

# **A practice change study: How a healthcare decentralization affects the practices of youth care practitioners**

## **Master thesis**

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## Abstract

In this thesis, I explore how the decentralization of the Dutch youth care system affected the practices of the youth care practitioners. This exploration is performed via a qualitative interview study, in which interviews were performed with youth care practitioners of several different youth care organizations in Gelderland (a province in the Netherlands). By applying a template analysis to the gathered data, I identified five practices that underwent the largest changes as experienced by the participants: youth care provision, care worker – client positioning, external relation management, result management and team management. The healthcare decentralization affected those practices (partially) via an increased influence of the institutional market logic. Based on those changes, four types of practice changes occurred: a goal adjustment, an introduction of new practices, an increased influence of administrative and managerial practices on the professional practice and a shift in the balance of different practices. The main contribution of this thesis to the practice literature therefore is twofold: I confirmed that a change in the institutional logics of a sector affects the practices, and I showed that a specific set of practices might change in different types of practice changes. The main practical contribution made by this thesis lies in the insights given on the actual change in practices, which shows Dutch youth care organizations what actual practice changes have taken place and how they themselves have a role of guidance in creating these practice changes.

**Keywords:** practices; practice change; institutional logics; healthcare decentralization; youth care

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## 1. Introduction

Healthcare systems all over the world have been under distress and are facing severe challenges (Regmi, 2014). Reason mentioned for this are that many healthcare systems have not been able to properly respond to the specific healthcare needs of the population within the changing “sociopolitical, environmental and organizational context of governance and public services” (Regmi, 2014, p. 1). So, in order to resolve the distress and challenges, the healthcare systems have to change in such manner that they will be better able to cope with the changing context. Many countries therefore have changed their healthcare system by means of a decentralization of their healthcare system (Bossert, 2014; Regmi, 2014; Saltman, Bankauskaite, & Vrangbæk, 2007). One of those countries is the Netherlands, that – starting on January 1, 2015 – decentralized both the decision-making authority and responsibilities for health and social care from the central government to the municipalities (Loketgezondleven.nl, 2016a; Movisie, 2015a). The Dutch decentralization consists of three separate changes in laws: the introduction of the Participation act; the transfer of tasks from the Act of Exceptional Medical Expenses [Algemene Wet Bijzondere Ziektekosten; AWBZ] to the new Social Support Act; and the transition of youth care (combined with tasks from the AWBZ) to the new Youth Act (Berenschot, 2012; Loketgezondleven.nl, 2016a). In the context of this thesis, the decentralization of youth care is of particular interest, as this is the only section of care in the Netherlands that has been completely decentralized during this decentralization. Other sections of care were only partly decentralized and therefore are more difficult to define.

The decentralization of the Dutch youth care system was instigated with the aim to increase the effectiveness and efficiency of care, while additionally making care more easily accessible for the care receivers (Rijksoverheid, 2016). Furthermore, the decentralization entails both a transition of the rules, laws and financing methods on national level, and a change in behavior, routines and methods for the local healthcare practitioners (Loketgezondleven.nl, 2016b). On the micro-level of the practitioner, this change aims at a better cooperation between professional and volunteering care-givers, new care activities, tools and services to support clients, and a different way of organizing the access to publicly financed care and support (Movisie, 2015a). Therefore, if implemented as intended, the decentralization of the youth care systems will create a change at the micro-level of Dutch the youth care system.

One of the aspects that is likely to change at this micro-level concerns the practices of the youth care practitioners. Practices are “shared routines of behavior, including traditions, norms and procedures for thinking, acting and using ‘things’ [...] in a broad sense” (Whittington, 2006, p. 619). When considering practices and practice change, one important approach is that of institutional theory on the micro-level. This theory states that “individual behavior and organizational practices” (p. 375) are shaped by a set of institutional logics (Goodrick & Reay, 2011). An institutional logic is “a set of material practices and symbolic constructions” (Friedland & Alford, 1991, p. 248) that guides social actors by shaping and constraining their behavioral repertoire (Goodrick & Reay, 2011). In reality, a sector often contains several logics that all (to some extent) affect the social actors at the same time, Goodrick and Reay (2011) call this a constellation of logics. Concluding, the set of practices of youth care practitioners is determined by the constellation of logics in the Dutch youth care system and a change in those practices requires a change in the constellation of logics.

The constellation of logics will change when it is socially recognized that a variation in the behavior of the actors is required and this required variation can no longer be guided or explained by the existing constellation of logics (Lounsbury & Crumley, 2007). Therefore, it is essential for creating change in institutional logics that a critical event in the sector takes place as the initiator for the required variation in behavior (Goodrick & Reay, 2011). It is to be expected that the Dutch decentralization has formed such a critical event for the Dutch youth care system, as it has formed a broad change that concerned the complete sector of youth care and included changes in the administrative, legal and financial framework of the field (Loketgezondleven.nl, 2016b; Movisie, 2015b). It therefore is likely that the decentralization of the Dutch youth care system has changed the practices of the youth care practitioners.

Overall, the studies of Friedland and Alford (1991), Goodrick and Reay (2011), Lounsbury and Crumley (2007) and Whittington (2006) show that the current literature on practice has studied what triggers change in practices. Other examples on this topic include the study from Reay et al. (2013) who studied how new ideas were transformed into a practice, or the studies from Labatut, Aggeri and Girard (2012) and Lounsbury and Crumley (2007) who study the creation of new practices from different angles. However, these studies do not go into the question of what specific changes might be expected in a set of practices for a professional. The study of Goodrick and Reay (2011) have made a good start here by investigating how different logics can be combined within one constellation, but the actual effect on the practices has remain unnoticed. Keevers, Treleaven, Sykes and Darcy (2012)

also take a step in this direction by studying how two professional practices changed as a consequence of the integration of results-based accountability practices. However, these studies do not examine what changes an exogenous change might create in a set of practices. Therefore, this thesis focuses on offering a contribution to this gap by studying an exogenous change, in the form of a healthcare decentralization, and its impact on the practices.

## **1.1. Research Aim and Research Question**

This study aims to contribute to the practice literature by examining how the Dutch youth care decentralization affected the practices of the practitioners working in the youth care system of the Dutch province of Gelderland. Additionally, this thesis aims to provide Dutch youth care organizations insights into how their practices might have changed in response to the decentralization of youth care. The research question of this thesis is as the following:

*“How does the decentralization of the Dutch youth care system affect the practices of the youth care professionals?”*

This explorative thesis provides an answer to this question by applying a qualitative research methodology on the base of seven unstructured to semi-structured qualitative interviews with practitioners of several different youth care institutions in Gelderland (a province in the Netherlands). The data gathered from those interviews then was transformed to conclusions by analyzing the data on the base of template analysis with three levels of coding.

This thesis continues with the theoretical framework in chapter two, which provides information on healthcare decentralization, the Dutch decentralization of youth care, practices and practice change. Then, the choices on the methodology of this study are represented in chapter three. This is followed by chapter four, which presents the findings of this study. Finally, the last chapter concludes by answering the central research question and elaborates on the implications of this conclusion for both theory and practice. Additionally, this chapter reflects on the strengths and limitations of this research and on the implications for future research.

## **2. Theoretical framework**

This chapter presents a theoretical background related to the key concepts of this study. First, a short introduction into the concept of a decentralization in healthcare is given. After that, the actual decentralization that has taken place in the Netherlands is described. Next, an elaboration on practices and institutional logics follows. Finally, the last paragraph goes into how practices can change, which is elaborated on the base of institutional logics, performativity, the recognition of anomalies and the model of motivations, opportunities and abilities.

### **2.1. Decentralization of healthcare**

During the past decades decentralization of healthcare has been a popular measure in many countries worldwide, and so far it still seems to gain in popularity (Regmi, 2014). In the context of healthcare, decentralization is related to the structure of the government and in specific to the allocation of authority and responsibilities, which are moved from higher to lower levels of that structure (Regmi, 2014). The idea behind the use of a decentralization is that the lower levels of the governmental structure contain a larger number of relatively small organizations, when compared with the organizations on the higher governmental levels. Subsequently, it is believed that “smaller organizations, [when] properly structured and steered, are inherently more agile and accountable than larger organizations” (Saltman et al., 2007, p. 1). As a consequence of this believe, the measure of healthcare decentralization has been a very popular one and has attracted national policy-makers from all over the world. This popularity has led to the existence of many different examples and executions of healthcare decentralization (Saltman et al., 2007). A decentralization of healthcare in one country, for example, might concern a devolution of power to the local levels, meaning that not only decision-making, but also management and finance are transferred. However, in other countries a decentralization might purely be a delegation of operational or financial decision-making (Regmi, 2014). To give more clarity on what the actual decentralization in the Netherlands entails, the sub-paragraph below will elaborate on both the Dutch healthcare decentralization and how that affected the Dutch youth care.

## **2.2. The healthcare decentralization in Dutch youth care**

The decentralization of Dutch youth care is part of the complete Dutch healthcare decentralization that was introduced in January 2015. In total the decentralization involves three transitions (meaning: changes in rules, laws and finances): the introduction of the Participation act, the transfer of tasks from the AWBZ to the new Social Support Act, and the transition of youth care (combined with tasks from the AWBZ) to the new Youth Act (Berenschot, 2012; Loketgezondleven.nl, 2016a).

All three transitions concern a decentralization from the central or provincial government to the local municipalities and aim at more effective and efficient care that also is more personal and easily accessible for the care receivers (Rijksoverheid, 2016). Besides these transitions, the central government decided to cut the healthcare budgets as well. For the municipalities this meant that they were required to organize these new care responsibilities in such a way that it better fits the demands, but at the same time needs less resources (Berenschot, 2012).

For youth care in specific the decentralization means that the municipalities now are responsible for youth help, mental youth care, secured youth care, child protection, juvenile probation and care for the intellectually disabled youth (ZorgWijzer.nl, 2014). This, for example, means that the municipalities now are responsible for strengthening the educational environment in families, districts, neighborhoods, schools and childcare, but also for advising professionals that have concerns regarding a child, or making sure that there are enough certified care institutions (Nederlands Jeugdinstituut, 2016). The aim for the decentralization of youth care in specific is to create youth care that works from the strengths and social networks of the youngsters and their parents (Rijk, IPO, & VNG, 2012). The implementation of this new system for youth care existed out of two components, namely a transition and a transformation. The transition concerns a change in the structure of youth care which took place on the first of January in 2015 and includes both the governance structure and the organizational structure required for the actual execution of youth care by the municipalities (Rekenkamer Den Haag, 2014; Rijk et al., 2012). The transformation concerns a shift in the support, help and care for the youth and their parents. This transformation aims to pay more attention to prevention, early intervention and self-help, and to create a provision of integral care that better fits local and individual care needs (Rekenkamer Den Haag, 2014).

In this new system of youth care the central government still is responsible and accountable for the society-broad results and for setting the administrative, legal and financial

frameworks within which the municipalities should fulfill their allocated responsibilities (Transitiecommissie Stelselherziening Jeugd, 2013a, 2013b). However, the municipalities have gained a lot of freedom on their own policies and have the responsibility for their own budget and care provision (Rekenkamer Den Haag, 2014; Rijk et al., 2012). As the new system knows only one legal framework and one funding system, it is expected that the new system provides more efficacy and opportunities for a reduction in unnecessary bureaucracy (Rijk et al., 2012). With this new system the actual delivery of youth care has also changed: previously the client would register at the provincial Youth Care Office (in Dutch ‘Bureau Jeugdzorg’) which then would redirect the clients over the other youth care providers, but in the new system clients register at the municipalities (Jeugd Berscherming Gelderland, 2015). Even though every municipality has the freedom to determine by themselves how to give substance to their role in this new system, it is determined nationwide which party should have what role (Rijk et al., 2012; Rijksoverheid, 2016). One of these aspects is that the youngsters and the parents themselves should have a role in care as well, meaning that the lighter youth care issues should be left to the social network of the youngster and its parents as much as possible (Loketgezondleven.nl, 2016b; Berenschot, 2012). Also, as the new aim is to use as little (severe) professional care as possible, the municipalities were made responsible for providing what they call the ‘first-line’ care – the less severe cases that do need youth care – and for reducing the redirection of cases towards the second-line care (Berenschot, 2012; Loketgezondleven.nl, 2016b).

A specific decentralization like that of the Dutch youth care system creates changes at the micro-level of a system. For the Dutch youth care, one of the important aspects likely to change at the micro-level is that of the practices of the youth care practitioners. The following paragraph will thereby go into the concept of practices.

### **2.3. Practices**

In the past decades the interest for practice-based research has clearly been growing, in social theory this trend even received a name, namely ‘the practice turn’ (Hopwood, 2016; Whittington, 2006). As Feldman and Orlikowski (2011) state in their article, this practice turn can imply three different ways of studying practices: via an empirical approach, a theoretical approach or a philosophical approach. This first approach sees the human actions as central to organizational outcomes and reflects on the importance of practices in that role. The second approach still has a focus on everyday activity, but really focuses on finding explanations for

an activity. Finally, the philosophical approach sees activities as central to the enactment of the social world (Feldman & Orlikowski, 2011).

Yet, a lot of studies also use the term ‘practice’ without any theoretical justification (Lounsbury & Crumley, 2007). So, what precisely is a practice? To answer this question Reckwitz (2002) applies a distinction between ‘praxis’ and ‘practices’, as the term ‘practice’ could be interpreted in a dual sense in social theory (Whittington, 2006). Within this distinction ‘practices’ refers to “shared routines of behavior, including traditions, norms and procedures for thinking, acting and using ‘things’ [...] in a broad sense” (p. 619), while ‘praxis’ concerns “what people do in practice” (Whittington, 2006, p. 619), or as Reckwitz (2002) called it: “the whole of human action” (p. 249). Jarzabkowski (2005) makes a similar distinction when comparing ‘activity’ and ‘practice’, in which an activity concerns all the (inter)actions from and between actors which are related to them performing their daily duties and roles, and practice concerns patterns of activities across different actors which are permeated with a “broader meaning and provide tools for ordering social life and activity” (Lounsbury & Crumley, 2007, p. 995). For example, in the strategic sensemaking and sensegiving of managers, one could identify four practices, namely translating the new orientation, overcoding the strategy, disciplining the client and justifying the change (Rouleau, 2005). As Lounsbury and Crumley (2007) already state in their article, this definition of practices implies that a practice could actually also be seen as an institution: a “multifaceted, durable social” structure that is “comprised of regulative, normative and cultural-cognitive elements that, together with associated activities and resources, provide stability and meaning to social life” (Scott, 2008, p. 48). Even though institutions (and thus practices) are durable social structures, they do change over time as the rules that underlie the institution emerge in interaction with the actions performed by the actors within the institution (March & Olsen, 1989; Scott, 2008). One important concept in how institutions change over time is that of institutional logics, for that reason the following subparagraph will elaborate on this concept.

## **2.4. Institutional logics**

The concept of institutional logics was first introduced by Friedland and Alford (1991). In this book chapter they argue that every institutional order or, as Goodrick and Reay (2011) name it, every societal sector has a central logic. This central logic concerns “a set of material practices and symbolic constructions” (Friedland & Alford, 1991, p. 248) and guides social

actors by shaping and constraining their behavioral repertoire (Goodrick & Reay, 2011). So, these logics guide the behavior of the actors within an institution and can help to understand individual and organizational behavior. Goodrick and Reay (2011) conceptualize four ideal type logics that may be reflected in professional work, namely the professional logic, the corporate logic, the state logic and the market logic. Professional logic means that the “professionals rely on abstract knowledge to conduct their practice solely or in partnership with others of the same profession” (p. 378) in this situation the professionals themselves have the control over content and the organization of work (Goodrick & Reay, 2011). The ideal type corporate logic comes to play when corporate managers (which may be non-professionals) are responsible “for evaluating the performance of all workers ... [and] determine the appropriate quality” (Goodrick & Reay, 2011, p. 378). In the ideal type of state logic it is not the corporate manager but the government that takes responsibility, which means that the state “controls professional knowledge, the credentials for professional practice, and the organization of work” (Goodrick & Reay, 2011, p. 379). Finally the market logic is seen when there is a free market and the market pressures shape the work and offerings of professionals. This requires that “professional knowledge is widely available and there are no specific credentials or educational requirements for professional work” (Goodrick & Reay, 2011, p. 379).

As these four logics are ideal type logics, reality often displays several logics coexisting at the same time (Goodrick & Reay, 2011; Scott, 2008). For a long time it was believed that, even though there were aspects of several logics, there always was one dominant logic (Goodrick & Reay, 2011; Lounsbury, 2007). However, the study of Goodrick and Reay (2011) has shown that logics can coexist in at least three different constellations. The first constellation corresponds with previous studies and shows one dominant logic, while the other three logics have either none, or a small influence on the social actor and his or her practices in comparison to the dominant logic. In the second constellation there are two strong logics and two somewhat weaker logics; here none of the two strong logics is actually dominant. A final third constellation arises when one logic is relatively strong, while the other three logics have a weaker influence. This third constellation is similar to the first constellation, but differs in the fact that the stronger logic is not dominant, as the weaker logics also have a clear influence on the behavior and practices (Goodrick & Reay, 2011). Where it first was thought that logics held a competitive relation with each other and therefore could only have one dominant logic, this study of Goodrick and Reay (2011) has now shown that multiple logics can influence the social at the same time. Their study shows that the

relations between logics can have the traditional competitive nature, but also a cooperative nature. Several logics can coexist when they either have facilitative or additive cooperative relations, or when the practices are segmented and different practices can be guided by different logics at the same time. In this last situation, the segmentation allows the logics to have a competitive relation while coexisting at the same time (Goodrick & Reay, 2011).

## **2.5. Practice change**

As practices are institutions, institutional theory and theories on how institutions change can provide theoretical backgrounds for practice change. This sub-paragraph elaborates on practice change from an institutional starting point.

**Institutional logics.** As mentioned before, institutional logics shape individual practices as they “represent sets of expectations for social relations and behavior” (Goodrick & Reay, 2011, p. 375). Additionally, institutional logics structure the attention of an individual with respect to rules and conventions used for determining what is important and therefore what issues should be resolved (Goodrick & Reay, 2011). So, a change in institutional logics will lead to a change in practices. However, for the institutional logics to change, several conditions are required. These will be discussed in the next paragraphs.

**Performativity and becoming.** The article of Lounsbury and Crumley (2007) provides a first step in answering how institutional logic might change by using the concept of performativity (Feldman, 2003; Orlowinski et al., 1995) to create a process model of practice creation. Performativity concerns the assumption that “individual performances of a practice play a key role in both reproducing and altering a given practice through variation in its enactment” (Lounsbury & Crumley, 2007, p. 996). The concept of performativity therefore includes both the strategically planned variations and those triggered by local contingencies. Tsoukas and Chia (2002) also discuss this concept of performativity and variations in their article, but under the terms of performative accounts and (organizational) becoming. The practice creation model of Lounsbury and Crumley (2007) also reflects the study of Tsoukas and Chia (2002) as both articles elaborate on appropriate variety and variety that triggers change. In the initial article of Tsoukas and Chia (2002) this is discussed as a stable core existing out of prototypical members (or variations) which account for stability. However, when the variety is non-prototypical a possible change is triggered. Lounsbury and Crumley

(2007) apply this theory to institutions and explain this difference in variations by the previously mentioned institutional logics. This means that, as long as variations in activities can be explained via the current constellation of logics related to a practice, the practice will not trigger renewed theorization of logics. Once the variation can no longer be explained via the current constellation of logics, a new theorization of logics is required (Lounsbury & Crumley, 2007).

**Recognition of anomalies.** Yet, one more aspect is required for an actual change in practices to arise. Lounsbury and Crumley (2007) call this part the social recognition of field-level actors that the variation is an anomaly. However, no more is mentioned than that for the creation of social recognition it is most likely that a collective mobilization is required. Other articles do provide more insights into this part of practice change. One example is the article of Reay et al. (2013) that investigated the required managerial actions critical for new practice creation, resulting in three phases: micro-level theorizing, encouraging to try it and facilitating collective meaning making. The first phase of ‘micro-level theorizing’ focuses on telling and trying to convince people to support the practice change (Reay et al., 2013). The essence of the second phase is already quite clear from the name ‘encouraging to try it’, the idea behind this phase is that by trying the practitioners will make sense of the change, so the manager facilitate meaning-making (Reay et al., 2013). Finally, the phase of collective meaning-making aims at a collective and consistent understanding of the practices over the complete organization. Another example is that of Cohen et al. (2004) who developed a model of practice change within healthcare, consisting of four elements and the relations between those elements. These elements concern the motivation of key stakeholders, the resources for change, outside motivators and opportunities for change. Assuming that the element of ‘motivation of key stakeholders’ might be related to the collective mobilization requested by Lounsbury and Crumley (2007), this study from Cohen et al. (2004) elaborates on how the three other elements influence this collective mobilization within healthcare via their interrelatedness. Examples of these influences are that some outside motivators for change might also motivate the key stakeholders - requiring for the organization to identify and stimulate these external systems – or that, by engaging the key stakeholders with the practices and with brainstorming, they might become motivated to change (Cohen et al., 2004).

**Motivation, Opportunity and Ability.** In 1995, Ölander and Thøgersen created a model that determines behavior: the Motivation-Opportunity-Ability (MOA) model. This

model represents the idea that the behavior of an individual is determined by three components: the individual's motivation, ability and opportunity to behave in a certain way (Ölander & Thøgersen, 1995). While performativity and the recognition of anomalies both show how a change is made possible, so how people become motivated to change and how the opportunity for new behavior is created, the ability-component still is missing. In addition to the above mentioned theoretical conditions, it therefore is important for an organization to recognize that a change in practices might require new knowledge and skills from their employees. And that, as shown by the MOA model, a new behavior will not be (effectively) displayed when an individual lacks the ability to adequately perform the specific behavior (Binney, Hall, & Oppenheim, 2007).

### **3. Methodology**

This chapter elaborates on the methodology used in this study. The chapter goes into the research design, the empirical context of the study and data collection and analysis. Finally the measures taken on quality of the research and ethics are discussed.

#### **3.1. Research design**

This thesis is based on a qualitative study to how healthcare decentralizations influence the practices of healthcare practitioners. The choice was made for qualitative research because of the explorative nature of the research question, that aims at gaining a “greater understanding of the phenomenon,” which in this case concerns the practice change of healthcare practitioners (Justesen & Mik-Meyer, 2012, p. 16). As this study aims to explore how participants experienced this phenomenon to be influenced by the recent healthcare decentralization, qualitative research is especially suitable (Bleijenbergh, 2013). Quantitative research on the other hand would have been more useful for research aimed at describing or explaining a phenomenon, which might be useful in later research once more knowledge is gathered on the effects a healthcare decentralization has on the practices (Justesen & Mik-Meyer, 2012). However, since explorative research is required first, I made the decision for qualitative research.

Within the stream of qualitative research several perspectives are used for research (Duberley, Johnson, & Cassell, 2012; Justesen & Mik-Meyer, 2012). In this specific study I used a phenomenological perspective, which is one of the many interpretivism perspectives. Interpretivism perspectives take “human interpretation as the starting point for developing knowledge about the social world” and entail “accessing and understanding the actual meanings and interpretations actors subjectively ascribe to phenomena in order to describe and explain their behaviour” (Duberley et al., 2012, p. 21). Phenomology emphasizes phenomena and sees people as subjects that experience a specific phenomenon, without those subjects the phenomenon would not exist. Also, this perspective emphasizes that people live in a “collective world [...] that forms a special horizon of meaning for the individual” (p. 22) and give their own meaning to a phenomena and to how they experience it, instead of an objective measurement (Justesen & Mik-Meyer, 2012). For this study this perspective was

especially useful as both practices and institutional logics focus on the collective world and this study emphasizes the personal experiences from the participants.

### **3.2. Sample and data collection**

The source of data in this study was interviews conducted with healthcare practitioners who were working in youth care institutions in Gelderland (in the Netherlands). The research participants were chosen on a non-probability base, namely via self-selection and snowball sampling. Both self-selection and snowball sampling are methods that allow the participants to volunteer themselves to take part in a study (Saunders, 2012). These two techniques both are often used for exploratory research or in a situation where it is difficult to gain access to participants, since it gives the participants the opportunity to identify themselves as a participant based on their “strong feelings or opinions about the research” (Saunders, 2012, p. 43). The fact that the research had an exploratory nature and was performed independently of any organization, made it difficult to know precisely where the valuable participants could be found. Therefore, the self-identifying characteristic of these sampling methods was useful and justified for this study. In first instance I searched for participants by placing requests on social media and sending requests to the different youth care organizations in the region to distribute an invitation towards their employees. As a result of this method a couple of participants volunteered. However, as I preferred to gather more participants than the number that had volunteered, I then used the snowballing method to gather more participants by asking these first participants whether they could ask colleagues or other acquaintances whether they would want to participate in the study.

The research strategy used in this thesis is the interview study. I chose this strategy since the study concerns an exploration of the subjective experiences of healthcare practitioners, which would not have been provided by other methods like document analysis or participant observation as they do not represent what someone is feeling or thinking. Due to this reason other strategies, like the field study or case study, did not add any extra insights into the current research question, thereby justifying the choice for an interview study (Bleijenbergh, 2013).

The specific data collection method that I used is that of interviews on the base of open questions, which were in between the unstructured and the semi-structured construction. The reason that the interviews were a little more structured than the unstructured interview style was that I really wanted to make sure that the interviews were comparable and at least

concerned the main topics, which requires at least a little structure (Justesen & Mik-Meyer, 2012). However, the study had an explorative character what made it difficult to know beforehand how the participants experienced the influence of the decentralization on their practices. So, based on this explorative nature, it was both difficult to create a pure semi-structured interview, and preferred to give the participants more freedom to tell what they thought was essential, making an unstructured interview fit better (Justesen & Mik-Meyer, 2012). Therefore, I made the decision to start all interviews with the same question and use sensitizing concepts to create some structure, while the openness of the first question and the fact that the concepts were not used in a strict order, still provided a very unstructured nature in the interviews (see appendix 1 for the interview guide). Furthermore, I made the choice to use open questions to allow the participants to provide information in their own wording and enable exploration of their personal experiences (Bleijenbergh, 2013). The sensitizing concepts that I used for this study were based on other articles which also studied practices and mentioned examples of practices and central concepts of practices in a specific job, examples of those articles are that of Keevers et al. (2012) and Norbäck, Helin and Raviola (2014). As these articles often discussed other jobs than I studied here, I then used my personal knowledge on Dutch youth care to build expectations for what practices a youth care practitioner might perform within their jobs. Additionally, for strengthening my personal knowledge on the Dutch youth care, I had a conversation with a nurse who worked in Dutch youth care and read Dutch news articles on the Dutch youth care. Eventually this led me to the following sensitizing concepts: daily tasks, client contact, internal communication, external communication, planning, forming decisions, budget management and accountability. Due to the explorative nature of this study, I aimed for the sensitizing concepts to reflected all possible practices performed by youth care practitioners and not specifically those which were influenced by the healthcare decentralization, as this information was not known beforehand.

In total there were seven interviews performed with employees from four different organizations of which some operated in the whole region of Gelderland, while others operated in smaller regions (mostly Arnhem and Nijmegen, and their surrounding municipalities). The four organizations represented organizations of both the first-line and second-line youth care and included both the outpatient care as the (semi-)closed institutions in which youngsters are internalized while receiving care. As the participants were gathered on the base of voluntary participation, the number of seven interviews was not specifically chosen and depended on the number of participants that volunteered. The interviews were

performed in a face-to-face setting on a location which was chosen by the participant, in practice this was either at the work location, in a café or at their home. I chose to perform face-to-face interviews (instead of for example telephone interviews), since these enabled me to study both the verbal and non-verbal communication of the participants, which in turn helped me to better interpret the experiences from the participants. Also, the above mentioned choices of face-to-face interviews and location choice were both aimed at making the participants feel safe and comfortable during the interviews.

Finally, due to the open-ended and semi-structured nature of the interview, I chose to record the interviews (in agreement with the participants) to make sure that all the information was captured and my personal attention during the interview could be focused on the non-verbal communication and further questioning.

### **3.3. Data analysis**

Directly after the interviews the recordings were transcribed and noteworthy non-verbal communications or personal thoughts were added to the transcript via memos with the aim of high accuracy and richness of information. These transcripts and memo's formed the base for further analysis.

The data analysis performed in this study was guided by the technique of template analysis. Template analysis is most used for analyzing “data from individual interviews” and uses the development of a coding template on the basis of “a subset of the data, which is then applied to further data” (King, 2012, pp. 426-427). Another justification for template analysis concerns the fit with the phenomenological perspective. Also, template analysis - unlike other analysis like IPA – is not as time consuming and really fits the heterogeneous sample of this study (Pietkiewicz & Smith, 2014; Smith & Osborn, 2008).

Template analysis in general starts with a priori themes that are defined by the researcher in advance of the study, after which an initial template is created on the base on a subset of data. This initial template is later applied to the rest of the data while it remains open for adjustments on the base of this new data (King, 2012). For this study I decided to start with a priori themes which were based on the sensitizing concepts (see paragraph 3.2). Another key aspect of template analysis is that it uses hierarchical coding – the clustering of similar codes to create a new, more general code of a higher order – without specifying a specific amount of levels of coding (King, 2012). On the base of the data this study applied three levels of coding, of which the first level of codes were Dutch and both the second and

third levels were English codes. A table with an overview of the second and third level codes can be found in appendix 2.

### **3.4. Quality of the study and ethics**

**Quality of the study.** To ensure a good quality of the data analysis and therefore of the study a couple of measures were taken. First measure was that I discussed a first transcript and the initial codes with a colleague researcher to see whether the codes seem to fit the transcript of the interview and ensure reflexivity on my part. Another measure was that the interviews included elaborate questions on the context in which participants worked before and after the decentralization, which I processed into a context description (see chapter 4, paragraph 1). The personal descriptions, however, were made anonymous and were not linked to the results to make sure that no individual statement could be related to an individual background. This context together with the context description in the theoretical framework (on the situation in Dutch healthcare and youth care) and the case description at the end of this chapter will help readers understand to what context this research is applicable to their situations.

**Ethical considerations.** Besides the measures taken to ensure the quality of the study, measures were taken to ensure an ethical treatment of both participants and their information. First measure that I took was to ensure voluntary participation, especially with the participants that volunteered on the request of an organization it was made clear that they still had every right and possibility to withdraw their participation. Also, to prevent possible negative side-effects for the participants, the results from this study were not shared with the organizations, unless the participants chose to do so themselves.

Secondly all participations were treated anonymously and all information shared was treated in a confidential manner. For this reason, I chose not to represent the results in a manner that statements could be traced back to individual participants. To further assure anonymity of the participants the results and quotes used in this report were send to the participants in order for them to check their own anonymity and for them to have the opportunity to ask questions on the results or provide further feedback.

## 4. Results

In this chapter the results of this study are discussed. The chapter starts with a paragraph on the context of the practices studied, in which the organizational changes and other influential aspects are discussed. After this practice context an analysis on five main practices is given.

### 4.1. Practice context

The healthcare decentralization, described in the previous chapters, not only has an effect on the municipalities. Via the municipalities, this decentralization also affects the youth care organizations and the youth care practices. Additionally, the changes made in the youth care organization as a response to the decentralization, affect the practices as well. Therefore, it is important to complement the knowledge on the national changes in the healthcare system (see chapter 2, paragraph 2) with knowledge on what specific circumstances were surrounding the practices of the participants within the organizations. This paragraph thus represents the context surrounding the practices at the time of interviewing as it was experienced by the participants of this study.

For the youth care workers that participated in this study the context of the practices consisted out of the following important aspects: working in self-managing work teams (SMWT), organizational retrenchments, new strategic visions and a high workload and uncertainty. First the SMWT's, these were seen in all organizations, but did differ in the extent to which they were implemented. In all situations this introduction of (semi-)SMWT's was accompanied by the removal of at least one management layer, namely the direct team leaders. In some situations this team leader was replaced by plus-type employees, which connected the team with the higher management. Secondly, the organizations had to make retrenchments on several areas. Examples of these retrenchments are reductions on the number of employees, less use of creative therapies (in Dutch "vaktherapieën"), diagnostic tools and follow-up care, and lower budget for camps or daytrips for the groups in (semi-) closed locations. A third aspect concerns the new strategic visions, a (small) strategy change was seen in all organizations, but for some this actually meant a large culture change which strongly influenced the work of the care practitioners. A fourth contextual aspect is that of the high workload experienced by the employees. This aspect appears to be temporal as it really was named to be a consequence of the retrenchments and other changes in the youth care

organizations. Still, employees did mention a strong (temporal) influence from this aspect on their practice performances. Finally, the decentralization brought large uncertainties for the complete field of youth care, as nobody knew what was expected of them in this new system of youth care. However, this a situation of chaos was already becoming clearer at the moment of interviewing.

## 4.2. Professional practices

This paragraph elaborates on what professional practices changed due to the change in the healthcare system and on how those specific practices changed. The healthcare reform created several previously mentioned changes for the youth care organizations and thereby changed practices. Even though many more practices might have changed this paragraph will discuss the five practices that represent the largest changes represented by the data, namely youth care provision, care worker - client positioning, external relation management, result management and team management. In this paragraph quotes are used to strengthen and enrich the elaboration of the results, these quotes all are placed between quotation marks and in placed in italics. Also, behind the quotes a number is stated, this represents the interview from which the quote originates.

**Youth care provision.** The practice of youth care provision is one at the center of the jobs of youth care workers, it includes all performances of the youth care worker aimed to actually provide care to their clients. Strikingly most participants stated that “*the substance of the care in the families*” [2] or “*what we do on the groups*” [4] has not changed as a result of the new healthcare system, some even stated that “*the essence of their work [...] 20 years ago, was the same as it is now*” [7]. The new care system, however, did require changes in how this essence of care would be provided, namely in a more critical and more targeting manner.

Before the decentralization it was normal to start a care trajectory and then “*just keep [on] doing and doing*” [5] care, until both parties agreed to end the trajectory. Besides that, the target audience for the care was less specifically stated, creating a situation where organizations had broad variety in the clients they had in their care and provided care to whoever needed it. However, since the introduction of the decentralization, youth care organizations have to compete with each other to acquire their cases. This newly found competition has led the organizations to choose a smaller and more specific part of the field of

youth care to serve and has increased the criticality of youth care workers in performing the practice of care provision. It thereby seems that a change in institutional logics has taken place, in which the market logic has gained a larger influence on this practice. This influence of the market logic is clearly shown in the following quote:

*“It is what [organization] focuses on by saying ‘hey we are specialists and lighter cases do not belong with us [...] so you become more critical to where you first thought ‘oh well an easier case is also fine’ [...] I think that because of that you are able to deliver more quality to the ones we do perform as well.”*[6]

This quote clearly shows that, because of the stricter choice on which clients to serve, the care workers have been obliged to strictly evaluate whether they themselves should provide the care or whether other, less intensive care would also do. Furthermore, this quote indicates that the market logic has a cooperative relation with the professional logic, as the participant states that the new way of working benefits both the position of the organization and the quality of the care. Additionally, the youth care workers nowadays have to define an end-date when they start their care and must officially request for an extension of the initial care order, which *“makes you way more targeted in the things you do.”*[7] This forms an indication that the decentralization has increased the influence of administrative practices, such as requesting extension, on the professional practices.

Another aspect related to the provision of care is that previously the care trajectory would just start immediately as the care was diagnosed to be required. At that time this was possible because all organizations received a budget for the whole year, while in the new system a care order (in Dutch “beschikking”) is required to receive the money for the hours spend. For the youth care workers this means that they *“can’t start as long as there is no care order. Before [they] said ‘oh well, we will start already, there is a high urgency’, [they] can’t do that anymore.”*[6] Again, this quote really shows the impact from the market logic in making a profit on this professional practice.

Overall, it seems that a large part of the change in this practice can be linked to a change in the constellation of the institutional logic used for the practice. While previously the professional logic seemed to be dominant in providing care, now the market logic has increased influence. These two logics seem to have a cooperative relation, as the first quote in this paragraph already showed that the participant believed the newly gained market logic to benefit the professional aspects of youth care delivery. Due to this gained influence of the market logic the practice of youth care provision changed towards a more deliberate, and

targeted provision approach. Also, this market approach brought some administrative practices that affected the provision of care, which was seen in the setting of an end-date and officially requesting extensions of care.

**Care worker – client positioning.** Closely linked to the care provision is the positioning of the care worker in relation to the client, which concerns all activities performed by the youth care worker with the aim of arranging him- or herself with respect to the client and the relation with the client. The change in this practice is most of all seen in the positioning of the relation with the guardians or parents within the system (in youth care used to refer to the family). Previously, the youth care worker was there to take care of both the youngsters and their parents, in this process the care worker would gently try to get the complete system on board but would never themselves use a coercive attitude. Back then, if it would have been found required for the benefit of the child, the youth care worker would “call [the Youth Care Office], like ‘hey, I need you now, you have to take a stand now so that I can continue’, but that no longer is the case” [6]. So, the youth care worker could ask the Youth Care Office to use their coercive power, which enabled the care worker to just focus on helping and getting people better. However, with the introduction of the healthcare decentralization the municipalities took over a large part of the role of the Youth Care Office, creating two parties who both have less coercive power. For the practice of care worker-client positioning this means that the youth care workers themselves now have to take a stand towards the parents if necessary and have to deliberately work on triggering and facilitating the own responsibility of their clients. This actively trying to trigger a sense of own responsibility from the parent is clearly shown in the following quote:

*“There is this work structure, it’s called ‘my plan, our plan’. [...] it is a simple thing, you got some parts on their living conditions, what are my worries, what are my wishes, how am I going to work on that [...] what does my network look like... Yes, really in first person. And then you are going to make an action plan in which you have to pay attention to ‘where do you want to go, what is going to help you get there’ uhh...” [3]*

This quote also shows the new focus on achieving results, which again is in line with a gained influence of the market logic. This since the market nowadays requires the youth care organizations to deliver a high quality of care in the least amount of time (and money),

creating a situation where it has become essential for the practitioners to focus on achieving results.

This change in practices is actually one that is positively received by the youth care workers as they often get frustrated when parents refuse to cooperate and sometimes even sabotage the treatment and progress of the children. The following quote is an example of how youth care workers see this change and how parents sometimes behave:

*“Anyway, that is also what has changed towards the clients in a sense that clients are more than before made aware of their own responsibility [...] And rightly so, in that respect we still have a lot more progress to make. I mean last week we had an intake [...] for which we need both parents, well, dad wasn't there. Well, a new appointment [...] mom was not there, dad was [...] you know it is so frustrating because before you have even done anything you are four or five weeks along. You know, in those aspects we are way too lenient, I think, to the parents.” [7]*

The participant of this quote clearly links the former positioning of the care worker - client relation as a negative influence for the professional practices. This forms an extra indication that the market logic has a cooperative relation with the professional logic, as this new line of thinking decreases the negative influence from parents who do not cooperate in the care trajectories.

Concluding, the practice of positioning the relation between care worker and client has strongly changed for the relation with the parent (or guardian) of the youngsters. The practice has not so much changed in a sense of a lot of new activities, but more in a sense of a new line of thinking which strongly deviates from what used to be normal before the decentralization. This change seems to be in line with the previously mentioned market logic, as it represents a focus on achieving results within a certain time (as is demanded by the market). Moreover, this practice change forms an indication of a cooperative relation between the market logic and the professional logic.

**External relation management.** The practice of external relation management comprises all activities performed to create, maintain and improve relations with external parties. This practice is new to the youth care workers and was created due to the fact that youth care institutions no longer have a yearly budget which is provided beforehand. Instead, since the decentralization, the municipalities are free to choose to which youth care institution they want to redirect the client and therefore who is going to be paid. This new way of

financing care has created competition between the different youth care institutions to show who delivers the best care for the lowest price, introducing the importance of good external relations.

Before the decentralization the contact of youth care workers with external parties was purely related to the case and its care content. Now, after the decentralization one can see that in general this contact has changed. However, this does depend on the organization, as this new practice is accommodated in different manners by the different organizations. Some organizations have placed this practice as a responsibility for the care workers themselves, others created a new job higher up in the organization to guide cases and manage the external relations and yet others added the external relation management to the departments responsible for the care contracting. For the youth care practitioners that actually were made responsible for this new practice included activities like going to network drinks, visiting the district teams of the municipalities, joining the team meetings of the district teams or staying a little longer at *“a joint conversation with the parents and someone from the municipalities [... to talk to the people from the municipalities and ...] just show your face a little more than merely on a specific case.”* [6] All these as activities are aimed at starting conversations, informing the district teams about the own services, promoting the own services and helping the district teams with possible difficulties or problems they experience. The importance of the use of these new practices is clearly shown in the following quote:

*“When you see in your figures that there were only three care orders from one specific municipality [...] well then you have to go and see and have a conversation with the municipality like ‘I am here from [organization] and hmhmm’ just to draw some attention to us again [...] Well, and then indeed the new care orders do come in again.”* [6]

Hence, the link between the use of this practice and the received care orders is quite direct. Therefore it is very important, from a market logic, for the organizations to effectively deploy this practice.

For the care workers who now were made responsible for these practices this meant a large extra responsibility in their jobs. One of the participants quite specifically showed that she experienced difficulty on finding a balance on how to perform this new responsibility in a fitting manner:

*“I personally find it difficult to, you know... I do want to go into conversation with the youth counselors of the district, but I am also not going to be like ‘hello, I am*

*here on behalf of [organization] do you have any cases for us?' you don't want that, however you do want to see where you can join in."* [2]

This quote really shows how much this practice is new to the care workers, and how much it requires a different way of working with the external contacts.

Additionally, besides the relation management towards the municipalities, the relation management towards other (youth) healthcare institutions has become more important. Especially for the youth care aimed at the more severe cases this type of relation management has become more important as their clients often enter and also leave the organization via other youth care institutions. Even though this previously should have been the case as well, clients often stayed in the same organization that offers the more severe care while receiving less severe care. However, in the new system with the new way of providing care (see 4.2.1) these clients are supposed to receive care from the most fitting care organization, requiring strong relations with those other organizations to find out *"what [...] they offer, so that we know which client of ours matches and could be placed there"* [5] This new way of providing care also requires *"that you have an ease entrance [...] because all trajectories have gotten shorter."* [5] So, as the clients spend less time in one specific organization, they spend their time in more different organizations, making the external relation management extra important for the practitioners.

Overall, this change in contact has created a new practice when implemented into the jobs of the youth care workers. For the employees this is an extra practice added to their existing practices, but also a real new way of working. This practice seems to be a logical consequence of the market logic, as the market forces instigated the need for external relation management. However, it does depend upon the structure of the organization whether this practice is accounted for by the youth care workers.

**Result management.** With the arrival of SMWT's some of the youth care professionals have become responsible for a new set of practices which previously was performed by the team management, namely the practice of result management. This practice concerns all activities performed to monitor and manage the team results. Before the decentralization all youth care workers that were interviewed had a team leader that had the responsibility for the results of the team. The youth care workers themselves only had to focus on their professional practice and had to keep in mind what their team leader had told them. The youth care workers wanted to have that focus and believed that *"if we are to do our jobs*

*properly, you have to keep that pressure [of the results] away from us and especially don't burden us with that, than we can do our work properly.*" [6] However, as the responsibility was purely on the shoulders of the team leader, it was relatively easy for the care workers to keep on working as they always did (regardless of their results). Now, with the introduction of the decentralization, this practice has become the responsibility of the SMWT. For the practitioners the influence of this new practice depends on their position within the team, as *"everyone has their own parts, as we have divided the tasks."* [2] So, every single team member has a personal task for which he or she is responsible. Meaning that, while everybody applies this practice to their personal healthcare outcomes, it depends upon their personal responsibilities whether they had the final responsibility for the complete team, for example for aspects such as the length of the average care trajectory, the caseload carried out by the team or the amount of filled-in questionnaires that were handed in.

In terms of specific activities, the employees now are responsible for monitoring the state of their personal responsibility and manage this to remain a desired state, this furthermore means that it has become their responsibility to fix errors in the figures in the computer system. The following quote represents an example of this practice from an employee which was responsible for a list of production figures:

*"We have to hand in a form which states how many cases we have handled [...] So, in our team meetings I discuss the form. You know, every time I really check like 'listen, our lead time is in 30% of our cases too long, so how can that be? What are reasons or causes for this figure and what can we do about it?' You know, that way I try to slowly get a grip on those figures."* [7]

So, after discussing the state of the own responsibility with the team, the team members together decide what has to happen and how they are going to approve, which is then mailed to the higher management. Even though this practice requires *"a change in the way of thinking and, ehm, learning what to do now"* [7] the employees do mention that they do not only experience a heightened joint responsibility as team, but that they also are *"more aware of uhh that when you need more time with a family, you are more aware now of what that means for your task given by the organization."* [6] Additionally, this last quote shows that this new practice of result management (for some) is of influence on the professional practices.

This practice in general is a new practice to the youth care workers, but not to the organization. However, as it is new for them, they really had to learn how to do this

monitoring and managing of the results. For some employees this practice had already become a standard routine while others were still struggling, which really showed that this practice required a learning process. Moreover, after the learning process, it still was visible that this new practice really made the care workers more aware of the influence of their professional practice upon the organizational results. So, one could say that this practice also contributed to the increased influence of the market logic on the professional practices.

**Team management.** Just like the new practice of result management, the team management became the responsibility of the team when they became SMWT's and thereby no longer had a team leader. The practice of team management contains all activities that are related to managing the group of employees within the team to function in an effective manner as one unity. Previously the team leader was there to make sure that the team as a whole was going in the right direction and that all team members were getting along in a healthy and satisfied manner. One employee mentions that this led to a situation where previously the youth care workers would "*fight the battles via the team leader.*"[7] However, now that the team leader is no longer in function, the youth care employees themselves are responsible for the team management and thereby have to address problems within the team themselves.

So, nowadays, the youth care workers themselves are responsible for addressing the behavior of their team members, resolving conflicts within the team and even addressing how other team members are functioning within their jobs. This last aspect has even gained in importance as it was mentioned on several occasions that no performance appraisals had been performed since the introduction of the decentralization in the beginning of 2015. Regardless of the importance, this new task of addressing each other on behavior and functioning appeared to be especially challenging for the youth care workers as this new practice was mentioned several times as a challenge that still had to be figured out. Yet, the newly used work-related figures do seem to help in addressing the team members as one participant does mention that possible dysfunctions are represented in those figures, making it more objective to address than "*how someone communicates or other abstract problems*"[7].

Besides being responsible for dealing with the problems within the team, the team has become responsible for a team-fit, meaning that they (in some organizations) are responsible for hiring the right new people and for making sure that everybody is on the same page. As one participant stated:

*“It used to be the problem of our team leader to make sure that that person got along in the rhythm [...] now it is our own course and then it also is our concern to say ‘hey someone new entered and has to join our course.’”[6]*

A final aspect related to team management that changed was found to be very challenging for the youth care workers, namely to manage their own time in relation to the amount of cases demanding their attention while simultaneously watching the mandatory caseload for the team. Previously, the employees only had to tell their team leader that they were up to their maximum caseload, now *“all these cases lie with the team and when receiving calls, it is someone from the team who is being called.”* [2] So, when a new case is registered in the region which falls under the responsibility of the team, they themselves have figure out how to integrate this new case in their caseload. Especially in the first period after the decentralization this new practice was still very difficult for the youth care workers, as they had to learn this new practice while working with less people due to the retrenchments and while receiving new extra responsibilities as a SMWT. For the employees this meant that they now themselves have to see *“hey what do I need to keep functioning and what do I need to prevent myself from collapsing.”* [6] Also, the team members have to decide together how to deal with people working overtime or working less due to being overwrought, as the team has a mandatory caseload to carry out which means that the individual balance influences that of the others within the team.

This practice of team management, new to the youth care workers, is not a practice that has influenced the work of the youth care workers in a very large proportion. However, it is a practice that should be present every day, as a team is build from every interaction between its members. The impact of this new practice is therefore not so much in the new activities, but more in the difficulty of this practice for the care workers. As the essence of their jobs is to care for others, it appeared quite challenging for these employees to have a more business wise attitude towards their colleagues or to tell them that they just did not agree. So overall this was another impacting change for the youth care workers.

**The influence of implementation.** While analyzing the data related to the five practices above, it became clear that, especially for the Result Management and the Team Management, there were large fluctuations in the extent to which these new practices were found in the work of the different participants. These fluctuations seemed related to the extent to which the SMWT’s were implemented and to the extent that this implementation was performed

successfully. In some organizations the SMWT were almost fully implemented and had received training and guidance via coaches which helped them to learn how to function like a SMWT. Other organizations were only halfway with the implementation and still worked in a semi-SMWT. And yet other organizations had implemented the SMWT, but only by removing the team leaders and providing the teams their freedom. In the organizations with a full, well guided implementation of the SMWT's there was a large practice change shown. Also, the care workers felt like they were more and more in control of their work and appreciated the SMWT's:

*“What I like is the joint responsibility” [2] and “there is a stronger bond because we all are very aware of the fact that we have to do this together, with our team, and yeah... I do feel that way. So in that respect it is positive.” [7]*

In the other organizations the change in practices was at least of a smaller scope, but in some occasions even almost absent. In these organizations employees said that to *“feel like we're drowning as a sort of speak, that we have to sort out how everything is working all by ourselves.”* [4] Overall, the effectiveness of the change implementation seems to be clearly related to the change seen in the practices and to how employees experienced the organizational changes.

## 5. Discussion

In this chapter an answer will be given to the research question, after which a conclusion will follow. After the conclusion, the discussion will link the results to the existing body of literature and the significance of this study for practice. Next, both the strengths and limitations of the study will be presented. Finally, the chapter ends with the recommendations for further research and practice.

### 5.1. Conclusion

This study aims to enlarge the understanding on how the practices of healthcare professionals change, by examining how the Dutch youth care decentralization affected the practices of the practitioners working in the youth care system of Gelderland (a Dutch province). This research question central to this thesis is the following:

*“How does the Dutch decentralization of youth care affect the practices of the youth care professionals?”*

This study showed that the Dutch decentralization of youth care seems to have created a change in the constellation of institutional logics in such a way that the market logic has increased in importance. This new market logic seems to have a cooperative relation with the previously dominant professional logic, creating a situation in which the youth care workers and youth care organizations now behave according to a constellation in which both the professional and the market logic are of great influence. For the youth care workers this new constellation meant that their practices experienced both a direct change from the new constellation of institutional logics and an indirect change of this constellation via the changes made by the organization. The specific organizational changes in Gelderland were aimed at re-establishing the market position, and for example included the implementation of self-managing work teams and several cuts.

Both these direct and indirect influences together have had an impact on the practices of the youth care workers. First, the practice of ‘youth care provision’ no longer is purely a professional practice, as both administrative and managerial practices have gained an increased influence on this professional practice. This change shows a new emphasis of the youth care workers while providing care, namely from emphasizing high quality care to

emphasizing a high quality in profitable care. Second, the practice of ‘care worker - client positioning’ has changed as the increased influence of market logic strengthened the focus on achieving results. Where it previously was normal to for the youth care worker to have an unconditional commitment to helping the youngsters and their family, nowadays the care workers deliberately motivate the parents to take their own responsibility and if necessary also take stand towards the parents. So, this practice changed as its goal changed due to the decentralization. Thirdly, the decentralization has led to three new practices for the youth care workers, namely ‘external relation management’, ‘result management’ and ‘team management’. These three practices all depended on how the organization had responded to the healthcare decentralization and whether they decided to make these new practices the responsibility of the care workers. With the change of the first two existing practices and the addition of the three new practices, the balance in the complete package of practices has changed for the professionals. Previously, their practices were more focused on their profession and on supporting their professional practice, but now their professional practices no longer are at the center of their set of practices. It has become their responsibility to make sure that their team not only provides a high quality care, but also that their team survives and if possible even thrives. So, the change is related to both the individual practices, as the balance in the set of practices.

Concluding, the practice changes induced by the healthcare decentralization were: an adjusted goal of the practice, an increased influence of administrative and managerial practices on the professional practice, an introduction of new practices and a shift in the balance of different practices. However, it remains important to realize that the presence and extent of these practice changes depended on how organizations responded to the healthcare decentralization and how they guided their employees through their envisioned changes. Especially with respect to changes like self-managing work teams, it seemed important that the right guidance was provided to the employees to actually achieve an effect in the practices.

## **5.2. Implications of the study**

This paragraph provides insights into the implications this study has on both the literature and practice. First, the theoretical implications for both practice theory and institutional theory will be discussed. Then the paragraph will end with an elaboration on the practical implications for the Dutch youth care practitioners.

**Theoretical implications.** Due to the explorative nature of this study, the results most of all provided a cautious set of first insights. However, this study does provide insights and therefore has its implications for the existing body of literature in both practice literature and institutional theory.

For the practice literature this study firstly contributes by showing that an increased influence of the market logic affected the practices, whereby it confirms that a change in institutional logics can form a trigger for a change in the practices. Secondly, this study shows that a specific set of practices might change in different manners, of which this study identified four: a goal-adjustment of the practice, an increased influence of administrative and managerial practices on the professional practice, an introduction of new practices, and a shift in the balance of different practices. Thirdly, this thesis provides an indication that the extent of the practice change depends on how the change is implemented. When relating this to the Motivation-Opportunity-Ability (MOA) model (Ölander and Thøgersen, 1995) it seems to be important that the guidance offered by the organization aims on motivating the practitioners, providing the opportunities for practice change and creating the ability of the practitioners to perform the new practices (Ölander & Thøgersen, 1995). In this specific study it seemed to be the case that the guidance lacked in creating the ability of the practitioners to behave in a self-managing manner.

The contribution of this study for the institutional theory most of all is coming from the indication that the healthcare decentralization triggered an increased influence of the market logic on the practices. This study thereby forms a confirmation of the finding from Goodrick and Reay (2011) that critical events can change the constellation of institutional logics. Additionally, this study indicated a cooperative relation between both the market logic and the professional logic, which was thought to be impossible before the study of Goodrick and Reay (2011)

**Practical implications.** This study has given insights into how the practices of Dutch youth care practitioners have actually changed as a consequence from the decentralization, and thereby offers an opportunity to evaluate the change and whether it has created the desired changes in practices. For example, one of the nationally set goals concerns a system of youth care that works from the strengths and social networks of the youngsters and their parents (Rijk et al., 2012). This goal is reflected by the change in the practices of ‘youth care provision’ and ‘care worker-client positioning’ which now start from the own responsibility and capabilities of the parents. Another example is the goal of reducing bureaucracy to

provide more room for the actual care (Rijk et al., 2012), this on the other hand seems to not have been realized as the influence of both administrative and managerial practices have increased, leading to the care workers experiencing less time for their care activities. However, as this study only represents a small number of participants, it should always be remembered that every organization is different and every individual will have their own experience. Organizations should therefore use this study as a base for studying their own situation, and combine that with conversations with their own employees.

Moreover, this study showed that it is very important for the Dutch youth care organizations to offer the right guidance to their practitioners when aiming to create a practice change. When applying the MOA-model (Ölander & Thøgersen, 1995) to this study, it seems to be the case that some youth care organizations forgot to work on the ability of their employees to work in a self-managing manner, which in turn led to a feeling of drowning as was mentioned by some employees. So, for managers aiming to create a change in the practices in their organization, it is important to keep on talking to their employees about how they experience their motivation, opportunity and ability to behave accordingly, and to intervene with measures necessary to create a change in the practices. For this specific case, the use of coaches or a temporary semi-SMWT seemed to help in learning the employees how to work in a SMWT.

### **5.3. Methodological considerations**

In using the findings of this study, it is important to consider both the strengths and limitations of this study. First, a strength of this study is that the respondents represented four different organizations, which all offered different types of care supply. By studying these four organizations a broad perspective was given on the practices of youth care and which implication the healthcare decentralization had for those practices. However, this variety in care supply also led to a wide variety in experiences represented in the seven interviews, which in turn made it more difficult to determine how well the experiences of the respondents were recognizable for other youth care practitioners. I would therefore encourage future studies to try to include more respondents from more different organizations, to see whether the findings of this study are transferable to other youth care workers. Also, as three out of the seven participants were from the same section in one organization, the experiences from those participants might have had a stronger influence on the results, creating a risk of misrepresentation. Even though I deliberately aimed to represent all participants in an even

manner in my conclusions, still some awareness of this risk is advised when applying the outcomes of this study to another, personal situation.

Second, due to the explorative nature of the study and the difficulty in finding participants, all participants took part in the study on a full voluntary basis. This might have formed a limitation for the study when only a specific type of people was willing to participate. For example, it could be the case that the participants all were people who had strong, negative feelings about the healthcare decentralization, or that all extreme cases decided not to volunteer as they felt the workload was too high. As the participants showed both positive and negative experiences, and both extreme and less extreme experiences, I had no direct indication of such a misrepresentation, but the possibility of this limitation must be considered. On the other hand, this voluntary participation also forms a strength to this study, as all participants were interesting for the aim of the study, open to the interviews and really showed a willingness to tell their stories.

Third, it must be considered that the interviews were performed at only one moment, which was one and a half year after the change. As several participants mentioned that they still were in the middle of the change, it is likely that their experiences and their practices still are changing. It therefore would have provided richer, more in-depth data if a longitudinal study would have been performed. However, due to time span of this study, this was not an option. Future research thereby might perform a longitudinal study which starts with interviews before the change and then choose several moments after the change introduction. As this study showed that the participants felt like they were in the middle of the change, future studies should pursue a long-term research time span.

Finally, a last strength of this study is that of the chosen stream of literature for studying the research question. When considering the outcomes of the study, the change in the practices for a large extent seems to be explained by the change in institutional logics. This, for me, shows that the combination of the institutional theory on micro-level with the practice literature is very valuable for this study and forms a possible explanation for the changes which otherwise might have gone unnoticed.

#### **5.4. Role of the researcher**

During my study I personally have taken an interpretivism perspective. For me this means that this study and its results were based on my personal knowledge, norms and values, which

formed the base for my interpretations. It is therefore important to elaborate on how I personally came to those interpretations.

When I started this study, my personal knowledge on youth care was very limited. I most of all felt a need to study this part of care on the base of news articles, which indicated that this would be a large and impacting change, and my personal believe that children should receive the best care and protection. Furthermore, I was worried that some children might become disadvantaged because of such a large change in the system. Then, after reading some more, I realized that nobody had studied the care workers (or ‘employees’ as I called them back then) in this change. As my personal background lies in the human resource management, I believe that those care workers are the ones who really experience the change and know what is going on as a result of that change. Due to those believes, my expectations on the decentralization might have been a little negative when starting my research. I deliberately tried to stay open-minded, but did notice that in the first interviews all negative experiences did felt like a confirmation of my expectations. However, as those interviews also showed me a lot of positive experiences, I adjusted my view on the change rather quickly.

Furthermore, my relative lack of knowledge on youth care also helped me to enter the interviews very open-minded with respect to their practices and experiences, which helped me in inductively approaching the data. However, not really knowing the youth care sector also might have led me to overlook certain cultural influences on the experiences from the youth care workers. For example, certain negative or positive attitudes might have been culturally imbedded in youth care. Such experiences might have been interpreted differently by youth care workers than by me personally. Therefore, my personal sensemaking might represent different interpretations due to my business and human resource background.

Another aspect is related to my focus. In the beginning of this study I looked at my research from the perspective of the healthcare decentralization that had its impact on youth care. However, based on feedback from others and a the literature, I started to shift towards a practice approach in which the healthcare decentralization purely formed the trigger for a change in the practices. My focus shifted even further as the data gathered in the interviews supported the perspective that several different practice changes had occurred.

With respect to the social interaction with the participants, I really tried to create an open and save environment. In order to create such environment, I decided to work independently from the youth care organizations, I allowed the participants to choose a location that they preferred (which led to conversations in a café, at home and at work locations). Also, I deliberately framed the interview as a normal conversation in which I

wanted to hear about their experiences. For me personally, I therefore experienced the atmosphere as very open and friendly, and the relationship with the participants as very equal. Off course, my personal responses still had an influence on what experiences were shared by the participants and just as I hope to have influenced the participants to be more open, I will likely also have influenced the content of the interviews. It therefore is important to realize who I am, and what my background is when reading the results of this study.

## **5.5. Recommendations for further research**

This study formed an explorative study and therefore further research is necessary to see whether the outcomes of this study are transferable to other situations and whether the outcomes change over time. A first recommendation for further research is to repeat this study later on in the change process of the Dutch healthcare decentralization. In this way the outcomes of this study can be combined with the outcomes later in time to see how the practices changed over time. For other, similar studies in the future I would advice to immediately use a longitudinal study that starts before the actual exogenous change is implemented. A second recommendation is to study the same decentralization of youth care in other provinces in the Netherlands. By examining several different locations and organizations more insight can be given into how this particular healthcare decentralization is able to affect the professional practices of youth care practitioners. Thirdly, it might be interesting to see how a similar exogenous change would influence other types of professionals and their professional practices. The interesting question here would be if the same type of changes would show in the practices. A fourth idea is to study other types of exogenous changes as those might trigger other changes in the institutional logics and therefore might trigger other practice changes. Finally, this specific situation of youth care has indicated that the extent of the practice change depended somewhat on the guidance that the employees received. It therefore might be interesting for further research to study whether the received guidance indeed affects the extent of the practice change. Additionally, it would be interesting to see how the guidance affects the practice change and what specific measures for guidance are required for a full practice change.

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## **7. Appendices**

This chapter provides the appendices to which is referred in this theses. The first appendix given is that of the interview guide used during the interviews. Secondly, the eventual template used on the data is represented.

## Appendix 1: Interview guide

Table 1

<b>Phase of the interview</b>	<b>Elaborated content</b>
Introduction	<ol style="list-style-type: none"><li>1. Thank participant for his/her time and willingness to have this conversation</li><li>2. Introducing myself: who am I, why so interested in this topic, why do I feel that someone needs to listen to the care workers and why I wanted to talk to them</li><li>3. Asking for permission to record the conversation (helps me to focus the attention on the conversation, recordings are purely for me)</li></ol>
Core	<p>The actual interview was started by asking the participant to introduce itself, the job and the organization he or she works for. Most of the time this automatically led to discussion on the decentralization. If this was not the case the following question was asked to focus the attention on the decentralization: can you tell me about your experiences with the decentralization, from the preparations until now? Subsequently, the following sensitizing concepts are used for further questioning: daily tasks, client contact, internal communication, external communication, planning, forming decisions, budget management and accountability. These concepts are not treated in sequence, but in a sequence fitting with the stories told by the participants.</p>
Closing	<ol style="list-style-type: none"><li>1. Asking whether there are aspects that have not been discussed in the interview so far, or whether the participant still has questions.</li><li>2. Thanking the participant for their time, trust and stories.</li><li>3. Telling the participant what the further procedure will be: I will transcribe the recordings, analyze the transcripts and send the chapter with the results, so that they can check the used quotes. When the complete thesis is finalized, the respondents will receive a copy of the thesis.</li></ol>

## Appendix 2: The resulting template

Resulting from the data a structure of codes arose. This structure was based on three levels of coding, however, as the first level of codes included Dutch codes instead of English codes, only the second and third level of codes are presented in table 2. A further explanation regarding the table is given on the next page.

**Table 2**

<b>Changed aspects in activities (2<sup>nd</sup> level coding)</b>	<b>Practices (3<sup>rd</sup> level coding)</b>
The essence of care	Youth care provision
Criticality of application	
Targeted application	
Care orders	
Unconditional care provision	Care worker – client positioning
Responsibility for care	
Taking a stand	
Informing others	External relation management
Promoting the organization	
Visiting the local teams	
Joining the meetings	
Starting conversations/negotiations	
Visiting networking events	
Monitoring	Result management
Discussing with the team	
Deciding on how to act	
Providing feedback to the management	
Addressing the team members	Team management
Resolving discussion and conflict	
Involving management	
Hiring new members	
Planning events for teambuilding	

In this table the rows represent the five practices this thesis focuses on and the columns represent the different coding levels. The first column represents the second level coding, which concerns the aspects that have changed due to the decentralization. These aspects either represent an activity that has changed or has been introduced, or a changed emphasis in the activities. The second column represents the third level coding and represents the names of the practices which have changed.