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An early assessment of the Flowchart Dementia in general practice

Health Sciences

Master thesis

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Abstract

Introduction: The population of the Netherlands is ageing rapidly. Consequently, the number of people diagnosed with dementia is increasing. Statistics show that in January 2011 there were 51.900 people diagnosed with dementia by a general practitioner, of which 19.900 men and 32.000 women. When diagnosed in an early stage, the effects of treatment plans and pharmacological treatments are likely to have the maximum impact. In 2013 a collaboration started between several organisations in the region Twente. Together their goal is to increase the expertise concerning dementia. The expectation is that the provided care will be better for patients and their family when health care providers have a better understanding of the disease. The flowchart dementia is a tool used to support general practitioners and nurse specialists in diagnosing dementia. The flowchart describes the steps a general practitioner can take and the process of referring to a specialist. After the implementation of the flowchart in the pilot program, the facilitators and barriers of the flowchart will be determined. The effects, as perceived by the GPs, will also be evaluated.

Methods: A combination of quantitative and qualitative data was collected to get more insights in the perceived effects of the flowchart dementia. The questionnaire consists of open and closed questions. The closed questions are based on the Measurement Instrument for Determinants of Innovation (MIDI) questionnaire. The open questions were formulated to receive extra information about the effects for the GP and the patient when using the flowchart dementia. The results of the closed questions were used to determine the facilitators and barriers when using the flowchart dementia. This data was analysed to see if there are important factors according to the GPs that are of influence on the usage of the flowchart. The results of the open questions were coded and systematically analysed to gain insights in the opinions of the GPs.

Results: A total of 22 responses were used in the analysis. According to the GPs the flowchart dementia is easy to use and a useful addition to their usual care. However, several barriers cause the innovation not to be used in every general practice. The overall comments made by the GPs were positive.

Conclusion: The overall effects for both the patient and the GP are positive. The flowchart dementia has made some promising steps toward more expertise of GPs concerning dementia in the region Twente. There are still steps that can be taken to improve the implementation process, but the overall the opinion of the GPs is positive. The recommendation is to further distribute this flowchart and give training to every GP in the region Twente, to stimulate the GPs to use it. More research is needed in a later stage to investigate the actual health effects for the patients.

Key words: Dementia, General practice, Flowchart Dementia, MIDI, Twente, Diagnosis, Theory of Planned Behaviour (TPB).

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Introduction

The population of the Netherlands is ageing rapidly. Consequently, the number of people diagnosed with dementia is increasing (World Health Organization, 2012). Statistics collected by the Rijksinstituut voor Volksgezondheid en Milieu (RIVM) show that in January 2011 there were 51.900 people diagnosed with dementia by a general practitioner (GP), of which 19.900 men and 32.000 women (Poos & Meijer, 2014). All of these patients were undergoing treatment at the time. Furthermore, in 2011 approximately 12.700 new cases of dementia were identified in the Netherlands (Poos & Meijer, 2014). The impact of a disease like dementia is huge. In addition to the financial impact on society, which is an estimated €4,8 billion – or 5,3% of the total health care costs – in 2011 alone (Meijer, 2014), the effects are enormous on the patient and their direct environment (Fox et al., 2013). The impact of dementia on health care providers, family and society can be physical, psychological, social and economic (World Health Organization, 2015). The changes in behaviour and psychological symptoms that are caused by dementia are of great influence on the quality of life of both the patient and their family (World Health Organization, 2012). After the first signs of dementia, patients have an average life expectancy of eight years to ten years (Papma, 2014c). The course of the disease varies greatly between patients and depends on the type and cause of dementia, but is always progressive (Papma, 2014c). Most of the patients that suffer from dementia will pass away due to comorbidity, for example cardiovascular disease (Moll van Charante et al., 2012). To prevent comorbidity and the progression of the disease early diagnosis is essential (Moll van Charante et al., 2012).

When dementia is diagnosed in an early stage, the effects of treatment plans and pharmacological treatments are likely to have the maximum impact (Milne, 2010). With early diagnostics the ability to cope or learn to cope with the disease increases, for both the patients and their family (Clare et al., 2005). A short support programme for relatives of patients with dementia showed a reduction of placement in care homes by 28% (Banerjee et al., 2007). Research in the UK showed that the advantages of early diagnosis of dementia are mostly for the families and the people who take care of the patients (ILiffe et al., 2003). Advantages to the patients were the reduction of uncertainty, the planning of support, the exclusion of a cure, accepting the diagnosis and a better possibility to avoid a crisis (ILiffe et al., 2003). This research also showed that in some cases the relatives would pressure the GPs to refer to a specialist or that an early diagnosis could have a destructive effect for the patient (ILiffe et al., 2003).

To better understand the current process of diagnosis and the importance of an early diagnosis for patients suffering from dementia, a further examination of the different methods of diagnosis is required.

The first recognition of dementia related symptoms usually takes places in the general practice. The general practitioners indicate that they look for changes over time in the behaviour of their older patients to recognize dementia (Hansen et al., 2008). Diagnosing dementia by the general practitioner can be divided into four stages (Moll van Charante et al., 2012):

1. Recognition of symptoms, by the patient and their surroundings;
2. Determination of dementia according to DSM-IV criteria [1];
3. Referral to specialist for further diagnosis;
4. Developing treatment plan for patient and the caregivers.

Important tools for the diagnosing of dementia have been developed over the years. The two most frequently used methods are the Mini-mental state examination (MMSE) and the clock drawing test (Moll van Charante et al., 2012). The Mini-mental state examination is used to measure cognitive functioning within ten minutes. It measures orientation, short term memory, language, recognition and the ability to reproduce a geometric figure (Moll van Charante et al., 2012). With the clock drawing test, or klokteken test (KTT), the patient is asked to draw a circle, add all the numbers and set the indicators of the clock to ten past eleven. This test measures different cognitive abilities and is easy to use (Moll van Charante et al., 2012).
There is no cure available for patients who suffer from dementia (World Health Organization, 2015), therefore the focus of treatment is on improving the quality of life of the patient and supporting the families. The treatment consists of a treatment plan and a support plan, these are adjusted over time to have the best possible treatment for the patient. Case management is often used for dementia patients, the case manager is primarily a health care provider and will support the patient in the whole process. (Richtlijn Diagnostiek en Behandeling van dementie, 2014).

A GP has a large variety of conditions and symptoms to diagnose, so the use of guidelines for a particular disease is sometimes too specific (Pimlott et al., 2009b). The process of diagnosing dementia is more complicated than other chronic conditions because of the complexity of the brain (Pimlott et al., 2009b). Especially in an early stage dementia is not always recognized due to uncertainty of the diagnosis (Pimlott et al., 2009b).

[1] A memory defect, one or more cognitive dysfunctions, a dysfunction that gives a significant limitation to social or professional functioning in comparison to the previous level of functioning, and no sign of delirium.

A number of obstacles were identified that could delay or prevent the delivery of appropriate care. Although GPs indicated that they think dementia should be diagnosed in an early stage, they feel embarrassed to perform a cognitive examination in an early stage when dementia is not clearly present (van Hout et al., 2000). The uncertainty of the disease being present is the most important factor for not giving the diagnosis to patients (Vassilas & Donaldson, 1998).

In order for a GP to recognize all the symptoms of dementia and thus accurately diagnosing the patient, several factors are important. Among others, it is important that the GPs have the required knowledge, skills and motivation for an innovation to be successful in their practice (Wensing et al., 1998). A study in the Netherlands showed that knowledge and skills transfer are necessary to achieve change, however this is not enough by itself. "Other barriers that may prohibit change include an inadequate practice organization, lack of time, negative financial incentives, negative attitudes in colleagues, or resistance from patients" (Wensing et al., 1998). To remove these barriers, the influence of a managerial body and influence of a social kind can help (Wensing et al., 1998).
Other barriers to successfully diagnose dementia in general practice have also been found in other studies. Among those is a study in Germany, where there is scepticism towards the dementia diagnosing process (Thyrian & Hoffmann, 2012). One third of the GPs felt competent to take care of patient with dementia, they also agreed that continuous guidelines and education are needed to have an optimal diagnosis (Thyrian & Hoffmann, 2012). However, general practitioners in Canada indicated that future guidelines should accurately reflect the daily challenges of physicians (Pimlott et al., 2009a). Although, research in the UK showed that GPs are not always willing to apply evidence based guidelines (Cranney et al., 2001). They think that the guidelines are only applicable in an ideal situation and when the patient meet the same standards that were used in the trial (Cranney et al., 2001). Some GPs viewed the guidelines as well-informed suggestions, while others saw it as a standard of care that has to be followed (Pimlott et al., 2009a). Others think that guidelines are an informational resource and will become less useful when used more frequently (Pimlott et al., 2009a).
An educational intervention for the diagnosis of dementia in the UK showed that a lack of time and unknown effectiveness of an intervention might be a discouragement for GPs to participate in an educational trial (Iliffe et al., 2012). The factor time can be seen as both a barrier and an enabler. When a GP has more appointments over time, small changes in the patient will be noticed. But time is also a barrier, over time patients will suffer from comorbidity (Pimlott et al., 2009b).

Research in Australia shows that several factors are important to determine the effectiveness of a new dementia screening (Grimshaw et al., 2004). A systematic review shows that the effectiveness and efficiency of guideline dissemination and implementation strategies result in improvements in overall care in 86,6% of the observations (Grimshaw et al., 2004). The main factor that must improve is the GPs identification of dementia, the distinction between dementia and other diseases, the GPs elimination of reversible causes of cognitive dysfunction and the active management by referring to the correct specialist in a certain situation (Pond et al., 2012). Outcomes that are important for the patients and their support are a more acceptable process for the patient and better health outcomes for the patient (Pond et al., 2012). Research in the UK showed that early diagnosis has positive effects on the quality of life of a patient with dementia (Banerjee et al., 2007).

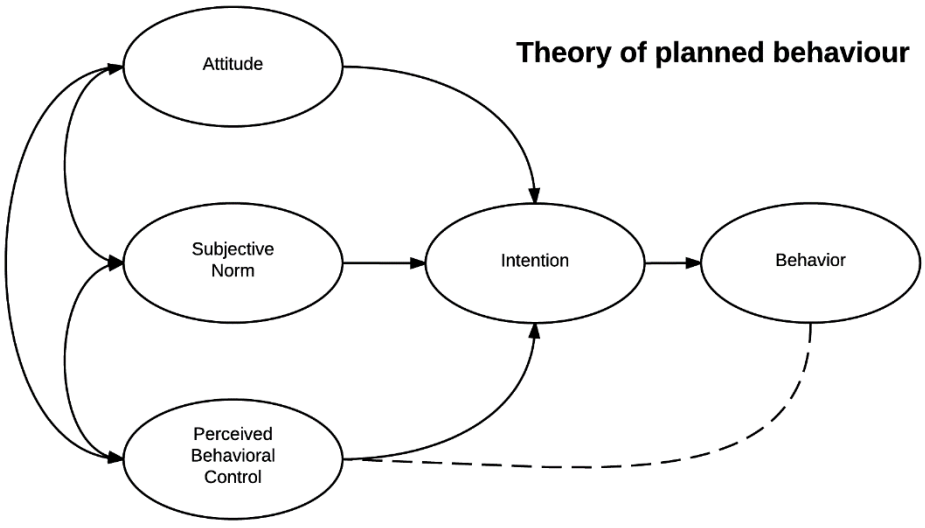
Before a new method of screening, or any healthcare innovation, can be broadly adopted, it needs to be distributed and accepted by its users. An important theory for the diffusion of innovations was developed by Rogers in 1983 (Rogers, 1983). The diffusion of innovation model describes five steps in the decision making process for clinical changes (Rogers, 1983; Sanson-Fisher, 2004). At first the developers of an innovation need the knowledge about the clinical change (Sanson-Fisher, 2004). After that the individual clinicians have to be persuaded about the advantages of the innovation (Sanson-Fisher, 2004). When clinicians are persuaded about the advantages they need to read, attend workshops and communicate with other clinicians to decide whether to adopt or reject an innovation (Sanson-Fisher, 2004). If a clinician is positive, he needs to incorporate the innovation in the daily activities (Sanson-Fisher, 2004). At last the clinician needs to discuss and compare the innovation with peers (Sanson-Fisher, 2004).
To have a successful implementation of an innovation in any field, the users of the innovation must embrace it. Therefore, they must show the intention to perform certain behaviour by using the innovation. The issues concerning the likelihood of a general practitioner implementing a new guideline can be placed in the categories mentioned in the Theory of Planned Behaviour (Kortteisto et al., 2010). When applied to this theory, this suggests that general practitioners have a slight tendency towards a negative attitude when it comes to implementing a new innovation. The Theory of Planned Behaviour (TPB) is a model that is used to explain human behaviour. This model states that individuals act in a certain way because they consider all possible implications of their actions in a rational way (Morrison & Bennett, 2010). A central factor in this theory is the individual's intention to perform a given behaviour (Azjen, 1991). Three different factors are of influence on the intention of behaviour, attitude (1), the subjective norm (2) and perceived behavioural control (3). The attitude is a positive or negative view toward the behaviour. The subjective norm is the perceived social

pressure to behave in a certain way. The perceived behavioural control is the perceived ability to perform the behaviour. The model can be found in

. The resources and opportunities of a person determine in some extent the likelihood to perform certain behaviour, but even more important is the perceived behavioural control (Azjen, 1991). The TPB suggests that a GPs intention to use an innovation is determined by his positive or negative opinion of the technology (1), the perception of the opinions of relevant others on whether or not he or she should use the technology (2) and the perception of the availability of resources and skills to use the innovation (3) (Chau & Hu, 2001).

This TPB is an important tool to predict and understand how people handle new innovations. If they have a negative attitude towards an innovation they will be less likely to use it. Therefore, it is important that all these factors of the TPB are positive to have a successful implementation. According to a study in Australia, the attitude and subjective norms are the most important predictors for the adoption of a healthcare innovation and the willingness to use it (O'Connor, 2007). Research in Finland showed that the subjective norm, perceived behavioural control and attitude are important factors to predict the use of clinical guidelines in general practice (Kortteisto et al., 2010). The most important factor for the intention to use of a new innovation for GPs is the perceived behavioural control (Kortteisto et al., 2010). This research also shows that the Theory of Planned Behaviour is a suitable theoretical framework for the implementation of guidelines in general practice (Kortteisto et al., 2010). A research in the UK also showed that the perceived behavioural control and the attitude, but not the subjective norm, were predictors for following guidelines (Rashidian & Russel, 2011).

Figure 1. Theory of Planned Behaviour



Current state in Twente

In 2013 a collaboration started between several organisations: Twentse dementieketens, Twentse Huisartsen Onderneming Oost Nederland (THOON), Regionale Ondersteuningsstructuur Eerstelijnszorg Twente (ROSET), Federatie Eerstelijnszorg Almelo (FEA) and IZO Twente. Their goal is to increase the expertise concerning dementia in general practice. The expectation is that the provided care will be better for patients and for their family when health care providers understand dementia better.

The other goal is to detect dementia in an early stage. To achieve these goals different tools are available to train medical professionals, one of these tools is the flowchart dementia. The flowchart was developed by different professionals in the region of Twente. An advisor of ROSET coordinated and supported the process of creating the flowchart. Several specialists were involved in this process: general practitioners, geriatric specialists, case managers, clinical geriatrician and neurologists. To help the new practices implement the flowchart, training and an e-learning course have been made available.

The flowchart dementia is a tool to support general practitioners and nurse specialists in diagnosing dementia. The flowchart describes the steps a general practitioner can take as well as the process of referring to a specialist. This tool describes when to refer to a specialist and what external parties can be of use for a specific patient. The contact information of several organisations that are involved with dementia are mentioned. See Appendix A: Flowchart Dementia for the flowchart dementia. This flowchart should be used by general practitioners when symptoms point to dementia. In this case the general practitioner can request a case manager. The case manager is responsible for guiding the patient through the dementia care process and advise him/her, so he will receive the best possible care. A case manager also has a central position in the network and is able to cooperate with different healthcare providers and keep everyone who is involved in the process up to date (Minkman et al., 2009). The strategies for case management vary in terms of care organization and content. This variation depends on the regional and local practices and random factors (Verkade et al., 2010).

In this study we will focus on the flowchart dementia, that is part of the new pilot dementia, developed by Dementie Twente. At the moment numerous general practices in the region Twente are using these new tools for diagnosing dementia. One of the organisations involved in this pilot program is THOON. Among its members a few general practices have joined the pilot program dementia. If the results of the pilot program are positive, further implementation of this method will be considered among all general practices. After the implementation of the flowchart in the pilot program, the effects of this new method of diagnosing will be measured. To get a first impression of

the impact of the pilot program, perceived differences between the new diagnosing method and the old method according to the GPs are investigated. The main goal of this research is to determine the facilitators and barriers for the general practitioners when using the flowchart dementia and if possible the effects of the flowchart for the GP and the patient.
Therefore, the following to research questions were formulated:

'What are the facilitators and/or barriers in the primary care process, after the implementation of the new flowchart in diagnosing dementia, from the perspective of the GP?'

'What effects of the implementation of the new flowchart dementia do the GPs experience, compared to the previous diagnosing methods?'

Methods

The aim of this study is to evaluate the facilitators, barriers and the effects of the new pilot dementia in Twente, according to the GPs. This study is a mixed methods research, it combines qualitative and quantitative data.

The measurement instrument for determinants of innovations (MIDI) is used as a basis for the questionnaire (Fleuren et al., 2014). This instrument can be used to measure determinants that can affect the implementation of a new innovation. MIDI has three different categories that will be evaluated in this research: determinants of the innovation, determinants of the organisation and determinants of the user. Each of these categories consist of questions that can be used to evaluate different factors. MIDI is a framework that can be used to evaluate an innovation, therefore the questionnaire was adjusted for this research. This section of the questionnaire serves as the quantitative part of the study. Open questions are used to get extra information and determine the effects of the flowchart dementia. These questions about the use, effects and opinions of the GPs in the process of implementation provide the qualitative data for analysis.

Study population

In a qualitative study the population is often relatively small and selectively chosen (Plochg et al., 2007). The following inclusion criteria are used for the selection of participants in this research. General practices are included when they are joining the new case management and early diagnostic pilot of Dementie Twente. Four different regions are included:

Northwest-Twente: municipalities Almelo, Tubbergen, Twenterand, Hellendoorn, Wierden and Rijssen-Holten.

Central-Twente: municipalities Borne, Hengelo and Hof van Twente.

Northeast-Twente: municipalities Oldenzaal, Tubbergen, Losser and Dinkelland.

Southeast-Twente: municipalities Enschede and Haaksbergen.

The total number of members of the organisation THOON is 188, while FEA has 137 members. These GPs will all be included in this research.

Data collection

The recruitment of general practices for the questionnaires is done with the help of the organisation THOON. THOON sent an e-mail to all practices to inform them about this research and send a link with the questionnaire. The questionnaire is distributed among general practices that participate in the pilot. The questionnaire is published mid-April and was available until the end of May. The question 'Are you familiar with the flowchart dementia?' was asked, after the questionnaire was sent to the GPs. This question was sent in an email to get more information about the usage of the

flowchart dementia. A different link within the email was sent to FEA and THOON to see whether there is a difference between the organisations.

Questionnaire

MIDI, developed by TNO, was used to determine the effects and the facilitators and barriers within this implementation process. The MIDI questionnaire evaluates three different categories: determinants of innovation, determinants of user and the determinants of the organisation. In Table 1 and Table 2 the subject of each questions can be found. The three categories named by MIDI can be found in the third column.

Some additions or adjustments are made to fit it to this particular research. The following adjustments were made to the MIDI questionnaire. The questionnaire can be found in Appendix B: Questionnaire.

Questions 13 and 14 are split up into two questions to check whether there are advantages and disadvantages in the use of the flowchart dementia. Question 15 is formulated to see if the GPs really think it is important to have a quicker diagnosis. Question 21 is added to see if the GPs need more information or education for the use of the flowchart dementia.

Question 29 is also added, this is to check whether the GP thinks it is important to have a faster diagnosis and if he is able to actually perform a faster diagnosis for his patients. This is one of the main reasons for the development of the flowchart.

Questions 33, 34, 35, 36 and 37 are open questions that are added to get some more insight in the opinions of the users of the flowchart, for example time difference in diagnosis and a time to referral to a specialist. Additional questions were used to determine the perceived health effects on the patients, process effects and the practical advantages and disadvantages of the use.

The first research question, *'What are the facilitators and/or barriers in the primary care process, after the implementation of the new flowchart in diagnosing dementia, from the perspective of the GP?'* focusses on the facilitators and barriers in the process of implementation of the new flowchart dementia. Several questions of the questionnaire can be used to find the facilitators and barriers in this process. These questions are primarily found in the closed part of the questionnaire. For example, if the information dissemination, time or financial means are limited, the adoption of the flowchart will be slowed or postponed. These are just examples of possible facilitators and barriers within this questionnaire, it depends on the results to find the factors that influence this process.

The second research question, *'What effects of the implementation of the new flowchart dementia do the GPs experience, compared to the previous diagnosing methods?'* focusses on the effects that

the GPs experience, after the implementation of the flowchart. The questions from the questionnaire that can be used to answer this, are focussed on the user and innovation categories. If the flowchart has a positive effect on the GP, for example a quicker and more efficient way of working, he will be more motivated to use this flowchart. The most important question to see the effects on the patient is question 35, this open question gives the GP the opportunity to tell more about the perceived effects on the patient. The open questions are optional, if it turns out that the response rate on these questions is low, additional interviews will be held to get this data.

The MIDI that is used in this research has some links to the TPB. In the fourth column of Table 1 and Table 2 the link is made between the MIDI questionnaire and the TPB. The three categories within the TPB can be linked to the questions in the categories attitude, subjective norm and perceived behaviour control, which are used to determine the weak points of the flowchart dementia. If the attitude towards the innovation is negative, they are not likely to adopt this flowchart. The same counts for the subjective norm. The greater the perceived behavioural control, the intention to perform certain behaviour should also be greater. The data that will be collected can specify the categories in which the negative attitude can be found. With this information THOON will be able to make a better implementation strategy to further implement the flowchart.

Table 1. Closed questions questionnaire

No.	**Subject**	**Innovation/user/ organisation**	**Attitude/subjective norm/ perceived behavioural control**
1.	Knowledge flowchart	User	Attitude/Perceived behavioural control
2.	Organisation	Organisation	-
3.	Formal guidelines	Organisation	-
4.	Coordination organisation	Organisation	-
5.	Other changes organisation	Organisation	Attitude
6.	Clear pathway activities	Innovation	Attitude
7.	Correct information	Innovation	Attitude
8.	Enough information and materials	Innovation	Perceived behavioural control
9.	Too complex	Innovation	Attitude/Perceived behavioural control
10.	Connection with normal work	Innovation	Attitude
11.	Effects are visible	Innovation	Attitude

12.	Appropriate for patients	Innovation	Attitude
13.	Advantages	User	Attitude
14.	Disadvantages	User	Attitude
15.	Important to have quicker diagnosis	User	Attitude
16.	Part of job	User	Attitude/Subjective norm
17.	Patient satisfaction	User	Attitude
18.	Patient cooperation	User	Attitude
19.	Support colleagues	User	Subjective norm
20.	Knowledge to use	User	Attitude/Perceived behavioural control
21.	Need for extra information	User	Perceived behavioural control
22.	Enough personnel	Organisation	-
23.	Enough financial means	Organisation	-
24.	Enough time	Organisation	-
25.	Enough materials to use	Organisation	-
26.	Transfer knowledge	Organisation	-
27.	Easy access information	Organisation	-
28.	Feedback to Dementie Twente	Organisation	-
29.	Quicker diagnosis expectation	Innovation	Attitude
30.	Expectation of use by colleagues	User	Subjective norm
31.	Able to stick to flowchart	User	Perceived behavioural control
32.	Colleagues using the flowchart	User	Subjective norm

Table 2. Open questions questionnaire

No.	**Subject**	**Innovation/user/ organisation**	**Attitude/subjective norm/ perceived behavioural control**
33.	Time to diagnose	Innovation	Attitude
34.	Quicker referral	Innovation	Attitude
35.	Effects on patients	Innovation	Attitude
36.	Advantages/disadvantages	User	Attitude
37.	Other remarks	-	-

Data analysis

The data will be processed with the use of SPSS and Microsoft Excel. Descriptive statistics will be used to determine the main results of the questionnaire. All the results will be shown in a table with the total of people who gave a specific answer and the percentages of the total group, to have an overview of the opinion of the general practitioners. This way it can be determined whether there is a positive, neutral or negative attitude towards a question. The answer categories 'totally disagree' and 'disagree' will be grouped as negative, the answer categories 'totally agree' and 'agree' will be grouped as positive. The 'neutral' answer will be grouped as neutral, this way there are three categories in the results table. Also a boxplot will be made to have a visual overview of the means, medians and range of the answers that are given by the GPs.

The results of the open questions will be coded with 4 different colours to have an overview of the results. The four different categories for this coding are: Positive, negative, never used/no answer and neutral/unclear. These answers will be translated in English, but the original Dutch results can be found in Appendix C: Coded answers to open questions in Dutch.

Results

The questionnaire was sent to all members of FEA and THOON, this is a total of 325 GPs.
The total number of GPs that filled in this questionnaire is 22 (n=22), this brings the response rate to 6.8%. The average age of the population is 51 years and there are slightly more male respondents than females.
The response rate on the question, 'Are you familiar with the flowchart dementia?' is 21.5%, 70 out of 325 GPs answered this question. The response rate for FEA (10.2%) was lower than THOON (29.8%). A total of 85.7% of the FEA respondents are familiar with the flowchart and a total of 75.0% of the THOON respondents are familiar with the flowchart.

Table 3. Familiarity flowchart dementia

Are you familiar with the flowchart dementia?	**FEA n (%)**	**THOON n (%)**
Yes	12 (85.7%)	42 (75.0%)
No	2 (14.3%)	14 (25.0%)
n	70	

At first the data that was collected by the closed questions was analysed. The summary of the data that is explained in the next part can be found in Table 4, Table 5 and Table 6.
In Table 5 a connection is made with the Theory of Planned Behaviour. Not every subject can be matched to a category of the TPB, these are left open and will not be taken into account for this analysis.
The closed questions have been answered positively by the general practitioners. The only question that was answered negatively was in the category subjective norm. This question was about perception of use by their colleagues. They indicated that they expect that only a minority will be using the flowchart. The overall attitude towards the flowchart dementia is positive, most questions are answered positively or neutral with a tendency towards positive. The GPs indicated that they have not used the flowchart as much as they would have wanted to, so that could be a reason for the large neutral group. But those who have used the flowchart are in general very positive. The answers that are categorized as 'perceived behavioural control' are also very positive, only one factor was answered neutrally. With this information we can conclude that the perceived behavioural control and the attitude of the GPs towards the flowchart dementia is good. They think it is a useful innovation and see themselves capable of actually using it.

The open questions are also answered in a positive way. The attitude is the only factor that can be researched for the open questions. But the overall attitude towards the flowchart is positive. The GPs rarely see any obstacles and are happy to use the flowchart now and in the near future.

The overall results of the closed questions indicate that there are more facilitators than barriers after the implementation of the flowchart dementia. The following barriers were found: a lack of coordination, other changes within the organisation, no formal guidelines, no knowledge transfer and the difficulty of giving feedback to Dementie Twente.
On the other hand, the following facilitators were found: a clear pathway of activities, flowchart based on correct knowledge, not too complex, a good connection with the daily work, appropriate for patients, no disadvantages, part of the job of the GP, expectation that the patient will cooperate and sufficient knowledge of the GP to use the flowchart.

Table 4. Demographics

Subject	**n(%)**	**n(%)**
Gender	*Male*	*Female*
	13 (59.1%)	9 (40.9%)
Organisation	*THOON*	*FEA*
	12 (54.5%)	10 (45.5%)

Table 5. Facilitators and barriers of the MIDI questionnaire combined with the TPB

Subject	**Negative** ***Totally disagree and disagree*** **n(%)**	**Neutral n(%)**	**Positive** ***Totally agree and agree*** **n(%)**
Attitude			
Clear pathway activities	1 (4.5%)	7 (31.8%)	14 (63.6%)
Correct information	-	5 (22.7%)	17 (77.3%)
Connection with normal work	2 (9.1%)	7 (31.8%)	13 (59.1%)
Effects are visible	6 (27.3%)	14 (63.6%)	2 (9.1%)
Appropriate for patients	-	9 (40.9%)	13 (59.1%)
Advantages	1 (4.5%)	12 (54.6%)	9 (40.9%)
Disadvantages	10 (45.4%)	12 (54.6%)	-
Important to have quicker diagnosis	2 (9.1%)	12 (54.6%)	8 (36.3%)
Patient satisfaction	-	16 (72.7%)	6 (27.3%)
Patient cooperation	-	10 (45.5%)	12 (54.5%)
Quicker diagnosis expectation	2 (9.1%)	12 (54.5%)	8 (36.4%)
	No		*Yes*
Other changes organisation	11 (50.0%)		11 (50.0%)

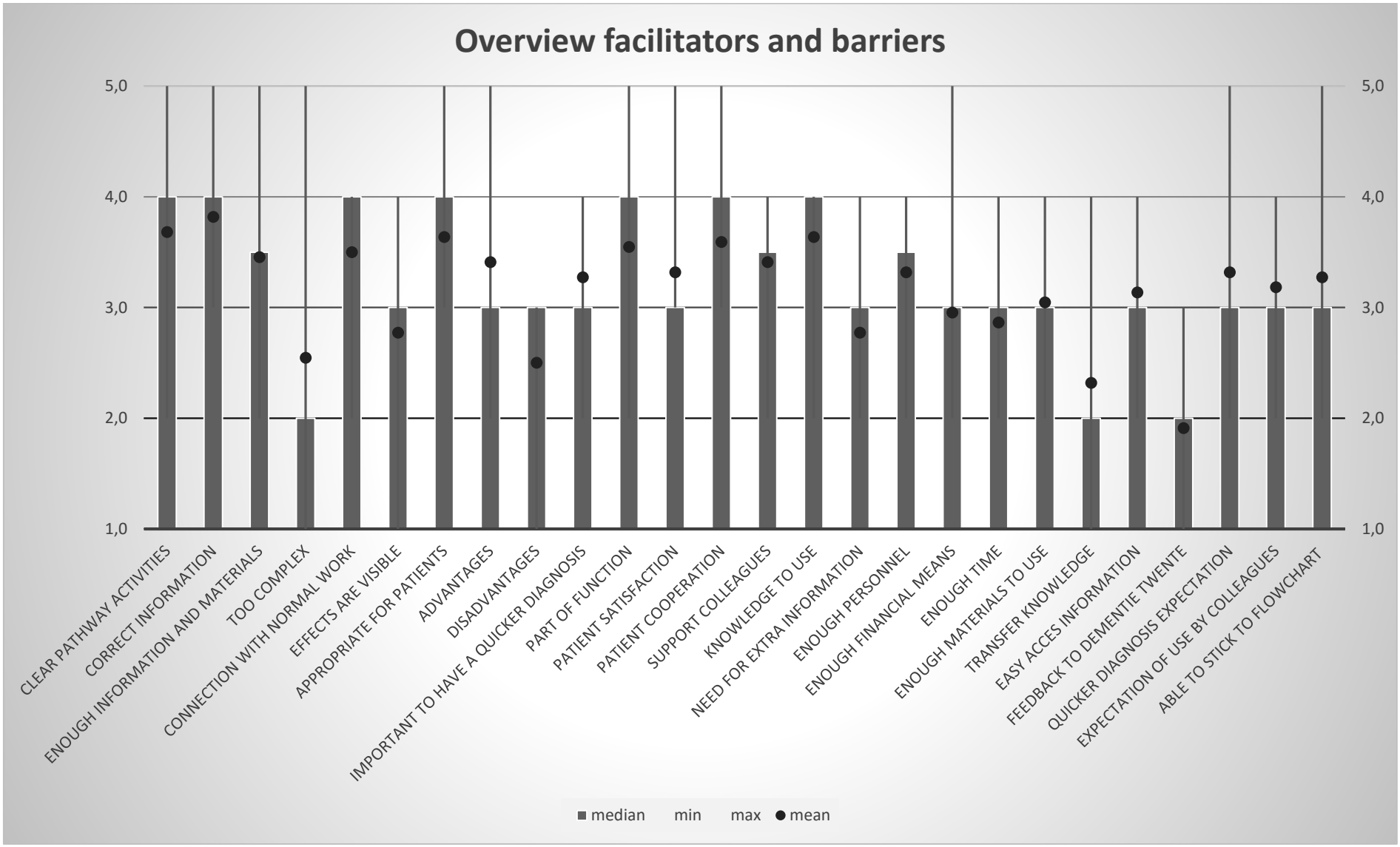
Attitude + Subjective Norm						
Part of job			2 (9.1%)	8 (36.3%)	12 (54.6%)	
Attitude + Perceived Behavioural Control						
Too complex			13 (59.1%)	6 (27.3%)	3 (13.6%)	
Knowledge to use			2 (9.1%)	4 (18.2%)	16 (72.7%)	
Knowledge flowchart						
No knowledge	*Know it but haven't read it*		*Know it and read it superficially*		*Know it and read it thoroughly*	
1 (4.5%)	-		14 (63.7%)		7 (31.8%)	
Subjective Norm						
Support colleagues			2 (9.1%)	9 (40.9%)	11 (50.0%)	
Expectation of use by colleagues			2 (9.1%)	14 (63.6%)	6 (27.3%)	
Colleagues using the flowchart						
No one	*Hardly any colleague*	*A minority*	*A majority*	*Almost everyone*	*All*	
1 (4.5%)	4 (18.2%)	9 (40.9%)	4 (18.2%)	2 (9.1%)	2 (9.1%)	
Negative 14 (63.6%)			Positive 8 (36.4%)			
Perceived Behavioural Control						
Enough information and materials			2 (9.1%)	9 (40.9%)	11 (50.0%)	
Need for extra information			10 (45.5%)	7 (31.8%)	5 (22.7%)	
Able to stick to flowchart			3 (13.6%)	11 (50.0%)	8 (36.4%)	
No TPB						
Enough personnel			4 (18.2%)	7 (31.8%)	11 (50.0%)	
Enough financial means			8 (36.3%)	8 (36.4%)	6 (27.3%)	
Enough time			5 (22.7%)	15 (68.2%)	2 (9.1%)	
Enough materials to use			4 (18.2%)	13 (59.1%)	5 (22.7%)	
Transfer knowledge			13 (59.1%)	8 (36.4%)	1 (4.5%)	
Easy access information			5 (22.7%)	9 (40.9%)	8 (36.4%)	
Feedback to Dementie Twente			17 (77.3%)	5 (22.7%)	-	
			No		*Yes*	
Formal guidelines			15 (68.2%)		7 (31.8%)	
Coordination organisation			14 (63.6%)		8 (36.4%)	

Table 6. Results questionnaire open questions

Subject	**Results**
Attitude	
Time to diagnose	Positive
Quicker referral	Positive
Effects on patients	Positive
Advantages/disadvantages	Positive
No TPB	
Other remarks	Positive

A visual overview of the results can be found in Figure 2. The vertical axis has the numbers 1 to 5, where 1 is totally disagree and 5 is totally agree. Two questions are answered negatively and you can see the range goes from 1 to 3, those are questions about disadvantages and feedback to Dementie Twente. The GPs answered that they see no real disadvantages in the use of the flowchart. They also indicated that there is no feedback to the developers of the flowchart. A large group of subjects are answered within the range of 2 to 4, the mean can be used to see if there is a tendency towards positive or negative.

Figure 2. Facilitators and barriers of the MIDI questionnaire



The open question part of this questionnaire was formed by the following five subjects: Difference in time needed to diagnose dementia, time to referral to a specialist, effects for the patient, psychologically, environment patient, health effects and effects on the health care process), advantages or disadvantages and other remarks or suggestions. An overview of all the answers in Dutch can be found in Appendix C: Coded answers to open questions in Dutch. In Table 7 the legend for the open questions can be found. Table 8 gives an overview of the number of answers in each category. The Table 9 and Table 10 give an overview of the open questions of the questionnaire. The answers are translated in English and coded according to legend in Table 7.

Time to diagnose

11 out of the 22 GPs indicate that they have not used the flowchart dementia yet, so they do not know if they will be able to have a faster diagnosis. Two doctors indicated that the use of the flowchart dementia takes more time than usual for them and the POH. A total of eight doctors indicated that they are very positive about the flowchart and think it will be faster in diagnosis, in what way they do not know yet. They know when and where to refer to and which tests they need to do themselves. This is indicated by the following two quotes. *'Hard to say, but the pathway is a lot clearer than before'. 'Hopefully it will save time, we refer later on in the process and when we refer to a specialist it is more focused.'*

One of the most mentioned comments on this question is the fact that the flowchart is very structured and clear. The GPs know where to find the information they need now. *'No, I wouldn't say the diagnosis is quicker, but you are able to find the right persons and contact information quicker now.'*

Time to referral

A total of twelve doctors have not used the flowchart yet or have not answered this question. Only one doctor thinks there is no difference between the moment of referral before and after the implementation of the flowchart dementia. Nine GPs were very positive about this question. They indicated that they refer to a specialist later on in the process, with the help of the flowchart dementia they now know when is the best time to refer to the specialist. *'I think a number of referrals can be prevented, when we refer to a specialist it is more specific.' 'Later on and more specific, we now have more knowledge about the NHG guidelines dementia thanks to the flowchart dementia.'*

Before the flowchart was implemented one GP indicated that he/she send every single case of possible dementia to a specialist. *'A lot less, I used to send everyone to a specialist for diagnosis.' When they refer a patient now, they know when a referral is needed. 'Later, a clear description of when a referral is needed and meaningful.'*

The GP's perceived effects for the patient

Ten doctors did not answer this question, the rest of them answered the ones in which they saw effects. The overall comments were very positive and they think that the flowchart is good for the patient as well. Some overall comments were made that can be applied for all the effects below. *'Quicker diagnosis.'* and *'Better.'*

The flowchart stimulates a quicker and more efficient diagnosis, the doctors indicated that these factors are very important for their patients. By having a fast diagnosis, the uncertainty and stress for the patients will be reduced. '*By quickly getting clarity about a possible diagnosis of dementia we can reduce the uncertainty and distress of the patient.'*
'Less confronting due to less referrals. This may lead to less commotion.'
According to the doctors, patients perceive a timely and effective diagnosis as important. The GPs indicated that the flowchart improves the diagnosis time and uncertainty around the diagnosis and therefore assume that the patients experience less uncertainty and stress.

The same factors are important for both the patient and their environment, they want to know for sure if their family member has dementia. So for them it is important that they have a fast and efficient diagnosis. When they are informed in an early phase, the tools that are needed to deal with the patient can be given. *'The environment of the patient can get the 'tools' needed to deal with the behaviour of the patient.' 'Clear information for the family, they know which people to call.' 'Less hassle.'* With this flowchart dementia the GP is the main person to diagnose a patient. But often worried relatives may push for further examinations because they want to make sure their family member has dementia. *'Sometimes they want more examinations, but those are not always needed.'*

The effects, as a result of the flowchart dementia, on the health of the patient, are not very clear yet. The GPs made the following statements about the possible health effects of the flowchart. *'Now a patient can get the right care at the right place.'* '*Quicker diagnosis is better for the further guidance.' 'Less demanding examinations.'.* These comments are not about the health effects for the patients, but more the indirect effects of the flowchart. Obviously a quicker and less stressful diagnosis is better for a patient.

The main effect on the healthcare process that was mentioned by the doctors was the better communication between healthcare professionals. With the flowchart dementia all contact information that is needed within one of the regions is summarized on the second page. This makes the communication much easier. *'Shorter lines of communication.'* and *'All health care providers have*

the same view on dementia now.' With these short lines of communication and less referral to the hospital the costs will be lowered as well. *'Less costs and hassle to go to the hospital.'*

The majority of the doctors indicated that they haven't used the flowchart as much as we expected. But they hope to use it in the near future. *'Nice flowchart to use in the general practice.'*
The current course for a patient with dementia is much clearer for both the GP and the patient. *'Overall a clearer pathway where the patient has more clarity early on.'*

Advantages and disadvantages

According to the GPs there are no disadvantages of the use of the new flowchart dementia. Five people indicate that they have not used it yet so they don't know. Ten doctors are very positive and think it is a great addition to their practice. The fact that the flowchart is very structured is one of the most mentioned comments. *'Logical steps and a better guide to referral.'*, '*A nice overview with all the information that is needed.'* and *'Very clear'.*
One GP also indicated that it is easy for the patient and cheaper than before. '*Easy for the patient and cheaper. When the situation is unclear, you can still refer to a specialist.'*

Other remarks

Two doctors indicated that they are very positive about the flowchart and hope to use it a lot in the future. One GP thinks that they won't use the flowchart as much as expected because there are not many patients with dementia in their practice that they need to diagnose. One other doctor commented that their practice is doing another major implementation process that has first priority.

The overall comments made by the GPs were very positive, according to these open questions there would be no reason why the flowchart dementia shouldn't be further implemented in the general practices. Almost every question that is answered is of a positive nature. They think the flowchart dementia is a great addition to their usual care.

Table 7. Legend

Neutral or unclear	Positive	Negative	Not yet in use/ no answer

Table 8. Overview answers open questions

			Effects on patients						
	Time to diagnose	Quicker referral	Psychological effects patient	Effects for the environment (family)	Health effects patient	Effect on healthcare process	Other effects	Advantages and disadvantages	Other remarks
	12	12	19	11	17	13	19	10	14
	2	-	-	-	-	-	-	-	1
	2	3	-	-	-	-	-	3	5
	6	7	3	11	5	9	3	9	2
n =	22	22	22	22	22	22	22	22	22

Table 9. Open questions overview 33, 34, 36, 37

Time to diagnose	Quicker referral	Effects on patients	Advantages and disadvantages	Other remarks
12	12	10	10	14
We have to do more research ourselves and this will take more time. Not clear how much yet.	Before the existence of the flowchart we have been working this way in our practice. The flowchart hasn't done anything new.	See next table for the effects on patients.	When there is a case of dementia I will have to get the flowchart because I need the information.	Incidence dementia too low in general practice to use it often
Will take more time for me and the POH.	I think it will be the same.		Before the existence of the flowchart we have been working this way in our practice. The flowchart hasn't done anything new.	At the moment we have other major implementations going on. Our elderly project has been running and will be adjusted to the flowchart in May 2016.
Before the existence of the flowchart we have been working this way in our	Earlier, the flowchart has given me more information and possibilities for this process.		Neutral	Flowchart is nothing but rules regarding the diagnosis dementia

practice. The flowchart hasn't done anything new.				with regional agreements. Nothing new.
Not very clear, it takes more time because of all steps. But the flowchart is very punctual.	I think a number of referrals can be prevented and that they will be more specific.		Can be used by everyone in the general practice, easier for the patient and cheaper. Referral is always possible if there is any doubt.	Only in use for 3 months, survey is held too early.
Hard to say, the pathway is a lot clearer though.	Less frequently. Previously, I referred everyone to a specialist.		Clarity.	I always thought a specialist team was needed for the diagnosis dementia. With the flowchart we can do it ourselves.
Referral is not always needed with a geriatric specialist you have a faster diagnosis.	Most cases won't be referred.		Clear instruction, referral not always needed.	First time seeing the flowchart. That's why my overall opinion is neutral.
No, the diagnosis is not faster, but you can find the right person/number quicker.	Less referrals, because diagnosis can be done in the general practice. This could shorten the waiting times for the specialist.		Logical steps and a better guide to referral. Does take a little more time.	Nice flowchart to use in the general practice.
No, hopefully it will save a lot of time, because you will refer faster and more specific.	Later and more specific, we learned more about the NHG guidelines because of the implementation of the flowchart dementia.		A summary of all information that is needed.	I hope to use it in the future.
The waiting time for the memory clinic be shorter	Later, the flowchart gives a clear description of when a referral is needed.		Clear, every possibility	
I don't know yet, but the pathway is a lot clearer	I think later.		If you follow the flowchart it is very structured.	
			I don't see any disadvantages.	
			More structure and clarity.	

Table 10. Open question overview 35

Psychological effects patient	Effects for the environment (family)	Health effects patient	Effect on healthcare process	Other effects
19	11	17	13	19
By quickly getting clarity about a possible diagnosis of dementia we can reduce the uncertainty and distress of the patient.	Quickly getting clarity.	Quickly getting clarity.	Quickly getting clarity.	Quickly getting clarity.
Less confronting for the patient because he won't be referred as much.	Less hassle.	Now a patient can get the right care at the right place	Less costs and hassle to go to the hospital.	We have to use the flowchart more carefully and talk about it afterwards.
Better.	By quickly getting clarity about a possible diagnosis of dementia the family can get the tools needed to deal with the behaviour of the patient.	Less demanding examinations.	All health care providers have the same view on dementia now.	Overall a clearer pathway where the patient has more clarity early on.
	Faster diagnosis.	Faster diagnosis is better for further guidance.	Knowing what is need faster.	
	Faster diagnosis.	Better.	Faster.	
	Clarity about the diagnosis.		Shorter lines of communication.	
	Nice overview of information and		More clear.	
	Nicer for the patient to be diagnosed by the GP.		Faster.	
	Sometimes they want more examinations, but those are not always needed. And it is easier to get the aid of a case manager dementia.		Better.	
	They often want more research to be done.			
	Better.			

Discussion

The main objective of this study was to evaluate the facilitators and barriers according to the GPs. Also the perceived effects of the GP, of the new flowchart dementia, on the diagnosing process for the GP were evaluated. The overall results of the questionnaire are in line with the results found in the literature. The link this research has made between the MIDI-questionnaire and the Theory of Planned Behaviour deepens the conclusions that can be drawn from it. This is the first time this comparison has been made. Also, for the GPs in the region Twente and the organisations that created the flowchart, this research can serve as a basis to improve the flowchart itself and its implementation.

In this study many results from earlier research are confirmed. Barriers and facilitators that were found in research done elsewhere have also been found here. The lack of coordination within the organization of the practices is clearly present as a barrier, along with the lack of formal guidelines by the management (Wensing et al., 1998). The lack of social support can also be a barrier for the GPs to use the flowchart dementia (Wensing et al., 1998). The short period the flowchart has been in use, and the lack of visibility of results, is not yet motivating GPs to actively use the innovation, making it a barrier (Iliffe et al., 2012).

The facilitators observed in this research have some basis in literature. Knowledge of how to use an innovation has been mentioned as a facilitator, and is also found in this study (Wensing et al., 1998). The basis of the flowchart in the daily work of the GPs is viewed as positive, making it a facilitator for this flowchart (Pimlott et al., 2009a). Also, the resistance expected from patients is low, thus confirming earlier research (Wensing et al., 1998).

This study shows that the overall effects, according to the GPs, for both the patient and the GP are positive. The perceived effect of a quicker diagnosis being a benefit for both the patient and the GP is in line with earlier research (ILiffe et al., 2003). The general practitioners indicated that an early diagnosis has overall positive effects on the patient and the quality of life (Banerjee et al., 2007). The early diagnosis also enables the family and the patient to learn how to cope with the disease early on, instead of only being able to respond to a rapidly escalating health condition (Clare et al., 2005). The position the families take in the diagnosing process is in line with cases described in other literature (ILiffe et al., 2003).

Many of the facilitators and barriers found can be mapped to a factor in the Theory of Planned Behaviour. The low perceived complexity, adequate knowledge to use and amount of information regarding the flowchart have all been mapped to the perceived behavioural control. Research shows that this is the main factor to determine the intention to use an innovation (Kortteisto et al., 2010).

The cooperation experienced from patients, along with the connection the flowchart has with daily work and its basis in correct and factual information are all factors linked to the attitude. Other studies have identified this as the second important factor that determined the intention to use an innovation (Rashidian & Russel, 2011). The connection with the Theory of Planned Behaviour is important, because if all the factors of the TPB are met, the likelihood of a change in behaviour increases. In this specific situation this would mean that the flowchart will used by a larger number of GPs.

Limitations

In an attempt to gain more response, two emergency clinics where GPs are stationed, were visited. At these clinics some additional information was gathered about the usage of the flowchart dementia. They indicated that it is too early to perform this research, because the flowchart has not been implemented in every practice. Some GPs indicated that they have not attended the training were the flowchart was explained, and some find the flowchart hard to use without this training. The diagnostic process itself is not clarified on the flowchart dementia, when an extra page is added with the NHG protocols this can be solved. It turned out that GPs are overwhelmed with research questionnaires by students and research organisations on a daily basis. The low response rate on the questionnaire can be attributed to this. With this low response rate, it is difficult to draw any final conclusions from the results. Only a small percentage of the focus group replied to the questionnaire. Because of this small amount of respondents, the results cannot be generalized to the entire group, therefore the external validity of the results cannot be guaranteed. The group that did not respond to the questionnaire has probably not used the flowchart as much as the population that did respond. The answers of this small group can give a distorted view for the overall population, this can go both ways. The most likely situation is that GPs that are currently working with, and have a positive attitude towards the flowchart, have responded to the questionnaire. This would give a more positive result regarding the flowchart. If the response rate was higher, a comparison could have been made between different groups within the population to see whether there are differences.

The question ‘Are you familiar with the flowchart dementia?’ was later added in an email to the GPs to find out the percentage of people that actually know the flowchart. A similar question was asked in the questionnaire about the knowledge of the flowchart. The majority of the GPs that filled in this questionnaire indicate that they know the flowchart and have read it superficially (63.7%) or thoroughly (31.8%). However, the overall familiarity of the GPs with the flowchart is a much lower, as shown by the results of the later e-mail question. A total of 14.3% of the FEA members and 25% of the THOON members indicate that they are not familiar with the flowchart dementia. Only one GP

that filled in the questionnaire indicated that he or she has no knowledge of the flowchart. This implies that the actual familiarity is a lot lower than can be concluded from the results of the questionnaire. This also means that the majority (95.5%) of the GPs that filled in the questionnaire have some knowledge about the flowchart, this makes their feedback even more important. The difference in familiarity of the flowchart dementia between the two organisations is something that should be further investigated. This difference could be attributed to the response rate. The response rate for THOON (29.8%) is much higher than FEA (10.2%). The cause of this difference is not clear, but there is a chance that there is a difference in distribution of the flowchart between FEA and THOON.

Recommendations

In order for the flowchart to be successful in the region, it is important that the flowchart becomes the standard protocol for diagnosis. Currently the usage of the flowchart within the population is low. To achieve a situation where the flowchart becomes the standard protocol, the adoption and usage of the flowchart must rise. This can be achieved by following the steps described in the diffusion of innovation model (Rogers, 1983). The results of this study suggests that the diffusion of the flowchart among the members of THOON and FEA is currently between the second and third phase (Sanson-Fisher, 2004). These are the stages between the persuasion of the advantages of the flowchart and the phase where the GPs are attending workshops and informational meeting to learn more about the innovation. The need for information is mostly satisfied, but the social pressure to adopt the innovation is not yet clearly present as well as the familiarity GPs in the region have with the flowchart itself.

A part of the population indicates that they need more knowledge to optimally use the flowchart. Currently there are meetings to give more information about the use of the flowchart dementia. Not every GP has the opportunity to go to these meetings, but may want to read some additional information online on how to properly use this flowchart. A suggestion to bridge the information gap is to publish the information online after the first few meetings. This could also be used as a reference in the future to look up details in the protocols.

Along with the rise in adoption, the structures in the organization, that allow the innovation to be used, need to be improved. The lack of formal guidelines and coordination within the organization have been identified as a barrier (Wensing et al., 1998). By removing this barrier, the further adoption and usage of the flowchart can be stimulated. A centralized development of these guidelines it the most optimal, in this way the protocols are uniform throughout Twente. The benefits of this uniformity are that all involved parties, such as specialists case managers and nurse practitioners, have patients that are diagnosed and evaluated according to the same protocols. This

could make it easier and less time consuming to continue the treatment because all patients that are referred, meet the same criteria and are not needlessly referred.
Feedback to the developers of the flowchart dementia is an easy way to improve the flowchart and promote the use of it. When the GPs can give direct feedback to the developers of the flowchart dementia and are able to talk about the use, they will be more likely to use it. This increases their perceived behavioural control on the flowchart and therefore their intention to use it. They will also be more likely to use it because they feel like their input is used for further improvements.
Half of the population indicated that there are currently other changes as well within their organisation. It is important to determine what those other changes are and see whether it is an option to combine it with the use of the flowchart. By implementing several changes at the same time, costs and time will be saved. The choice to delay the implementation to a more suitable moment can also be made for practices that do not have the time to implement it.
This study shows that the expected number of colleagues that will use the flowchart dementia is low. By improving the points that are mentioned above, the three different factors of the Theory of Planned Behaviour will improve. By stimulating every general practitioner to use the flowchart, the subjective norm will be more positive. When the GPs feel like they are having influence in the development of the flowchart, their perceived behavioural control will improve. The overall attitude will rise when all these points are adopted. All these factors have been shown to impact the intention a GPs will have to use a new innovation. By taking steps to improve each of these factors, the overall adoption of the flowchart will most likely rise. This will help the developers of the flowchart to achieve their goal of raising the bar on dementia-related health care in general practices in the region of Twente.

Future research

The flowchart dementia has been in use since November 2015. Therefore, it is too soon to accurately assess the impact of the flowchart. In order to do so, additional information is required about a large number of patients that have been diagnosed using this flowchart. Ideally this group should be compared to a group that has been diagnosed using the old method. In this way the health effects can be measured.
To assess the effects for the GP, more experience and usage of the flowchart is needed. It was clear that the GPs did not use he flowchart very often and were hesitant to answer the questionnaire. This may change over time, so further research can be done in a later stage to get a broader range of respondents. With the measured effects by the any future research, the GPs can be convinced to use the flowchart. An important stage for the diffusion of an innovation is to persuade the users by

showing them the advantages of using it (Sanson-Fisher, 2004). The current study can serve as a benchmark to assess any improvements in the distribution and implementation of the flowchart.

Conclusion

The main objective of this study is to determine the facilitators and barriers of the new flowchart dementia, and evaluate the effects of the new flowchart on the diagnosing process for the GP. The overall experience of the GPs with the flowchart dementia is positive, there are no negative effects for the patients and themselves according to the GPs. Some facilitators and barriers were found.
The recommendation is to further distribute this flowchart and give training to every general practitioner in the region Twente. The familiarity with the flowchart dementia is not as high as expected, so this can definitely be improved. By changing the method of distribution to a peer-based approach, this familiarity can rise. This will give the flowchart the momentum it needs, to be adopted by the majority of GPs in the region.
By eliminating the barriers that GPs described, focussing on reserving more time for them to get familiar with the flowchart and providing more information, the GPs can be persuaded to start using the flowchart more. Also by improving the organisational aspects such as, a lack of coordination, other changes within the organisation and the lack of formal guidelines, it will be easier for GPs to adopt this innovation. Focussing on the facilitators like the absence of disadvantages, a good connection with daily work and the fact that the flowchart is based on correct knowledge, the position of the flowchart as a widely accepted diagnosing method in the region Twente will be strengthened.
After the flowchart has been used for a while, the actual health effects on the patient should be measured to see what the effects of using this flowchart are on the health of the patients.
Summarizing, the flowchart dementia has made some promising steps toward more expertise of GPs concerning dementia in the region Twente. There are still steps that can be taken to improve the implementation process, mainly focused on the factors laid out by the Theory of Planned behaviour, but the overall the general opinion of the GPs is positive.

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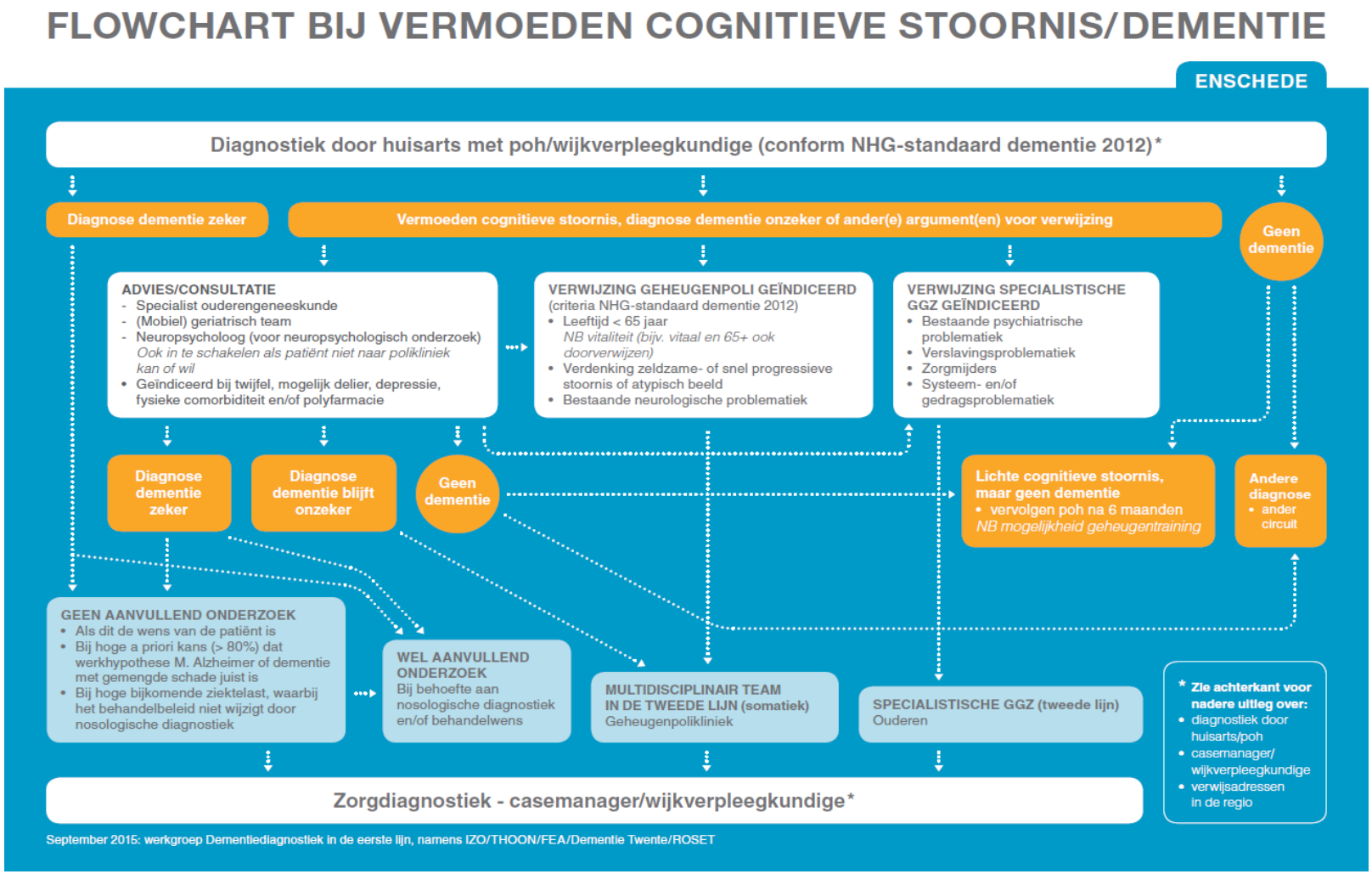
Appendices

Appendix A: Flowchart Dementia



DIAGNOSTIEK DOOR HUISARTS MET POH/ WIJKVERPLEEGKUNDIGE

1. Afnemen observatielijst dementie (OLD)
2. Anamnese: aandacht voor geheugen, afasie, apraxie, agnosie, oordeel- en kritiekvermogen en ADL
3. Heteroanamnese
4. Lichamelijk onderzoek: in ieder geval RR, pols, oriënterend neurologisch onderzoek
5. MMSE en kloktekentest
6. Laboratoriumonderzoek

De verwijsbrief van de huisarts voor diagnostiek met betrekking tot cognitieve problemen omvat:

- (hetero-) anamnese
- lichamelijk onderzoek
- MMSE, kloktekentest, zo mogelijk Trazag/Easycare
- (recent) laboratoriumonderzoek (neuropsycholoog, specialist ouderengeneeskunde)
- voorgeschiedenis
- actuele medicatie

Casemanager/wijkverpleegkundige

Bij de diagnose van dementie schakelt degene die de diagnose stelt een casemanager/wijkverpleegkundige in. Bij een vermoeden van dementie, kan de huisarts al vóór de diagnose een casemanager/ wijkverpleegkundige voor de patiënt aanvragen. De casemanager/ wijkverpleegkundige kan dan desgewenst ook het traject rondom de ziektediagnostiek begeleiden. De casemanager/wijkverpleegkundige houdt contact met de huisarts om tot afstemming te komen in het vervolgtraject.

VERWIJSADRESSEN IN DE REGIO ENSCHEDE

Geheugenpolikliniek (verwijzing via Zorgportaal of fax)
Medisch Spectrum Twente/Bruggerbosch : tel (053) 487 28 50, fax (053) 487 28 82

Specialistische ggz (verwijzing via Zorgportaal)
Mediant Ouderen - Aanmeldbureau : tel (053) 475 59 00, fax (053) 475 59 10;
via Media@tree, via de link www.entree.mediant.nl

Casemanagement dementie (wijkverpleegkundige/casemanager via zorgorganisatie naar keuze patiënt)
Maartje : tel (053) 537 55 55, fax: (0541) 51 00 70,
via www.maartje.nl/verwijzing, via info@maartje.nl

AriënsZorgPalet : tel (053) 482 66 88
Livio : tel (0900) 92 00
De Posten : tel (053) 475 37 53
Zorggroep Manna : tel (053) 483 23 00

www.dementietwente.nl

Werkgroep Dementiediagnostiek in de eerste lijn,
namens IZO/THOON/FEA/Dementie Twente/ROSET.
Er zijn ook andere partijen die kunnen worden geraadpleegd.

Appendix B: Questionnaire

Evaluatie Flowchart Dementie

Uw huisartsenpraktijk gebruikt sinds kort de flowchart bij vermoeden cognitieve stoornis/dementie. Omdat dit een nieuw hulpmiddel is, zijn we benieuwd naar uw ervaringen in het gebruik. Dit onderzoek wordt uitgevoerd onder alle praktijken in de regio Twente, samen met de Universiteit Twente, de Federatie Eerstelijnszorg Almelo (FEA) en de Twentse Huisartsen Onderneming Oost Nederland (THOON).

Het doel van dit onderzoek is om de effectiviteit van de flowchart dementie in kaart te brengen. Dit onderzoek bestaat uit het invullen van een vragenlijst en een aantal open vragen en zal ongeveer 15 minuten in beslag nemen.

Alle gegevens die worden verzameld in dit onderzoek zullen vertrouwelijk worden behandeld en de onderzoeksresultaten zullen niet tot u als persoon te herleiden zijn.

Alvast bedankt voor uw medewerking.

UNIVERSITEIT TWENTE. Thoon Federatie Eerstelijnszorg Almelo e.o.

<u>Algemene informatie</u>

Naam:……

Praktijk:……

Geslacht: M/V

Leeftijd:……

1. In hoeverre bent u op de hoogte van de inhoud van de flowchart dementie?

- ☐ Ik ken de flowchart niet
- ☐ Ik ken de flowchart wel, maar heb hem (nog) niet doorgelezen
- ☐ Ik ken de flowchart en heb hem oppervlakkig doorgelezen
- ☐ Ik ken de flowchart en heb hem volledig en grondig gelezen

2. Bij welke organisatie is uw samenwerkingsverband aangesloten

- ☐ FEA
- ☐ THOON
- ☐ Anders, namelijk:……

3. Zijn in uw organisatie formeel afspraken vastgesteld door het management over het gebruik van de flowchart dementie (in beleidsplannen, werkplannen en dergelijke)?

- ☐ Nee
- ☐ Ja

4. In mijn organisatie is/zijn één of meerdere personen aangewezen voor het coördineren van de invoering van de flowchart dementie.

- ☐ Nee
- ☐ Ja

5.Zijn er, behalve de invoering van de flowchart dementie, andere veranderingen waarmee u momenteel of binnen afzienbare tijd mee te maken heeft? Denk hierbij aan een reorganisatie, verhuizing, fusie, bezuinigingen, personeelsverloop, andere innovaties

- ☐ Nee
- ☐ Ja

Hieronder vind u een aantal stellingen en vragen. Vink de kolom aan die het beste aansluit bij uw ervaringen.

Nr.	Vraag	**Helemaal**	**Mee oneens**	**Neutraal**	**Mee eens**	**Helemaal mee eens**
6.	De flowchart dementie geeft helder aan welke activiteit ik in welke volgorde moet uitvoeren.					
7.	De flowchart dementie is gebaseerd op feitelijk juiste kennis.					
8.	De flowchart dementie biedt alle informatie en materialen die nodig zijn om er goed mee te kunnen werken.					

9.	De flowchart dementie is te ingewikkeld voor mij om te kunnen gebruiken.					
10.	De flowchart dementie sluit goed aan bij hoe ik gewend ben om te werken.					
11.	Ik vind de effecten van het gebruik van de flowchart dementie duidelijk zichtbaar.					
12.	Ik vind de flowchart dementie geschikt voor mijn patiënten.					
13.	Het gebruik van de flowchart dementie biedt mij voordelen					
14.	Het gebruik van de flowchart dementie biedt mij nadelen					
15.	Ik vind het belangrijk om met de flowchart dementie een snellere diagnose te kunnen stellen.					
16.	Ik vind het tot mijn functie horen om de flowchart dementie te gebruiken.					
17.	Patiënten zullen over het algemeen tevreden zijn als ik de flowchart dementie gebruik.					
18.	Patiënten zullen over het algemeen meewerken als ik de flowchart dementie gebruik.					
19.	Ik kan op voldoende hulp van mijn collega's rekenen mocht ik die nodig hebben bij het gebruik van de flowchart dementie.					
20.	Ik beschik over voldoende kennis om de flowchart dementie te kunnen gebruiken.					
21.	Ik heb het gevoel dat ik aanvullende kennis nodig heb om de flowchart dementie optimaal te kunnen gebruiken.					

22.	Er is voldoende personeel in onze organisatie om de flowchart dementie zoals bedoeld te kunnen gebruiken.					
23.	Er zijn voldoende financiële middelen beschikbaar om de flowchart dementie zoals bedoeld te kunnen gebruiken.					
24.	Onze organisatie stelt mij voldoende tijd beschikbaar om de flowchart dementie zoals bedoeld te integreren in mijn dagelijks werk.					
25.	Dementie Twente stelt mij voldoende materialen en voorzieningen beschikbaar om de flowchart dementie zoals bedoeld te kunnen gebruiken.					
26.	In mijn organisatie zijn maatregelen getroffen om, indien nodig, de kennis over het gebruik van de flowchart dementie over te dragen.					
27.	Ik heb in mijn organisatie makkelijk toegang tot informatie over het gebruik van de flowchart dementie.					
28.	In mijn organisatie vindt regelmatig terugkoppeling plaats naar Dementie Twente over de voortgang van de invoering van de flowchart dementie.					

Nr.	**Vragen**	**Zeer zeker niet**	**Zeker niet**	**Neutraal**	**Zeker wel**	**Zeer zeker wel**
29.	Ik verwacht dat met de flowchart dementie ik daadwerkelijk in staat ben een snellere diagnose te kunnen stellen bij mijn patiënten.					
30.	In hoeverre verwachten uw collega's dat u de flowchart dementie gebruikt?					
31.	Acht u uzelf in staat om u te houden aan alle delen van de flowchart dementie?					

32. Hoe groot is volgens u het deel collega's in uw samenwerkingsverband voor wie de flowchart dementie is bedoeld, die ook daadwerkelijk de flowchart dementie gebruiken?
    - ☐ Geen enkele collega
    - ☐ Bijna geen enkele collega
    - ☐ Een minderheid
    - ☐ De helft
    - ☐ Een meerderheid
    - ☐ Bijna alle collega's
    - ☐ Alle collega's.

33.Is er een verschil in de tijd die het kost om de diagnose dementie te stellen sinds het gebruik van de flowchart dementie? Zo ja, hoeveel scheelt dit dan?

34.Wordt er met het gebruik van de flowchart dementie eerder of later doorverwezen naar een specialist dan voorheen? Waarom is dit het geval?

35.Wat zijn volgens u de effecten op de patiënt? Denk hierbij aan zowel negatieve als positieve effecten, bijvoorbeeld een betere kwaliteit van leven of grote weerstand tegen een diagnose.

Psychische effecten patiënt Effecten voor de omgeving Gezondheidseffecten voor de patiënt Effecten op het zorgproces Andere effecten

36. Wat zijn voor u voor en/of nadelen in het gebruik van de flowchart dementie? Denk hierbij aan dezelfde categorieën als bovenstaande vraag.

37. Heeft u verder nog opmerkingen over het gebruik van de flowchart dementie die niet aan bod zijn gekomen?

Hartelijk dank voor uw medewerking.

Appendix C: Coded answers to open questions in Dutch

	33. Tijd diagnose
1	de praktijk heeft al een systeem en ingeleerde protocollen en samenwerking die hiermee op de schop moet. nu is daar niet meteen mankracht en tijd voor. dus wachten we tot er gelegenheid is , per mei 2016
2	moeilijk precies aan te geven, in ieder geval is het te doorlopen traject duidelijker
3	In het verleden was het makkelijker om mensen naar de geheugenpoli te sturen. Deze gang van zaken is goedkoper, en sluit aan bij de NHG standaard. Het afnemen van de MMSE en klokkentest door ons zelf en vervolgstappen kost meer tijd. Onduidelijk hoeveel.
4	Ook vóór het bestaan van de flowkaart werd binnen onze praktijk al op deze manier gewerkt. In dat opzicht heeft de flowchart geen duidelijke winst opgeleverd.
5	nee
6	Nog niet gebruikt
7	Verwijzing blijkt niet altijd nodig, met specialist ouderenzorg snellere diagnose
8	Dit kan ik nog niet precies zeggen, het kost nu wat meer tijd omdat ik alle stappen volg en ook het gesprek met de patient aanga over de diagnose, Voorheen deed de POH ouderenzorg dit. Maar het volet wel als zorgvuldig.
9	nee, de diagnose is niet sneller, maar je vindt sneller de juiste personen / telefoonnummers
10	x
11	Kost meer tijd voor mij als huisarts en POH
12	heb de kaart nog niet echt gebruikt
13	nee, het scheelt hopelijk juist tijd, omdat je minder snel en gerichter vewijst
14	wordt niet gebruikt
15	geen idee. nog nooit gebruikt
16	x
17	de wachttijd op geheugenpoli vervalt
18	nog niet te zeggen , slechts opp doorgelezen, wel met cursus oouyderezorg bezig :-) daar komt dit in terug
19	Geen idee
20	weet ik niet, maar stappen zijn wel duidelijker
21	x
22	Weet ik niet, nog niet gebruikt

	34. Snellere verwijzing
1	ik gebruik de kaart nog niet
2	ik denk dat een aantal verwijzingen wordt voorkomen, en dat de verwijzingen specifiker zijn
3	Minder vaak. Vroeger stuurde ik iemand voor diagnostiek altijd door.
4	Ook vóór het bestaan van de flowkaart werd binnen onze praktijk al op deze manier gewerkt. In dat opzicht heeft de flowchart geen duidelijke winst opgeleverd.
5	x
6	nog niet gebruikt
7	meestal niet verwezen
8	Ik denk niet eerder of later, hetzelfde.
9	eerder, door de kaart is de mogelijkheid van SO mij helderder geworden
10	x
11	Minder verwijzingen, omdat de diagnostiek in de eerste lijn kan (en mag) worden uitgevoerd.\r\n\r\nBij specialistisch hulp wellicht de wachttijden korter (?)
12	nog niet te sprake gehad
13	later en gerichter, omdat we ons ook weer beter hebben verdiept in de nhg standaard dementie, mede door de komst van deze flowchart
14	nvt
15	weet ik niet
16	x
17	nee
18	waarschijnlijk eerder , weet dit nog niet
19	Geen idee
20	later, duidelijker omschreven waneer verwijzing geindiceerd en zinvol is.
21	x
22	Ik denk later

35. Gezondheidseffecten

	Psychische effecten patient	Effecten voor de omgeving
1	onbekend	onbekend
2	?	Sneller duidelijkheid
3	x	Minder gedoe
4	door het snel duidelijkheid krijgen omtrent een mogelijke diagnose dementie kun je de onzekerheid en lijdensdruk van de pati:ent verminderen	door het snel duidelijkheid krijgen omtrent een mogelijke diagnose dementie kun je de onzekerheid en lijdensdruk van de pati:ent verminderenfamilie verminderen em krijgen ze 'tools' om om te gaan met het gedrag van de patiënt
5	x	snellere diagnose
6	x	x
7	x	snellere diagnose
8	x	duidelijkheid over diagnose
9	x	duidelijk adres-aanspreekpuntalles
10	x	x
11	minder confronterend ivm minder verwijzingen. Leidt wellicht tot minder onrust	prettiger in 1e lijn, geeft soms voor parters ook onzekerheid (moet pt niet toch naar het ziekenhuis?)
12	kan gaar nog geen uitspraak over doen	x
13	x	soms teleurstelling omdat ze meer onderzoeken verwachten, die niet altijd nodig zijn. Gemak bij bijvoorbeeld het inschakelen van de casemanager dementie
14	x	x
15	x	x
16	x	x
17	x	willen soms meer onderzoek
18	beter	beter
19	x	x
20	x	x
21	x	x
22	x	x

	Gezondheidseffecten voor de patiënt	Effecten op het zorgproces	Andere effecten
1	onbekend	onbekend	onbekend
2	idem	idem	idem
3	geen	minder kosten en minder gedoe om naar het ziekenhuis te gaan	-
4	door het snel duidelijkheid krijgen omtrent een mogelijke diagnose dementie kan de patiënt de juiste zorg op de juiste plaats krijgen	bij alle zorgverleners betrokken bij de patiënt staan de neuzen dezelfde kant op	x
5	x	sneller in beeld wat nodig is	x
6	x	x	x
7	minder belastend onderzoek	sneller	x
8	bij lab afwijkingen wordt een behandeling ingesteld/betere begeleiding van patienten	betere begeleiding van patienten	zorgvuldiger de flow chart volgen en nabespreken met Poh ouderen.
9	x	sneller	x
10	x	x	x
11	snellere diagnose is bevordelijke voor verder begeleiding	kortere lijnen	x
12	x	x	x
13	idem	overzichtelijker	x
14	x	x	geen, sluig aan bij huidige praktijk
15	x	x	geen idee nog
16	x	x	x
17	x	versnellen	x
18	beter	beter	x
19	x	x	x
20	x	x	In het algemeen een duidelijker traject waardoor patient ook meer en sneller duidelijkheid heeft
21	x	x	x
22	x	x	x

	36. Voor- en nadelen
1	onbekend
2	moet \'m er wel altijd weer even bij pakken.
3	Kan gewoon door personeel in de huisartsenpraktijk gedaan worden, makkelijker voor patiënt en goedkoper. Bij onduidelijk beeld is altijd verwijzing mogelijk.
4	Ook vóór het bestaan van de flowkaart werd binnen onze praktijk al op deze manier gewerkt. In dat opzicht heeft de flowchart geen duidelijke winst opgeleverd.
5	x
6	helderheid
7	duidelijke instructie, verwijzing niet altijd nodig
8	Voordeel: logische stappen en betere onderbouwing voor verwijzing of niet verwijzen. Nadelen: Kost wat meer tijd.
9	alles snel bij elkaar
10	x
11	Voordelen:\r\nDuidelijk, in eerste instantie mogelijkheden binnen de eerste lijn.
12	als volgt dan heel gestructureerd
13	x
14	neutraal
15	weet ik nog niet
16	x
17	moet het nog incorporeren
18	weet ik (nog) niet
19	Geen mening, dat moet ik nog uitvinden
20	zie weing/geen nadelen
21	x
22	Heeft meer structuur en eenduidigheid

	37. Overige opmerkingen
1	op dit moment wordt verwacht dat de praktijk in korte tijd grote majeure implementaties doet. elke actiegroep heeft haar belang maar erkent het belang van andere actiegroepen niet. wij hebben het overnemen van medicatiebeleid van de jeugdpsychiatrie (begeleiden van op ritalin ingestelde kinderen die door overheidsbeleid naar de 1e lijn terugvloeien , geprioriteerd wegens het directe grote risico voor jonge kinderen en de onbekende lange termijn effecten. ons ouderenzorg protocol loopt al. en moet bijgesteld worden naar de flow chart. dat gaat in mei 2016 gebeuren.
2	Nee
3	Nee
4	De flowchart is m.i. niets anders dan de "regels" omtrent het stellen van een (mogelijke) diagnose dementie vanuit de NHG-standaard en andere richtlijnen vertalen naar regionale afspraken en is in dat opzicht "niets nieuws onder de zon".
5	x
6	De incidentie in de huisartspraktijk is niet van dien aard dat de flowchart snel routine zal worden
7	x
8	handige kaart voor gebruik in praktijk
9	ik heb het nog maar 3 maanden, deze enquete is misschien daarom wat vroeg
10	x
11	x
12	x
13	x
14	Ik was in de veronderstelling dat er een PGOT nodig was voor een indicatiestelling. Volgens de flowchart is het mogelijk om bij duidelijkheid over de diagnose PGOT te omzeilen en direct te verwijzen voor indicatie verpleegkundige. Dat is nieuw voor mij.
15	Ik moet eerlijk zeggen dat ik de flowchart hier pas voor het eerst heb gezien. Vandaar ook dat ik alles neutraal heb ingevuld. De optie n.v.t. ontbrak helaas
16	x
17	x
18	ik hoop hem tzt te gaan gebruiken
19	Geen mening, moet ik nog uitvinden
20	Nee
21	?
22	Nee