination, not a management determination. It is based upon the customer's actual experience with the product or service, measured against his or her requirements - stated or unstated, conscious or merely sensed, technically operational or entirely subjective - and always representing a moving target in a competitive market .... The purpose of quality measurement is to determine and evaluate the degree or level to which the product or service meets the expectations of the customer. (p. 326, 1991)

Pragmatic concerns regarding the ability of healthcare organizations to develop and encourage the necessary mechanisms to address patient concerns has been a focal debate in the continuous improvement literature (Elbeck, 1992; Lehr & Strosberg, 1991; Nelson, Hays, Larson, & Batalden, 1989). In many instances, healthcare organizations act in the best interests of patients to design improvement efforts addressing the assumed patient needs. Healthcare practitioners typically make decisions they consider in the best interests of their patients, often without consulting them. Further, healthcare practitioners often develop quality standards and clinical indicators without consulting patients (Donabedian 1988). The notion of developing quality improvement measures without gathering "current reality" evaluations of patient's experiences was highlighted in one hospital's efforts to redesign the process for providing breast surgery ("Panel Discussion", 1993). The authors discussed the method by which nurses and physicians developed a
program to change the breast surgery process to help patients deal with postoperative complications. Though the authors indicate improvement they fail to realize the stark absence of patients in the efforts designed to improve patient experiences. As such, this represents one lag in the healthcare adoption of industrial quality trends. Clearly, efforts to ascertain patients ongoing process evaluations is the next step for healthcare in the shift from quality assurance to continuous improvement.

Some have attempted to bring patient perceptions into the process through the development of satisfaction indices (Elbeck, 1992; Nelson et al., 1989). These measures have in some cases been grounded in the experience of patients (Elbeck, 1992) and always rigorously developed both methodologically and statistically (Nelson et al., 1989). This approach is useful and necessary as healthcare organizations must develop data to support their methods, however, it is somewhat incomplete through the continuous quality lens. Characteristic of the paradigmatic shift from quality assurance to continuous improvement is the movement from reliance on outcome to the emphasis on both process and outcome. The satisfaction survey only emphasizes the outcome component, but does not include the in-depth patient perspective in the process they are involved with.

To support the necessity of patient involvement, one may consider a recent study (Nelson & Larson, 1993) assessing the impact of “patient surprises” on their perceptions of quality. The study found 39% of inpatients reported a surprise, (16% good, 13% bad, and 10% reported good and bad) during their hospital experience. Results indicated good surprises experienced by patients were positively related to overall patient satisfaction.
Those patients reporting good surprises tended to rate their global satisfaction with the hospital higher than those reporting bad surprises. Further, after controlling for sociodemographic characteristics, patient health characteristics, and patient evaluations of overall quality, bad surprises had the greatest negative impact on satisfaction self reports (Nelson & Larson, 1993).

Interestingly, the themes related to surprises focused on interpersonal aspects of healthcare (attitude and amount of attention shown by nurses, perks, and treatment of family and friends) and not on skill of physicians, technology and equipment. One might infer from this study that a primary focus to improve patient experiences would involve emphasis on interpersonal aspects of patient care. Further, as suggested by Nelson and Larson:

Healthcare providers who are serious about improving quality may want to do their own "customer research" to determine what they might do to delight their patients; what they must do to avoid disappointing them and what they should do consistently, efficiently, and compassionately to meet the basic expectations of their patients. (p. 94, 1993)

Still the debate in the improvement literature continues over the method and implications of including patients. This is particularly the case when considering mental health patients. Some cite ethical implications indicating that patients lack expert knowledge to inform their decisions (Smith, 1994). But, the same argument can, and has, been made for industrial processes. Consumers do not understand the technical aspects of
the industrial design. Yet before developing improvement efforts in successful industries, designers take considerable time to understand consumer needs and preferences (Lehr & Strosberg, 1991). As stated by Lehr and Strosberg (1991) the change from provider center to patient centered is one of the greatest challenges facing healthcare organizations and models must be developed to guide providers in meeting this formidable task.

Addressing this challenge hospitals are attempting to develop more client focused measures. Recently, the Joint Commission published *Understanding the Patient’s Perspective: A Tool for Improving Performance* (1995) detailing examples of distinct methods for collecting and incorporating input from patients for quality improvement. One such example included assessing the experience of a panel of breast patients and their close family members. Each participants experience was elicited in a panel format followed by a 45-minute individual phone interview inquiring about critical incidents (key episodes) in their experience. From this procedure surveys of patient needs were established. Data from these surveys were used to redesign the discharge procedure to include the provision of a computer to each patient for three months post-operation. The computers provided 24 hour patient access to information and extensive readings to help patients deal with post-operative questions and aid in the recovery process (JCAHO, 1995).

Another example detailed a university medical schools “Quality Functional Deployment” on a medical procedures unit. This example involved an eight-step procedure to include customer groups (referring physicians, students, employees, payers,
medical staff, and patients) to develop quality improvement. The eight steps included the following (JCAHO, 1995):

1. Identify customer groups.
2. Conduct customer focus groups.
3. Analyze the voice of the customer.
4. Verify customer priorities.
5. Determine priorities of customer requirements.
6. Analyze the organizations strengths and weaknesses.
7. Compare findings to competitors.
8. Align resources to meet customer expectations. (pp. 97-98)

In another instance (Reiley et al., 1996) four different units (cardiac surgical, stroke, medical, and med/surg units) developed interdisciplinary work groups at Beth Israel Hospital examining methods to improve the discharge process in their respective units. Over the course of 4 years the researchers administered pre-post surveys and conducted patient/family discussion groups in which recently discharged patients and their families relayed their experience with the discharge process and provided suggestions for improvement. Specifically, each unit focused on how well prepared each patient felt at discharge and areas the patients would identify for improvement. Researchers surveyed a random sample of patients by phone asking their perceptions regarding hospital personnel and events during their stay. Each team held one discussion group with 2 to 8 patients (and family members if available) and nurses, physicians, and social workers from each
respective unit. The researchers stated their objective was to “begin a process whereby patients, family members, and providers would work together as equal members of the healthcare team to develop strategies to improve the discharge planning process” (p. 314). The discussion groups had two components. The researchers referred to the first phase as “informational” with the researchers asking questions about discharge. Example questions were “Please think about one thing that was most helpful to you in preparing you to go home. What was that?” “Now we would like each of you to think of two or three things that you wish had been done better in preparing for your discharge. What were those things?” “What kinds of information did you receive regarding your discharge that was helpful?” “What information was lacking?” The group then broke for a light meal and resumed for a “brainstorming session. During this phase patients completed some of the following sentences: “Thinking about being discharged from the hospital, I wish that....” or “Things could be better if...” It is interesting to note the researchers commented how fascinating it was to observe providers, patients and their families collaborating to improve the discharge process. The main emergent themes were: 1) there is a need for more family involvement in the preparation for discharge; 2) staff cannot understand how frightening it is for patients to go from the “intensiveness” of hospital care to home, where there are no supports; 3) patients and families want more follow-up after hospitalization; 4) information should be as concrete as possible and should be in writing; 5) there is a need for the discharge day to be less rushed; 6) patients and families felt that more education on what could and could not be done following discharge would have been
helpful; 7) there is a need to pay more attention to symptom management in the post-discharge period; and 8) billing and financial issues were troublesome. After development of these domains each respective work group developed interventions based on the information provided during their group. The authors note the major outcome of this project has been “increased appreciation among clinicians about the importance of patient and family feedback (p. 317).” The teams then developed interventions in each respective unit based on patient information and completed post tests, highlighting the significant change in some of the patient identified areas.

Similarly, a group of nine researchers (Niles et. al, 1996) from a Cardiac Services Improvement Group developed a patient flow chart of sequential patient experiences (i.e. I am referred to a cardiologist, I find out about my heart, we decide on a procedure ... go home, return for follow-up etc.) to become “customer centered.” The goal was to examine the customers’ experiences and maintain a process focus which is the sequence or flow of activities that creates the service or product. The researchers took an employee minded approach supporting the attitude “quality problems are almost always the result of bad processes, not bad people and, moreover, the insights and involvement of the front-line employee are critical to process redesign and improvement” (p. 324). Further they stated “the goals of patient-centered care are to regain confidence and trust by systematically incorporating patient perceptions of care into the quality management apparatus to refocus organizational culture on high-quality patient care from the patient’s (original emphasis) viewpoint” (p. 324). To accomplish these aims the researchers
conducted two focus groups with about 18-20 patients eliciting patient reactions to each sequential step in the process identified by the flowchart. From this patients identified six key quality characteristics: **comfort** (relief of physical pain and provision of emotional support for both patient and family to help deal with fear and anxiety), **convenience** (respect for patient's preferences and time), **caring** (concern for the patient's well being and respect for his or her unique values, needs, and individuality) **communication** (provision of education and information to patients in a timely and easily understood manner), **certainty** (patients confidence in the reliability, coordination, integration, and continuity of care as well as preparation for what lies ahead), **costs (to patient)** (nonreimbursed medical expense, particularly medications, time from work (lost wages), and travel time and expense. The researchers then created a patient based quality measurement tool assessing each step in the patient flow sequence with the six key quality characteristics identified by the patients. From the results of their survey the researchers identified the particular areas in the process that needed attention. Improvement teams were created with front-line persons from each target area to examine necessary changes in the process. In conclusion, follow up surveys assessed whether the needed changes were accomplished.

These examples illuminate current efforts in the healthcare industry to develop models to incorporate the experiences and requirements of patient consumers, as well as other customers, into quality endeavors. This trend has also begun to extend into the mental healthcare arena, though the development is not nearly as advanced. Some
(Barnette & Clendenen, 1996; Chowanec, 1996; Sluyter, 1996) mental health treatment facilities are attempting to implement continuous quality measures in the form of Total Quality Management (TQM). However, in reviewing these ventures there is a paucity of methods to generate patient experiences and use these factors to plan and design improvement enterprises. Sluyter and Berman (1996) cite the unique challenges associated patients with limitations or mental health considerations as a primary roadblock to taking this next step.

The following study addresses the challenge to develop models to move one step further in bringing patients into the improvement process in mental health settings. Rather than designing quality efforts, implementing them, and assessing the impact on patients, this study brings the patient into the design phase of the improvement enterprise. Patient experiences and evaluations were assessed to develop greater understanding of the interface between the multiple levels of a hospital when seeking mental health services. The data generated will eventually be presented to a group of internal stakeholders which may generate incremental improvement efforts as well as challenge the fundamental components of the service provision process (Berman, 1995).

**Systems Theory**

Systems theory provides a useful framework for understanding the principles of performance improvement and the necessity to include patients in the process. The premises of performance improvement hinge on the recognition of the interdependence of people and processes in an organization. The improvement efforts involve
individuals/units within the hospital defining parameters or boundaries to demarcate a system working to accomplish core functions within the hospital. This system or self-defined group cannot be understood in terms of component parts, but must be viewed as a whole (Whitchurch & Constantine, 1993). This is congruent with the shift from strategizing improvement endeavors with individuals within departments to examining the interface between individuals and processes organized around a goal or function. In essence, the shift from organizing improvement around structure (e.g. departments) to function (e.g. patient care) and process necessitates a systemic perspective. This is analogous to the shift in psychotherapy from looking solely at intra-individual difficulties to examining intra- and inter-individual difficulties (Becvar & Becvar, 1993). In this analogy the problems are no longer seen as deficits within individuals but rather patterns of behavior and interactions among individuals.

Previous quality efforts designed along structural lines were more easily defined and “tidy” but did not adequately capture the complexity of the healthcare organization. As such, many of these efforts failed to accomplish the desired outcomes. Instead, the failed effort resulted in people blaming “the system.” The Joint Commission recognized this shortcoming and strived to place emphasis on the interrelationship of processes and people across departmental lines. Systems theory would indicate since this is a human system defined by interrelationship around some function, it has the capability to be self-reflexive (Constantine, 1986). Thus, performance improvement requires those within the system to make their own behavior and interactions the focus of examination.
In this process of examination, it is important to understand the forces that influence change or stability of the system. Systems theory would dictate that each system balances morphogenic and morphostatic tendencies (Becvar & Becvar, 1993). Morphostasis implies that the system organizes itself in such a way as to maintain the current state. In contrast, morphogenic forces are system enhancing behaviors allowing for growth, creativity, altering rules and ultimately change. The mechanisms which promote the change amplifying or change attenuating are feedback loops (Kantor and Lehr, 1975). Negative feedback loops act in such a way as to promote stability of a system, whereas positive feedback loops act to alter the system in some fundamental way (Senge, 1990). In the present setting the discussion between and among patients and staff adds the necessary feedback loops to create the cybernetic recursion to stimulate morphogenesis.

In the healthcare setting, the performance improvement effort acts in a similar manner to a therapist working with a family from first order cybernetic perspective. The therapist attempts to understand the family and then intervene in such a way as to promote change meeting the needs of the family. These changes may fit within the rule system of the family (first order change) or they may alter the family in some fundamental way (second order change). In much the same way, interventionists in the hospital setting rigorously analyze the system and attempt to alter the processes that occur either by incremental improvements or altering the design in some fundamental way. The
information promoting stability or change results from information gathered in the
analysis.

This study suggests the performance improvement system must maintain openness
of boundaries and build in a feedback mechanism to permit the flow of information from
patients. Maintaining this posture re-focuses the system on the goal for which the system
has been organized; to serve patient’s needs. The inputs from this component of the
system add an important voice in the morphostatic/morphogenic balance. Gaining this
voice in the design phase of quality endeavors provides a mechanism to increase the
likelihood the information will be addressed in a more timely manner. Further, the self
defined healthcare system’s boundary permeability and willingness to incorporate the
inputs from patients influences how the quality improvement effort impacts patients.

**Family Therapy**

The process of family therapy involves a pragmatic expression of the application of
systems principles. The family therapist attempts to understand the rules of the family by
attending to interactional patterns and the meaning that is generated through these
interactions (Watzlawick, Beavin, and Jackson, 1967). However, the family therapist
moves beyond simply looking at the family as if it were a black box and could be
manipulated from without. Rather, the family therapist adopts a second order cybernetic
perspective and recognizes she/he is an active participant in the observed system (Keeney,
1983). This promotes a meta-step to include the observer’s role in constructing the reality
that is under observation (Mayhew & Alessi, 1995).
Collaborative Languageing Systems

Promoted by Harlene Andersen and Harry Goolisian, the collaborative languageing approach suggests that systems are not defined by social organization or biological relatedness but rather by people who are organized in conversation about an issue or problem (Wulff, 1995). Through this conversation the members of the system go through a process of defining and giving meaning to the problem or issue at hand (Andersen and Goolisian, 1988). The conversation in therapy then becomes an exploration through dialogue of ideas of each member of the system. The evolution of these ideas leads to the dissolving of the problems or issues and change in the system (Andersen & Goolisian, 1988). As stated by Andersen and Goolisian (1988):

The role of the therapist is that of master conversational artist - an architect of dialogue - whose expertise is in creating a space for and facilitating a dialogical conversation. The therapist is a participant-observer and a participant-manager of the therapeutic conversation. (p. 372)

In order to maintain this stance the family therapist must communicate a genuine interest in the client’s reality. A stance of “not-knowing” is suggested (Andersen and Goolisian, 1992). This implies the therapist does not assume prior knowledge based on his/her own theory or experience. Rather, the therapist maintains the state of continually being informed by the experience and expertise of the client(s) (Andersen & Goolisian, 1992). "The therapist’s role, expertise, and emphasis in this conversational process is to develop a
free and open conversational space and to facilitate an emerging dialogical process by which 'newness' can occur" (Andersen & Goolisian, 1992, p. 12).

In much the same manner as the therapist collaborating with families to create change through conversation, the researchers will seek to create a conversational space with patient participants to promote understanding and exploration. Further, taking a stance of "not knowing" invites participants to explain in detail the full measure of their experience in interfacing with the mental health delivery system (Andersen & Goolisian, 1992). In the "not knowing" approach, the research attempts to prevent from assuming understanding of the patient perspective. Rather, the researcher curiously questions participants to draw out and understand the patient perspective (Cecchin, 1987).
CHAPTER 3

METHODOLOGY

Assumptions and Rationale for a Qualitative Design

Given the nature of the study, a qualitative methodological approach appeared the appropriate mode of inquiry. Researchers operating out of the qualitative or phenomenological perspective seek to understand the meaning of events, actions, and interactions in their naturally occurring contexts from the participant's perspectives (Moon, Dillon, & Sprenkle, 1990). As such, research questions in qualitative methods attempt to guide the initial phase of inquiry while allowing flexibility in the design to be more fluid and responsive to data. Such flexibility is generally not present in most quantitative designs (Lincoln & Guba, 1985; Patton, 1988).

The assumptions associated with qualitative inquiry methods can be best understood when contrasted with the quantitative paradigm. On the ontological level, quantitative approach assumes there is an "objective" reality "out there" which can be accessed through appropriate methods (Creswell, 1994). In contrast, assumptions of qualitative methods recognize reality as constructed by the individuals involved in the inquiry and there is no "objective reality" to be discovered. Guba (1981) states, "that there are multiple realities, that inquiry will diverge rather than converge as more and more is known, and that all 'parts' of reality are interrelated so that the study of any one part necessarily influences all other parts" (p. 77). Further, at the epistemological level, quantitative research holds that the researcher maintains separation from the observed to
maintain objectivity (Moon et al., 1991). The qualitative stance assumes the researcher seeks to minimize the distance between the observed and the observer (Creswell, 1994). Further, it is assumed the observer cannot fully create separation from the observed regardless of systematic attempts to reduce subjectivity (Moon et al., 1991).

Given the assumptive differences, the qualitative paradigm provides a useful approach for studying the complexity of human relationship interactions. As is stated by Joanning and Keoughan (1997):

The strength of this approach to research is its evolutionary nature. Traditional research assumes a theoretical model which is established prior to beginning of a project and is not changed during the project. Such an approach does not take advantage of information generated during the course of the project. (p. 3)

Further, qualitative methodology promotes understanding of human phenomena grounded in the experience of research informants (Joanning, Newfield, & Quinn, 1987).

In qualitative methods the primary tool of investigation and analysis is the researcher. Data are mediated through this human instrument rather than through inventories, questionnaires, or machines (Merriam, 1988). This permits responsiveness to participant interactions allowing the researcher to comment on both process and content occurring during the data collection. The researcher then has the opportunity to continually “improve the tool” during the process to be responsive to the evolving design. Further, immersion in the study context provides information that might otherwise be lost to less context sensitive methods.
There is a wide range of data collection approaches in qualitative research. One such data collection tool is the focus group. A focus group collects a small number of individuals for discussion around some common organizing theme (Joanning & Keoughan, 1997). The groups typically range from three to twelve persons with one or two facilitators. The individuals are typically a relatively homogenous group of people or share a common experience (Patton, 1987). In the present study, focus groups were the primary data collection tools based on the advantages of economy of time, flexibility, direct contact between researchers and participants, and the ability to capture interaction among participants (Krueger, 1994; Morgan, 1988). Moreover, through the conversational process a synergistic effect resulted in the production of data or ideas that might not be otherwise uncovered or generated (Stewart & Shamdasani, 1990).

**Researcher Profiles**

**Primary Researcher**

The primary researcher and group co-facilitator is a 27 year old white male. As a doctoral student in a Human Development and Family Studies Department with a specialization in Marriage and Family Therapy, this therapist completed a one year clinical internship at the mental health clinic under study. After completing the internship the primary researcher obtained full-time employment at the facility under study. In this role the primary researcher had continual contact with patients, becoming increasingly aware of their varied experiences negotiating the system. Additionally, the researcher had approximately four years experience as a clinician. Through the course of employment
and education, the researcher had involvement facilitating therapy groups and observing therapy research related focus groups.

With training from a family systems perspective the researcher understood the patient complaints as examples of breakdown between interdependent aspects in the system. Patterns emerged illuminating how different parts of the system mutually influenced each other impacting the provision of mental health services. Consequently, the researcher began exploring intra-clinic attempts to improve the system. The project evolved from these initial curiosities and the researcher's interest in improving mental health service delivery.

In addition, the researcher recognized the following personal assumptions prior to beginning the exploratory evaluation. These assumptions developed through the researcher's experience as a clinician, researcher, and participant in the site under study. The following assumptions "calibrate the researcher as the instrument of measurement."

- One cannot assume experiences of consumers without in-depth investigation.
- Mental health patients can provide valuable evaluations of the services they receive.
- Those affected by improvement results should participate in inform those interventions.
- Due to the exploratory nature of this study, qualitative methodologies are most appropriate.
• Having the researchers as the primary tools of investigation permits flexibility and responsiveness to participants, capturing a more in-depth assessment of their experience.
• Customers/patients may provide information which questions processes within the mental healthcare system suggesting potential changes.
• Researchers should first engage in exploratory research before confirmatory research.

Co-researcher

The co-researcher was a 31 year old white male. Like the primary researcher, this researcher was a doctoral student in Human Development and Family Studies with a specialization in Marriage and Family Therapy. This researcher also completed a clinical internship at the site under study and had been employed for two years beyond this internship. In addition, this researcher had approximately six years of clinical experience as a Marriage and Family Therapist. The co-researcher worked collaboratively with the primary researcher through all phases of data collection and assisted in analysis.

Observers

The three individuals serving as focus group observers all received training in qualitative methods. Two observers were doctoral level students in a Marriage and Family Therapy program. One of the doctoral students was a Caucasian male in his early 40's who was completing a clinical internship at the site under study. This individual had nearly 15 years of mental health clinical experience in a variety of outpatient settings prior to his involvement. The other student was a Caucasian female in her late 30's. This
individual had approximately 3 years of clinical experience prior to her involvement in the study. The third observer had earned a Ph.D. in Marriage and Family Therapy and was experienced in qualitative methods having completed her dissertation utilizing such methodology. This third observer was a Caucasian female in her early 40's who was employed as private practitioner and an employee assistance provider.

**Dependability Auditor**

The researcher’s major professor served as a dependability auditor supervising all aspects of the study. The auditor has extensive experience directing qualitative projects. The auditor ensured the project conformed to accepted practices in qualitative research throughout the studies duration.

**Process Auditor**

The process auditor was a doctoral level licensed Marriage and Family Therapist with experience utilizing qualitative methods. The auditor was a Caucasian female in her early 50's with extensive experience working in psychiatric inpatient and outpatient facilities as well as in a managed care organization. Further, she is the president of a consulting firm specializing in human systems assessment, intervention, and training. In this capacity the auditor examined the overall research process critiquing the methods and results. The process auditor provided a letter summarizing her conclusions (See Appendix 5).
Role of the Researcher

In quantitative methodological approaches, the researcher must be objective and not inject bias into the research process. To pursue the objective ideal, researchers follow strict protocols and attempt to limit confounding effects on results (Badia & Runyon, 1982). In essence, the researcher maps the procedure including all necessary data collection instruments at the study's outset and follows the map until the project is completed. Contrastingly, in qualitative research the researcher is the primary data collection instrument. Like quantitative research, the qualitative researcher must follow detailed methods to establish trustworthiness. This involves ensuring interpretations and assertions established represent the experience of participants. Further, researcher biases are made as explicit as is possible to allow the consumer insight into the interaction of researcher and data. However, unlike quantitative methods, qualitative epistemological assumptions allow the researcher to be responsive to information learned through the course of the study and modify as necessary (Creswell, 1994; Marshall & Rossman, 1994).

In the present study, the two primary researchers were involved in all phases of data collection including design, participant recruitment and all focus group discussions. This prolonged engagement allowed the researchers the ability to adapt questions throughout the discussions to ensure all relevant points were addressed. Further, the researchers' skills facilitating the process of discussions permitted responsiveness to verbal and nonverbal communication encouraged greater "mining of the depths of meaning" (McCracken, 1988) of participants' experiences.
Site Approval

Access to the site and participants was gained through a sequential process. First researchers approached the Outpatient Mental Health Department Director for explicit permission to identify and proceed questioning the appropriate representatives in the hospital hierarchy. Second, the researchers contacted the Director of Medical Information Management who was responsible for the hospital wide performance improvement. After obtaining verbal permission to proceed with the project, the researchers drafted a complete proposal including, informed consent, specific research procedures to be utilized, and the projects utility to the hospital (Bogdan & Biklen, 1992) (See Appendix 1). This proposal was distributed to the Outpatient Mental Health Director, the Director of Medical Information Management, the Director of Community Relations and Development, and the hospital Medical Director. Each expressed interest and support for the project. Last, written approval (See Appendix 1D) was obtained from the Medical Director and the hospital Human Subjects Committee to sanction the project initiation.

Sample

Participant Recruitment

Researchers selected participants using a homogeneous opportunistic, purposive sampling strategy. The rationale for a relatively small homogenous group involved the intention of choosing information rich participants for in depth study (Patton, 1987). This approach seemed most appropriate given the intent of the study was not to generalize to a
larger population, but rather generating a vivid description of the patient experience in the particular setting.

The researchers developed a number of criteria for participant involvement. First, the patient informants had to be at least 18 years of age to ensure validity when signing informed consent. Second, participants had to be receiving services from the outpatient mental health clinic of the hospital under study. Patients were not restricted by diagnosis, however those experiencing active psychosis were excluded from the study. The determination of the presence of active delusions/hallucinations was based on clinical judgment of the co-facilitators and diagnostic information gleaned from psychiatric records. In addition, patients had to be a minimum level of 45 on the global assessment of functioning (GAF) scale. The GAF is a clinical rating scale considering the psychological, social, and occupational functioning of an individual. The scale is a continuum from 0-100 with the 0-10 range representing persistent danger of severely hurting self or others and the 90-100 range representing superior functioning in a wide scope of activities (Diagnostic Statistical Manual, 1994). The GAF scale is listed on the fifth axis in the traditional five axis diagnosis. According to the GAF, individuals in the 41-50 range are showing signs of more serious symptoms including serious impairment in social and occupational functioning. Thus, this range was considered the minimum level of functioning to permit constructive participation in focus group discussions.

The researchers solicited patient participants by the following methods: 1) flyers posted around the hospital requesting patient volunteer participation in two focus group
meetings (See Appendix 2) 2) mental health therapists on staff were asked to provide letters to their patients informing them of the study with directions as to who to contact if interested (See Appendix 1A), and 3) the same letters describing the study and requesting participation were placed at the front desk easily accessible for patients when they were scheduling. These methods were employed for two weeks prior to the first scheduled patient focus group.

Patients who responded to the flyers, expressed interest to support staff or therapists received a letter describing the scope of the project. The researchers obtained potential participant’s names and contacted them to discuss any questions and solicit their involvement. If individuals expressed willingness to participate and met the established criteria, the researchers scheduled them up for one of the two focus groups. The participants understood each group would meet a minimum of two successive times.

Participant Description

Initially 20 patients indicated interest in focus group participation. Of those expressing interest, 11 patients participated in the focus groups and individual interviews. The remaining nine participants were unable to meet the full requirements of participation due to schedule conflicts. In the event redundancy of information was not reached in the focus groups, the remaining volunteers were asked if they would participate in individual interviews. All patients agreed to individual interviews if necessary. Of the 11 patient volunteers, 10 participated in the focus groups (one patient participated only in an individual interview). Four patients were in group A and six in group B during the first
round of interviews. For round two, the same four patients returned for group A. Five of the original six patients returned for group B. In addition, late in the study, another patient specifically asked to participate in the study. Given this individual met the criteria for participation but had missed the patient only focus groups, he was asked to provide an individual interview. The following section provides a thick description of the project participants. It must be noted, the author attempted to provide as complete a description as possible without compromising the confidentiality of participants. However, the author omitted some information or provided general ranges for numeric data to protect participants’ identities.

Patient one (P1) was a white male in his middle 60s. The patient was married and had four children and nine grandchildren. The patient indicated his joint income with his spouse was in the $10,000 to $20,000 range. The patient’s employment status was retired. He reported his most recent work experience in assembly work. The patient received education through the 12th grade. The patient reported two primary insurance sources, Medicare and private insurance. Patient one had been involved with adult outpatient mental health for approximately 40 years. The patient has carried a number of axis I diagnoses but most recent was Schizoaffective Disorder with ongoing psychosis comorbid with alcohol dependence in full remission. The patient did not carry any axis II diagnosis. The axis IV psychosocial and environmental stressors indicated for this patient most recently included, adjustment to retirement, financial difficulties, and concerns regarding social isolation. The patient’s global assessment of functioning (GAF) was 50. In recent
years the patient has had seven inpatient mental health admissions at the facility under study.

Patient two (P2) was a white male in his middle 50s. Patient two divorced recently for the second time. The patient has four children. The patient reported his most recent income in the 0-$10,000 range. The patient reported being unemployed most recently. His last work experience was as a self-employed small business owner. The patient received education through grade 11. The sole source of insurance for this patient was social security disability. Patient two indicated being involved with the outpatient mental health clinic for approximately three years. The patient’s axis I diagnosis was Major Depressive Disorder recurrent, with significant anxiety and agitation. Axis II diagnosis was Personality Disorder Not Otherwise Specified. The axis IV psychosocial and environmental problems included moderate to severe stressors concerning conflict with ex-spouse. Global assessment of functioning was 50. Number of inpatient admissions was unavailable.

Patient three (P3) was a white female in her middle 40s. The patient’s marital status was divorced with no children. The patient reports no income source. Patient three was unemployed with a disability claim pending. The patient’s most recent work experience was as an administrative assistant in 1993. The highest level of education achieved included high school diploma with approximately two years of college. The patient did not have any insurance and therefore qualified for a medically needy spend down which resulted in receiving free care. The patient was applying for disability
insurance. Patient three had been involved with the outpatient mental health clinic for approximately two years. The axis I diagnosis was Mood Disorder due to pain. There was no axis II diagnosis noted by her psychiatrist. Axis IV stressors included an injury due to a automobile accident and the consequent inability to work. The global assessment of functioning was in the 50-55 range. The patient had two admissions to the facility's inpatient mental health unit.

Patient four (P4) was a white female in her middle 40s. The patient was married but experiencing considerable relationship difficulties and consequently separated from her spouse. She reported having five children. The patient indicated income in the $20,000 to $30,000 range. The patient reported employment in clerical positions. The highest level of educated received was high school diploma plus one and one half years of college. The patient indicated private insurance as primary with the hospital covering the 25% co-pay if applicable. The patient indicated one year and two months of involvement with the outpatient mental health clinic. The patient carried an axis I diagnosis of Depressive Disorder Not Otherwise Specified. The axis II diagnosis was Cluster B personality traits. The axis IV stressors included continued family conflict, financial stress, spouses chronic illness and the loss of child. The global assessment of functioning was 70. The patient had one admission to the facility’s inpatient mental health unit.

Patient five (P5) was a white female in her late 30s. Patient five was divorced with four children ranging in age from six to sixteen. Her oldest child was from her first marriage. The patient has three children from her second marriage. She divorced her
second husband. The patient reported an income range of $10,000 to $20,000. The patient did not have any outside employment. She received social security disability. The patient received education through the 12th grade. The patient’s primary insurance source was social security. The patient had been involved with the outpatient mental health clinic for approximately two years. She carried an axis I diagnosis of Dysthymic Disorder vacillating from depression and anxiety to aggression. The axis II diagnosis was Borderline Personality Disorder. The axis IV stressors included inadequate social support, preoccupation with past lack of support, and undifferentiation from family of origin. The axis five global assessment of function was in the 55 to 58 range. No admissions to the inpatient unit were noted.

Patient six (P6) was a white female in her late 20s. The patient was single and never married with no children. The patient reported income in the 0 to $10,000 range. The patient did not work at the time of the focus group. She indicated previous employment in the insurance industry. The patient received a high school diploma. The patient reported no insurance and therefore received a medically needy spend down which equated to free care. The patient had received treatment at the outpatient mental health clinic for approximately three years. The primary axis I diagnosis was Major Depressive Disorder, recurrent, with moderate to severe anxiety. The patient carried an axis II diagnosis of Personality Disorder Not Otherwise Specified. The axis IV psychosocial stressors included family difficulties, job loss, parents divorce, and sexual abuse. The
global assessment of functioning was 55. The patient had one admission to the inpatient unity.

Patient seven (P7) was a white female in her early 30s. The patient was divorced one time. At the time of the focus group she was cohabiting with her partner. She reported having two children. The patient reported annual income in the $20-30,000 range. The patient was interviewing for employment during the time of the focus groups. Her most recent work experience was in corrections. Level of education and insurance source were not available. The patient carried an axis I diagnosis of Major Depressive Disorder and Polydrug Dependence in remission. The patient did not have an axis II diagnosis. The axis IV stressors included the death of two siblings in the past three years, financial difficulties with paramour, aggravating injuries from an auto accident, and parenting difficulties. The most recent global assessment of functioning was 95. The patient did not have any inpatient admissions.

Patient eight (P8) was a white female in her middle 30s. The patient was married with one previous divorced. The patient had two children, one from her first marriage and a second child from her current marriage. The patient reported one grandchild. The patient indicated income in the $30,000 to $40,000 range. The patient was not employed at the time of the focus groups. She reported previous employment in market research. No information was available regarding level of education. The patient indicated she had private insurance. The patient carried an axis I diagnosis of Major Depressive Disorder recurrent, superimposed over Dysthmic Disorder and Anxiety Disorder Not Otherwise
Specified. She did not have any axis II diagnosis. Axis IV stressors included inability to work due to illness. The global assessment of functioning was 55. She did not have any admissions to the inpatient unit.

Patient (P9) was a white female in her late 30s. The patient's marital status was divorced. She had been married twice with six children from her first marriage. The patient indicated income in the $10,000 to $15,000 range. The patient was not employed at the time of the focus groups. The patient indicated she was a government employee for a number of years until her illness forced her to discontinue employment within the last three years. The patient receives disability income from this position. The patient indicated she completed her education through grade 12. The patient reported her most recent insurance source was Medicaid. Time of involvement with the outpatient mental health clinic was approximately one year six months. The patient carried axis I diagnoses of Bipolar Disorder, type II, versus atypical Depressive Disorder with emotional lability, Post-Traumatic Stress Disorder, and Substance Dependency (alcohol dependency in alleged remission, cannabis dependency continuous, stimulants/methamphetamine dependency continuous). The axis II diagnosis was Cluster B Personality Traits. Axis IV stressors included loss of custody of children and unemployment. The global assessment of functioning was 55. Records indicated the patient experienced seven admissions to the inpatient mental health unit at the hospital under study.

Patient ten (P10) was a white female in her early 50s. Her marital status was divorced and she indicated being divorced a total of five times. The patient reported
having one child. The patient’s work status was unemployed with no source of income. Educational information was not obtained for this participant. The patient had no source of insurance and therefore received free care. The patient indicated seven months of involvement with the outpatient mental health clinic. Her axis I diagnosis was Major Depressive Disorder recurrent, Nicotine Dependence, Alcohol Abuse, and Cannabis Abuse. She carried an axis II traits toward passive/aggressive and compulsive behaviors. Axis IV psychosocial and environmental stressors included a history of suicidal ideations and behaviors, relationship difficulties, and lack of financial resources. The global assessment of functioning was approximately 55. Records indicated the patient had one admission to the facility’s inpatient unit.

Patient eleven (P11) was a white male in his early 40s. The patient was single, never married with no children. The patient reported no income source at the time of the interview. The patient reported his employment history as primarily positions in the music industry. His highest level of education completed was grade 12. The patient had no insurance source and therefore received free care through a medically needy spend down. The patient indicated involvement with the hospital outpatient mental health clinic on an inconsistent basis for approximately seven years. The patient carried axis I diagnoses of Obsessive Compulsive Disorder, Major Depressive Disorder, and Alcohol Dependence. The patient did not carry any axis II diagnosis. Axis IV stressors included unemployment and social isolation. During the seven years of involvement with the hospital the patient reported approximately 150 admissions to the inpatient/detoxification unit.
The reader is directed to Table 1 for an overview of patient participation throughout the project. Table 1 details the frequency of patient participation in chronological order.

Setting Description

The outpatient mental health clinic is located in a medical center classified as a small (200 licensed bed capacity), urban (city population over 100,000), county funded hospital. Further, out of 27,851 inpatient days for the 1994-1995 fiscal year, 15,066 of those days were classified under mental health. Also, out of 202,409 ambulatory care visits for the same period, 42,845 were classified under Psychiatric Outpatient (Newsletter, 1996). The patients served by the mental health organization are predominantly Caucasian and of low social economic status. Further, the vast majority of the mental health patients do not carry insurance and are funded through public resources.

The researchers conducted the focus groups and individual interviews on site at the medical center. The context in which the focus groups occurred was a medium sized room (called the “group room”) located in close proximity to the outpatient mental health reception area. The capacity of the group room was approximately 15 to 18 adults. The group room was well lit with natural and incandescent lighting. The group room adjoined a smaller room equipped with a large one-way mirror to permit observation. The group room was wired with extremely sensitive microphones which led to speakers located in the adjoining observation room. Finally, the observation room came equipped with a dual cassette tape deck connected to the microphones to permit audio recording capability.
Table 1. Total number of patient participants (coded in the first column) interviewed including dates in chronological order of all focus group interviews

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<sup>a</sup> Participated in an individual interview in addition to group participation.

<sup>b</sup> Only participated in an individual interview.
Study Procedure

After scheduling patients, the following protocol occurred:

Patient Focus Groups Round One

- Patients who agreed to participate received a reminder postcard five days before the focus group.
- Patients were called the night prior to the focus group and again reminded.
- On the day of the focus group patients the research team greeted patients and provided with refreshments and the option to enjoy a light meal throughout the group.
- Patients were briefed on the purpose of the project highlighting the fact that no deception would be involved at any point. The principles of confidentiality were discussed. Participants understood there would be no identifiers connected to their responses, rather, researchers were interested in their information as a whole.
- Next participants read the informational letter and signed the informed consent.
- After these initial introductions the facilitators asked a number of open ended questions regarding the patients' experiences receiving services in this system.
- After the 1 & 1/2 hour meeting, the participants were reminded of the next focus group scheduled for three weeks

Patient Focus Groups Round Two

- The research team employed the same protocol to remind patients for the round two focus groups.
- When arriving patients were greeted and provided with refreshments and a light meal.
• The researchers convened the group and provided each participant with an initial memberchecking document while briefly describing the process used to derive the document.

• Each group took approximately 30 minutes and read the membercheck document noting any questions or comments. If difficulties with the initial categories arose, the researchers noted them and made appropriate corrections. Only a few participants raised questions and those were related to how staff might interpret their comments. Patients did not want any misinterpretation. After completing the review of the summaries the participants signed and dated the document. This step verified each participant had examined the summary and commented on any areas of discrepancy. Such measures created further steps toward credibility of the findings.

• The researchers then proceeded with questions generated from the transcripts and those not addressed from the previous discussion.

• Upon completion of the focus group the facilitators thanked patients for their participation and told some of them might be called with a request to participate in a joint focus group with staff.

Conjoint Patient/Staff Group One

• Selected members from the original focus groups were asked to participate in a conjoint focus group with an interdisciplinary staff group (for a description of the staff participants see Kerber, 1997). Since almost all the group members were strong informants the researchers struggled with whom to ask to continue participation. Only
one member was purposely not chosen as she tended to be a group monopolizer. Due to scheduling conflicts and the desire to keep the group manageable four patient informants were chosen for the combined patient staff group.

- Patients received a copy of the initial synthesis statements and themes from the staff focus groups prior to joining the session.
- The same procedure was followed when the group began including the greeting and refreshments.
- The facilitators allowed time for introductions between staff and patients.
- Again, all participants received full packets of the initial synthesis statements and themes from both patient only and staff only groups and given 10 minutes to read and refresh their memories.
- The facilitators structured the group such that patients would first talk and staff listen and then reverse the process.
- The driving questions were as follows: “Thinking about improving outpatient mental health, things would be better if...” (Reiley et al., 1996) “If we had the opportunity to ask staff to complete the same sentence would you think they would say?” “Imagine you are sitting with the CEO and board of directors and you really had their ear how would you tell them to improve outpatient mental health?”
- After giving patients ample time to address the questions, the facilitators switched the “talker” and “listener” roles to allow staff to respond.
• The facilitators asked staff, "What did you learn when listening to these patient informants?"

• After the staff responded, the one and a half hour meeting drew to a close. Another conjoint focus group discussion was scheduled.

Conjoint Patient/Staff Group Two
• The same patients and most of the same staff returned. Similar procedures for greeting and providing refreshments were followed.

• The facilitators developed a less structured setting as compared to the first conjoint group. The researchers presented follow up questions from the first conjoint group.

• Additionally, the facilitators introduced questioning about where the information generated from the groups should be disseminated. All participants indicated they wanted their information summarized and provided to upper administration.

• The facilitators asked participants for their involvement in a follow-up focus group approximately three to four months in the future. All agreed to participate.

Conjoint Patient/Staff Group Three
• The last focus group served as a final memberchecking effort. All staff and patients were asked to respond to statements prepared by the researchers. The researchers generated Combined Patient/Staff Thematic Statements by presented themes that emerged from the analysis related to information discussed in the conjoint groups. These statements were paired with a Likert scale to determine the degree to which the
participants agreed with each theme (see more complete discussion of the statements under Data Analysis).

- After the conjoint group responded to and commented about the Combined Patient/Staff Thematic Statements, the patients and staff were separated. The patients met with one facilitator and the staff with another. The patients were asked to respond to the Patient Thematic Statements and the staff to the Staff Thematic Statements.

- After completing the respective statements, discussing the themes and providing justification for certain responses the groups were concluded. It is important to note this final step was very extensive with the final patient group lasting two hours and twenty minutes.

**Grand Tour Questions**

In a qualitative inquiry questions tend to be open-ended and discovery oriented. The researcher attempts to approach phenomena with as few a priori assumptions as possible (Moon, Dillon & Sprenkle, 1990; 1991). Questions tend to be holistic and stated in very general terms to prevent guiding participants into specific answers. Further, question protocols may change as the researcher ‘learns’ from participants. This stands in stark contrast to quantitative methodological questions that are carefully formulated at the outset, tend to be reductionistic and focus on specific relationships remaining unchanged through the research process (Cavell & Synder, 1991).
In the present study, initial “grand tour” (Spradley, 1979) questions were
developed to access patient experiences and evaluations of specific system aspects without
artificially limiting the inquiry. As such, researchers posed questions in an open ended,
non-directional fashion. Many of the particular question phrasings borrowed stylistic
components from a study examining client perceptions of therapy effectiveness in a
university-based training clinic (Sells, Smith & Moon, 1996). The question ordering
matched the temporal sequence the researchers observed patients experiencing moving
through the system. Early questions prompted participants to describe their general
experience as they encountered the system. Interestingly, participants frequently answered
later questions through the course of their response to the first few general questions.

Prior to utilizing the following questions in the focus group situation, the primary
researcher enlisted a patient who served as a mental health consumer advocate to review
the questions. This patient provided insight regarding wording and ordering of questions.
The resulting grand tour questions are listed in Table 2.

Data Analysis Procedures

Qualitative data analysis is a process of bringing order, structure and developing
meaning out of the extensive collection of data (Marshall & Rossman, 1994). The
researchers utilized the following steps to “make sense out of the narrative data” (Tesch,
1990) and develop an organizing scheme. The researchers developed a hybrid method for
establishing an organizing system borrowing from the Developmental Research Sequence
(Spradley, 1979) and Tesch’s steps to an organizing system (1990). This analysis process
Table 2. Grand tour questions

1. If I were to come to you as a friend never having been to (Clinic name) Outpatient Mental Health before and asked you to please tell me what your experience was like, what step-by-step description of your experience of Outpatient Mental Health would you give me?

2. As if talking to a fifth grader, would you give me a description of what you experience when you come to (Clinic Name) Outpatient Mental Health?

3. On a given day when you come to an appointment, can you tell me step-by-step what you have to do from the time you come for your appointment until you leave?

4. Who are all of the different people you come in contact with, either in person, through the mail, or through any other form of communication?

5. What was/is your experience setting up your first appointment?

6. What was/is your experience with your intake interview?

7. What was/is your experience with the secretarial services?

8. What was/is your experience with registration?

9. What was/is your experience with managed care?

10. What was/is your experience with the therapy staff?

11. What was/is your experience with billing?

12. What was/is your experience with the pharmacy?

13. If you could change this organization in any way you wanted what would you do?

14. Things would be better if.....

15. What is your experience of this process of being interviewed about your opinions regarding outpatient mental health?
began with data collection and continued through the write-up phase of the project.

- The researchers contracted with a support person to have the audio tapes transcribed.

- The researcher listened to audio tapes and corresponding transcripts to ensure consistent transfer of data and note analogical phenomena (voice tone, inflection, intensity). This step further acted to help the researcher recollect the data collection events.

- Through repeated exposure to the transcripts the primary researcher insured immersion in the data. Two different researchers, well versed in qualitative analysis, also reviewed the data. Finally, peer debriefing notes, field notes, and tapes were reviewed, assisting the primary researcher's decision making process for further text analysis. Idea segments were identified as the text was read and re-read. These segments represented one unified concept captured by a word, phrase, or sentence. The segments were denoted by underlining or highlighting the text. The criteria for defining idea segments were as follows:

  - Text that was important, or related to the research questions.

  - Text that was important to informants, based on direct acknowledgment, analogical indications, and/or broad group consensus.

  - The text was then de-contextualized (Tesch, 1990) taking these idea segments, which were grounded in the language of informants, and grouping them based on some emergent commonality. The synthesis of the idea segments created the initial themes and began the process of organizing the data. In addition, the peer debriefing
audiotapes, field notes, and observer notes were used to help determine the salience of particular concepts. As new data were collected, they were added to these initial themes. The analyst revised the organizing scheme if themes insufficiently accommodated the new material.

- Once the initial themes were constructed, they were organized as summaries in the temporal order in which they emerged in the focus groups. The analyst then exposed the participants to the summaries for their review (See Appendix 3). This step constituted the first formal member check to confirm the re-presentations reflected participant responses and recollections of focus group discussions. The participant feedback regarding the accuracy of the summaries was recorded and used to adjust themes.

- After making participant suggested adjustments, the themes were printed and cut apart for ease of grouping.

- Along with a co-researcher who served as an observer and had a high level of familiarity with the transcripts, the analyst grouped the themes into logically connected piles. The concepts linking the themes in each pile were then defined and such definitions constituted the initial domains. This process involved the researcher explicitly defining rules for inclusion. These rules resemble Spradley’s notion of “semantic relationships” (Spradley, 1979).

- Next the co-researchers took the themes and created “statements” corresponding to the themes. These statements were constructed by the two primary co-researchers.
The researchers took the themes emerging from the analysis and placed them in a survey format. Each statement was paired with a seven point Likert scale ranging from strongly disagree to strongly agree. These statements were created for themes emerging from patient only groups and conjoint patient/staff groups. The intent of creating such statements was to provide a second opportunity for participants to confirm the themes re-presented the information generated in the discussions. For an example of the statements (labeled Patient Thematic Statements) see Appendix 4. It is important to note, some of the patients' statements appear heavily loaded in a positive or negative direction. This loading reflects the nature in which the themes emerged from patient discussions.

- With the domains and corresponding statements defined, the researchers convened the final conjoint patient/staff focus group. The researchers presented the statements to participants as a second memberchecking step. As stated above, this step provided another opportunity for participants to confirm the researchers' re-presentations of the themes emerging from the focus groups. Given only four patients participated in the final conjoint group, statements were mailed to the remaining participants. All but two focus group participants completed the statements (one participant was out of state at a treatment facility and another was severely suicidal and dropped well below the GAF criteria.)
After compiling patient responses to the statements, the researchers incorporated new information generated from the final memberchecking step to refine the domains as necessary.

Last, the process auditor complete the summative process audit. This audit compared established domains, included themes, demarcated idea segments, and raw text for consistency. This audit resulted in fine tuning the domains, ended the re-contextualizing process and concluded the analysis procedure.

Methods for Verification

Qualitative researchers enlist a number of steps to ensure the results "can persuade his or her audiences that the findings of an inquiry are worth paying attention to, worth taking account of" (Lincoln & Guba, 1985, p. 290). In the present study a number of measures were taken to establish the readers' confidence in the truth value of the findings. Given the final determination of trustworthiness lies with the research consumer, steps toward credibility, dependability, transferability, and confirmability are presented to demonstrate indicators of rigor.

Credibility

Credibility or determining if the researchers have represented the constructed realities of the informants is analogous to internal validity in quantitative methods (Brotherson, 1990). Researchers utilized a number of methods to ensure credibility. First, the two co-researchers co-facilitated all focus groups during the study. Consequently, the researchers engaged in continual peer debriefing throughout the study.
Additionally, a third outside person serving as the observer debriefed the co-researchers for approximately 30 minutes after each focus group. This allowed researchers to test growing insights and expose thinking to peer review (Patton, 1990). Second, memberchecking methods were used after the first round of focus groups and at the last phase of data collection. Summary documents were provided to participants between the first and second rounds of focus groups. Additionally, patient participants responded to thematic statements (Patient Thematic Statements) at the conclusion of data collection. Both of these steps subjected the researcher’s organization of the data to the scrutiny of the persons who provided the information (Lincoln & Guba, 1985). Third, the researchers utilized negative case analysis, continually refining interpretations based on new information that did not fit the initial interpretations (Lincoln & Guba, 1985). Fourth, triangulation of data sources (field notes, audiotapes, transcripts, observer notes, peer debriefing tapes, and participant responses to statements) and researchers (two primary researchers and three observers) supported credibility of findings. Further, the primary researcher, the co-researcher and one of the observers completed varying levels of analysis independently. Emerging themes were compared to ensure the constructed realities of the informants were adequately represented. Essentially, this process served as a form of triangulation of researchers. Last, the researcher maintained prolonged engagement with the data, the site, and the participants, further ensuring credibility in this perspective.
Dependability

Dependability is concerned with consistency or stability and is comparable to reliability in quantitative methodology. In this study dependability was established through three primary methods, triangulation, audit trail and dependability audit (Lincoln & Guba, 1985). As mentioned above, the researcher established triangulation through multiple data sources and researchers. Also an uninvolved party, versed in qualitative methods conducted a dependability audit throughout the course of the project. The auditor examined interpretations, methods, and conclusions related to the study to ensure the maintenance of consistency and sound procedural rationale. Last, the researcher maintained a continual audit trail primarily focusing on day to day decisions related as the study progressed. Given the emergent method of inquiry, the audit trail served as a method to track the project development through the analysis and write-up phases.

Transferability

Transferability refers to applicability or generalizability of study results to other contexts. Transferability is analogous to external validity in quantitative methodology. The researchers used two specific measures to address this indicator of trustworthiness. First, the researchers provided a clear definition of the purposive sampling guidelines and methods used for soliciting participants. Second, a thick description of participant characteristics and the research context provides a detailed picture for the reader. This thick description enables the reader to make judgments regarding the fittingness of results to other contexts (Guba, 1981).
Confirmability

Confirmability refers to the notion of neutrality or objectivity in quantitative methods. This entails ensuring that all data can be tracked to their original source and the logic used to derive interpretations is explicitly stated (Guba & Lincoln, 1989). Two methods were utilized to address this indicator. First, triangulation of data source and researchers allows the development of the consensus process. Aberrant viewpoints are exposed and commonalties are emphasized. Second, explicit detail of the researchers audit trail demonstrates the logic used in analysis. Third, the process auditor examined the document in its entirety to verify that the interpretations made represented the data (Brotherson, 1990). Additionally, the researchers have attempted to remain aware and report their biases through the process detailing specific methodological and personal assumptions.
CHAPTER 4

OUTCOME OF STUDY

Results

The analysis process described previously yielded a number of domains of meaning relevant to the questions of interest. The themes are not organized in levels of importance, rather in relation to the ordering of the research questions posed by the study. Further, within each theme, participant comments are presented in the temporal order in which patients move through the system (e.g. enter parking lot, see secretaries, then registration, then providers, then get bill, etc.). Due to the evaluative purpose of the study some of the domains were both researcher imposed and informant derived. Patton (1990) describes researcher imposed domains as “analyst-constructed typologies” and participant derived themes as “indigenous typologies.” The primary difference in these two types of domains is the origin of the domain. The researcher imposed domains are developed apriori based on some desired evaluative question posed by the researcher. In contrast, participant derived themes emerge from the responses and interaction among the participants. These emergent domains are grounded in the experience of the participants and are not accessible to the researcher at the outset (Glaser & Strauss, 1967). The researcher imposed domains are particularly evident in domains regarding evaluations of experience with the mental health system and the focus group process. However, other domains were informant derived and did not directly relate to previously developed grand tour questions. This section of the paper discusses these domains and related themes.
derived from participant responses. Further, based on the “data as star” premise asserted
by Chenail (1995), researcher domains and themes are supported by verbatim excerpts
from the data. This allows the reader to move towards capturing the richness, breath, and
depth of participant responses.

For the reader’s ease, the following details the results section layout. The five
domains are presented in bold print followed by a succinct description. Corresponding
themes subsumed by the domain follow, further describing the related phenomena. Last,
text descriptions of individual statements or exchanges among participants are presented
to support each theme. Each text representation identifies the patient participant
responsible for the statement by an abbreviated code in parentheses. For instance (P2)
indicates a statement made by participant number two. Further, many themes have a
reference to the number of participants supporting the stated theme. When applicable,
these numbers are presented in parentheses in the thematic description. For example, if
seven participants supported a particular theme the author demarcated this distinction as
(seven participants) or (seven). The author generated these supporting numbers from two
sources. First, the author tabulated participant responses to the Patient Thematic
Statements and the Conjoint Patient/Staff Thematic Statements. Second, the author
counted participants’ references made to a particular theme in the focus group transcripts
for those individuals who did not complete the Patient Thematic Statements and the
Conjoint Patient/Staff Thematic Statements. Numerical information from these two
sources were added together to develop the ordinal data describing support of the
emergent themes. See Table 3 for an abbreviated list of the five domains and corresponding themes. A more detailed description of the domains follows.

**Domain 1: Evaluation of experience receiving services from the adult outpatient mental health system**

Through the course of focus group and individual interview discussions, participants identified a number of evaluative statements regarding perceptions of service provision. Some statements reflected positive experiences while others were framed as frustrations which participants found as cumbersome and at times antithetical to stress reduction. Participants often stated evaluative information in less explicit terms through contrasts. In addition to evaluative statements regarding specific services and people within the system, many participants provided information regarding their assessments of the system as a whole.

**Perceived positive aspects of outpatient mental health experience**

Participants provided some very clear indicators of quality in the system. Some indicators related to particular processes making their experience positive. Other comments addressed interpersonal interactions or relationships contributing to positive perceptions.

**Pre-registration.** One procedural aspect related to the registration process clearly reduced participant’s frustration level. As will be noted in the following themes, appointment registration was a particularly difficult process. If however, patients were pre-registered this frustration was nonexistent.
Table 3. Domains and corresponding themes

**Domain 1: Evaluation of experience receiving services from the adult outpatient mental health system**
- Perceived positive aspects of outpatient mental health experience
- Frustrations with mental health system
- Patients describe benchmarks for care through contrasts
- General evaluation: “Mixed bag but I’m still here”

**Domain 2: Communication Flow**
- Person to person
- Hospital function to hospital function
- Computer to computer

**Domain 3: Patient Dignity**
- Feelings about receiving services at the county hospital
- Factors contributing to dignity and positive perceptions of quality
- Factors that detract from dignity
- Communicative value of time

**Domain 4: Solutions: Things could be better if....**
- Current implicit solutions generated by patients
- Structural/procedural solutions
- Interpersonal solutions

**Domain 5: Focus group process with patients is valuable**
- Empowering to patients
- Suggestions for focus group
- Focus group communicates caring by the organization
- Need for focus group process in other areas of the hospital
- Value of focus group even if change does not occur
(P2) I am not speaking for the rest, but my personal experience is it is really quite a system. I walk in and I am already pre-registered. I just walk in and they call my therapist and say your next appointment is here. It’s ten minutes one way or the other you know and I usually just get a magazine. Then my therapist comes out.

Process after therapy. Another procedure which made the process of receiving services smooth and more satisfying to many participants (eight) involved scheduling future appointments in the therapist's office.

(P8) I like the fact that you don’t have to stop up there and make your next appointment. They got carbon now of appointment sheets, they just write it down and give you your copy and then the other copy goes to the desk so you don’t have to go back in there.

(F) Back in where?

(P8) The reception desk.

(F) O.K., so that is helpful?

(P8) Yes, it is, you can just walk right out the door, you don’t have to stop and talk to anyone because sometimes after you come from therapy sometimes you don’t feel like it.

(P2) Oh, really, really! You just walk out but I have to walk by the secretaries and...I got to wave good bye. They seem to realize you know that you just come out of a meeting or whatever and they seem to have that intuition that they know
this person might be a little...tight. And you are gone, that is it, no hassle, no
nothing.

(F) Is that the way you would like to end the meetings?

(P3) Yeah, and if you are upset over something and you know they are busy, I
mean you are not angry with them or anything, but you are just kind of wound up
you hit on something that was very difficult to deal with that day in therapy and
you know all your emotions are right there. Then you have to wait, even if it is
only for a couple people you have to wait, and all you want to do is get out of
there.

Therapy. The recognition of satisfying relationships clearly produced positive
perceptions of quality. Even in relation to the most frustrating aspects of the system
patient participants identified their relationships with people as reducing the negative
perception.

(P3) I want to make the comment that my treatment by the registration people has
been fine it is just registration is not the smoothest part of the process.

Further, the patients' relationship to their therapists appeared to be a crucial indicator of
quality. This is demonstrated in later descriptions of the overall satisfaction system rating.

Ten of the participants indicated their therapist's demonstration of caring and the rapport
built with the therapist contributed to the positive perceptions.
(P6) I feel very comfortable with my therapist, well, she was at day treatment when I was before, so I know her really good and I just feel like I have a really good bond with her and she really listens to everything.

(P4) That some people care, like someone said before, your counselor really cares. This is the way I feel, I really think a lot of the fella (therapist). And he really has helped me and I have done a lot with him, I’ve been able to call him on the phone and ask, “What do I do about this or what should I do about this situation?” He will always call me right back.

Another patient exchange illustrated similar sentiments.

(P7) I would have to say for me it is the rapport with my therapist that keeps me here. It is so hard to find somebody that you really feel comfortable sharing anything with.

(P1) Or trying to express yourself with. The counselor keeps you going on your problems to get them out, express your viewpoints you know.

In addition, patients recognize the impact therapy has had on functioning which contributes to favorable evaluation.

I am having some problems at work now lately and just from things that I have learned especially with my counselor, like how to work with others, I am able to deal with that a lot better. I was able to like talk to my supervisor about something that was going on there without being afraid and feeling I was going to get put down. I feel like you gain, I think a lot of it too is we have lost a lot of our
self esteem. You are feeling better about yourself. And coming here I got that
back and am able to express myself better.

**Frustrations with mental health system**

The patient participants provided descriptive statements regarding the parts of
their experience which were troublesome. Patients were definitive regarding structural,
procedural and interpersonal aspects of service rated as substandard. It must be noted,
given the context and the presentation of the project as an evaluation meant to drive
improvement, a demand characteristic may have been created. As such, patient
participants may have felt the need to emphasize negative aspects of their experience more
so than positive points to target areas for improvement.

**Parking.** Patient participants expressed frustration regarding their experience with
structural difficulties relating to the parking lot. Both patient focus groups began with
descriptions of their experiences with this point. Though renovations were recently
completed all of the patients agreed the improvements did not influence their ability to
obtain parking. This was the case for the entire hospital but particularly near the entrance
to the outpatient mental health wing.

(P3) If there is one or two spots open, that is good!

(P9) OK, I am going to start back into the parking lot. I am a late bird. I pull in
that parking lot there is no where to park, you run into that all the time. So that
puts me back, that puts me behind five minutes.
Registration. During focus group discussions a recurring theme emerged around the difficulties associated with the process of registration. This theme dominated discussion early in the focus groups. However, after conjoint staff and patient groups were initiated, registration staff took measures to address some difficulties expressed by patient participants. As such, when patients were asked to complete membercheck statements their ratings were considerably less negative than during initial focus group meetings.

Rapid turnover of personnel was a salient factor contributing to difficulty with registration. This rapid turnover led patient participants to speculate if registration was a position new employees would use as a stepping stone to other positions. From this patient participants (four participants) hypothesized that registration was not an important position which contributed to the feeling registration was a nuisance.

(P1) It seems that they have different people in the registration all the time and they are not up on the procedures. It makes it hard on you. It is real frustrating. You come in here and you feel good, and when you get out after seeing your therapist or your shrink and you have to go to registration then you are back to ground zero.

Though not a strong overall impression, some participants developed the perception the registration function was not important.

(P2) You need some continuity, you know like your supposed to go here, then you go there, so you know what to expect. You don’t know what to expect from
week to week at registration. And you sign that registration sheet, I don’t know how many times, and you ask them what is it for? What is it about? O.K., if you don’t have a purpose for these things, to us they are not important, O.K., and when you treat them to us like they are not important, it gives the hospital a bad name or out patient treatment a bad name you know. In fact, it is almost the opposite of when you walk in the door and see the secretaries.

Other frustrations with registration focused on the disorganization of the waiting area for registration, the length of time required to wait, the nuisance of continually answering the same questions, and the inconsistent registration procedures prior to one’s appointment.

(P9) I go over to the secretary one week she had a registration sheet for me and I didn’t have to go to registration before my appointment. No problem, great. Next week I come and they send me over registration. And I go over registration, and knock on the door. Is somebody in there? And there is two more people sitting waiting and I don’t know who’s next. And then I have got to wait and then the last registration girl, because they switch these girls all the time, she’s messed up the computer, and my insurance is all wrong and then I gotta go through all this stuff and next thing I know, I am twenty minutes late.

Additionally, patients expressed significant stress associated with having to repeatedly correct information which was supposedly corrected in the computer previously.
(P1) ... and by the time you get through waiting for registration, and your doctor, you are all worn out and you don't know what to talk about and just bugs you. I mean that kind of stuff stresses me out. I hate that... I can't take stress. Mentally I have a lot of problems, I am a schizophrenic, and I have a lot of problems. When I get down I get real stressed out and depressed and going through this procedure that we have to go through every six weeks or four weeks when we come in here—is stressful. It gets to you.

Stress associated with registration was further exacerbated by the emotional state of patients. Participants (eight) indicated the procedure associated with registration was particularly negative when experiencing a crisis situation.

(P8) I don't know about you but when I came here for the very first time, I was a mess. I mean I was crying, I was uncontrollable, you know and I had to go to registration. I was in there sitting and crying while she was asking me all this stuff, and I am... it took forever you know and I just wanted to see someone... you know to get feeling better. I am like.. oh, my God this is taking forever to see someone.

Psychiatry. Participants expressed concerns specific to their interactions with the psychiatrist in terms of their evaluation of service. Patients described the unavailability of their psychiatrist as a major concern. Participants directed complaints towards psychiatry staff who were only at the hospital on a limited basis. For participants whose psychiatrist was only available one or two days a week, the inability to contact their psychiatrist when
undergoing medication changes and side effects from medication became a significant problem.

(P7) Well, one of my main concerns was brought up before and that was that the psychiatrists only being here once a week. For me that has been a real big problem. Like when starting new medication and maybe the side effects are messing with me or whatever and I have to wait a week to talk to him again or if the dosage needs increased or whatever. Again, I end up just having to wait a week.

Supporting this theme, patients expressed how their satisfaction is related to the availability of psychiatric services.

(P4) The out patient services, I would give them a real plus overall except for the psychiatry end of it. And one reason I say about that is like she said they are not here all the time, but I do also understand that hospital is a learning hospital so a lot of people are in and out just like the other departments in the hospital. I understand that. I still wish they did have more people that were permanent psychiatrists on staff. They would be here so there was always someone to get a hold of.

Further, patients perceive the coverage policy for an absent psychiatrist as inadequate to meet their needs.

(P2) One doctor won’t prescribe for another doctor while he’s covering for the doctor while he is on vacation. They are all on vacation all the time. So they got
one doctor handling the whole department, and you need meds and the secretary
can’t write a prescription, and we lean all over the secretary. I have seen her
crying too. There’s got to be a doctor around her to write a prescription before
we go into a seizure. But I mean it’s ridiculous. You’re in a hospital and no one
can write a prescription.

Another area of concern related to psychiatry involved patient perceptions of
control of their psychiatric care. Some (six participants) expressed concern over the
ability to tell the psychiatrist exactly what they wanted and he/she would prescribe it.

(P2) For me the psychiatrist is ten minutes a month and like someone else
described, I walk in and tell the doctor, “I am feeling anxious.” and he says, “O.K.,
here is the prescription.” Then it is like, next concern. Once you get to the
psychiatrist, at least my doctor you can order up what you want.

(P8) You know what, that is right. You know I believe that. It’s like you are
kind of yourself in charge of your own medical care.

(P2) And it is scary, because I am not a pharmacist.

(P8) Right! Well, I know a little about drugs you know, but I told him the Zoloft
wasn’t working and he said we’ll go back to the Prozac. I said, “I told you when I
very first called you that I didn’t like the Prozac for a certain side effect.” And so I
said to him, “have you heard of a drug called Serazine?” He said, “yes, it is
supposed to be just as good as Prozac without this certain side effect.” I asked if I
could try that and he said, “Sure, there’s the prescription.”...
(P2) I did the same thing with another drug! .... I mean we don’t feel real confident being psychiatrists. I mean we haven’t spent eight years in college. However, one patient stressed that though she was not comfortable with the perception of having total control over her psychiatric care, she felt it imperative patients did not go to the other extreme and give total control to the doctor.

(P3) The negative point is that sometimes due to limited time with your doctor it is hard to get a comfortable, secure feeling about treatment and medication. But on the other hand, it is important that patients participate in treatment and developing their goals.

Participants expressed concern over changes in their psychiatrist. One participant had experienced difficulties with her psychiatrist and a change was initiated without consulting the patient. Participants expressed recognition of the natural turnover in a teaching hospital, but indicated the need for continuity in psychiatry.

(P8) I have only seen my psychiatrist twice and then nobody even said anything to me and as a matter of fact I just now noticed it. On my card it has a different psychiatrist name for my next visit. Nobody even said anything to me. I had no idea I was being changed.

(P3) To me I think this is real important and I understand why you are upset especially when you are in the main clinics. They are going to have turnover because they have residents and students, but when you get in regular clinic it is real important to have trust in your position. When you are coming in to a mental
health area, I think it becomes even more important that there is a level of
continuity and that when you have a frequent turnover in that caregiver, to me I
think that would be extremely stressful.

(P8) I am just kind of worried about getting doctors switched in mid stream here.
I have only seen this other doctor like I said two times. But I feel like now we
have kind of got the medication straight I feel better. Now I am going to see
somebody else I don’t know and here we go again.

In addition, many patients (ten participants) recognized a lack of support staff to
handle the responsibilities for the outpatient psychiatrists.

(P2) I think she does have a full plate (psychiatrists’ secretary).
(P8) Well, then they should get someone to help her.
(P2) You betcha!
(P8) That is what I think because..
(P2) She is a nice gal, but she is just overloaded.

Billing. Though not a pervasive theme, some patients (six) indicated difficulty with
the billing process associated with mental health (as well as other aspects of their
healthcare at the hospital). The primary problem results from mis-information in the
computer system leading to the wrong insurance company being billed or the individual
receiving the full bill.

(P1) I have had a problem for the last four years on billing. I go in there
somebody keeps taking it out of the computer, I spent this last year fooling around
at each station where I check in to register, to get them to send it to the right
insurance company. They don’t send the bill to Medicare properly, they don’t
send it to Medicare as primary, and my insurance as secondary. And I have had to
do this for four years—I finally give up and told my therapist, “I can’t take any more
of this it is getting to me.” Each time I go it is different on the computer.

Further, patients express concern that they will be responsible for billing when the hospital
makes an error and does not bill the appropriate external payer source.

Last time they made me sign this paper for help you know that I was going to need
financial assistance and this lady made me sign it. I said I can’t sign it, I’ve got
title nineteen, I don’t have to pay it. I was just all confused and I thought no, I
ain’t leaving this place until it’s straight you know because I know them bills is
going to start flying into my home. I went downstairs and I found the billing guy
and I says what do I owe and he shows me a $5,000.00 bill. I am like OHHH No!

Patients describe benchmarks for care through contrasts

Participants provided evaluative information in both explicit (as demonstrated
above) and implicit means through the use of contrasts. In many instances throughout the
evaluation process patients made reference to a benchmark of quality or understanding of
roles in the system by comparing either two internal system components or an intra-
hospital aspect to an external referent.
In one instance a participants made the contrast between the mental health clinics two main secretaries and other secretaries experienced in other clinics. The comparison highlights the importance of empathy and caring as a benchmark for support staff:

(P3) First of all, I worked around clinics and teaching hospitals as a medical secretary and you know when people talk to you, you can get an honest response which is what I think we get from these secretaries. They show empathy and so forth and a caring attitude. Or you can get the person who professional but doesn’t smile or laugh much. Then you get the person who is doing the job and some of those people are able to get a little bit of power, so they are able to kind of jerk you around a little bit. And thank God with these secretaries, it is just not there. They are there not only to help you get through what you need to get through, but to do it with a lot of humanity and humor—humor goes a long way.

(P2) Yeah, you go to most doctors’ offices and receptionists can be uncaring you might say.

(P8) A little cool.

(P2) It is different. It is just different here.

Contrasts also emerged between different types of mental health providers, particularly therapists as compared to psychiatrists. Participants described role differences and perceptions of interpersonal treatment between these two classes of providers. Many (nine participants) understood the psychiatrist’s role as focused solely on medication management and therapists’ role as focused on emotional aspects.
My psychiatry appointment is all about looking over the medications and reporting on the medications. There is not a lot of other discussion. Counselors do the emotional part. Psychiatrists are just there to ensure that your medications are appropriate.

I just decided OK, now I get the system. Now I get how it goes. Don’t talk to him about anything but your medicine and don’t talk to her about any medicine, so I just go with it.

This distinction often resulted in animosity regarding participant judgments of caring and concern on the part of the provider.

The psychiatrist didn’t care, she did not care, the therapists here and the social workers—they care more than the psychiatrists here.

I had a similar experience kind of when I first started coming here.

I have given a lot of thought to the same thing and I am finding a psychiatrist outside of here. I love my therapist to death but, it is so hard to get any communication with my psychiatrist that I want to look outside the hospital.

Another exchange highlights similar sentiments.

I found too your therapist will talk to you but your psychiatrist just doesn’t want to spend the time.

I realize their (psychiatrists) problem too. They got maybe 20-25 people to see in a day time.
(P 6) But that doesn’t make any difference. They still should treat everybody the same I think.

(P10) I agree. It seems like that is the way it is set up here. All the psychiatrist does is write scripts. OK, the psychiatrist spent three hours with me and she went so far as to walk me all the way to the pharmacy down here—it was my first time here and she was very nice. After that all she does is copy what happened last time and every two months come and write a new script.

A contrast was drawn between this county hospital and other hospitals in the community regarding the willingness to help patients requiring financial assistance. This contrast highlighted the general understanding of staff regarding the financial needs of patients and the patients perceptions of staff possessing the necessary information.

(P4) If you go to another hospital here in the city and you ask for information social services, government programs, anything like that to help you—they know absolutely zilch about government programs or anything to do with where to go to get help. My problem came from last December, my husband suffered a very debilitating stroke and my life went down. He is only 49 years old and he was put in another hospital and I was trying to get help, from the county, the state, or whatever, because he was going to need a lot of physical help that I could not provide. Do you think they would help me in any way? No way. I came here and I talked to people here. What do I do, who do I go to? How do I do this? And they had the answers! .... The other hospital just said we don’t have the knowledge
available to us and I said as far as I am concerned any social department in any hospital in the state should all have the same answers and the same information.

The couldn’t answer my question.

(P1) That is one good thing that this hospital has is doctors that are very informative.

**General evaluation: “Mixed bag but I’m still here”**

Toward the end of the second round of focus groups patients were pressed to give some impression of their overall satisfaction with their experience receiving services at the mental health clinic. Overall reactions seemed to indicate a general satisfaction with their services (nine participants). One participant indicated nothing but excellent service.

(P10) That is why I wanted to come to this group to share the fact that I have had nothing but good service here and these people have helped me. When yea, I was desperate and you know had to have help. Not that I necessarily wanted it. But they had to .. Everybody is just so good.

Many prefaced their responses to overall satisfaction with the phrase, “it’s a mixed bag.” Facilitators questioned further to attempt to ascertain if this mixed bag fit much of the earlier evaluative information that had emerged in the groups. Responses indicated consistency with earlier statements.

(P7) I would have to say it is a mixed bag for me.

(F) O.K., and why do you say that?
I really felt on one hand you know I have had a lot of problems with the psychiatry part of it, but on the other hand I have just loved my therapist to death. She is real respectful of my feelings. She is real informative at the same time. She seems like she cares a lot more. The psychiatrist I didn’t real feel was in my best interest you know.

And another participant very specifically stated aspects of the system perceived as favorable and areas of difficulty.

(F) How about the things like we talked about in the past. The secretaries?

(P9) Good.

(F) Registration?

(P9) Bad.

(F) Billing?

(P9) Bad.

(F) Therapy?

(P9) Good.

Though some cited significant problems, many if not most choose to continue receiving services at the outpatient clinic. Facilitators asked participants if they had the choice to go elsewhere, would they do so. A majority (seven participants) indicated sufficient satisfaction to continue receiving services at the outpatient clinic.

(P8) I’m still here .... I have insurance I can go somewhere else. I am happy here. I have actually had good treatment here. I don’t know what it is like in other areas
of the hospital outside of outpatient mental health. That is not to say I have not been upset with some things, but over all. I have had good treatment here in outpatient. But over there in psychiatry I just don’t feel...like they are doing what they could.

(P5) Same for me. I wouldn’t go anywhere else. I have dealt with a lot of therapists with my older boy and you know you got the same care there as you do here.

Only one participant indicated resoundingly he would go elsewhere. The stigma associated with having to receive services at a county hospital contributed to this patient’s resolve.

Domain 2: Communication Flow

This domain addresses an emerging cluster of themes related to channels of information flow. Participants noted particular areas in the system in which continuity of care was compromised due to breakdown in communication channels. Three types of breakdown identified were between: 1) persons, 2) hospital functions and 3) technical support tools. Participants elaborated on how these perceived gaps in communication influenced their care.

Person to person

**Therapists and psychiatrists.** Some patients perceive little connection between their therapy and psychiatric providers (eight participants). This perceived gap led participants to question the effectiveness of either provider when acting as completely
separate treatment units. Further, participants resent having to update one provider on the activity of the other provider, stating such responsibility lies with the organization not the patient.

(P2) My psychiatrist and therapist, it is like they are two completely separate entities where I think it should be all the same ... basically. I mean how can one be effective without knowing what the other one is doing?

(P8) I tell my therapist what the psychiatrist has changed me to and how many milligrams or whatever.

(P5) Is that the patients responsibility? What if I couldn’t?

(P2) That is an excellent question. Is it the patients responsibility? Is it?

(P8) There is no answer, see.

(P2) I don’t think so. I don’t think it is the patients responsibility. We come here to get guidance not to guide you.

(P3) Let’s face it sometimes we are a little confused or maybe not right on that day.

(F) So if a patient chooses to share that information like you are saying that you do. That is fine?

(P8) My therapist doesn’t ask me. I just tell her.

(F) But it should be clear that the provider or clinicians should be communicating better to keep up to speed about what each other is doing?

(P2) Yea, on the progress.
I think it is important that the patient try to be aware, but given our situations, I think it is safe to say that there are days you are doing good just to hold a sentence together let alone trying to keep track of things, but I think the main responsibility lies with the department organization to be coordinated among one another, to be up to snuff on the individual patients records and stuff. And I know I have only got a few minutes and just have to sit there while they hurry up and read real quick trying to remember what my case is and stuff.

Patients and psychiatrists. Participants identified contact between psychiatrists and patients as another communication gap. However, participants clarified this breakdown as primarily telephone communication as opposed to face to face contact. Six participants indicated communications with psychiatrists are not as difficult when in person, however, telephone contacts are troublesome.

(P5) I have had no problems communicating with my psychiatrist.

(P8) You lucky girl you! Seriously I have had no problems at all you know. I go right into the psychiatrist and he will say something and I am like last time I said my anxiety is high, I told you this two months ago. I can’t take it, I need something more. O.K. That is all I need to hear. He writes me out a prescription. No problems, no communication problems.

(F) So, it is much cleaner for you it seems like?

(P5) Yea.
(P8) When you are talking directly to the doctor, I think that makes all the difference between face to face and telephone.

Further, the main difficulty surrounded lack of understanding about polices for medication refills and the psychiatrist (or support staff) returning telephone calls. This results in many patients going without medication or becoming extremely frustrated with this aspect of their care. Patients perceive the lack of return contact and the need to speak with answering machines all as indications of lack of concern though they recognize the heavy load of the providers and support staff.

(P8) I never get called back. I was out of meds last week.

(P2) Don't get into the pharmacy!!

(P8) No, But I was out of meds and I called the receptionist, and ... well it was that damn answering machine ... I hate that machine. I left my message on there, it was nine o'clock on Thursday morning I am out of meds could you please order me some. Well, I have had a problem with them before that.

Before that I had a big problem because I called her and told her I was out of meds another time and she said O.K., you know, and I waited and waited at home for someone to call me back and no one called me back. Well then the next day I happened to have a meeting with my therapist and she asked if called them back and I said no. It is just that no one called me back, I didn't know what was going on. She called over there and they had already called them in to the pharmacy. So
I had been sitting there all day worrying and fretting and not taking them for no reason.

(F) They had already been called in?

(P8) I didn’t know that. My family doctor, she always calls me and says O.K., I called that in you know. So then my therapist called the secretary and said, “I have a patient over here who needs a med called in and she said we called them in yesterday.” The secretary said, “what is her problem?” So my therapist said, “how is a person that hasn’t been here very long supposed to know that?” She said, “yea, you are right. It must have just been a miscommunication.” Well then the second time I called for meds because my psychiatrist canceled my appointment the day before I was supposed to have the appointment-I don’t know for what reason. Because I had only seen him once. And she said, well, I was on the answering machine, and I left a message and what they said before is if you don’t hear back from us, they have been called in, so I called the pharmacy.

P4 - Is that what they do?

P2 - Yea, that is what they say, if you don’t hear from them, unless there is a problem, the only time you are going to hear from them is if there is a problem, then they will call you back, otherwise they have been called in. So I called my pharmacy that evening, they weren’t there. The next day it was noon-they weren’t there!
**Hospital department to hospital department**

Though the researchers' questioning focused primarily on provider and ancillary service associated with the function of providing outpatient mental health this was an artificial distinction from the patient perspective. Patients viewed their mental healthcare as a holistic piece. However, the mental health section of the hospital was organized in many distinct sections meeting different patient needs. In addition to outpatient services, the hospital provided inpatient, crisis evaluation, partial hospitalization, case management, and homeless outreach mental health services. To patients, these distinctions were not clear as they perceived them all being related to their mental healthcare. Further, patients questioned the continuity of care they are receiving from these different sections.

**Inpatient and outpatient.** For some patients, one of the primary gaps existed between inpatient and outpatient services. Patients note discontinuity of medication and diagnoses. Participants perceived the responsibility of notify staff regarding treatment differences between inpatient and outpatient services as primarily resting with patients. Further, most viewed this as misplaced responsibility.

(P9) I know this is about outpatient, but I am going to mention the last time I was in at inpatient. My doctor does not see me inpatient so I got another doctor. I was suicidal and my family talked to my outpatient doctor and the doctor told them to throw away all my meds for that night and to call him the next morning because he didn't even know my pharmacy which I could not believe he did not know my pharmacy after a year and half of seeing me. And, I did that and guess
what? He was out of the world for the day! And I was going to die because of going cold turkey, you know. Luckily my case worker had run into him on the streets and so the doctor called me in a prescription and I found out that he did not even know that I was inpatient and neither did my counselor. And my counselor was very upset because she said she would have came down and saw me. You know.

(F) So you are saying?

(P9) Lack of communication between the inpatient and outpatient doctors.

Yea, then the inpatient doctor, he says I don’t think you have all these mental problems that the other doctor said I had. So he started weaning me off my Valium. Well, I get out and instantly because there was no communication, my outpatient doctor jacked me back up with the Valium and so this has been two months now and there is no weaning off that Valium yet.

Discontinuity was also noted between the crisis unit and outpatient mental health.

(P4) I find that too, the first time I came over here they had me go to the crisis team. The outpatient unit over here and the crisis team do not communicate. I could not make them, no matter what I did, I could not make them communicate.

And I felt that was very bad because ... now look, you need to know what they said, what they did, you know and nobody would even listen to me.
Computer to computer

A group of related comments emerged regarding the inconsistency of information at different points of contact in the system. Though this was not an overwhelming problem for all patients, those experiencing the difficulty expressed intense negative emotion regarding the frustration resulting from this inconsistency. Patients recognize the cost of technical support equipment, but regardless quickly recognize the inadequacies.

(P2) I really don’t feel that the computer system is adequate. It is another communication thing. They aren’t up to snuff on the computer programs. I know they are very costly but these kind of things should be immediately apparent.

The difficulties associated with the computer system result in patients (four participants) repeatedly having to return and correct information problems. The patients recognized human error often result in difficulties but did not understand why, after taking measures to correct the difficulty, the erroneous information remained in the computer system.

(P1) I have had problems. She knows (pointing to the registration person in a conjoint staff/patient focus group). When I come into registrations and ask them if they got my insurance right in the computer, my Medicare and private insurance. I don’t know how many times she had to punch it back in and this has gone on for a year or better. And it is frustrating for me to come in and have to go through that. I went through every computer in the business at the hospital. All of them were different. They never had it right which was primary and which was secondary, my insurance or the Medicare.
Domain 3: Patient Dignity

Participants made numerous general references throughout focus group discussions regarding experience related to their personal dignity. First, participants experienced a pervasive sense of social stigma carrying the mental health patient classification. As later comments will support, mental health patient identification often gave participants the perception they were “not normal” and carried lesser status than physical health patients. Second, for many, the fact they were receiving services from the county hospital exacerbated this lower status perception. Patients identified the general and professional communities’ viewpoint of the county hospital and how this impacted patient’s perceptions of themselves receiving services at this hospital. Additionally, patients provided clear indications of staff activities contradicting the social stigma associated with being a mental health patient at the county hospital. Likewise, participants described how certain staff behaviors communicated lack of concern detracting from patient dignity and influencing perceptions quality of care.

Feelings about receiving services at the county hospital

The county hospital designation carried additional meaning for participants beyond merely a name. Six out of ten participants perceived the greater community to identify the county hospital as the place you go “only if you absolutely have to.” To a large degree, participants felt this sentiment by the greater community held for outpatient mental health services.
(P3) There is a perception and it has been like this since I can remember. This is a county hospital.

(P5) You are right!

(P3) And as such, you never know what is going to happen here and if you got insurance by God go somewhere else.

(P3) But ... you know the funny thing is I was surprised, I mean I was very apprehensive about having to come here. I had the same doctor elsewhere for you know like twenty years and it was upsetting to me. One what had happened to me (had serious car accident left her unable to work) and then to have to come over here you know because I feel like a beggar. That is difficult so then any problems you have here adds to it. But there has always been a perception that you only went to (hospital) on the most dyer need basis.

(P2) The perception of the people in the metro area is that this is the place you go only if you absolutely positively have to.

However, some patient’s experience contradicted the general perception. In fact six out of ten indicated they would not choose to go elsewhere if given the option.

(F) Does that hold for out patient mental health?

(P2) Yes.

(P3) Here? No, not to me.

(P8) Well, then I am stupid. I have insurance I can go somewhere else but I don’t want to.
(P3) I am happy here. I am talking about perception outside. I have actually had good treatment here. I don't know what it is like in other areas of the hospital. That is not to say I have not been upset with some things, but over all.

(P8) I have had good treatment here in outpatient. But over there in psychiatry I just don't feel...like they are doing what they could or like you said what another doctor I went to outside of the system might do.

(P5) Same for me. I have dealt with a lot of therapists with my older boy and you know you got the same care there as you do here.

Patients provided clear rationale for their decision to continue with the outpatient mental health even if given the choice. Reasons provided include the interpersonal aspects of care including relationship with some providers, support staff and demonstration of concern express by the outpatient mental health staff.

(P6) They have been really nice and they have been understanding and ... once I got used to the system of coming here, now I feel very I feel very comfortable. My therapist, well, she was at day treatment when I was before, so I know her really good and I just feel like I have a really good bond with her. She really listens to everything I say and my Dr., he's really nice, he always listens, he is very understanding, so I think I would keep coming here.

(F) So even though you have mentioned there is a considerable amount of stress with the billing or with the registration you would still choose to continue coming.
Well, yea, because of my SSDI I have to come here and if I don’t come here and don’t get my medicine, well then, all I am going to do is I am going to end up getting stressed and I am going get sick and I am going to end up back here again. So..I mean if I have to go through this....every time, then I guess that is just something that I am going to have to learn to deal with.

Another indicated the perception of the hospital would influence her enough to leave given the option.

I am not for sure you know like I said when I got this new insurance, I am like, I am out of here. (hospital name) has got a bad name, I am sorry. They have got a bad name.

In addition, the perception of care received and competence of the hospital as a whole is reflected in the professional community.

I saw a doctor outside of the (hospital name) system OK. A reputable doctor with his own practice OK. This doctor told me, he says, “(Name) you have got quite a few things that need attention. I don’t think you’re getting well. Is there any way you can get out of the county system and see some real doctors?

This participant went on to express his rationale for the greater communities viewpoint regarding the county hospital (and sub-clinics).

They are not hungry for business first of all. I guess this isn’t a business, it is an institution. They are not hungry. They don’t need clients. They don’t need to
They got patients coming out of their ears. They can hire anybody. You know and get by with whatever.

(F) And you think they do?

(P2) Where I have been, what I have been through, places and that, yes there is a degree of that. Yes.

Factors contributing to dignity and positive perceptions of quality

Participants often began examples of staff behaviors promoting dignity by describing their current situation. These descriptions highlighted how difficulties and mental illness have resulted in major life transitions. Such changes have in many instances stripped them of their dignity, sense of self worth and significantly reduced their support networks.

(P3) Most of my family does not understand this illness and aren’t interested in understanding it, I think I am an embarrassment. You were talking about dignity. And I don’t know about the rest of you first of all, but I having gone from a comfortable single life and then hitting this slide and going down. My sister has got all my suits and stuff. I have a pair of jeans, I have three sweat shirts and you know that is it. Not being able to at least dress up for a special occasion like a 50th anniversary party or something, but a lot of times when you talk to people, you lose a lot of your dignity. To have some people kind of subtly or unsubtly let you know that you know you are really not up here with the rest of us now. That is real difficult. I don't know if you guys have ever experienced that.
Well, my grandmother was manic depressant and my mom never believed that my grandmother was sick, and so therefore when I was growing up I never believed my grandmother was sick. Now I am like my grandmother, you know, now I am depressed and I have an illness and my mom still doesn’t believe it is a real illness. So I can’t talk to any of my family about it, the only people I can talk to about it are the people that are here.

The indignity experienced due to their illness and treatment by others was juxtaposed with experiences with staff (and most notably support staff) in outpatient mental health. All eleven participants agreed or strongly agreed that support staff bolstered feelings of personal dignity through their actions. This theme recurred numerous times throughout focus group discussions. Further, if patients expressed an interpersonal difficulty with another individual or group the difficulty was contrasted with the positive experience with support staff. Participants detailed numerous behaviors and impressions support staff conveyed to demonstrate concern, caring, empathy, respect and dignity both in person and in telephone conversations. The overwhelming response suggests that in a mental healthcare setting, therapy begins the moment the person enters the door. Further, it may be the initial contact that creates a positive halo effect for the rest of their experience.

As I approach the secretaries they are like, “Hi (name)! How you doing today?” You know. And I remember last Spring when the one gal, she is on duty today remembered my name. I mean that feels so good you know she’s, “Hi
(name).” How do you remember my name when you have so many people every morning?

(P7) Pam is like that. She remembers everybody’s name.

(P10) Yea, it really helped. I mean immediately they just, the gals you know whoever is on the desk takes care of you and go on over to registration. The gals in there most of them know me and are nice and cheerful. They are helpful. And tell you wait for the therapist and, you know the doctor, whichever...

(P1) Makes you feel at ease—don’t it?

(P10) Oh, yea. I am just. That is why I wanted to come to this group to share the fact that I have had nothing but good service here and these people have helped me. When yea, I was desperate and you know had to have help. Not that I necessarily wanted it, but they had to. Everybody is just so good.

Another participant described sentiments regarding support staff:

(P3) Pam and Roberta are great. I have dealt with Pam a lot. But those two, I mean Pam makes everything so much easier to deal with and if you are having a bad day, good day, whatever, you walk in and you know you are at ease. And Roberta is really nice. She is always nice to make time to at least say hi depending on how busy they are. Even if they are busy though, they take time.

In an attempt to capture the range of behaviors patients appreciate from the support staff, facilitators probed for specifics. Participants provided some very observable behaviors
while other interpersonal aspects were difficult to describe. Participants expressed considerable positive emotion when detailing these positive aspects of care.

(F) What do you see the secretaries actually doing?

(P5) Treating you like a human being.

(P8) Thank you!

(F) Treating you like a human being?

(P3) They care.

(P5) You can, well you can walk in there. I have times where I have been so depressed and I have walked in there and Pam will say, “You are not having a good day today are you? No I am not.” She always knows your name too ... do you notice that? She knows your therapists name too. I don’t know how she remembers all this.

(P8) She grabs the right book.

(P5) Yea, and she will just say that is too bad what is going on and you will say something happened with the kids or something. She will respond, “I understand, tomorrow will be a better day.” And she just you know, she is great.

In another participant exchange, patients recognize the support staff providing extra effort further emphasizing the importance of meeting patient care.

(F) It sounds to me like what you are addressing is the way they do what they do.

(P3) There is a lot of enthusiasm.

(P5) Like it is not just a job to them.
(P3) No, no. There is a lot of empathy, there is a lot of effort, I think, in my opinion that they put out extra effort. They are not just doing what they have to do. They are going those extra steps and well, for instance. I went to Colorado Springs for a couple months in the summer to visit a friend out there that just bought a new house and I was having some problems back here and I called Pam if she could check on some things for me, no problem. You know, I mean just .... and I knew I didn’t have to worry about it because I knew she would do it. I have experienced other places where they will tell you they will do it, and you call two weeks later, and they say oh I am so sorry, we just oh...I don’t have that problem here.

(P2) They are just not normal!

Positive experiences with support staff were not limited to face-to-face contact.

Participants reported similar favorable interactions with supports staff in telephone contact as well.

(P9) Then I come in and Roberta and Pam are wonderful, wonderful people. Like you said, over the phone, not over the phone, there are times that I have needed to talk to my shrink and he is was not available and the secretaries will listen to me. They give me comfort like a counselor. I know that is not their job, but I can hang up and feel much better you know.

Support staff also break down some of the stigma associated with the mental health patient label.
Even if you walk in depressed, they will cheer you up.

They know your name, they know what you are here for.

And that feels good?

It is not like you are a number. They know you.

Or a nut.

Or a psycho.

The secretaries talk with you in such a way that you don’t feel like they think you are a number or a nut or a psycho?

They treat you as an individual.

Support staff also show respect for patients after therapy recognizing the potential emotional impact after sessions. Further, the support staff maintains a consistent interaction style with patients and encourages them to return.

You just walk out, but I have to walk by Berta and Pam, I got to wave good bye.

I tell them good bye and they say, “Good bye (say name), see you next week.”

They seem to realize you know that you just come out of a meeting or whatever and they seem to have that second or intuition that they know this person might be a little...tight. They know how to...hope to see you back, ok! And you are gone, that is it, no hassle, no nothing.
Patients also commented on the importance of familiarity. Patients desire consistency in personnel as this engenders a sense of trust. Continual changes in personnel communicates lack of concern for patient comfort with both support staff and providers.

(P4) We become attached. We know this face is always here. And when that face isn’t there we get worried. One day when I came for an appointment Roberta wasn’t here. There was a fill in person and I was just like where is Roberta? This person doesn’t know what they are doing! You look for someone you know.

Factors that detract from dignity

Participants illustrated circumstances detracting from their sense of dignity with equivalent levels of passion as when describing pro-dignity behaviors. The main experiences detailed by participants included the procedure in registration and aspects of relationships with psychiatrists. Six out of eleven participants indicated some level of frustration due to the lack of organization and physical structure limitations while waiting for registration. Participants felt intrusive on others while trying to determine if anyone was in the registration office.

(P2) Have registration organized. Something like please take a number or something to that effect so that there is some organization to it.

(P5) So you are not sitting out there when no one is in there.

(P2) Yea! So you aren’t sitting there like a dummy, you know or you are not butting in on somebody like a dummy. Ok? And then you go in there and there is
some sort of continuity so you know what to expect. Otherwise it is just kinda
free lance wide open at the registration desk and it seems to be taken lightly.

(F) So you say continuity?

(P2) Yea, you know like you go here, you go there, and do this and that and
know what to expect. You don’t know what to expect from one week to another
at registration. And you sign I don’t know how many times, and you ask yourself
what is it for? What is it about? Ok, if you don’t have a purpose for these things,
to us they are not important. It gives the hospital a bad name or our
hospitalization or out patient treatment a bad name you know.

This lack of organization is particularly difficult for people who are new to the system.

(P5) And they need some way to let you know that somebody is in there. I have
sat there and observed and watched how they ....

(P8) Honey, I open the door every time. I am sorry, I go right to it.

(P5) Some people are new and they have sat there and I realized somebody wasn’t
in there and they have sat there, and sat there, and sat there. Finally,
after about ten minutes, I will get up and say, “You can go ahead and go on in,
there is nobody there.” But they didn’t know. How can they see?

(P8) It’s that wooden door, you can’t tell if somebody is there. That is why I
open it and if she says I am with someone, I go fine. Or sometimes she’ll go come
on in.

(P5) It is irritating!
Further, patients recognize recent changes made in the registration function as contributing to their frustration. Most notable changes involved having to go to registration on most visits and the firecode requirement to keep the solid wooden door to registration closed at all times.

(P4) The only thing I have to say about the registration is when they changed things here, I don’t know how many months ago, it was where they didn’t leave the door open over there by the registration, they had to keep shutting the door, that I don’t like.

(P7) I noticed that too.

(P4) They said it was something to do with the fire code or something. Jeff, maybe it was you I was telling one day, or some young man in here, I said why don’t they put a window in that door or something it makes you feel so ... like you don’t want to go up to that door and knock. Is somebody is in there. It feels very closed.

(P10) You are right, the door used to always be open.

(F) So is that an experience other people share?

(P10) Oh yea, you don’t want to open that door or knock. You approach because you have to come through registration .... you don’t know if there is anybody in there or not because the door is closed. So you knock and open the door a little bit, oh, excuse me. You feel like fool. You really do.
The registration function requires patients to describe a range of information related to income, job status, historical data, as well as other personal facts. For some participants (five out of eleven) the act of continually repeating this information produced considerable stress. The questions asked by the registration clerk involved bringing back many of the events precipitating mental health treatment.

(P6) I mean that kind of stuff stresses me out. I hate that. I mean like going through the registration because then because then I have to explain well yea, I have had to quit my job because I got sick and it’s just all so depressing to have to even mention that and say that. And it is just sometimes I feel I feel even worse than I felt before I went in.

(F) Answering those questions in registration can sometimes lead you to feeling a little bit worse?

(P1) Yea, I can’t take the stress.

(F) I want to be clear about this, what stresses you out specifically?

(P6) When you are in registration, and they when they ask you about like well, when I worked at BCBS and I had the insurance well, then I got sick and I lost the insurance and my job. Then I had to come here and it is like they’ll bring it up, they will still ask if I am on disability and you know all this stuff and they will bring up my old job and it just really..

(F) Bring up, you mean...
(P6) Like they will say, “Oh you worked at BCBS.” And then they will say, “You are not employed right?” And I will say, “yea.” Then they will say, “Well you still get SSDI” and they will say the amount and I am like yea. Well it is just bringing that up that just really gets to me ... hashing over old stuff.

Communicative value of time

The importance of time emerged many times throughout the focus group discussions. The main difficulties involved having to wait for things they perceived as important (first appointment), those seen as unimportant (registration) and time with their providers (psychiatrists). In different situations, the element of time communicated different messages regarding their sense of dignity. Though not a concern shared by all (four of eleven patients), the amount of time that elapsed between requesting a therapy appointment and seeing a therapist exceeded a comfortable time limit. To some this communicated their problems were not serious or important.

(P7) The other thing that for me that has been a big problem was intake process was too slow for me. When I originally felt that I needed counseling, and I went to seek my own help, it took I think before I actually got my own therapist a couple of months. And I am thinking boy I am glad I am not worse off. Lucky I was fairly stable!

(P6) That happened to me when I first started coming here. I had to wait about a month or two before I could finally—I could see my therapist.
(P7) And then I have also worked at a correctional facility real close by and I had to refer people over here for treatment. It was a 70 day program in the correction facility for most, so they might get the intake and then they are out of here already you know. It was really too slow.

In another instance, a patient described her intake experience having to complete her intake with a stranger due to a double booked time slot. The patient describes the uncomfortable experience resulting from efforts to consolidate time on the part of the provider and the length of time she had already waited to get an appointment.

(P7) I remember when I got my intake there was not enough time slots scheduled for everybody that day and they did two of us in the time. I felt like I don’t know like I had to be very open with my problems and what was going on with me in my personal life and there was another person there besides the intake therapist.

(P6) That is not right

(F) Two patients?

(F) Were you both talking to the same person?

(P7) Right.

(F) In the same room with more or less a stranger?

(P7) Right.

(P4) And you both did intake interview at that time. So you heard a bunch of stuff about this other patient as they heard stuff about you?
(P7) Right, right that bothered me a lot. I don’t know if that happens all the time, but that was what happened.

(P4) I never heard of anything, I think if I were you I would have gone out and said “Roberta what is going on?”

(P7) I didn’t know any better at the time. That really bothered me though. He said they double booked somebody so he was going to have to do it this way.

(F) Would you have rather come back at another time?

(P7) Yea, I think I would. Even thought I was feeling like it was already taking forever to get in to start seeing a therapist, I think I would have.

The registration function appears to be one area were patients perceive they are waiting for something they don’t understand and is of little importance. This topic generated considerable emotion and all participants agreed this particular aspect of their services was extremely frustrating.

(P8) Yea, they are slow. And they always seem to have a lot of people sitting out there waiting. Just like me, you know, ... and they don’t really do anything. You go in there she types up all the same stuff each time. And you say, “yea this ok looks good to me.”

(F) You said that it doesn’t seem like they do very much when you are in registration

(P8) I don’t understand what it is for I guess-I really don’t.
(F) Ok, has anybody ever explained that to you. Do you want to know what it is for?

(P2) I would have to guess. No one has explained it to me. I would guess it is for financial....to prove that they can bill somebody for the services.

Participants perceive the message as their time is not valuable and this is not respected by the outpatient clinic.

(P9) Even though I don’t work, I still work, I am booked because then I am in recovery all over the place and I book like a doctor. I have an appointment right after this one. After my therapist, I have another one so I don’t have time to go sit another twenty minutes or twenty five minutes to register but I will do it because that is what I told my therapist that I will do it.

Participants came to consensus that registration becomes more frustrating when it takes time away from provider appointments. As will be discussed later, this is particularly the case with psychiatry appointments in which time is such a valuable commodity.

(P9) I went in to my counselors appointment and told her I was ready. I told her I had been here for you know fifteen minutes. My therapist then came out and she interrupted registration and said, “I am taking her in and we are starting.” I was already, fifteen, twenty minutes late, my therapist said, “She will go register after we are done with our session.” That is when I hit her up and I said this is bull you know I told her I had been going through this for months.
Everyone is chuckling so this is a common experience here.

The very first time I came someone I felt someone should have told me to come early because you have to register and all that and it was like a half an hour after my appointment was supposed to start. See what I am saying, it cut into my appointment time, so the first time my therapist saw me, she had a half an hour with me. If it was gonna take that long they should have told me, but the girl in registration was new and so maybe it took longer than they anticipated. But last time I was in there, it was like that even though it wasn’t my first appointment.

The element of time carried important messages when patients discussed experiences with their psychiatric providers. A primary theme voiced by participants related to the amount of time spent with their psychiatrist and how time related to the doctors level of concern. All eleven participants questioned how the psychiatrist could understand their case and all related circumstances in such limited amounts of time. Further, participants questioned if psychiatrists took time to review the patient’s medical chart to brief themselves on therapeutic progress. These circumstances led all participants to speculate about the psychiatrist’s concern for their care.

If the psychiatrist just reads what the therapist wrote down on a paper when they talk to you, if the doctor took the time, he would find out about these things, he gets you in there fifteen minutes, five minutes, run you out.

See that is what I don’t like about the psychiatrists because when I was at Methodist, they always talked to you a lot longer. And like I find with my
psychiatrist, I can maybe talk to him maybe ten, fifteen minutes and it’s like I
almost feel like he’s like shoving me out the door for $180.00. Where at the other
place I felt like the psychiatrist was more understanding. You know they listened
more. Here, my psychiatrist always says to talk to my therapist. I mean, you
know, why can’t I talk to him (the psychiatrist) too.

(P4) I found too, your therapist will talk to you. Your psychiatrist just doesn’t
want to spend the time.

(P6) Yea.

Patients recognize the intensive caseload carried by psychiatrist. However, such
acknowledgment did not override there desire for psychiatrists to demonstrate more
concern.

(P1) I realize their problem too. They got maybe 20-25 people to see in a day
through one day.

(P6) But that doesn’t make any difference. They still should treat everybody the
same I think.

(P1) That is their problem. You got that many people...it just takes time to get
the information from you to the doctor or the therapist, I think they should spend
more time with us.

(F) The psychiatrist?

(P1) Yea.
(P10) I agree. It seems like that is the way it is set up here. All the psychiatrist
does is write scripts.

At times, psychiatrists’ statements to patients reinforced a general lack concern and
willingness to understand circumstances before making recommendations.

(P5) I go in and I sit down and he says how is everything going, and one time he
told me right away, “I think you need to go to school.” Yea, told me I needed to
go to school and uh...

(P2) Did he go into detail or anything?

(P5) No, he just told me that he thought I should go to school

(F) What did that say to you?

(P5) You (the psychiatrist) are not paying attention here to what is going on. So I
went and talked to my therapist.

The patients attempted developing some rationale for the their treatment to avoid from
blaming the psychiatrists on a personal level.

(P7) I don’t know that mine would necessarily want more time. But it gets to be
a little disconcerting sometimes you know when you do have to try to get a point
across to somebody that fast. I don’t know if there is really anything that can be
done. But I am getting twenty minutes and the rest of you are only getting ten
maybe fifteen then I am...

(P4) I think it may have something to do with the insurance, cause I always have
to tell them that I am on Principle insurance.
Domain 4: Solutions: Things could be better if....

One of the research questions involved exploring patient generated solutions to inform performance improvement efforts in the outpatient mental health clinic. The rationale driving this inquiry revolved around the notion that those stakeholders who experience the system as consumers provide a unique vantage point largely out of the awareness of those who provide the services. As such, a number of open ended questions were posed to participants to draw out their consumer experience to inform the improvement generation process. The emerging data pointed to two general areas of improvement; structural/procedural and interpersonal changes that would enhance the service provision of the system. It must be noted, many of the suggestions for solutions came in the form of complaints which pointed towards areas requiring improvement. Interestingly, a cluster of ideas emerged surrounding implicit solutions patients had already generated and put into place to negotiate some of the cumbersome aspects within the system.

Current implicit solutions generated by patients

Throughout focus group discussions, participants described various methods they had devised to make the system more user friendly. These methods were not seen as permanent solutions, rather as a means to deal with the current state of procedures in the clinic. These current solutions focused on three particular functions; registration, psychiatry, and billing.
One of the first suggested solutions to deal with frustrations associated with registration involved reframing the situation as humorous. The patients did not understand the reason for the difficulty and unpredictability in registration and therefore perceived humor as a coping mechanism to deal something they felt little power to change.

(P3) It is irritating.

(F) And you laugh. What is the laughter about though? You guys are giggling about ...

(P8) This is kinda, I mean comical at times.

(F) What do you do to make it better?

(P3) Oh, then we crack jokes about it. I just try to use humor in a lot of stuff. I mean unless it is something really serious or whatever ... just try to find something funny about it because the likelihood is you are not going to be able to do a whole lot about it. And unless the person is rude or something, then you can even joke around with them, you know I mean people don’t mind that unless you are being out of line somehow. But, might as well laugh at the stuff while you can because ... that is just life.

(P2) Us outsiders looking in we think it’s stupid to the point of hilarity. I know we are supposed to be sick ... supposedly.

Others learned that reporting no changes in personal information resulted in expediting the registration process and avoiding the necessity to repeat information.
(P4) You got to understand them asking you questions. Sure they have to get whatever information to show that person in front of them is the same one on that screen. They are asking you is this and that correct? I also understand also, that it upsets us to say, well, yea, this is still right or that ... you know it gets old.

(P6) I can understand what they have to do but...

(P10) You know what I have gotten to do ... I go in to registration and I say nothing has changed. Because nothing has changed since last week. And they go right through.

Last, some patients (six out of eleven) discussed utilizing their therapists help to overcome difficulties with registration. This involved either going to their therapist and complaining about registration or seeing their provider before going to registration. Conducting their session prior to registration prevented patients from sacrificing time with their provider to sit in registration.

(P8) One time my therapist took me into her office to have our therapy meeting before I went to registration. It was easier doing it afterwards because it wasn’t cutting into any of my therapy time.

(P9) With registration I gotta go through all this stuff and next thing I know, I am twenty minutes late. And last week I finally I went to see my counselor, and I went to her and I said this is bull, I said I am being charged, somebody is being charged for me to get an hour of service and I am not getting an hour of service
and I said this happens a lot. She told the registration person we would have our session and then I would go to registration.

Another area of patient generated solutions was with psychiatry. Participants discussed methods to make dealings with their psychiatrist more satisfying and goal oriented given the relative short access time. Further, patients devised methods to solve shortcomings in their experience with psychiatrists by utilizing other people’s assistance. This involved gaining information from others as well as using others to get access to their psychiatrist. Some chose a very straightforward, direct approach during the course of session with their psychiatrist.

(P5) So next time that I went in to see the psychiatrist I said, “I am having terrible anxiety attacks I want the Lorazepam raised.” He said, “Oh, OK, fine.” And he raised it. So I guess the game is you have to go in and just say this is how I am feeling and this is what I want done.

Many attempted to develop leverage with their psychiatrist by working through others in the system. One common vehicle to get to psychiatrists was through their therapy providers (five of eleven participants).

(P1) Going back to what someone said early about having to wait for the doctor, when I go to my Clozaril group on Wednesday if I got a problem, I come up here to my therapists office and talk to him. I tell him to have my psychiatrist call me on the phone because I am having problems with my medication, and that seems to work pretty good for me.
Others utilized the outpatient mental health secretaries (not the secretaries responsible for support services for this patient’s psychiatrist).

(P3) Well, I had a little trouble because I was in Colorado Springs. I was only supposed to be there for two weeks, but I ended up there for two months which meant I needed to get meds sent to me. And I was trying to get a renewal on medication and of course getting a time trying to catch the doctor and stuff didn’t work. So finally I called and explained to Pam (secretary in outpatient mental health) because I don’t know who I had talked to but I had been put off a couple times and I told Pam what was going on and that I had been calling ahead of time because I knew I was running out of medication and it took me over a week to get it settled. Once I talked to Pam in outpatient mental health, she knew what was going on. She got it taken care of.

(P8) She got the ball rolling.

(P3) Then my girlfriend came over with my car to pick up the medication and mailed it to me.

Others went directly to the head of psychiatry when experiencing difficulties with this particular aspect of the system.

(P2) One doctor won’t prescribe for another doctor while he’s covering for the doctor and they are all on vacation. They are all on vacation all the time. So they got one doctor handling the whole department, and you need meds and the secretary can’t write a prescription. We lean all over that secretary, I have seen
her crying too. There's got to be a doctor around here to write a prescription before we go into a seizure. And the doctor who's covering, he won't write nothing, it's got to be your doctor.

(P8) Right, that is what I said.

(P2) You gotta call Indonesia? Huh, or wherever they are—the golf course? Do what you gotta do man.

(P2) The only reason I was out of meds. anyway was because they canceled my appointment the day before I was supposed to have an appointment.

(F) Boy There is obviously a little emotion in this!

(P8) You know what I finally had to do is call the head of psychiatry.

(F) The head of psychiatry?

(P8) Yes, sir, I did because I had four different problems with them in a month!

 Structural/procedural solutions

Though a majority of participants felt somewhat satisfied (seven of eleven) with the physical surroundings of the outpatient mental health clinic, participants had some definitive suggestions for improvement. Some suggestions would serve to improve processes patients experience while receiving services. Other suggestions related to comfort and convenience, while some addressed changes to increase patient dignity. When discussing solutions participants repeatedly mentioned necessary changes structurally related to registration.
(P8) This is what I want to talk about!

(P3) Yea, the registration is a real pain ... slow, slow, slow. They know you, I mean I come weekly, I have individual therapy once a week, I have two groups. And, like when I come in, a lot of times my paperwork (pre-registration sheet) isn't there for the girls to give me, so I have to go the registration to get that. I think I have been luckier than most but there have been times when they have been too busy and...

(F) They have been too busy?

(P3) The registration area. They have people waiting.

(P8) Yea, and that makes you late for your appointment.

(P3) Yea, and that closed door and you can't see if they have got anybody in there or not. So, you know you wait and try to remember who is in what order and then you go in. The person I have dealt with lately in there has been I think a little better to work with ... not that the other people were bad but ... it does seem to go a lot faster. But one day I had to go twice because I saw my therapist then I had to see a doctor who follows my meds ... and I had to go into registration twice. I mean I guess from having worked in places it seems like there could be a simpler way of doing all this.

When pressed for suggestions to address these frustrations participants quickly provided logical solutions.
(P3) I think that you know a door with a window in it would at least make it easier to see if someone is in there. And they could have a bigger room at least that would make it easier on the patients that have to go in there. You know avoid the innocence, the people who don’t know what they have to do ...

(P5) You know those outside potties where it says open and you go in and when it is shut it says occupied? They need that on the outside of their door. Open, shut, occupied.

(P3) You know the way we go in there I mean as soon as one person is walking out the next person is already up and going in and so it is almost a revolving door. Maybe they could put a little revolving door there.

Another exchange colorfully expresses similar sentiment.

(P9) What is wrong with putting a fiberglass window in the door you know in case we get nutso and bust out a window, you know. And that way we would be able to walk up to that door and peek in and see that they are with a customer. Or what about a half door. We had those for years, you know half doors. Because that is rude to the customer sitting there too.

(P6) And I think they should just have the registration sheet at the desk (secretaries desk). Just sign in and you know, not everybody feels like they want to have to go to registration and sign everything and they don’t want to have to talk about their personal stuff. I would just rather just sign it at the desk and get
the piece of paper and wait to see the therapist or the psychiatrist instead of having
to go and update my information and everything like that.

Patients responded to questioning regarding their ideal outpatient mental health clinic with a number of structural suggestions. All participants agreed their ideal clinic would have brighter colors, more magazines, more comfortable chairs, the option of a beverage, and a play area for children. Participants identified these factors as contributing to a more relaxed, comfortable surrounding.

(P5) I would change it so when I came up and walked in that door, as the creative designer that I am, I would like the walls to be mauve. I would like to see border up on the ceiling. I would like to see more comfortable chairs. And the one frustrating thing I have seen as being a mother, some women come in there with their children and they can't help it and they are upset, but they had to bring their children. There is not a play area at all for these children. No toys. So what are they doing? They are messing with the magazines, they are jumping, they are bothering the other patients.

(P3) Causing stress.

(P5) Causing stress so you need a more comfortable, more relaxed more organized area. When you walk in. I would like to see brighter colors, I mean when I see walls like this I think, gee this is kinda depressing. They need a border around here, I would feel much more better.

(F) OK.
At Mercy Hospital when my daughter had a baby ... did you ever see their birthing rooms now? It is like you are at home.

Right, and that is the feeling that you would like to have...

You are right at home. It gives you a, I don't know what it gives you, but it does something.

It gives you a good, warm feeling on the inside. You are all relaxed.

It sure does.

It takes a lot of tension and stress and scariness away.

However, participants recognize some physical limitations to their suggestions.

When I go to my lawyers office, first thing he does is he says, “We got to get you a cup of coffee.” And I like my coffee. A lot of people like coffee. I guess we are supposed to have decaf most of us. I will take decaf, but it would be nice if that would be offered or pop would be there or something.

They have asked me before if I would like a cup of coffee, I don’t drink coffee so I always tell them no, but they have asked me. Pam, she has asked me before.

I am sure that they would get it for us but, I kinda feel sorry for them. They got two phones one in each hand and I am saying get me coffee. I think I am out of line there.

I don't think it is likely ... having coffee pot out in that area could possibly be a problem if you had like a difficult child, or an adult patient that went a little
bonkers that day or something. Then you have got this hot item that could cause allot of damage to the people.

The last structural change recommended focused on the challenges faced by some mental health patients. The stigma associated with being a mental health patient receiving services at the county hospital presented threats to their dignity. Participants requested a structural alterations engendering more respect for their personal privacy needs. Most participants (nine) shared the desire for increased privacy in their waiting room experience.

(P4) There are times where it might be more convenient for me if I could be isolated and not have to face other people. I don't know if it is a guilt factor or dignity factor, or pride or the stigma or whatever of you being a nut case. I know, that’s not the terminology, OK, for the lack of better terminology. You have emotional problems or something. And there is something about I don’t know how to explain it, can you (P3)?

(P3) I think just given whatever somebody might be dealing with, some people have a lot bigger issues and all that stuff is well under the top anyway and they don’t want to be around somebody else they would like to have a little privacy and... you know I don’t ...I know that you have to deal with generalities when you are doing these things but there are some people who are .. I don’t want to say delicate, but are sometimes overwhelmed with all the stuff and to have to sit in a group I can just see might be agitating for them or make them feel worse about their situation.
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(P8) The first time I came I was delicate as you put it and I was crying from the minute I got here and even until after I left and then half the day at home. I hated kind of sitting out there even in front of Pam and Roberta, I didn’t know them you know. Because I couldn’t stop it. And so everyone is kind of staring and I kind of felt like a spectacle.

Interpersonal solutions

Participants identified interpersonal aspects of care that would enhance the outpatient clinic and their experience as patients. These included pleas for empathy from staff, increased assistance when negotiating the system, a more seamless system to prevent difficulties with staff, appreciation of good support staff, and personal treatment like that provided by outpatient mental health secretarial staff. Many of these suggestions arose during conjoint meetings with staff and were shaped through this interaction.

Consequently, patient participants appreciated the willingness of staff to listen and encouraged the hospital as a whole to become more empathetic to their situations.

(P3) There have been references been made today. I know I have made them in the past. “Walk a mile in my shoes.” Unfortunately I don’t see how as patients someone would be able to step into our shoes because most people have to go through something similar. There is no way for us to be able to explain it to you. There is no way for you to really experience it. But if somehow we could get individuals to, as one of you (the staff) has put it, be less afraid of people in this section of the hospital and be more open to what we are saying and realize like my
problem. It can happen to anybody. You know you lose something. Then another problem happens and you start sliding. The next thing you know it doesn’t matter that you made a good income. It doesn’t matter that you belonged to all these social clubs or whatever. You are homeless. You have nothing.

For participants a more empathic stance by the hospital would result in attempts to rectify many of the recurring difficulties experienced by patients. Further, with this increased attention to the patients perspective, changes would include altering the computer system providing continuity streamlining their experience of receiving mental health services. To facilitate participants reactions, they were asked to respond to a hypothetical question, “If would have the undivided attention of the CEO of the hospital, what would you tell him or her about outpatient mental health?”

(P3) It goes back to the continuity issue but also there is a lot of confusion.
Different people are saying things to you but you have no idea how the whole is connected and my insurance issue is one of them. I don’t know why I am still having to run around trying to figure out how this is because I have applied for the free care etc. So why is there problems related to billing always coming up? You know that just adds to the stress. So is there some way to smooth it out, maybe it is a matter of what we have talked about before, new software. And, some way so that people in different areas can connect within the computer system so they can check on things and then go forward. As a patient, it is very upsetting if you are having a bad day, and then you are supposed to be running around trying to get
answers that they should be able to take care of themselves within the hospital. It adds stress to those bad days....

(F) Others?

(P4) You are making me think. Ok, if I were to go to the CEO, over all I would tell him I am pleased very much with the counselors, the therapists, the secretaries and through the registration process they are really trying, but they do need more help with the registration to smooth the process out to match what you have when you come in registration downstairs.

Participants occasionally discussed difficulties with their providers and all participants expressed a desire to have the policy for changing providers posted. Participants felt this was their right to change therapists or psychiatrist if they did not feel they were progressing or if they experienced difficulties developing a relationship with a particular provider.

(P10) I haven’t been able to see my therapist lately because he has been ill and in and out and I was kind of disappointed with him anyway because he is narcoleptic. I have to raise my voice to wake him up. Well yea, so I am not getting any benefit from it and I asked the shrink last week when I was here for the two month appointment .. I says how do I go about changing therapists and she said I don’t know it ain’t got nothing to do with me.

(P4) I think you could request a change. I was just going to say that maybe that should be something that is done, posted somewhere.
(P10) He has helped me and he is not a bad guy at all that. You know I don’t want to offend him or anything.

(F) You want a change...

(P10) I truly would like to try a different therapist. The shrink, last week she says oh I don’t have anything to do with that.

(P4) You know it is your right to change therapists if you need to—thank God I don’t need to but I wouldn’t know squat about what to do if I needed to change.

(P7) I would really like to find out the procedure on switching psychiatrists too.

Another suggestion addressed patient advocacy. Participants indicated a desire to develop methods to help them negotiate the system. The specific suggestion involved creating a position (either volunteer or part-time paid) staffed by a patient, former patient, or someone intimately familiar with the patient experience to assume a number of roles. These roles include guiding new patients and acquainting them with the system, directing patients when problems arise, and acting as a liaison with providers.

(P4) I have a suggestion. I had in some other businesses experienced advocates.

(F) Advocates you say?

(P4) Advocates I am not sure if I am using the right word. Jeff I am not...

(F) Go ahead, you are doing fine.

(P4) One of us type of people, that had been through this since ... I have been through it for a long time. Someone new coming in doesn’t understand you know what is going on with this that and the other.
(F) Someone new coming in?

(P4) A new patient. A new patient coming in going through this and if you say had a person on your staff that had been a patient or even a volunteer who could answer a lot of questions for this person, “why do I have to do this, why do I have to do that.” Or make things easier for them. Do you understand what I am getting at.

(P2) You see we all walk along the same path too many times.

(P3) Yea, and there would be somebody right there that could get this all for them now and step in and help them because there is no other person. They are totally confused when they come in and they don’t know where to go ... you know guide them through, take them through. Sorta like a guide. You know advocate was a good word.

(P4) I would say if one of us say was put in that position of an advocate, we would become much more understanding of the positions ... what managed care does, inpatient, out patient etc. ... and we could answer these questions for them. They wouldn’t have to go to (the staff) and say, “What do I do about this? Can you solve this?” We would know the answers and we would break down a lot of their time trying to find the whys and the this and that of things.

(P2) Also, I would think if you had been in the care of a doctor for a year or so that, and if you had followed the rules, the suggestions of the doctor .... people most of these complaints are against the doctors if I am reading it right. If after a
year or so, you didn’t feel you were getting any better that would be time to have someone on your side that you trust. An advocate or whatever that would be able to act a liaison between you and the doctor and telling the doctor he ain’t getting it instead of the patient confronting the doctor on a one to one basis. The doctor will usually chew them up and spit them out. Ok. Where an advocate would be able to know how to communicate with the professional.

Given, much of this discussion took place in the context of the conjoint staff/patient groups, staff added one of the functions of this role could involve developing provider feedback mechanisms.

(Staff person) But I see that role as different from the role we talked about before and maybe advocate is the wrong word. We talked about somebody to and I can’t remember whose idea that was. But I kinda went oh! Somebody to take somebody around to help them with the ropes you know. A guide. Whatever word you want to use. I am mulling this over in my brain cells. The fact that it could be a volunteer position, it could be a part time paid position. Clients, certainly that would need to be at a certain level of wellness. Certainly supervised by someone say in out patient mental health. But then I was taking it a step further because there you have your ongoing feedback to administration. To supervisors on what is working, what is not working.

(F) Say more about that.
(Staff person) Because you would have, say you would have a staff, maybe they are part time people. Three or four people that rotated in this position.

Volunteers. I am not sure volunteers would work, but maybe part time people. Because I think there has to be a certain amount of accountability. But I think there has to be the knowledge of the client position. So I am not quite sure.

In addition to the structural suggestions mentioned earlier, patients responded to questions of their ideal outpatient mental health clinic with numerous interpersonal suggestions. All participants agreed in their ideal clinic they would feel understood, welcome, the staff would be courteous and would take the necessary time they need. Further their providers would be in close proximity to ensure improved communication and ideally some would choose to only see one provider. Participants recognized many of these interpersonal aspects as present in their relationships with the outpatient clinic’s staff and most notably with the support staff. In addition, participants value the role the support staff play in providing their service.

(P8) I would have both my appointments on the same day so I could get out of here, not have to worry about...

(F) Would you have two appointments?

(P8) Yea, because I would have one with my therapist ... I'd like it to be like it is over here. The people friendly, courteous, I feel welcome over here, I feel understood over here. And I would like maybe the psychiatrists to be in the same
building. And have his staff to be as friendly and courteous and you know take the
time that I need. Of course, that is dependent on insurance and I understand that.

(P3) Ideally I would like to only have to see one person. I don't see how that is
going to happen. But ideally it would be nice. But I have known them both since
the beginning so they do both have a feel for me and my situation.

(F) Others?

(P2) Out patient, this department right? Well first of all I think all of the
psychiatrists should be in the same building. Bottom line, it starts with personnel.
So the number one thing that I would start with the likes of what we mentioned
their names earlier, the secretaries. Start with that type of personnel.

(F) Clone them?

(P2) Clone them. On the psychiatrist side, on the therapist side. I have been in
business OK, and my success in my opinion, was the help. I didn't do it, I just
directed them. OK, the help did it. I had good crews. Always had good crews for
some reason. And hell they would tell me to get out, OK. And they could do it
almost as good or better than me. Each one had their own field. I would let them
go, I would say, heck, he is better at it, he's in charge of that let him go. OK, I
wouldn't take one doctor and make him god. First of all that is blasphemy. But or
ten doctors and make them all god, that is ten gods! Wow, now you have got
serious problems. Have I made my point?
Domain 5: Focus group process with patients is valuable

The final domain addresses the last research question exploring participants' experiences of the focus group evaluation process. Participants were asked to comment not only on the site under study, but also on the process utilized for the evaluation. Similar to the client debriefing process often practiced by family therapists (Newfield, Joanning, Kuehl, & Quinn, 1991), the researchers encouraged participants to describe their perceptions of the evaluation. This line of questioning led to descriptions of satisfaction, willingness to continue participation in continued evaluation, suggestions for improvement, and suggestions for similar endeavors in other areas in the hospital. In addition, participants described how taking part in the evaluation affected their well being and altered their perceptions of the organization.

Empowering to patients: Focus groups as intervention

Participants provided overwhelmingly positive responses regarding their experiences. All of the participants indicated being asked to contribute to the patient focus group (or individual interviews) was to some degree positive for their self-esteem. The focus group evaluation communicated concern for the patient perspective and value for mental health patients. For some, the emotional state developed through participation in the focus group evaluation completely contrasted the reasons for seeking mental health treatment.
(F) Last question, OK. Let's kind of step back a little bit from the content of what we are talking about here and I want to ask you about what is your experience being in a group like this. An out patient mental health area gives you a call or asks you to be involved with a group like this. What is this experience like?

(P8) 100%. I like it!

(P5) Yep

(P3) I was real surprised that all the ideas that came out of it and just the liveliness of it, I thought it was going to be very cut and dried and .

(P8) I like it because we are a smaller group because really, for a focus group it isn't a viable group unless it is eight. But, right, by the book, but for this small group as we are, we all get a long pretty well.

(P2) Yea, we fed off of each other.

(F) OK, other thoughts?

(P2) It makes me feel totally opposite of what I am coming in here for. OK, my lack of self esteem, no one cares about you or needs you, you are not important, all of that stuff. It has done a lot for me, just being asked to be part of something and contributing something and being considered ... a person.

(F) You are really experts.

(P2) I mean I was bragging to my brothers, darn hospital asked me to help them run their place.

(F) You are a consultant.
(P2) Yea, consulting and I am exaggerating, but I want to make that point. I want to make that point strong. It is an upper. Essentially, the focus group counteracted the mental health patients’ perceptions of lower status treatment by others. Participants recognized their expertise and the necessity to be consulted for quality improvement that will be responsive to patient experiences.

(P3) I think that there is a tendency by some individuals to just automatically think if you have any kind of mental illness that automatically you don’t have a real good grasp on reality. You don’t have the ability to be able to think straight, clearly. And I think for some of us that is true on some days but on the over all we are just average people who have through various reasons fallen into troubles that have taken us down a dark path ... We are the ones being treated and I think that we could be good advocates in this type of program. After all who knows better than the consumer.

The focus groups served to validate patients recognizing other patients shared their same experiences with the system. In turn, the patients had the opportunity to learn from each other and feel comfortable sharing opinions.

(F) What has your experience been?

(P4) Very interesting and I have learned a lot from other people and I don’t just feel like its all just happening to me. There are other people that are ... worse off.

(P7) Yep, there is a lot of people that are worse off and have more problems than what I had.
(F) What has it been like here, discussing that here?

(P4) I feel very comfortable.

Participation produced the perception of normalcy for people often feeling anything but normal. Consequently, participants indicated an overwhelming willingness to continue volunteering their time for the evaluation.

(F) You covered many of the things that we wanted to talk about today in a lot of different ways. But there is much more we want to learn from you so...

(P5) We should have either made the meetings longer...

(P3) We just hit the tip of the iceberg

(P5) Or have an extra meeting and have three.

(F) That is not out of the question. We may end up doing that so...

(P2) I am not speaking for the rest of the people, but god I enjoy this.

(P3) We are not so isolated ... I am staying at a friends, I am usually there most of the day, I go out to my meetings and you know, grocery shopping and that is about all I have got any more and I am used to having lots of interaction.

(P8) I can't go to the store because of my illness.

(P3) I am used to having a lot of interaction with a lot of different people ... you know to me this is as close as I have come to normal conversation in a long time.

(P2) Wonderful, rarely am I ever accused of being a part of a normal conversation. I am not sure how to handle that!
Additionally, participants recognized secondary gains from their involvement beyond the mental health evaluation.

(F) Is this something that is a useful experience for you?

(P4) As you go on through your life, and they ask you on applications for work, what have you done? How can you relate to other experiences? You can use this and say I have participated in these focus group meetings. This says something. It says that you have a purpose and you are willing to contribute more of yourself, therefore you have a better chance of doing what they are looking forward to in the job or something.

(F) We have not heard that prospective yet.

Further, involvement in the focus groups contributed to a sense of power over the care they receive.

(P7) It certainly makes me feel like I have a little bit of power over the process here.

(F) O.K.

(P4) Instead of feeling so powerless.

(P7) Maybe some things will change ...

(P4) I had one comment for both you guys. You know we have all said our biggest downfall is the psychiatrists. Is this the same things you are hearing from the other group? Why had you let this go on so long. Why haven’t they done something like this focus group previously.
Patients indicated the perception of power, in addition to staff participation in conjoint focus groups, instilled hope for change. Moreover, participants did not expect dramatic, immediate changes as the result of their participation, yet recognized the potential impact.

(P3) I think there is a certain amount of hope in what has been discussed and suggestions, frustrations that have been voiced. Whether or not there are huge changes made I think that would be unrealistic. But there is hope that at least some of these concerns will fall upon interested ears. It may not happen immediately, but I think there are some people out there that are willing to hear what is said and keep that in mind over a long term rather than, “yeah, great that is interesting, but we don’t have time.” There are people who are going to keep it in mind. And for me hope springs eternal, some days more so than others. So I think that at some level we have had an important impact.

During a conjoint staff/patient group, one staff person made the statement supporting the need for patients to voice their concerns as she perceive them having significant power with administration.

(Staff person) I have learned and it has just been in the last month or so that when the patients speak out, administration tends to listen a little more around here versus when employee say something. Like the door patients dislike so much is being changed. The room is being changed.

As mentioned in a previous domain, participant’s alluded to the need for guidance to negotiate the system. The patients identified the focus group as serving this need.
Interestingly, the participants did not view the guidance as coming from the facilitators rather the patients provided support and information for each other.

(P4) The one thing that I have come across with the group I was with, one thing we did, we asked each other things. You know.

(F) The group you were with--you are talking the patients you were with?

(P4) The patient group I was with. I noticed one thing we did was, you know, answer questions for each other about what to do when you got in a certain situation. How did you solve it? Who did you go to? You know we were getting the answers between us because all of us have been different. Like one woman was asking me a question about one financial thing and she said, “Well I didn’t know that. How did you find that out?” It is like patients asking each other. If there was a person here who knows, the patients would know those answers.

Though, the findings had not been reported to the hospital administration the conjoint staff/patient focus groups served to created a more richly cross joined system allowing for information exchange from patient to staff informants. Consequently, the information flow resulted in some immediate changes in the system. Though primarily structural changes, the staff were able to address patient evaluative information quickly.

(P4) Can I ask (a staff person) something? The last time we were in here we mentioned that door problem. You said oh it is fixed or it is going to be fixed or whatever.
(Staff person) They have issued a work order to put a fire safety clamp on it so that we can swing it open and it will clamp and then when the fire alarms go off it will shut. Instead of propping it open with my homemade prop. So that is what is going to happen. We will be able to have it open or close it.

Last, participants were asked to discuss their overall satisfaction of the focus group. All strongly agreed they enjoyed participating. Further, the staff involvement encouraged patient participants and created an atmosphere of cooperation.

(F) Anything more we need to hear? Last shot.

(P4) I really enjoyed doing this. I feel that you know you are actually counting you are not just a number, you are actually a person and someone cares about you. You care about us (to staff people), we care about you. We are trying to work together and I feel encouraged by that.

(P3) Thanks for remembering, for keeping the humanity and being human here. Because it is very encouraging and comforting that people really do care. So thanks to all of you. I think the two (facilitators) of you have done an excellent job in how you have handled this. Your thoughts on it, the directions that you are going and your openness to exploring different avenues. Thank you for that.

Suggestions for the focus group evaluation process

When questioning participants about their focus group experience a number of suggestions emerged to improve the focus group evaluation process. Some recommendations specifically targeted alterations to improve the evaluation of the mental
health clinic under study. However, many suggestions addressed more general issues applicable to uses elsewhere. Patients directly commented on preferences for a qualitative format in this type of an evaluation. Additionally, patients commented on methods to minimize risks when conducting patient/staff groups.

Most suggestions regarding the focus groups for the mental health clinic involved inclusion of other important stakeholder groups. All four patients who participated in the conjoint staff/patient group indicated the combined format was helpful, however key staff representation was lacking. Most notably, participants identified psychiatrist involvement as necessary in the future. It must be noted, due to the distinction between the medical and nonmedical administrations and psychiatric time constraints, psychiatrists were not directly involved in staff focus groups. However, one of the co-researchers interviewed a psychiatrist with administrative duties on two occasions to brief him on the evaluation.

(P4) I have a comment. O.K., just in the last meeting and just from reading this summary from the other group it seems to me that most of our problems as far as working with the personnel are coming from the psychiatrists. We feel that they are the ones that are not taking the time with the patients themselves that our counselors and therapists do. That is where I think it would be much more important for them to be in on this. That is just instinct. Because it seems like most of the ... I mean does anyone else agree?

(P7) Yea, I do. I agree with you.
(P4) Like what you are saying. I feel like we are putting them down. You know, we are all against them and no one else and to have them come in here and they are going to look down on us and go ... All these people are complaining against us? You know. I mean I just feel it is important that at least one or two be here.

During one exchange between a patient and a staff person during a conjoint group, the issue of methods of evaluation arose. A staff person questioned whether a satisfaction survey or suggestion box would provide sufficient means to relay patient information to staff. Patients clearly indicated value in developing communication channels between patients and staff, however, patients desired a more qualitatively oriented format.

(Staff person) I have a quick question from my prospective. As one staff person said when clients say something on this or that matter, we have had action. That is good. We are here solely to serve our clients and for no other reason. Is like a survey were would like ask just a quick one sided question, "has your visit today been convenient, fast, friendly, did you get the results desired?" Would that be something that you would be willing to fill out as clients and that would give us information? I mean I don't know, it is just something off the top of my head.

(P2) He made a suggestion of a suggestion box or survey type thing. I don't believe in them ...it is not very effective, but I think something like this group would be much, much more effective. Much more effective so I like your direction, but the format ... not the format.

(F) I see a lot of head nods supporting this.
Another patient expressed similar sentiments regarding evaluation format during the course of an individual interview

(P11) This is the first time I have been asked about my experience like this. I have been given surveys but this allows me more time to comment and surveys send the message you are not really personally interested in the patient’s experience as when you do something like this (individual interview). You have to do this, it is the only way to get an understanding of patients on an emotional level ... you can’t make decisions from an office.

During preparation for conjoint staff/patient groups, patient participants discussed potential interpersonal difficulties that might arise. Patients expressed some concern over the particular staff involved and consequently explored options to minimize potential for conflict. Patients stated they might feel inhibited if particular staff they had previously had difficulties with were involved. To address this possible risk, the facilitators and patients decided to develop a list of staff scheduled to be involved in the conjoint group. This measure allowed patients more control, provided valuable insight to prevent the likelihood of difficulties, and helped insure patients were able to provide honest responses with decreased inhibitions.

(P4) I would like to know about I guess confidentiality and things like that. Say I have a comment that I am trying to convey about a certain staff member. And say they are present, and I would like to try to get around that but at the same time I don’t want any reprisals you know.
(F) No reprisals?

(P4) I mean like the staff are human at the same time and might take things personally.

(P1) Do we know what staff is coming in?

(F) That is a good question.

(P9) I got another staff member that if he is here, I don't want to be here.

(F) What I could do is see if it is O.K. with all the staff people if they would mind if we mailed you a list of their names just as a list of participants. And that gives you the option of seeing if there is anybody on there that you know you have some kind of... difficulty with.

(P4) That is a very good idea.

Last, patients commented on the importance of developing a context conducive to open, respectful exchanges. The facilitators attempted to emphasize the value placed on patient input to help improvement.

(F) Can I just encourage you to speak louder. You have a lot of good comments that sometimes when I listen to the tape I can't hear them real well.

(P4) I am sorry

(F) My voice, believe it or not, when I listen to myself on tape, it doesn't carry very well. And I wanted to make sure that we got all the comments of everyone and...

(P4) Gee, you are making me feel important!
Further, considerable time and effort was given at the outset of patient and patient/staff groups to promote an environment favorable for open, honest discussion of experiences. Continual emphasis on addressing difficulties with the system, rather than rooting out bad people added to an atmosphere of personal respect.

(P3) I just want to say that it has been interesting for me because I have been on the other side of all this as a medical secretary, I have been a recruiter, I have worked in teaching hospitals. I do understand how hard it can be on the other side but as a patient I also know how frustrating it is ... the fact that care is being managed more tightly and stuff now and that adds to frustration. I think that when you are dealing with patients that are deeply depressed or have a lot of frustrations going on in their lives, it is hard for them to look at the bigger picture sometimes. Your life becomes very small and tight and very focused and so I have walked on both sides and I am glad to hear that we are going on so much and that nobody is taking this personally. It is the big picture we are concerned with.

Focus group communicates caring by the organization

All participants indicated the focus groups were positive for adult outpatient mental health. Clearly patient's perceived the clinic's qualitative evaluation as communicating concern for patients regardless if major changes happened immediately.

(P3) The fact that the facility is willing to have something to allow it to be.....

(P2) I think they want the answers.
(P3) I think in today’s market, over all patients are beginning to feel kind of alienated, and stuff and just shuffled through. So to have something like this I think is real positive.

Moreover, conjoint patient/staff focus groups moved beyond merely gathering evaluative information. Patients developed a sense of ownership over their care. Interestingly, the patient/staff dichotomy evaporated as information was exchanged. The group developed into a relatively cohesive unit working towards a common goal of system improvement.

(P2) We ended up as far as I was concerned, we are all good guys. I personally thought that we came together on a lot of issues.

(P3) I don’t think that we are clear on how to make everything better, but I think that it was very important to have both sides of the equation here. I felt very sorry for you (registration person) because as registration, that is a very hot issue and I think you walked away knowing that it wasn’t a personal, but a business kind of thing, that was good. I was real surprised, I guess not surprised, I was pleased to hear that we are really pretty close on both sides. The patient’s concerns, I think pretty well matched staff concerns. So I think that is a very good thing and I think it will make it easier for everybody to kind of calm down the important issues and come up with some succinct ideas on what will make this better in the future and what might be possible. Obviously everything won’t be.

(F) So you are remembering that as a sense of consensus?
(P4) Yea, I think we were closer than I might have imagined at first. I don’t think there is much difference between either side.

(F) Is there anything else that comes to the top that was important last time?

(P3) Well, I think for me it is just knowing that staff, regardless of what level they are at, do understand that especially when you are talking outpatient or inpatient psych, there are a lot of emotions and stuff. Sometimes it is harder to deal with the small daily frustrations that happen and it is reassuring that the staff are also aware of how difficult that can be. They may not be able to do a lot about it, but that they are aware of it and they will do what they can .... It is reassuring to know that so many of the individuals on the other side are aware. They are open minded about things. And they feel as strongly, and I am not sure in some cases, maybe more strongly about certain issues. Thank you all.

(P4) For the past three weeks I have been thinking a lot about what we did here last time we were together. I really think it is great that the staff and just some of us common people can get together. As someone else said you know common ground, we have the same problems. But also some of us have developed communication with parts of the hospital that others haven’t. We can work this information together.

Though patients acknowledge caring and concern by staff present in the focus groups, they expressed concern how administration would take the evaluative information.
Administration is perceived as acting without taking into consideration all necessary information resulting in wasted resources.

(P3) A lot of times people up here think that they have a lot of the answers and they implement things. Think this is going to be great. But in fact what they end up doing is making things more difficult or less clear or whatever. Some of them are open to hearing why it is not. A lot of them say OK this is what we need to do. Bing, bam that is it. And it creates a more difficult working atmosphere and it complicates and slows down the processes. I think it comes down to are they are going to listen and are they willing to say yes there may be an easier way, a clearer, way, a simpler way. But it gets back to everybody has to have some input and if you don’t listen to the input then there is a lot of wasted time.

Need for focus group process in other areas of the hospital

Woven throughout the discussions, patients alluded to the need for a similar evaluation in other aspects of the hospital beyond outpatient mental health. All participants agreed focus groups capturing patients experiences were needed. The primary areas identified included the pharmacy, crisis team, inpatient mental health unit.

(P11) They changed the pharmacy a while back and now it’s a pain in the butt. The wait is ridiculous, the windows are never open, you are always standing in hallways. Why don’t they put a row of benches along the wall. It was just poor placement of the pharmacy. They should have done something like this before the changes.
Another participant expressed a desire to be involved in a similar procedure in regard to the inpatient unit at the hospital.

(P9) You know where they really need to do something like this is that inpatient unit. You let me know when they have a group on the inpatient unit. I want to be involved in that!

**Value of focus group even if change does not occur**

At the culmination of the focus groups participants indicated the groups were useful even if dramatic change did not occur. The impact on self esteem and the perception the organization cared for patients, created a sense of value, in and of itself, for the patients.
CHAPTER 5

DISCUSSION

The results generated from patient participation present many implications for performance improvement within the clinic under study. Also, many emergent themes provide valuable information for the qualitative evaluative process with mental health patients. The following section discusses researcher interpretations of some emergent domains, implications for the site under study, implications for the process of focus group evaluation, and implications for marriage and family therapists. Recognizing the nature of a qualitative inquiry, no statements of causality can be made through this interpretive process. However, given the prolonged engagement with the participants and data generated, the researcher is in a position to speculate about meanings, make conjectures about significance, and offer hypotheses about relationships (Patton, 1990). Further, this interpretive process involves: 1) making the obvious obvious, 2) making the obvious dubious, and 3) making the hidden obvious (Schlechty & Noblit, 1982).

Implications from Evaluation

Shift from Structure to Function: A Team Approach

Many pragmatic suggestions for performance improvement emerged from the patient participant discussions. The focus group process provided data grounded in patient experiences to inform future plans to design efforts at performance improvement for the function of providing mental health services (JCAHO, 1995). Some of the recommendations were explicitly stated by participants while others emerged during the
analysis and researcher interpretation. The following section discusses some pragmatic suggestions for the site under study.

Clearly participants desired more connection between people in the system. Some areas related to information flow between people while other trouble spots identified lack of connection between computers influencing patient care. In essence, patients recognized the need for a more systemic view of their treatment. Participants viewed their clinical care as being compromised when their therapy providers and psychiatric providers did not work collaboratively. The message communicated to patients was therapy and psychiatry are two different functions. Many patient responses highlight the need for movement toward a more holistic approach to treatment in this facility.

In addition to the lack of connection in facets of treatment, patients identified gaps with ancillary services. Some patients experienced extreme frustration when their personal information varied at different computer stations in the system. Specifically, the computers in the registration department held different information than computers in the billing department. The resulting gap led to significant confusion over services received, insurance information, and the patient's monetary responsibility. For instance, a patient might inform registration of an insurance change, however, due to the gap in communication with billing, the information would not be passed to billing. Consequently, the wrong insurance company might be billed resulting in a rejected bill. The stress associated with having to repeatedly correct the bill or receiving a full bill for services, proved to be disturbing to patients.
These gaps in communication noted by patients characterize a too loosely cross-joined system (Hoffman, 1981). The system is still able to function and meet some of the desired goals. However, due to an insufficient web of information flow the system operates at a less than optimal level. Analogous to a disengaged family, people in a loosely cross-joined system become isolated, withdraw, and have a tendency toward apathy. Such sentiments appear scattered throughout the evaluative information patients provided.

The personal and technical breakdowns identified above highlight the Joint Commissions suggestion for movement from a structural to a functional arrangement. The mental health system under study is organized along structural or departmental lines. The patients recognize these departmental lines as points of potential difficulty. A more seamless system with sufficient communication between component parts is indicated. This implies potentially abolishing the traditional departmental lines and developing teams organized around meeting the entire needs of an outpatient mental health customer. This shift conforms to the Joint Commission shift to organization around core functions (JCAHO, 1995) and the need for a more cross-joined system. These teams would include treatment professionals, possibly two psychiatrist and multiple therapists. However, these teams would also include the ancillary services like registration, billing, secretarial, and receptionist representatives. Given the difficulty patients expressed with the unavailability of their psychiatrist, each team would always have one psychiatrist available (within regular business hours) to fill prescriptions as necessary. Regular treatment team contact
meetings would involve psychiatrists and therapist routinely discussing mutual patients. Further, people could be cross-trained for ancillary services to handle the patient from registration through the final bill to prevent the many breakdowns identified. This also suggests increased linkage between the current registration computer system and the billing system. In addition, resources would be allocated to ensure the valuable patient reception activities continued. Essentially, instead of the patient moving through the system, the system would create a web of connected staff organized around the patient. Such an approach would collapse the identified gaps and would holistically meet the patients mental health needs while handling all of the necessary ancillary requirements. Further, this patient focused system would likely result in less waiting and more time with their providers satisfying the need for greater access to providers (particularly psychiatrists).

**Changes in Registration**

The above suggested shift would represent a dramatic reconfiguration of the outpatient mental health system. Other, more incremental, pragmatic performance improvement suggestions developed out of the patient discussions particularly related to registration. During the first round of focus groups the participants noted the need for more organization and order when waiting for registration, less waiting time cutting into appointments, more consistency, less repetition, and less staff turnover. Further, patients viewed all the hassle associated with registration as an unnecessary irritant, as they perceived registration as unimportant.
From the hospital's perspective, these issues represent significant roadblocks to financial solvency. Registration is the first information port of entry from which all bills are generated (T. Miles, November 11, 1996). If incorrect information is generated, the entire billing process is compromised resulting in either the hospital absorbing unpaid charges or patients inaccurately receiving a full bill for services. It must be noted, changes resulted through a combination of the focus group process and hospitalwide efforts to improve registration. In essence, a positive feedback loop developed as a result of information generated from patients and then shared with staff (Becvar & Becvar, 1993). First, changes included more structured and lengthy training for registration staff to prevent “being through to the wolves” promoting staff retention (no staff turnover since the new training process began). Second, structural reorganization of the office occurred allowing for more privacy. Third, the door was equipped with a magnetic doorstop connected to the fire alarm system. This allowed the door to remain open yet conform to the firecode so patients could determine if registration was occupied. Last, improved efforts at pre-registering patients provided more consistency, less unnecessary trips through registration, and less repetition.

Evidence of these changes came when comparing the intensity and frequency of round one focus group discussions of registration as compared to patient responses to the statements completed five months later. The participant responses to the Patient Thematic Statements demonstrated much less intensely negative reactions compared to round one discussions. Further, participants often wrote in the margins on the Patient Thematic
Statements responses like, “registration has improved,” “since the group the registration door is always open,” and “now that Bill has taken over things are run more smoothly.” These changes may result in fewer patient conflicts with registration, correct patient information, and increased likelihood of accurate billing procedures.

**Patient Choice**

Throughout focus group discussions patients alluded to factors influencing their personal dignity. As discussed earlier, carrying the mental health patient status coupled with receiving services from the county hospital, many participants felt their dignity challenged. However, participants were able to directly and indirectly comment on methods to contradict these challenges. First, participants stated the desire to be consumers with choices. By posting the policy by which patients could understand how to change providers would give them a sense of options if they experienced difficulty with their provider. This option of choice is available to consumers in most markets and promotes a sense of control which is often a factor bringing people to seek mental health services. In fact, for some patients, exercising an assertive stance to make changes in their provider if they feel necessary, may be an indicator of clinical improvement. Further, by virtue of posting such policy, the clinic moves along the continuum toward becoming more consumer focused.

**Interpersonal Aspects of Care Influencing Quality**

One of the most overwhelming common threads connecting the emergent domains involved the impact interpersonal aspects of care played in patient perceptions of quality.
When facilitators probed for patient satisfaction with the system, most positive and negative aspects noted related to interactions with people in the system. The patients clearly recognized the support staff as one of the most positive aspects of the system. The support staff demonstrated empathy, concern, patience, and the willingness to go beyond expectations to assist patients. As such, when reporting overall ratings of the system, these interpersonal aspects significantly contributed to positive global ratings. In fact, one patient clearly stated though he found some deficits in his experience, the support staff more than compensated for the negative aspects. Similarly, when many patients reported negative comments about the system, they were related to the desire for more attention to the interpersonal factors. Patient desires for more time and increased demonstration of empathy in relation to their psychiatrists further highlights this point.

The heavy emphasis on interpersonal aspects of care supports previous research detailing factors contributing to quality (Nelson & Larson, 1993; Niles et al., 1996; Reiley et al., 1996). In prior research, themes related to staff attitudes toward patients, amount of attention patients received, and treatment of friends and family members resulted in higher global satisfaction ratings in the hospital setting (Nelson & Larson 1993). Further, demonstration of caring for patients well being, respect for unique patient needs, and provision of emotional support for patients proved to be key quality characteristics for healthcare patients (Niles et al., 1996). The present study recognizes these same characteristics are similarly critical to mental health patients.
These findings have important implications for the site under study. First, the role the support staff play in quality assessments of the clinic are undervalued. In fact, monetary deficiencies have resulted in cutting the support staff. This significantly taxes the support staff resulting in less energy and time to devoted to patient attention. In light of the findings suggesting the substantial role support staff play in ratings of quality, these staff positions appear critical to protect. Second, other staff members in the system, particularly the providers, could benefit from efforts to emulate some of the behaviors exhibited by the support staff. Last, the clinic would be well advised to examine some of the patient requests for advocacy and design performance improvement around the indicators described. Many of the functions the patients suggested for this position revolved around meeting interpersonal aspects of care. Though the position may not be financially feasible, the functions of the suggested role should be addressed.

**Interventive Quality of Focus Groups**

Questions exploring patient experiences of the evaluation procedure provided a range of implications for mental health service evaluation. Through this process, researchers asked patients to reflect on their participation as co-researchers. First, this genuine request for patient collaboration and placing them in the expert position contradicted patients' self perceptions. Participants commented the focus groups made them feel the total opposite of the reasons they sought mental health treatment. In addition, patients began to express some sense of control over their treatment. Though many recognized the discussion would not likely result in dramatic immediate changes,
they felt empowered. In fact, some participants indicated the focus groups were valuable even if no changes resulted. Further, participants indicated validation that others shared their experience. In some instances this common experience resulted in supportive relationships among participants. Such effects have dramatic implications for a population of people who feel stigmatized, troubled, and view themselves as not normal.

Additionally, the patients viewed the organization differently as a result of their participation in the process. Patients perceived the larger message as this organization really cares about its patients if such an elaborate process is undertaken to understand patient perspectives. It is important to note, though the organization did support the project, the initiation of the evaluation developed from needs identified by the researchers. One might speculate the overall effect on patient perceptions of the organization if such a project developed hospitalwide and received support on all levels in the system. In addition to invaluable information, secondary effects like becoming more consumer focused, empowering patients, and improving the reputation of the organization in the community might result.

Moreover, at a very pragmatic level, the patient participants provided a level of understanding largely inaccessible to internal stakeholders. This understanding pointed to suggestions on many levels. Further, other less interactively oriented evaluative methods could not access this information and the related emotion. At this initial exploratory level, the focus group method of inquiry allowed researchers to capture a more complete perspective that most surveys would not have the sensitivity to highlight. As is
characteristic of the focus group process, people often develop and learn to articulate their experience through the interaction with others (Krueger, 1994). As the primary tools of inquiry, the researchers probed initial responses to encourage participants to provide rationale for responses and support participant interaction to further define the phenomena. This encouraged the evolution of suggestions for improvement from the consumer perspective.

Conjoint Patient/Staff Focus Groups

The conjoint groups created an atmosphere of collaboration. At the outset of conjoint patient/staff groups, patients expressed interest in what “they” (staff) would say about the many issues raised. In some instances, the patients used language equating the staff with the “bad guys” and the patients as the “good guys.” However, this adversarial dichotomy collapsed after the conjoint groups began and the conversation evolved. The discussion moved to how can “we” work together to solve some of the problems identified in the earlier evaluation.

This shift represents the effect of creating a more richly cross-joined system (Hoffman, 1981). The cross-fertilization of information through descriptive summaries served to develop a cognitive understanding of the issues other stakeholders indicated. Then bringing this stakeholder group together in conversation allowed emotional understanding to follow. Cohesiveness evolved when participants recognized their interdependence and similarity of concern. Patients felt they could convey their perspective to people who understood and could impact the patient experience.
Moreover, staff gained an understanding of how their work impacted patients. Though some showed cynicism changes would occur, staff expressed value and commitment to this process.

The results of this project suggest this process should continue. This method promotes the maintenance of feedback loops allowing the organization to continually learn and maintain a self-reflexive quality (Senge, 1990). Exploring the mental health clinic as a whole promotes an ecological view respecting the complexity of the system (Bronfenbrenner, 1977). Likely effects include becoming more customer focused, increasing understanding of the system, and targeting areas for performance improvement efforts. In addition, this process corresponds to the Joint Commissions requirements that all healthcare organizations maintain hospitalwide continual quality improvement.

**Future Uses for Patient Thematic Statements**

One methodological strength of the present study is the repeated attempts to verify the credibility of emergent domains. The thematic statements (Appendix 4) represented important areas for patients at this clinic from the researchers' vantage points. However, the researchers took the opportunity to subject their insights to the scrutiny of the participants to make necessary alterations and bolster the trustworthiness of the findings. This step proved to generate considerable discussion regarding the themes either supporting or suggesting necessary alterations. An added benefit to this process involved the ability to explore changes resulting from the first round of focus groups to the last memberchecking step. For instance, patient participants commented on their Patient
Thematic Statements and in the final discussion about the changes that had occurred in the registration department. During the six month course of the project, information generated from the focus groups fed back to the appropriate sources resulting in procedural changes in registration. The use of the thematic statements and final memberchecking discussion allowed the researchers to recognize the changes occurring as a result of the focus groups.

Another benefit generated from this evaluation includes the early phases of a quality assessment questionnaire grounded in patient experiences. As presented, many of the thematic statements are inappropriate due to their directionality. However, each question could be rephrased in a more nondirectional manner and serve as a beginning quality questionnaire. Though, patients suggested they preferred the focus group evaluation over survey methods, this initial inventory could provide additional continual feedback from a larger representation of the patient population. It is this author’s assertion the best approach would involve maintaining the focus group evaluation on a regular periodic basis with intermittent administration of the adapted quality questionnaire.

Context Setting in the Focus Groups

A number of factors contributed to the development and progression of the focus group process in this study. The researchers/facilitators carefully established the context to allow the information to emerge and contribute to the depth of experience accessed. The researchers established good rapport with participants from the initial contact through the project’s duration. Through this prolonged engagement (Lincoln & Guba, 1985) the
researchers conveyed the perception of patients as experts and the desire to enter a collaborative relationship with patients to understand their perspective and generate consumer friendly improvements. Patient participants commented on how the facilitators' actions helped them feel important, valued, and more than "subjects" or "numbers" in an experiment. It is this author's perspective that this climate developed through the cultivation of the researcher/participant relationship.

This relationship developed out of the assumptions and planful action initiated by the co-researchers. The researchers assumed much of the perspective of the patients would evolve though conversation with others who experienced similar events. However, this evolution was predicated on an environment of trust and comfort. To establish comfort the research team conducted the entire process as if entertaining colleagues with genuine hospitality and congeniality. The other key component of trust developed through the facilitators management of the conversation and recognition that through dialogue, each participant would further develop his or her perspective of the system (Anderson & Goolishian, 1992). As such, the facilitators served as the "master conversationalists" (Anderson & Goolisian, 1988) to create the atmosphere of respect and maintain the boundaries of the conversation. One of the difficulties of the involved maintaining the stance of curiosity and exploration (Cecchin, 1987) without the dialogue turning toward personal therapeutic issues. At times the facilitators had to gently redirect the course of the discussion from intra-personal or family difficulties back to experiences of the system.
In summary, it is imperative for focus group facilitators to emphasize the above mentioned points to create a context conducive to trust, safety, and honest. This method of inquiry hinges upon the balance between defining the boundaries for the conversation without closing down the expression of multiple perspectives. Further, this type of approach toward inquiry requires recognizing the research process is more than gathering information. Rather, this approach engenders participant investment and the recognition of their status as co-researchers in the process.

Implications for Mental Healthcare Facilities

As mentioned earlier, mental health organizations are searching for new methods to improve the quality of patient care. Like physical healthcare organizations accredited by JCAHO, mental health clinics are mandated to move beyond traditional quality improvement indicators. As often occurs in a paradigmatic shift, the transition represents significant organizational stress as clinics explore new avenues that accommodate the revised requirements. In addition, the mental healthcare field is under close scrutiny by managed care organizations to maintain cost-containment yet provide the highest quality of care. As such, the field is grasping for new methods to improve quality and maintain JCAHO compliance amidst ever present financial constraints.

Past quality improvement attempts evolved to become paper audit trail exercises to meet the JCAHO standards (Roberts et al., 1987). These quality assurance indicators were often generated from administrators offices and fulfilled the JCAHO audit requirements, but had little impact on consumers. In establishing the movement away
from quality assurance, JCAHO, defined the standards each organization must follow (plan, design, measure, assess, and improve) to "improve performance." However, as pointed earlier, before beginning the improvement efforts the organization must understand what must be improved. It is this author's assertion that without in-depth customer research, such ventures will result in limited impact on patient care and fuel cynicism among staff.

The present study represents one attempt to address the paradigm shift and establish indicators of quality from the mental health consumer perspective. This project lends support to the ability of mental health consumers to demonstrate clear ideas of what is considered quality care. Plus, this in-depth evaluation has produced a number of suggested areas for improvement which will satisfy JCAHO requirements and clearly impact patient customers. As such, it is recommended other mental healthcare organizations explore similar consumer research to satisfy external requirements while judiciously utilizing their limited resources on improvement activities with real impact.

The next step for researchers in this area involves using this approach to identify the necessary changes and then constructing appropriate interventions. Investigators must develop methods to monitor how the system perturbations impact patient consumers. Such efforts would involve using the patient grounded quality questionnaires periodically (in addition to ongoing focus groups) to generate empirical data to determine the impact. The present study lays the groundwork for developing such an ongoing self-reflexive
system but lacks the long-term exploration of how such feedback processes evolve over time.

**Developing a Socially Constructed, Self Reflexive Process for Quality Improvement**

Many of the findings from the evaluation represented information specific to the clinic under study. However, the process by which the context developed, information was generated, and the lines of communication increased holds significance to other human systems. In designing the study, the researchers recognized many of the important stakeholders in the system lacked appropriate communicative connections. To address this discontinuity the researchers established a structure to allow the system to become more richly cross-joined (Hoffman, 1981).

To create this structure the researchers first generated information from part of the system previously without a voice. Second, the information produced from the each patient focus group was shared with the parallel patient group. The researchers then created a venue to channel this patient information to the multi-disciplinary group of staff. Next, the conjoint groups were initiated to develop communication channels at both digital and anological levels. Through the development of this structured exchange the researchers created a cybernetic feedback loop (Becvar & Becvar, 1993). The structure allowed the infusion of new information to stimulate morphogenic forces to amplify the potential for change in the system. Moreover, the network of information flow evolved in a context promoting collaborative, respectful conversation. The result is the development
of a structure for self-correction in the system. As stated in Joanning and Keoughan (1997):

We have found that if we can get people talking in collaborative ways that we call 'languaging,' the human system can improve itself. What has often happened in the human systems we deal with is that self-corrective processes have never existed or have become blocked. By re-introducing collaborative conversations into the human system around relevant issues identified, self-corrective processes emerge which enable the human system to improve itself. (p. 14)

Conceptually, this process brings more voices into the construction of what occurs in the system. Prior to the project, the patient voice held marginal status in the social discourse defining the system and what improvement would and should look like (Gergen, 1985). In many instances, patients experienced such lack of involvement as neglect. However, through conversation with facilitators and staff, the patients perceived their voice as contributing to the development of the system. Interestingly, the researcher observed an isomorphism emerge. Patients, at times, felt powerless to change their experience with staff. Correspondingly, staff expressed similar sentiments with regards to their perceptions of administration. Given the perception of marginalization experienced by both patients and staff, the need for the cross-joining process to include the administrative level is evident. Such connection, if explicitly and implicitly supported by administration, would likely result in staff experiencing a voice in the dominant conversation defining the future of the system (White & Epston, 1990). A similar
empowerment effect parallel to patients' experience might occur. Though "equality of voices" might never exist, recognition and involvement by administration would provide confidence and empowerment to staff. Such effects would likely reverberate to better quality care and additional recognition of the importance for patient involvement. It is this author's perspective that the organization's culture must change to permit the addition of these marginalized voices to the dominant dialogue. If these voices are not counted in creating the future of the organization, the closed boundaries will not permit any new information to enter the system. The system will likely stagnate and be unable to survive in the rapidly changing mental health field.

The value inherent in this method could be transferred to other mental health, hospital or business systems. Many human systems lack the necessary structures to permit information flow allowing the organization to "learn" about itself from the multiple perspectives of varying stakeholder groups (Senge, 1990). In all human systems communication occurs. However, as almost all people have experienced, the communication is often not necessarily effective. Therefore, applying a structure intended to enhance the network of communication seems appropriate for organizations interested in being responsive to all stakeholder groups, particularly customers. Participation in such a process engenders a sense of involvement and commitment to goal directed behavior of the system (Covey, 1989).
Implications for Researchers and Consultants

Through the course of the present study, the researchers learned valuable information regarding this type of interventive evaluation. First, it is important to have no more than eight focus group participants, with the ideal being between four and six. This corresponds with Morgan's (1988) suggestion of four to six participants. Previous marketing research commonly utilized up to 12 focus group participants. It is this author's assertion that a great deal of valuable information would be lost with more than eight group members. Further, with four to six participants the researcher may be able to capitalize on the best dynamics of both the in-depth individual interview and the focus group interview. The facilitators can attend closely to each individual while still receiving the richness of information occurring through the interaction among participants.

Second, it is important to have co-facilitators to attend to all the verbal and nonverbal information generated throughout the discussion. It was this author's experience that having a co-facilitator allowed one facilitator to probe for further meaning with one participant while the other facilitator observed and commented on other participants' reactions. Such teamwork promoted the observation and questioning of much of what was "not said." It must be noted, both facilitators were clinicians and had worked together extensively over the course of five years promoting relatively effortless teamwork.

Another important insight gained involved the number of focus groups necessary to capture the information and engender a sense of involvement from participants. In the
present project, patient only groups met on two occasions and patient/staff groups on three occasions. In the patient only groups, the first sessions proved to be the primary information gathering session. The round two focus groups allowed the researchers to expose the patients to the summaries for memberchecking purposes. However, it was quite obvious the information in the round two groups was largely a redundancy of information gathered in the first group (except for the comments related to the memberchecking summaries). In the conjoint patient/staff groups, the first two groups were necessary to convey the information from patients to staff and convince patients of staff members' genuine interest. The third group proved necessary to allow the patients and staff to complete and process the thematic statements. This last group appeared to be very important to the patients as they discussed the statements for two hours and twenty minutes, clarifying their responses and commenting on changes that occurred.

Another valuable lesson learned involved the necessity to develop participant commitment. The researchers established good rapport from the first phone contact through the last focus group. Extra steps including repeated contact through phone, reminder postcards, and thank you cards, conveyed the value the researchers placed on the participants and their information. It is this author's position that the effort given to create this atmosphere was essential in the success of the project. Those considering interventive evaluations of this nature must consider these aspects of the same magnitude as methodological considerations.
Last, the present project involved considerable time and effort given the numerous steps taken for an academic endeavor. To make such a project cost effective for other settings a number of steps may be omitted. The use of audiotaped recordings and transcription are necessary, however, the extensive utilization of observers could be excluded. Further, as the qualitative evaluators improve as the primary tools of investigation, the thematic data will emerge more readily during the focus groups, requiring less transcript analysis. Also, the extensive audit trail activities regarding the process will become less necessary as the evaluator becomes more adept at facilitation. One important point, however, is to be cautious to avoid losing richness by becoming too concerned with efficiency. Inherent to this method is the necessity to allow participants to develop involvement further ensuring the emergence of information crucial to understanding these stakeholders' perspectives.

**Implications for Marriage and Family Therapists**

Currently, the marriage and family therapy field is struggling to define new areas for expansion. The mental health market share is becoming increasingly more competitive and less stable due to the advent of managed care. Each mental health specialty is struggling to claim their slice of a shrinking pie. Given, the state of the mental health field, it is imperative marriage and family therapists find new markets to utilize their skills.

The current project represents a potential growth area for marriage and family therapists. The skills associated with viewing the patterns of connection and understanding systems can be transferred to other human systems beyond families and
couples. Therefore, “human systems” researchers can apply many of the same skills used when working with family systems (Joanning & Keoughan, 1997). As with families, the human systems researcher must develop a clear understanding of the system, explore attempted solutions, search for new solutions, intervene in an ecologically sound manner, monitor the systems reaction, and continue to make modifications (Joanning & Keoughan, 1997). Further, marriage and family clinical training promotes skills to manage the conversation and maintain appropriate boundaries to continue the focus on the phenomena of study and not shift to “personal therapy group.”

Within the mental health and physical healthcare fields, marriage and family therapists can promote themselves as human systems therapists. Constructing similar procedures as described in this study will promote the development of improvement efforts meeting the JCAHO requirements while maintaining responsiveness to patient stakeholders.

**Limitations of the Study**

Several limitations come to light when examining the process and results of the present study. Though one of the main strengths of the project was the sustained involvement of the researchers in the study context, this also represented a stark limitation. As Patton (1990) indicates, the human factor is the great strength and the fundamental weakness of a qualitative inquiry and analysis. The researchers attempted to make biases overt, but such efforts are always limited. By nature, bias often escapes the awareness of the participant observer further mediating the data collected and interpretations drawn.
Another strength of a qualitative investigation involves the depth of investigation of the phenomena under study. However, with the constraints of time and energy of such in-depth exploration, qualitative researchers sacrifice breadth for depth. In the present study, the researchers “mined the depths” of participants at the expense of “surveying the landscape” (McCracken, 1988). The sampling procedures the researchers utilized captured a range of different patient characteristics. However, the sample was not representative, contained a limited number of participants, and lacked racial minority representation. In addition, by the act of volunteering, the participants may be significantly different than many of the people who were given the same opportunities to participate but choose otherwise.

One other potential characteristic important to comment about, involves the position of the researchers in the system under study. One main strength in the investigation surrounds the researchers prolonged engagement with the mental health clinic’s patients. From this perspective, the researchers could move beyond a surface glimpse of the system and examine consistent patterns developing over time. However, such involvement brings the personal bias of the researcher as a participant in the system to bear on the data interpretation process. Additionally, the participants understood the primary co-researchers’ positions as therapists at the clinic. This fact could have resulted in either overreporting or underreporting evaluative information about therapists.

Another, limitation involves the author’s assertions of the interventive nature of the focus groups. Though many of the patient responses indicated positive impact on self
esteem and perceptions of the hospital, there is no supportive empirical data. As such future research examining the impact of the qualitative evaluation should consider measures to assess this suggested interventive effect.

Last, the perspective of the new patient was not accessed. All participants involved had a significant span of involvement with the site under study. It is likely those who interfaced with the system only one or two times would bring a valuable perspective lost to relatively long-term repeat customers.
Purpose of the Study

Our interest lies in the success of the Performance Improvement initiative which is in the early phases of implementation at Broadlawns Medical Center (BMC). Mandated by the 1996 JCAHO reaccreditation standards, Performance Improvement is the cornerstone of all core functions identified for healthcare organizations. The success of Performance Improvement hinges largely upon careful attention to the planning and design phases of improvement efforts. This research is an attempt to examine and develop methods to improve the quality of mental health service provision at BMC. It must be stressed the study will examine all facets of service provision except confidential information expressed within the confines of the therapeutic relationship. Rather, this research will explore patient and staff evaluations regarding the provision of mental health services. Focus groups with both patients and staff will yield data regarding current perceptions of service provision as well as suggestions for change. Patient focus groups and a multidisciplinary staff focus group, will exchange and process evaluative information leading to the development of a combined team. Such a team, consisting of both patients and staff, may well serve BMC as a valuable consultant to ongoing Performance Improvement efforts.

Research Design

Qualitative methods will be utilized for data collection. Two focus groups with adult mental health outpatients and/or their families will be conducted by both researchers conjointly. Each patient focus group will meet a minimum of two times for approximately one and a half hours and will consist of eight to twelve participants. Concurrently, a focus group with eight to twelve staff persons will be conducted by both researchers conjointly. The staff focus group will meet a minimum of three times for approximately one and a half hours. Information from the patient/patient family focus groups will be shared with the staff focus group thereby beginning an exchange of information between patients and staff.
Such an exchange will culminate with the formation of a combined patient/staff group/team. All focus groups are projected to be completed within a three month window beginning in September, 1996. However, the focus group schedule will be dependent on logistical considerations and emergent design characteristics of qualitative research.

Data Analysis

The data will consist of transcript narrative taken from audio taped interviews and researcher field notes. Transcripts will be analyzed using the Developmental Research Sequence established by James P. Spradley (1979). This method of analysis is advantageous as it allows description of social phenomena without statistical data reduction that may obscure meaningful distinctions. In addition, analyses will ensure all descriptors of patient and staff identities will be kept anonymous so as to protect the confidentiality of participant responses.

Potential Benefits

The proposed study has a number of potential benefits for the Division of Patient and Family Services and Adult Outpatient Mental Health Services. First, the research will make efforts to understand and address patient and staff evaluations of service provision; thus, providing valuable information regarding the strengths and weaknesses of current BMC procedures. This information will be shared with staff in order to generate improvement strategies leading to better quality patient care. Second, the invitation for meaningful patient collaboration with improvement efforts conveys a message that BMC seeks and values patient involvement. In turn, the meaningful involvement of staff will likely enhance ownership and greater commitment to Performance Improvement changes. As stated by Backer (1995), "The single best validated principle in the literature on management of change is that the people who will have to live with the results of change need to be deeply involved in designing and implementing new processes. Unfortunately, they rarely are." Third, this project will foster a collaborative effort between BMC and Iowa State University researchers. Finally, if this exploratory project proves useful, the procedures used in this research may be tailored to assist the development of Performance Improvement initiatives associated with other core medical center functions.

Potential Risks

This research is not intended to cause any discomfort or deception of participants. Patient informants will be invited to participate through an informational letter detailing specifics which clearly define the parameters of the study (See Appendix 1A). These letters will be available through individual therapy staff as well as in common areas of the outpatient mental health department. Staff persons will be informed and invited to participate through formal presentations at regularly scheduled staff meetings. All participants will be provided an Informed Consent letter in addition to the complete project description (See Appendix 1B). For all informants in this study, participation is completely voluntary and no incentives will be offered.
This research promotes the evolution of ideas in the group context. However, if informants strongly oppose group participation, appropriate accommodations will be made to conduct individual interviews. It should be stressed confidentiality of group discussion is included on all Informed Consent documentation. As such, group participants will be strongly encouraged to refrain from discussing group member identities and/or input outside of the group context. Nevertheless, participants will be reminded confidentiality is never 100% guaranteed.

Confidentiality and Consent

During analysis, personal identifiers will be used only to differentiate among informant responses on transcriptions from audio taped focus groups. Each participant will be issued a code name and number (e.g., Patient #1 or Staff #5). There is no follow-up phase planned; thus, the inclusion of names with the data will not be necessary. It should be noted each participant will be required to review and sign Informed Consent documentation which will be kept separate from all data (See Appendices B & C). For a complete description of the Informed Consent and Descriptive documents, please see the attached letters.

Conclusion

We appreciate the consideration of this proposed research. It is our belief this research will address some of the recommendations suggested by the recently published Community Focus Groups conducted by the Community Relations and Development Department at BMC. If you have any questions and/or concerns please contact either Jeff Angera, M.S., ext. 5695 or Jeff Kerber, M.S., ext. 2493. Thank you.
Appendix 1A: Patient Informational Letter

Dear Broadlawns Outpatient Mental Health Patients:

Broadlawns Medical Center is committed to providing the best possible services. Broadlawns Medical Center Outpatient Mental Health Services is striving to ensure that we are in line with this mission. However, due to the great numbers of patients we serve at times it is difficult to evaluate if we are doing our best in the eyes of our patients and their families.

In an effort to hear the voice of our patients and their families, we are asking for volunteers to participate in two focus groups. The aim of the focus groups is to ask patients and their family members to evaluate their experience with our outpatient services to help us improve what we do in order to best meet your needs. Our primary interest is not specifically what happens between you and your therapist or psychiatrist. Rather, we want to understand how you evaluate all the “nuts and bolts” of Broadlawns Outpatient Mental Health. For instance, this could include the first time you made contact with outpatient mental health to set up an appointment, register for services, to your last contact with our billing department. We know each patient has different situations and we would like to hear your experience.

The requirements for your participation are minimal. As stated earlier, you will be asked to participate in two focus groups led by two facilitators who are therapists on the Broadlawns staff. These focus groups will last approximately 1 & 1/2 hours and will begin in mid-September. To ensure we do not miss any of your valuable input we will be taking notes, audiotaping the discussions, and later transcribing them to determine common themes of experience. Though we will be taping your responses we will not identify your name. All responses will be completely confidential. The questions will not address sensitive issues between you and your therapist, but as stated earlier, will ask about your experience with Broadlawns Outpatient Services as a whole. In addition, refreshments will be provided after your participation.

If you are interested please inform one of our secretarial staff (282-5695), your therapist, or contact Jeff Angera (282-5695) or Jeff Kerber (282-2493). We ask that you leave your name, phone number and/or address where you can be contacted. You will be contacted as soon as possible. We strongly encourage your participation. You can make a difference in improving the services you receive. We look forward to hearing from you!

Sincerely,

Jeff Angera                        Jeff Kerber
Appendix IB: Staff Informational Letter and Informed Consent

To: Patient and Family Services Staff

From: Jeff Angera, M.S., Mental Health Therapist
       Jeff Kerber, M.S., Mental Health Therapist

RE: A research project, “Patient and Staff Evaluations of Mental Health Service Provision and Organizational Readiness for Change: Implications for Performance Improvement”

Dear Participant:

This letter is intended to fully inform you of the proposed research and how you may choose to be involved. The following sections will adequately detail: a.) rationale for the project, b.) overview of the entire project, c.) what you may expect to experience if you choose to be involved, and finally d.) a request, for those interested, to sign the informed consent statement at the conclusion of this letter. It is important you know both Broadlawns Medical Center and Iowa State University Human Subjects committees have evaluated and approved this project.

**Rationale.** Our interest lies in the success of the Performance Improvement initiative which is in the early phases of implementation at Broadlawns Medical Center (BMC). Mandated by the 1996 JCAHO reaccreditation standards, Performance Improvement is the cornerstone of all core functions identified for healthcare organizations. The success of Performance Improvement hinges largely upon careful attention to the planning and design phases of improvement efforts. Meaningful involvement of staff will likely enhance ownership and greater commitment to Performance Improvement changes. As stated by Backer (1995), “The single best validated principle in the literature on management of change is that the people who will have to live with the results of change need to be deeply involved in designing and implementing new processes. Unfortunately, they rarely are.” This research is an attempt to examine and develop sound and meaningful methods to improve the quality of mental health service provision at BMC.

**Overview.** This study is qualitative in nature and makes use of data derived from transcript analysis taken from audio taped focus group interviews. It must be clear, this research will examine all facets of service provision except confidential information expressed within the confines of the therapeutic relationship. Rather, we intend to explore patient and staff evaluations regarding the provision of mental health services. Beginning in September of 1996, two focus groups with adult mental health outpatients and/or their families will be conducted by both researchers conjointly. Each patient focus group will meet a minimum of two times for approximately one and a half hours and will consist of eight to twelve participants. Concurrently, a focus group with eight to twelve
multidisciplinary staff persons will be conducted by both researchers conjointly. The staff focus group, again approximately one and a half hour in duration, will meet a minimum of three times. Information from the patient/patient family focus groups will be shared with the staff focus group thereby beginning an exchange of information between patients and staff. Such an exchange will culminate with the formation of a combined patient/staff group. This combined group may well serve BMC as a valuable consultant to ongoing Performance Improvement efforts. All focus groups are projected to be completed within a three month window. However, the focus group schedule will be dependent on logistical considerations and the emergent design characteristics of qualitative research.

**What you may expect.** This research is not intended to cause any discomfort to or deception of participants. If you should choose to participate you will first and foremost expect to review, discuss, and sign the informed consent statement at the conclusion of this letter. Further, you have the right to be informed of some potential benefits and risks due to your involvement with this research:

- **Benefits** may include the opportunity to directly influence changes in the way BMC provides mental health services. Such changes would be intended to improve service delivery systems, i.e., changes allowing us to work smarter and better. Working smarter may be evidenced by less redundancy of paperwork, improved communication systems among departments, and more efficient responsiveness to emerging developments in service delivery. This research will provide valuable information regarding the strengths and weaknesses of current BMC procedures.

- **Risks** may include the sharing of critical information in a group context. In sharing such information there may be political concerns. However, it is important to remember the goal of the project is to improve, not find fault. If participants strongly oppose group participation, appropriate accommodations will be made to conduct individual interviews. It should be stressed confidentiality of group discussion is included on all Informed Consent documentation. As such, group participants will be strongly encouraged to refrain from discussing group member identities and/or input outside of the group context. Nevertheless, participants will be reminded confidentiality is never 100% guaranteed.

You will be asked a variety of questions concerning your unique vantage and evaluation of mental health service delivery. All interviews will be audio taped in group room two. In addition to audio taping there will be a third researcher observing either behind a one way mirror or in the room taking extensive notes. The audio tapes will then be transcribed by personnel outside of the BMC system. Audio tapes will be destroyed within one year from time of taping.

**Informed Consent.** I have read and understand the above information. I understand my participation is voluntary and I may withdraw at any time without prejudice or penalty.
Date & Signature of Participant: ____________________________

Date & Signature of Witness: ____________________________
Appendix IC: Patient Informed Consent

Dear Participant:

The following project is designed to gather your evaluations and experiences of receiving outpatient mental health services at Broadlawns Medical Center. In collaboration with Iowa State University researchers, Broadlawns outpatient mental health is attempting to evaluate its services and make necessary improvements to provide the best care possible. The information that you and your fellow patients/family members provide will be shared with a group of Broadlawns mental health staff persons. In addition, representatives of your group will be asked and/or may volunteer to join the staff group to attempt to generate appropriate courses of action. As you have been previously informed, each focus group will take approximately 1-1/2 hours and will be approximately three weeks apart. Further, to ensure none of the valuable information you provide is lost, the focus groups will be audio taped, notes will be taken, and later transcribed for analyses.

It is hoped that the information you provide will enable Broadlawns to continue providing services you think are satisfactory and make changes where necessary. In all, it is hoped your participation will allow Broadlawns to provide the best possible services for patients. This project is not designed to cause any discomfort; however, if you do feel that you do not want to continue to participate at any time throughout the focus groups you may choose to quit without any repercussions. Though we prefer you participate in a group setting, if you are completely uncomfortable the facilitators will provide the option of an individual interview. If you do experience any difficulties, both facilitators are staff therapists and will take appropriate measures to provide services if necessary. Further, your responses will be taken very seriously and therefore it is asked you to be as honest and open as possible.

In order to protect the confidentiality of each person's responses, it is asked that all information stays within the confines of this group. In addition, the facilitators will code and analyze the information provided in such a way to ensure that no participants names will be identified. Audio tapes will be destroyed within one year from time of taping.

If you have any questions throughout the project please feel free to discuss them with the facilitators, Diane Notch (Director of Adult Outpatient Mental Health) 282-5695, or Dr. Harvey Joanning (Iowa State University Professor and supervisor of the project) 294-5215.

I have read and understand the above information. I understand my participation is voluntary and that I may withdraw at any time without prejudice to me.

Participant: ___________________________ Date: ___________________________
Witness: ___________________________ Date: ___________________________
MEMORANDUM

Appendix 1D: Hospital Letter of Project Approval

TO: Diane Notch
FROM: Dennis Walter, M.D. [Signature]
DATE: August 27, 1996
RE: RESEARCH

The proposal you submitted on behalf of Jeff Kerber and Jeff Angera is supported and approved as a study of our Patient and Staff Evaluations of Mental Health Service Provision and Organizational readiness for Change: Implications for Performance Improvement and we understand this study is to complete their doctoral degrees at Iowa State University.

We would ask that we receive timely updates and progress reports on this report for our "Human Subjects Research" notebook.

/c

[Signature]

Dr. William Iowa 50314-1597
If you are a patient using Broadlawns Medical Center Outpatient Mental Health we are very interested to learn about your experiences in order to evaluate and improve our services.

We will be holding 1 & 1/2 hour focus groups on the following dates and times: Please volunteer for one of the options below:

Option #1: Thursday October 3 at 4:00 pm & Thursday October 17 at 4:00 pm.
Option #2: Thursday October 10 at 9:00 am & Thursday October 31 at 9:00 am.
Option #3: Friday October 11 at 12:00 noon & Friday November 1 at 12:00 noon.

If you are interested in participating in one of the above focus groups please do one of the following:
• Pick up information & sign up at the front desk in outpatient mental health
• Talk to your therapist
• Contact Jeff Angera at 282-5695 or Jeff Kerber at 282-2493

We are very interested in your experiences. Please join us.

Free food and drink will be provided. Bus tokens will be available.
APPENDIX 3
INITIAL MEMBERCHECKING SUMMARY

Patient Focus Group 1 (PF1)
Initial Themes

The following represents general themes and many verbatim comments from our last focus group. They are not arranged in any order of importance. Rather, they represent themes as they emerged from the flow of our discussion. We would ask that you review the information and verify if it accurately represents the discussion from our last focus group. If you have any changes you would recommend please comment to the facilitators. Remember, there is no right or wrong answers, only that we represent your experiences. We want to remind you that the majority of these themes emerged from the following general guiding question (which spurred many important offshoots): “As if talking to a fifth grader, what do you experience when you come to Broadlawns Outpatient Mental Health?”

First step to coming to therapy pf1.3
- Secretaries greet you - “Hi, how are you doing today?”
- Secretaries remembered my name! That feels so good!
- Secretaries immediately take care of you.

Wanted to come to this group to share that I have had nothing but good service here. I was desperate and they helped. pf1.3

Things secretaries do to take care of you. pf1.4
- Look you up in the computer.
- Get your blue card and stand the sheet.
- Ask you to sign.

Registration. pf1.4
- Changes happened months ago.
- Didn’t leave the door open anymore.
- Don’t like the shut door.
- Told the door must be closed for the fire code.
- Why don’t they put a window in that door.
- Makes you feel you don’t want to go up to that door and knock - somebody is in there.
Door in Registration always used to be open. pf1.5
- Something to do with the fire code.
- I thought it was so stupid.
- Secretaries are out in the open at the desk, why is registration in a closed box.
- Don’t know if there is anybody in registration.
- Knock and open the door and if someone is in there you feel like a fool.
- No problem with the closed door but can understand others might be uncomfortable.
- Staff told patients they don’t like the door closed either.

What is registration for? pf2.5
- So they know you are here.
- Place to sign the papers.
- Your billing - so you can pay.
- I think they should have it at the front desk.
- Not everyone feels like going to registration and they don’t want to have to talk about that.
- Would rather sign it at the desk and wait to see the therapist instead of go and update information.

Printout. pf1.6
- Sometimes have it at the front desk.
- It depends if they have it run off or not.
- Depends on the efficiency the day before.

Parking Lot. pf1.6
- No where to park all the time.
- Puts me five minutes behind.

Secretaries. pf1.6
- Wonderful people on the phone and in person.
- Need to talk to my shrink and they listen.
- They give comfort like a counselor though its not their job.
- Can hang up after talking to them and feel better.

Registration. pf1.6
- Open that door - I do not like that door closed.
- One week they have a registration sheet the next week they send me to registration.
- When I go to registration there are many people sitting there.
- Have to wait all the time.
- Switch girls all the time and so messed up the computer and my insurance is wrong.
- Wrong information in the computer and have to go through all this stuff.
• Leads to being 20 minutes late!
• Being charged for an hour and not getting an hour. Happens a lot.
• This is bull, I’ve been going through this for months.
• Window issue - what’s wrong with a window.
• Why do you have to keep that registration door shut when everything else is open?
• Staff is trapped in the registration room and customers don’t like the small room.
• It’s rude to intrude on others when you open the door and they are in there.
• Sit and wait.
• It’s better lately because I take a paper with my insurance number, my Medicare and another paper.
• After waiting for registration you are all worn out and don’t know what to talk about - it just bugs you.
• You can be stressed too. That kind of stuff stresses me out - I hate that.
• Have to explain that I quit my job because of my sickness - so depressing to mention that, sometimes I feel worse than when I went in.
• I can’t take the stress because of my illness.
• Going through this procedure when we come in here is stressful - it gets to you.
• When you get to your counselor you are so frustrated and stressed out you spend 15 minutes complaining about registration.
• I see a different face in registration each time and that’s confusing.
• The blonde is good - she knows what she is doing.

Solutions for registration. pfl. 8
• Fiberglass window - be able to walk up to the door and peek to see if they are with a customer.

Ways to intervene with registration. pfl. 7
• Went to counselor and said this is bull!
• Counselor takes patient in office and go to registration later.
• Worked with therapist to give registration the proper information to have insurance pay but they are still trying to make me pay. Send bills and threaten collections - that is stressful!

Causes of stress in registration. pfl. 14
• Lost my job and insurance due to illness and had to come to BMC and bring up these losses through questions.
• Ask about unemployment.
• Ask about SSDI
• Bringing up losses each time really gets to me - hashing over old stuff.
• Understand why have to ask such questions - just gets old and upsets patients.
Don't have time to sit in registration - I am busy. pf1.7

Billing pf1.8
- Someone keeps taking my insurance out of the computer - had this problem for four years.
- Sent my bill to the wrong insurance company.
- They don't send the bill to Medicare properly or as the primary insurance.
- Very frustrating - tell my therapist I can't handle it.
- Billing problems depend on who is doing the billing the first time.
- Get bill when it should go to insurance - BMC bills incorrectly.
- Insurance rejects bill.
- I have to come to BMC and straighten out billing problems and it takes forever.
- Whoever puts it in the first time doesn't do it correctly then the bills get sent home.
- Bills keep kicking back and I have to keep coming back to the hospital to straighten out.
- Don't know how the hospital survives when they don't bill you right.
- I have had to come out once a month.
- You got to keep on top of these things all of the time otherwise you got a mess.
- Stressful trying to straighten something out constantly when you keep telling them "don't do this" and it's being done over and over.
- It's not really the registration people's fault, I think it is whoever put it in the computer the 1st time.
- No connection between the registration computer and the billing computer.
- Went straight to billing when had problem. They said I had a huge bill and I said "I am going to stop, I don't care about shrinks and counselors, I am going to be stuck with a $5,000 bill & I don't have $5,000. The bill was not showing up on the computer in registration.
- Go to billing with problems but they have a huge turnover there as well.
- Get huge bills and it really stresses me out because I will never be able to pay it back.
- Intervened with billing problem by going to the therapist and getting therapist’s help to iron out.
- Told therapist it was too stressful and since the therapist has taken over I'm more at ease and relaxed. Get stressed even talking about it.

Way around questions in registration. pf1.14
- Say "nothing has changes" to registration person.
Registration turnover. pfl. 9
- Person not up on the procedures.
- Makes it hard on the patient.
- Real frustrating.
- You come in here and feel good, and when you leave you are back to route one.
I have had to make the rounds to each station I register at to get it right - someone keeps knocking my information out of the computer. pfl. 13

Things the outpatient secretaries do. pfl. 10
- Put you at ease.
- Cheer you up.
- Know your name and what you are here for.
- You are not a number.
- They know you.
- They don’t treat you like a “nut” or a “psycho”.
- Treat you as an individual.

BMC outpatient mental health providers better than other (outside BMC) providers when comes to being on time. pfl.

Procedure after therapy. pfl. 17
- Some therapists make next appointment in their office.
- Some therapists have secretaries make appointments.

Counselor and psychiatrist booked so heavy I have to book weeks in advance. pfl. 17

Have to keep after therapist and psychiatrist time after time to get a medication change. pfl. 17

Poor communication between inpatient and outpatient. pfl. 18
- My outpatient psychiatrist does not see me inpatient so I got another Dr.
- My outpatient Dr. and counselor did not know I was inpatient.
- Lack of communication between inpatient and outpatient Drs. on my medication. The inpatient gave me different dosage than my outpatient.

Crisis team. pfl. 19
- Had to wait for 6 hours and I was in real bad shape and was ready to do myself in.
- Called hospital and they promised it wouldn’t happen again and the next time it was 3 hours.
- Poor communication between the crisis team and the inpatient unit. Nobody would listen when I would try to explain what the other department had done.
Ways to speed up getting into the inpatient unit. pfl.19
- Prior suicide attempts.
- Dr. has written it in the chart that he would approve admission.

Psychiatrist only here one day/week. pfl.20
- Big problem when starting new meds and side effects are messing with me.
- Have to wait a week to talk to him again to alter dosage.
- Don’t think it is right that Dr. is only here one day/week.
- Called Deitz clinic for Dr. but he doesn’t have my records there.
- Lucky, my Dr. is here every day.
- Cautious about new shrink because he is only here one day/week.

Intake process to slow. pfl.20
- Took a couple of months before I got my own therapist.
- Glad I wasn’t worse off.
- Referrals from correctional facility - get intake and out because the corrections program is only 70 days.

Way around waiting for Dr. pfl.20
- When need to get Dr. go to therapist and tell about meds.
- Then Dr. calls me back.

Problems with psychiatrist - fired that person and took 3-4 months to get another. pfl.21

Counselor really cares. pfl.22
- Has helped me a lot.
- I have done a lot with him.
- Can call him about situations for advice.
- Always calls me back.

Psychiatrist pfl.22
- Can’t get through to them by phone.
- She doesn’t help
- She doesn’t really care.
- Had some back situations with shrink and was going to leave. However, have rapport with my therapist and will stay even though problems with shrink.
- You are paying $ and you want to get well and you have to have good rapport to work with them.
- I can talk to him for maybe 10 - 15 minutes and its like I almost feel like he’s shoving me out the door for $180.
- Elsewhere I felt like my psychiatrist was more understanding, they listened more.
- See psychiatrists role as writing prescriptions and the therapists does all the work.
- Shrinks need to care about you more.

**Therapists and social workers care about you more as a person than psychiatrists.** pfl.22

**Shrink was not helpful when asked about changing therapists.** pfl.28
- Asked advice about changing therapists and the shrink said she didn’t know and it had nothing to do with her.

**Therapist will talk, shrink doesn’t want to spend the time.** pfl.27

**Recognize the heavy caseload of psychiatrists. But feel they should still treat everybody the same and I think they should spend more time with us.** pfl.27

**Question about how to change to a different therapists.** pfl.28
- Should post the procedure.
- Don’t need to but wouldn’t know what to do to request a change.
- It should be your right to change therapists if you need to.

**Love my therapist to death, but finding a psychiatrist outside of BMC - too hard to get any communication with my psychiatrist.** pfl.22

**Reason to come to or stay with BMC even if given the choice.** pfl.23
- They have been really nice.
- They have been really understanding.
- Once I got used to the system I felt comfortable.
- Have a really good bond with my therapist and she listens to what I say.
- My Dr. is nice and listens and is understanding.
- This hospital is more on top of mental problems that other hospitals (inpatient). When admitted have a better atmosphere. Get you over the period of coming in and being frustrated. I will come here first to get help. Other hospitals just take your money and give you shock treatments.
- They are caring.
- They try to take care of your problems.
- They know you.
- Get along with the secretaries and most people.
- Rapport with therapist - it is hard to find a person you really feel comfortable with or can express yourself with.
Don’t have a choice to come here. pfl.24
- Because of SSDI and if I don’t come here and don’t get my medicines then I am going to end up getting stressed and I am going to get sick and end up back here so I guess if I am going to go through this every time, I guess that is just something that I am going to have to deal with.

BMC has a bad name. pfl.25
- When I got new insurance I said, “I’m outta here” they have got a bad name.

Therapist. pfl.26
- Keeps you going on your problems to get them out.
- Express your view points this way they can return information to the Dr. so he can take time with you.

I have read the above material and agree the information accurately represents the focus group discussion I participated in. If I have any discrepancies or changes to recommend I have expressed them to the facilitators and/or made comments on this sheet.

Signature_________________________ Date__________________

Facilitator Witness_________________________
APPENDIX 4
PATIENT THEMATIC STATEMENTS

The following statements are re-presentations of themes generated from the Broadlawns Medical Center (BMC) Adult Outpatient Mental Health Patient Focus Groups. Please take time to read the following statements carefully and circle one response per statement that best fits your opinion. If you have additional comments regarding any of the statements please make comments in the margins or on the back of the sheets. Thank you for your time and consideration!

1. Registration is not treated as important by the outpatient mental health staff.

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<th>Strongly Disagree</th>
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2. The purpose of registration is not clear.

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3. Registration is frustrating when it takes time away from my therapy/psychiatry appointment.

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<th>Strongly Disagree</th>
<th>Disagree</th>
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4. Registration is frustrating because they ask the same questions all of the time.

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5. Registration is frustrating because it is slow, and there is no organization when waiting.

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6. Registration is frustrating because there is no way to see if someone is in the registration office.

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7. Registration is stressful when I have to repeat all the information which lead to my mental illness.

1 2 3 4 5 6 7
Strongly Disagree Disagree Somewhat Neutral Somewhat Agree Agree Strongly Agree

8. Registration is stressful when a person is in crisis.

1 2 3 4 5 6 7
Strongly Disagree Disagree Somewhat Neutral Somewhat Agree Agree Strongly Agree

9. If you have difficulties with registration the best way to deal with the problem is to tell your therapist/psychiatrist.

1 2 3 4 5 6 7
Strongly Disagree Disagree Somewhat Neutral Somewhat Agree Agree Strongly Agree

10. The secretarial staff at BMC outpatient mental health show patients they care.

1 2 3 4 5 6 7
Strongly Disagree Disagree Somewhat Neutral Somewhat Agree Agree Strongly Agree

11. The secretarial staff at BMC outpatient mental health are helpful in person and over the phone.

1 2 3 4 5 6 7
Strongly Disagree Disagree Somewhat Neutral Somewhat Agree Agree Strongly Agree

12. There is not enough parking spaces in the BMC lot.

1 2 3 4 5 6 7
Strongly Disagree Disagree Somewhat Neutral Somewhat Agree Agree Strongly Agree

13. My personal information is often different at different computer stations.

1 2 3 4 5 6 7
Strongly Disagree Disagree Somewhat Neutral Somewhat Agree Agree Strongly Agree

14. If there is an error in my personal information in the computer I have to go to each station I have contact with to change the information.

1 2 3 4 5 6 7
Strongly Disagree Disagree Somewhat Neutral Somewhat Agree Agree Strongly Agree
15. The limited amount of time with and limited availability of my psychiatrist is a problem.

| Strongly Disagree | 1 | Disagree | 2 | Somewhat Disagree | 3 | Neutral | 4 | Somewhat Agree | 5 | Agree | 6 | Strongly Agree | 7 |

16. Sometimes I feel I am in control of my own psychiatric care.

| Strongly Disagree | 1 | Disagree | 2 | Somewhat Disagree | 3 | Neutral | 4 | Somewhat Agree | 5 | Agree | 6 | Strongly Agree | 7 |

17. To solve problems with my psychiatrist I must go through other people (e.g. adult outpatient mental health secretaries).

| Strongly Disagree | 1 | Disagree | 2 | Somewhat Disagree | 3 | Neutral | 4 | Somewhat Agree | 5 | Agree | 6 | Strongly Agree | 7 |

18. I sometimes question if my psychiatrist demonstrates concern about my mental healthcare.

| Strongly Disagree | 1 | Disagree | 2 | Somewhat Disagree | 3 | Neutral | 4 | Somewhat Agree | 5 | Agree | 6 | Strongly Agree | 7 |

19. Telephone communication with BMC psychiatrists is difficult.

| Strongly Disagree | 1 | Disagree | 2 | Somewhat Disagree | 3 | Neutral | 4 | Somewhat Agree | 5 | Agree | 6 | Strongly Agree | 7 |

20. Communication with BMC psychiatrists is not as difficult when in person.

| Strongly Disagree | 1 | Disagree | 2 | Somewhat Disagree | 3 | Neutral | 4 | Somewhat Agree | 5 | Agree | 6 | Strongly Agree | 7 |

21. The secretary for outpatient psychiatry is overloaded.

| Strongly Disagree | 1 | Disagree | 2 | Somewhat Disagree | 3 | Neutral | 4 | Somewhat Agree | 5 | Agree | 6 | Strongly Agree | 7 |

22. Dealing with BMC billing is stressful.

| Strongly Disagree | 1 | Disagree | 2 | Somewhat Disagree | 3 | Neutral | 4 | Somewhat Agree | 5 | Agree | 6 | Strongly Agree | 7 |

23. When I have a billing problem with adult outpatient mental health charges I have to return repeatedly to the billing department to straighten out the problem.

| Strongly Disagree | 1 | Disagree | 2 | Somewhat Disagree | 3 | Neutral | 4 | Somewhat Agree | 5 | Agree | 6 | Strongly Agree | 7 |
24. Sometimes I get billed for adult outpatient mental health services when the bill should go to the insurance company.

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25. Sometimes the wrong insurance company is billed for my adult outpatient mental health services.

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26. There is no connection between the registration computer and the billing computer resulting in incorrect information.

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27. One way to deal with a billing problem is tell my therapist.

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28. I was surprised at the quality ideas that came out of the patient focus group.

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29. I like a smaller number (4-7 people) in the patient focus group.

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30. Being asked to contribute to the patient focus group has been positive for my self esteem.

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<th>Disagree</th>
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31. Having patient focus groups is positive for adult outpatient mental health.

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32. I have enjoyed participating in the adult outpatient mental health focus groups.

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33. At my ideal adult outpatient mental health clinic I would feel understood, welcome, the staff would be courteous, and the staff would take the time I need.

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34. At my ideal adult outpatient mental health clinic the colors would be brighter, the chairs more comfortable, and there would be a play area for children.

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35. I wish there was more privacy in the BMC adult outpatient mental health waiting area.

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36. I would like the option of a beverage in the adult outpatient mental health waiting area.

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37. I am satisfied with the physical layout and surroundings of adult outpatient mental health.

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38. There is a communication gap between my psychiatrist and my therapist.

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39. My therapist demonstrates he/she cares.

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40. My perception of the psychiatrist’s role is to be concerned about medication.

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41. My perception of the therapist's role is to be concerned about personal issues/concerns.

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42. Therapists sometimes act as advocates with the psychiatrists.

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43. I prefer to schedule my next appointments in my therapist's office so I don't have to stop at the front desk after therapy sessions.

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44. I would like the procedure for how to change therapists to be shared with the patients.

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45. The span of time between when I called for an appointment and when I was scheduled for my intake was too long.

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46. The Des Moines community's perception of BMC adult outpatient mental health is it is the place you go only if you absolutely have to.

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47. Overall, I am satisfied with adult outpatient mental health.

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48. If I had the choice I would go elsewhere for mental health services.

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49. The patient focus group process should be employed for other areas of the hospital.

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Thank you for your time and consideration. Please return these forms to Jeff Angera in Outpatient Mental Health in the envelope provided. Please do not put your name on this document. If you have any questions you can contact me at 282-5695.

Jeff Angera
June 28, 1997

To: Members of the Dissertation Committees
   for Jeffrey Angera and Jeffrey Kerber

From: Patricia Keoughan, Ph.D., President, Human Systems Consultants

Re: Audit of Angera and Kerber Dissertations

This memo is to inform the Committees that I have reviewed both Mr. Angera’s and Mr. Kerber’s dissertations and found them to be methodologically sound. I have been involved with their dissertations since they began. I originally consulted with them regarding their initial research questions and proposed methodology. I also joined them in meeting with administrators of the medical center to explain the project and solicit the hospital’s cooperation. I have meet regularly with Mr. Angera and Kerber as the project has developed. My involvement has been largely consultative. We have discussed a variety of methodological issues such as who to interview, how to interview, number of informants to sample, specific questions to ask, how to handle logistical issues which have emerged, how to analyze data collected, how to interpret the data, and issues to explore in the final discussion section of the dissertations.

Throughout this project I have found both Mr. Angera and Kerber to proceed in an ethical and professional manner. They have been very attentive to my suggestions and eager to conduct a thorough and competent study. I have been especially impressed by the sensitivity they have shown to their informants and the care they have exercised in analyzing their data. In sum, I find their studies to be of high quality and illustrative of competent consulting.
REFERENCES


