

The future of the GRC

Applied research into the developments in the GRC and the redesign of the infrastructure for implementing the new strategic goal.

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Abstract

The GRC (Geriatric Rehabilitation Care) is a specialism in elderly care. The goal of the GRC is to rehabilitate elderly people in several circumstances. This research consists of two parts. In part one of this research a strategic external analysis is performed in order to examine the development in the GRC. The research question devoted to this part of the research is:

*What strategic scenarios can be developed based on the strategic analysis and which scenario fits *Attent Zorg en Behandeling* best?*

This external analysis is performed on the basis of selected dimensions that contribute to the analysis of the external environment. The results of this strategic analysis are used to formulate different scenarios. One of the scenarios, Ambulatory GRC, is selected by the organization to implement. This scenario has become the new strategic goal of the organization. In part two of this research an infrastructural redesign is created. This redesign contains the infrastructural conditions which are necessary to implement Ambulatory GRC. The research question devoted to this part of the research is:

What is the required organizational structure and human resource management and what design can be developed in order to successfully implement the strategic decision?

In this redesign we focussed on the infrastructural conditions in the area of the structure and the HR. The redesign is created on the basis of theory about organizational structures and human resource management. Based on the information from the focus groups and the theory about these two areas a redesign of the production structure, control structure and a redesign of the human resource management are created. Since this research is applied research and part of an intervention, intervention methods are performed in both parts of the research to reach the goals of both parts.

In the redesign of the production structure two team options are formulated. Team option 1: The classical team formation: Multidisciplinary team with classical task division and team option 2: The classical team formation, but with different division of tasks. Broad healthcare providers supported by therapists. In both team options five main action can be distinguished: Intake, preparation of treatment plan, carrying out rehabilitation programme, client dismissal and after care. As regards the control structure it is important to determine one healthcare provider who is in control of the care a particular client receives and it is important to work with a case manager, who has an overview of all the parties involved. As to the human resource management the focus is on the merging of the home care department and the GRC department of the organization. During the inflow stage new healthcare providers have to be selected on the basis of the right knowledge, skills and motivation. During the flow stage healthcare providers that lack of the right knowledge and skills will be educated and trained.

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Chapter 1

1.1 Research problem

The GRC (Geriatric Rehabilitation Care) is a specialism in elderly care. It is a type of care that starts after a medical indication and aims at the rapid return of elderly people to their home situation. In the past years GRC encountered a tremendous growth in demand and with the increasing aging and the current political policy in elderly care is it very likely that this demand will increase further.

Healthcare institutions, engaged in this type of care, need to find a way to deal with this increase of demand in GRC and have to make strategic decisions on how they will respond to this development. After a strategic decision is made it is important that this can be implemented in the organization. Therefore, it will be examined what infrastructural conditions are required in order to successfully react to the developments in GRC and implement the chosen strategies.

This research is focussed on the organization *Attent Zorg en Behandeling*. *Attent Zorg en Behandeling* is an organization that provides services in the areas of living, welfare and care, especially for the elderly people. They do this in the region of Doesburg, Dieren, Rheden, Velp, Arnhem and Elst. *Attent Zorg en Behandeling* provides these services wherever the client stays. That can be in one of its locations, but also at their homes. Their vision is to provide services that are familiar and close for the client. They do this by offering its services with strong regional staff who are locally oriented.

With *Attent Zorg en Behandeling*, approximately 1400 employees and 600 volunteers work to provide its services to more than 1500 clients. One of these services is GRC.

Since the increasing demand of GRC, *Attent Zorg en Behandeling* has to think about different ways of organizing this specialism. To find out what the best ways for *Attent Zorg en Behandeling* are to adapt to the increasing demand an external strategic analysis is needed. *Attent Zorg en Behandeling* operates in the area around the city of Arnhem and the vision of *Attent Zorg en Behandeling* is familiar and close. It is important to ensure this vision. Therefore, the realization of the GRC will be in the area around the residences of the clients. This means that the focus of the research will be on Arnhem and surroundings. We will look at the developments of the GRC in this region in particular and the strategic decisions have to be based on these developments.

In this research a strategic analysis will be performed in order to figure out what the recent developments are in the field of GRC. Based on these findings possible scenarios for the future will be established. After one scenario is selected, research will be done in order to find out what the required conditions are of the human resources management and the structure of the organization to implement the selected scenario.

1.2 Goal of research

The aim of this research is to make a strategic external analysis to examine what the developments are in the GRC and what the best ways are for *Attent Zorg* to respond to the increase of demand of GRC. Following the results of the external analysis, different strategic scenarios will be formulated. *Attent Zorg* can choose one scenario which becomes the new strategic goal of the organization. After the selection of one scenario follows an infrastructural redesign. During focus groups we investigate which infrastructural conditions in the area of HR and structure the organization has to comply to in order to successfully implement the selected scenario. Based on these outcomes a design of the organizational structure will be developed and the requirements regarding human resource management will be determined which will help to successfully implement the strategic goal.

In accordance with the aim of the research to create a scenario that becomes the new strategic goal of the organization and the development of an organizational structure and human resource management

requirements to successfully implement the strategic goal, the following 2 research questions and associated theoretical and empirical sub questions can be derived:

- 1. What strategic scenarios can be developed based on the strategic analysis and which scenario fits *Attent Zorg en Behandelng* best?**
 - Theoretical sub questions:
 - 1.1 How can scenarios be developed according to theory?
 - 1.2 What is a strategic analysis and what concepts are necessary to perform an external strategic analysis?
 - Empirical sub questions:
 - 1.3 Given the concepts, what is the situation of the GRC in the area of *Attent Zorg*?
 - 1.4 Given the situation of the GRC and given the theory, which scenarios can be developed and which one will be chosen to become the strategic goal of the organization?

- 2. What is the required organizational structure and human resource management and what design can be developed in order to successfully implement the strategic decision?**
 - Theoretical sub question:
 - 2.1 What does theory say about designing organizational structures and human resource management?
 - Empirical sub question:
 - 2.2 How can these design principles be applied to the organization *Attent Zorg*, so the strategic goal can be realized?

In figure 1 the conceptual model belonging to the two questions is shown. The figure explains the relation between the required conditions of HR and structure and the realization of the selected strategic goal concerning GRC. It shows how the required internal infrastructural conditions positively contribute to achieving the goal.

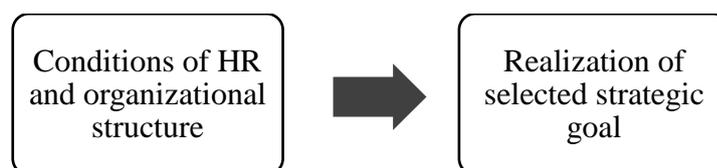


Figure 1. Conceptual model research question

1.3 Relevance

1.3.1 Practical relevance

By providing an answer on what the external developments are in GRC in the environment and developing several strategic scenarios, *Attent Zorg* can make a well-considered strategic choice on how to adapt to the increasing demand of GRC. Secondly, the organization gains insight in what the requirements of the strategic goal are in the area of human resources and the organizational structure. This makes it easier to carry out the implementation of the strategic decision.

These both things are valuable for the society and the (future) GRC clients. When the organization is well-prepared for the increase in demand, the more clients can receive quick, appropriate care with high quality standards.

Besides it is also beneficial for the organization itself. If the organization does not adapt to the future demand, the competing parties will gain much benefit and *Attent Zorg* will lose share. Secondly when

the strategic goal is implemented well, it positively contributes to the working conditions of the employees.

In general, healthcare institutions can take example of the process that preceded making a strategic decision and the research what is done before starting the implementation of a strategic scenario.

1.3.2 Scientific relevance

In early research the problem about the increase of demand in GRC is recognized. Besides there is research about the substantive improvements of the GRC to deal with the increase of demand. An example of an article that describes both subjects is the article of Fransen (2018).

However, there is little understanding of the dynamic and fast developing market of GRC. This research contributes to research with an orientation of the GRC market and provides more insight in the developments in the GRC. The research affords knowledge of the situation in the changing care landscape of GRC and provides scenarios to deal with the developments and increase of demand.

Second, in literature there are a lot of models created to perform external analysis. None of these models focuses specifically on the healthcare sector, which is a very multidimensional and turbulent sector. This research selects the necessary concepts of different models that are used to perform external analysis and applies this specifically on the healthcare sector. It clarifies how these concepts must be used in this particular sector.

Third, there are a lot of healthcare institutions that are in the same condition as the organization we are researching. The infrastructural factors that are important to take into account while starting the implementation of a scenario are also important factors for other healthcare institutions that want to implement the scenario. It is useful to redefine these factors based on the healthcare environment these organizations are in.

1.4 Outline of research

This research consists of two parts. Each part has its own theoretical background, methodology and results.

The aim of the first part is the selection of one scenario concerning GRC that becomes the strategic goal of the organization. The first part consists of a strategic analysis which provides the necessary information to develop the scenarios. Based on this information the scenarios are formulated. When the scenarios are formulated one of them has to be selected by the organization and becomes the strategic goal.

The second part consists of a research into the required structure and HR conditions to implement the strategic goal. The results provide a redesign of the organization which ensures a successful implementation of the selected scenario.

Part 1 Generating and selecting scenarios

Introduction to part 1

The goal of part 1 of this research is the development of the strategic scenarios and the selection of the scenario. This scenario becomes the strategic goal for which the conditions of the structure and HR will be determined in part 2. This part of the research provides an answer on the first research question: *What strategic scenarios can be developed based on the strategic analysis and which scenario fits Attent Zorg best?*

In order to reach this goal, chapter 2 provides an outline of the theoretical background and answers the two theoretical sub questions. Chapter 3 describes the methodology that helps to analyse the environment to create the scenarios and helps to select one scenario in the end. In chapter 4 the results are analysed and the developed scenarios are described. This provides answers on the two empirical sub questions. Finally, we can conclude which scenario will be selected.

Chapter 2 - Theoretical background: Developing a scenario

2.1 Introduction

This research consists of two parts; the strategic analysis to develop scenarios and the redesign of the organization. The theoretical section of this chapter will discuss the theory that is used to complete the first part of the research. Later in the report a theoretical chapter will be dedicated to the second part of the research. The goal of this part of the research is to perform an external analysis in order to develop scenarios. To develop a scenario, it is important to know how a scenario should be developed and how the external environment should be mapped. That is why the first part of this theoretical section is dedicated to theory about scenario planning. To develop scenarios models are needed that help to examine the field, to perform the external analysis. The second part of this theoretical section focusses on the models needed to perform the analysis. There are several theoretical models that could potentially be used for the analysis of the meso level environment. First of all, the models will be compared by describing their main goal, their important dimensions and the relation between the dimensions. Based on these conclusions and the theory about scenario planning the models will be assessed on suitability. Finally, one model or several aspects of models will be selected, based on the suitability of the models/aspects and the background of the case.

2.2 Scenario planning

Based on the results of the external analysis strategic scenarios will be developed. In order to develop a scenario, theory about scenario planning is studied. Below we follow Lindgren and Bandhold (2003). In their book they outline the theoretical aspects of scenario planning but also link this to performance in practice. The main points that have to be taken into account and the practical guideline to perform scenario planning are described in the part below. We start with the most important theoretical aspects followed by the practical guidelines.

Scenario planning in theory

Scenarios or scenario planning can be defined as; “*A disciplined method for imaging possible futures in which organizational decisions may be played out*” (Lindgren & Bandhold, 2003).

Scenario planning is the combination of scenario analysis for strategic goals and strategic planning based on the outcomes of the scenarios.

Scenario planning can be used for several purposes. There are 4 different purposes that can be distinguished. The first purpose is innovation, with the focus on new business. In this case scenarios function as inspiration. The second purpose is scenario learning. Then a scenario is a prerequisite of change. The scenario is used to challenge existing paradigms. The third purpose is evaluation, with the focus on the old business. In this case scenario planning is used to evaluate the existing business. The last purpose discovered is strategy/planning. The scenario is used to develop practical results (Lindgren & Bandhold, 2003). In this case the purpose of the scenario planning is innovation. The developed scenarios will function as inspiration to change in a particular way with the focus on new business.

Regardless of the purpose for which the scenarios are planned a good scenario must meet seven criteria (Lindgren & Bandhold, 2003):

- **Decision-making power.** *A scenario must bring useful insights.*
- **Plausibility.** *The scenarios have to be realistically possible.*
- **Alternatives.** *Each scenario should be probable.*
- **Consistency.** *Each scenario must be internally consistent.*

- **Differentiation.** Each scenario should be different.
- **Memorability.** Each scenario should be easy to remember. It is advisable to reduce the number to between three and five.
- **Challenge.** The scenarios should challenge the organization

Scenario planning in practice

In order to achieve concrete scenarios, it is important to know how the theory should be applied in practice. In the part below describes the practical guidelines of scenario planning.

A common method in scenario planning is the TAIDA method. This method is a framework that is often used by scenario planning and offers a clear and structured guideline for applying scenario planning. The method consists of 5 steps (Lindgren & Bandhold, 2003):

1. Tracking.

The first step in the TAIDA-process is tracking. Tracking is about looking at the future. It is about tracking changes that may impact the focal question. So, finding trends, uncertainties and drivers that need to be considered in the work, since they influence the future. Tracking can be done in several ways. Examples are; media scanning, focus groups and web polls.

2. Analysing.

With the tracking done, the second step is the analysing phase. This phase is about identifying drivers and consequences in order to understand how the identified tracks interact. After the analyses scenarios have to be generated based on the changes that are identified.

3. Imaging.

After generating plausible scenarios, it is time to look to create pictures of the desired future. Creating visions.

4. Deciding.

In the deciding phase of the process, everything is put together. The future environment is tracked and it is clear what the vision is. In this phase development areas and strategies are identified which meet threats and achieve visions and goals.

5. Acting.

This phase acting is about taking action and how to follow up scenario planning.

In order to complete the first two stages: Tracking and Analysing. It is important to elaborate on the theory about how to generate scenarios. This will be described in the next paragraph.

How to generate scenarios

After analysing the interrelationships between the founded trends and drivers the most common step to start with creating the scenarios is summarizing the 'certainties'. In other words, what are you relatively certain will be a prospective development. This helps to set a timeline of future events and by developing the scenarios these certainties definitely have to be taken into account (Lindgren & Bandhold, 2003).

Nevertheless, scenarios also provide a way to handle uncertainties/trends. During the tracking phase trends will be discovered that are likely to have a great impact on the focal question. However, it is not sure how this will happen. Besides there will also be uncertainties discovered that are so uncertain that they are called wild cards. These could have great impact, but their predictability is so low that they have no meaningful use (Lindgren & Bandhold, 2003). The most profitable way to build scenarios is to pick out two important uncertain trends and consider them together in a scenario matrix. This leads to four different scenarios where both trends are combined.

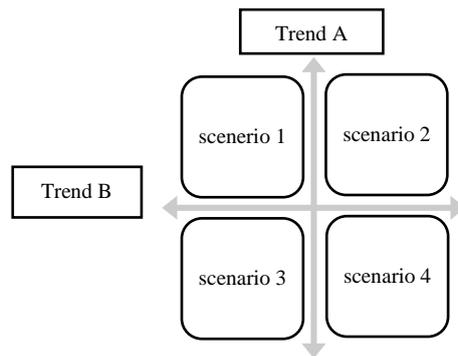


Figure 1. Scenario model

2.3 Overview of models

Given that we want to look at the future and the environment of *Attent Zorg en Behandeling*, we need dimensions that help to research this. That is why in this part of the theory various models are highlighted. For each model is explained what the goal is, what the most important dimensions are and what the relation is between the dimensions. The suitability of the model will be determined by looking at several elements. In this research it is important that the model focusses on the external environment of the organization to examine what the developments are in the GRC outside de organization. In order to analyse and map the developments in GRC, factors as competitors, channels to reach customers and the resources needed, have to be taken into account. The goal of the external analysis is to enable the creation of scenarios. The purpose of the scenario is innovation. The chosen dimensions have to contribute to the purpose of scenario planning and must allow to find future trends, thereby it must not stand in the way of the 7 criteria of good scenario planning.

2.3.1 Stakeholder model by Mitchel, Agle and Wood (1997)

The first model that will be discussed is the model of Mitchel et al. (1997) The model can help top management manage their stakeholders effectively in order to realise their strategic goals. Their aim is to contribute to a theory of stakeholder identification and salience. They do this by looking if stakeholders possessing one or more of the three relationship attributes: power, legitimacy and urgency. Stakeholder salience is positively related to the cumulative number of stakeholder attributes, power, legitimacy and urgency, perceived to be present. The salience of the stakeholder will be low when only one of the stakeholder attributes is perceived to be present. When two to stakeholder attributes are perceived to be present the salience of the stakeholder will be moderate and when all three the attributes are perceived to be present the salience of the stakeholder is high. The stakeholder typology is based on the attributes present. Therefore, seven different stakeholder typologies can be distinguished. Dormant stakeholder, discretionary stakeholder, demanding stakeholder, dominant stakeholder, dangerous stakeholder, dependent stakeholder, definitive stakeholder and the nonstakeholder.

The model of Mitchel et al. (1997) is a well possible way to give an overview of all the (potential) stakeholders and their salience. The model allows to look at the future and does not stand in the way of the 7 criteria. However, stakeholders are not the only elements we have to take into account while making the external strategic analysis. The model leaves out a lot of important elements which are crucial to make a complete analysis. This implies that the model of Mitchel et al. (1997) is unable to help creating a complete strategic analysis in this research.

Table 1
Overview Stakeholder model by Mitchel et al. (1997)

Goal	Mapping out organizational stakeholders and appoint the relationship attributes present
Important dimensions	<ul style="list-style-type: none"> • Stakeholder with power • Stakeholders that are legitimate • Stakeholder that have urgency
Relation between dimensions	<ul style="list-style-type: none"> • Power: Dormant stakeholder • Legitimacy: Discretionary stakeholder • Urgency: Demanding stakeholder • Power + Legitimacy: Dominant stakeholder • Power + Urgency : Dangerous stakeholder • Legitimacy + Urgency: Dependent stakeholder • Power + Legitimacy + Urgency: Definitive stakeholder • Non of the attributes: nonstakeholder.

2.3.2 Balanced score card by Kaplan and Norton (1992)

Secondly, we will discuss the model of Kaplan and Norton (1992). Called the Balanced scorecard. The balanced scorecard helps managers to look at their organizations from different perspectives.

The model provides answers to four basic questions what gives insight in four critical perspectives. Starting with the question from Financial perspective: How do we look at shareholders? Secondly, Customer perspective: How do customers see us? Thirdly, internal perspective: What must we excel at? And finally they look at the Innovating and learning perspective: Can we continue to improve and create value? (Kaplan & Norton, 1992).

The perspectives can be arranged in a pyramid. The top of the pyramid is formed by the financial perspective followed by the customer perspective, the next layer is the internal perspective and the bottom of the pyramid is formed by the innovating and learning perspective (Voelker, Rakich & French, 2001). When applying the model in healthcare organizations the layers of the pyramid are built differently. The top of the pyramid is formed by the mission of the organization, followed by the stakeholder perspective; how do stakeholders see us, the third layer is formed by the financial perspective, the fourth layers is formed by the internal perspective and the bottom of the pyramid is formed by innovating and learning perspective (Voelker et al., 2001).

The model of Kaplan and Norton (1992) allows to look at the future and does not stand in the way of the 7 criteria. The structure of this model really looks like the structure of this research. In order to fulfil the mission different perspectives have to be taken into account. However, the model is not complete enough and remains superficial. This can be deduced from the large focus on the financial goal in the model. And despite of the mission that is on top of the model in the healthcare pyramid and the stakeholders that are taken into account in this pyramid, the model is still too much focussed on the internal aspects of the organizations. Therefore, it lacks to take into account other important external dimensions.

Table 2
 Overview Balanced score card by Kaplan and Norton (1992)

Goal	Look at organization from different perspectives in order to reach the goal
Important dimensions	<ul style="list-style-type: none"> • Mission • Customer perspective/ stakeholder perspective: How do customers/stakeholders see us? • Financial perspective: How do we look to shareholders • Internal perspective: What must we excel at? • Innovating and learning perspective: Can we continue to improve and create value?
Relation between dimensions	To reach the goal or mission of the organization all the different perspectives have to be taken into account and contribute to goal that is set.

2.3.3 Business model canvas by Osterwalder and Pigneur (2010)

The third model that will be discussed is called the Business model Canvas created by Osterwalder and Pigneur (2010). This model is created to map the current business model or to create a new business model. The model consists of nine elements; *value proposition, key activities, partner network, key resources, client segments, client relationships, distribution channels, cost structure & revenue flows*. These nine elements are taken into account analyzing the organization and formulating the business model. The centre of the model is the value proposition of the organization. Around the value propositions the other elements, contributing to this value proposition, are determined.

The business model canvas of Osterwalder and Pigneur (2010) allows to look at the future and does not stand in the way of the 7 criteria. It also can be an effective model to create a well-thought out business model. Especially when the company does not have a business model yet or wants to create a whole new business model. The business model canvas takes 9 elements into account. Some of these elements are not useful in this research since not the whole business model has to change. However, some elements can be important to include in the research, since these elements illuminate essential factors of the environment. The useful elements are: partner network, key resources, client segment, client relationship, distribution channels.

Table 3
 Overview Business model canvas by Osterwalder and Pigneur (2010)

Goal	Map the current business model or to create a new business model.
Important dimensions	<ul style="list-style-type: none"> • Value proposition • Key activities • Partner network • Key resources • Client segments • Client relationships • Distribution channels • Cost structure • Revenue flows
Relation between dimensions	The model guides you through the dimensions that have to be taken into account during the process of strategizing. The primary focus is on the value proposition of the organization, which forms the centre of the model

2.3.4 Five forces model by Porter (1979)

The last model discussed is the five forces model of Porter (1979). The model consists of 5 forces that shape the industry competition. Awareness of these forces can help a company stake out a position in its industry that is less vulnerable to attack (Porter, 1979). The middle circle of the middle refers to the rivalry among competitors in the particular industry. But competition for profit goes beyond the

established competitors in the field. The rivalry of the industry is influenced by four other forces as well; threat of new entrants, power of suppliers, power of buyers and the threat of substitutes.

This model allows to look at the future and does not stand in the way of the 7 criteria and is a very useful model to analyse the environment of an organization in a particular industry. The model includes all the crucial aspects which shape the competition among companies in a particular industry. Unless the model takes less aspects into account than some of the models described above. The five forces model analyses the environment of the industry in a clear and compact manner. On the basis of the elements included in the model a clear strategic analysis can be performed.

Table 4
Overview Five forces model by Porter (1979)

Goal	Create awareness of the 5 forces that shape industry competition, which helps a company stake out a position in its industry that is less vulnerable to attack.
Important dimensions	<ul style="list-style-type: none"> • Rivalry among competitors in the particular industry • Threat of new entrants • The power of suppliers • The power of buyer • The threat of substitutes
Relation between dimensions	The middle circle refers to the rivalry among competitors in the particular industry. But competition for profit goes beyond the established competitors in the field. The rivalry of the industry is influenced by the four other forces as well.

2.4 Selection/ construction of a model for the purpose of this research

The selected model has to contribute to a comprehensive and clear strategic analysis and should have a main focus on the external environment of the organization in order to analyse the developments in the GRC. The model has to allow to discover future trends, uncertainties and drivers that might influence the future. Therefore, it has to take into account competitors of the organizations, channels to reach customers and the resources needed. Also they do not have to stand in the way of the 7 criteria of good scenario planning.

The models explained in theory all have differences and similarities. Some models turned out to be more useful in this study than other models. All the models look at external environmental factors and all the factors in de models allow to look at the future of the organization. Besides they all do not stand in the way of the 7 criteria of scenario planning. However, there is a difference between the models concerning how many different external factors they include in their analysis and how much they also focus on the internal organization. Notable is that all models look at the stakeholders of the organization. Nevertheless, it is important that the organization obtains insights in many different aspect of the environment. Also the internal focus is not taken into consideration in this research. Therefore, the model of Mitchel et al. (1997) and Kaplan and Norton (1992) are eliminated to serve as a base model. Mitchel et al. (1997) only focus on stakeholders and the model Kaplan and Norton (1992) focusses besides stakeholders only on internal factors. Their models do not contain dimensions that are not included in the other two models.

Based on the requirements; not standing in the way of the 7 criteria and including the appropriate external factors, and the case in this research the most suitable model is the model of Porter (1979) 'The five forces that shape industry'. The model focusses on the external environment of the organization and captures several essential elements of the environment. This contributes to the comprehensiveness of the analysis. The model of Porter can serve as the basis model. However, as mentioned before a few

aspects of the business canvas model Osterwalder and Pigneur (2010) are also useful to fulfil the external analysis. Some of these aspects are not included in the model of Porter (1979). The missing aspects from the business canvas model are: *partner network, key resources and distribution channel*. The three valuable missing aspects of the business model canvas will be merged with the model of Porter. Concluding, the analysis will be based on the following dimensions: ***rivalry among competitors in the industry, new entrants, suppliers, buyers, substitutes, partners in network, key resources and the distribution channel***.

Since these dimensions are selected they have to be defined. This will be done in the following part. We will describe what the definition of the dimension is in general, what the definition includes against the background of the case and the type of source that will be researched based on the definitions. At the end of the paragraph, the dimensions and their definitions against the background of the case will be presented in a table.

First of all, we start with the dimension obtained from the model of Porter (1979) ‘The five forces that shape industry’.

The first dimension, ‘**rivalry among competitors in the industry**’, refers to the competition in general between different organizations that offer the same product or service.

In this research competitors are the other healthcare organizations in the region of the organization that offer GRC as well. In this dimension the activities allied to GRC performed by other healthcare organizations will be questioned.

However, competition is also shaped by four other forces.

The first force that shapes competition is ‘**the threat of new entrants**’. New entrants in an industry create new capacity and the desire to gain market share. This puts pressure on prices, costs and the rate of investments necessary to compete (Porter, 2008).

In this case, new entrants can be defined as other parties that enter the market to offer GRC. The sources aligned to this dimension that will be researched are existing healthcare institutions in the region that expand their care offer with GRC and new healthcare institutions that offer GRC in the region.

The second force that shapes competition is ‘**the power of suppliers**’. Powerful suppliers can take more value to themselves by maintaining higher prices. A powerful supplier can put a lot of pressure on the profitability of an industry when they are unable to pass on cost increases in their own prices (Porter, 2008).

The suppliers in this dimension are organizations/persons in the network that are crucial to deliver GRC. In the GRC the suppliers are the health insurance companies. They are the most powerful suppliers of the GRC. They are also the only supplier, since there is no other institution that reimburses the GRC. Besides it is too expensive for clients to pay for the treatment process themselves. Healthcare organizations have to purchase the GRC from health insurers. Therefore, are health organizations dependent on the deals they make with insurers.

The third force is about ‘**the power of buyer**’. Powerful buyers can forcing down the prices, demanding better quality of better service. They mostly play industrial competitors off against each other, at the expense of industry profitability (Porter, 2008).

In this research the buyers in this dimension are the persons that receive or are going to receive GRC. They are able to pick the organizations they want to receive GRC from. This makes it important that the way GRC is offered by the organization is well assessed.

The fourth and last force that shapes competition is **‘the threat of substitutes’**. A substitute performs the same or a similar function as the product a particular industry offers, by a different means (Porter, 2008). Substitutes are always present, but easy to overlook, since they can be very different than the industry’s product. When substitute threat is high, the profitability of the industry suffers.

Regarding this research, substitutes for GRC are not very obvious. There are no forms in healthcare, reimbursed by insurers that offer the same kind of healthcare. It is possible that during the analysis substitutional offers will be explored. Therefore, general organizations specialized in the developments of GRC will be questioned to research if there are upcoming trends that can substitute the GRC.

Finally, the three dimensions obtained from the business model canvas by Osterwalder and Pigneur (2010) will be explained.

Firstly, the dimension **‘key resources’** refers assets required to deliver the product of service that an organization offers. Key resources can be physical, financial, human or intellectual. The resources can be owned by the company or acquired from key partners. What key resources you need depends on the type of business model (Osterwalder & Pigneur, 2010). The sources aligned to this research are the persons/organizations allied to GRC that are crucial for the operational execution of the GRC. In the GRC the most valuable resources are the human resources. The medical staff permits the implementation of the GRC.

Secondly, the dimension **‘partner networks’** is about the activities that are outsourced or resources that are acquired outside the enterprise. Four different types of partnerships can be distinguished: Strategic alliances between non-competitors, Coopetition: strategic partnership between competitors, joint ventures and Buyer-supplier relationships (Osterwalder & Pigneur, 2010). The sources aligned to the dimension are persons/organizations the organization cooperates with to deliver GRC.

In this research there are some relationships that are already clear. The relationship between the health insurance company and the organization is important for the revenues. The relationship between the hospital and the organization is important for reaching the clients, since the hospital refers the clients to the GRC. However, for completing the scenarios it is also important to explore if new relationships in any kind of way, may be a strategic decision to consider.

Finally, **‘distribution channels’** refer to how the organization distributes their services. The products and services are delivered to customers through communication, distribution, and sales. Channels play an important role in the experience of the customer. They serve several functions, such as: raising awareness among customers about the products and services of the company and allow customers to purchase the product and services (Osterwalder & Pigneur, 2010).

In this research the sources that have to be examined are the channels concerning GRC that reach the (future) clients. What channels reach the clients and influence the decision of the clients where to receive GRC. The hospital plays an important role in the distribution of the clients.

2.5 Overview of the dimensions and their definitions against the background of the case

Table 5

Overview of the dimensions and their definition against the background of the case

DIMENSIONS	DEFENITION OF DIMENSION
RIVALRY AMONG COMPETITORS IN THE INDUSTRY	<i>Other healthcare organizations in the region of the organization that offer GRC as well.</i>
THREAT OF NEW ENTRANTS	<i>Other parties that enter the market to offer GRC.</i>
THE POWER OF SUPPLIERS	<i>Organizations/persons in the network that are crucial to deliver GRC and can take more value to themselves by maintaining higher prices.</i>
THE POWER OF BUYER	<i>Persons that receive or are going to receive GRC and can forcing down the prices, demanding better quality of better service.</i>
THE THREAT OF SUBSTITUTES.	<i>A substitute that performs the same or a similar function as the GRC, by a different means.</i>
KEY RESOURCES	<i>Assets required to deliver GRC.</i>
PARTNER NETWORKS	<i>External persons/organizations the organization cooperates with that perform activities necessary to deliver GRC.</i>
DISTRIBUTION CHANNELS	<i>Channels concerning the distribution of the GRC.</i>

Chapter 3 - Methodology

3.1 Introduction

The goal of this methodology section is to think about the how the analyses in the first part of this research should be addressed. This research consists of two parts; the strategic analysis of the environment, which leads to the development of different scenarios and the redesign of the structure and the human resources management. This research is no theoretically focussed research but applied research. The research is part of an intervention. Therefore, two forms of methods are used: research methodology and intervention methodology.

Research methods are used to release particular information in the context of the research, which must be obtained in a scientific manner. The research methods include data collection and data analyses. Secondly the intervention methods consist of an explanation of the decisions that are made in the functional dimension, social dimension and the infrastructural dimension of the intervention. In this way the data that is obtained and analysed is used and provided in a responsible and structured manner. The set of sequenced and planned actions help to increase the effectiveness of reaching the goal and ensures better cooperation with the people involved. The TAIDA method is used to guide the data collection and the data analysis. The TAIDA method forms a guideline to structure the process of analysis. In this part of the research the focus is only on scenario analysis and not on the strategic planning of the selected scenario. Therefore, only the first four steps of the TAIDA method will be completed in this part of the research; Tracking, Analysing, Imaging and Deciding.

3.2 Research methods

The research methods consist of data collection and data analyses. The data collection part is part of the external strategic analyses. The data obtained from this strategic analysis will be analysed during the data analysis and must result in the strategic scenarios. First the data collection methods will be described, secondly the data analysis will be described.

Data collection.

The goal of the data collection is to collect data to generate scenarios. By performing the data collection, the first stage of scenario planning is executed, the 'tracking' stage. To discover and identify changes, new trends, uncertainties and drivers qualitative resources will be consulted.

The selection of the resources is based on the dimensions selected in the theory: rivalry among competitors in the industry, new entrants, suppliers, buyers, substitutes, partners in network, key resources and the distribution channel.

Given the definitions that are coupled to the dimensions, sources will be selected to research. This research contains interviewing the sourced by means of semi-structured interviews and one focus group. The sources are important parties in the environment of the organization or is important literature. The parties that will be researched have to cover all the dimensions describes in the theory and/ or contribute to the overall view of GRC. Based on the environment of the organization and the dimensions that have to be researched the sources are selected. In table 6 the sources that are selected are listed. Also the particular person aligned to the source we would like to research is noted. Since most parties also concentrate on other topics than GRC, and GRC is a very specialized topic we chose to interview one person from each selected party. This gives the opportunity to speak with the most informed person about the GRC of the selected source. Besides, the method of interviewing is most likely to provide us in-depth and specialized information about the developments of the GRC.

Table 6
Overview selected sources and selected persons

Organization: Insurance company CZ
Person to interview: Care purchaser GRZ
Organization: Branche organization Actiz
Person to interview: Policy advisor
Organization: Goudenhart
Person to interview: Coordinator short-term treatment
Organization: Attent Zorg
Person to interview: Specialist geriatric medicine
Organization: Rijnstate Ziekenhuis
Person to interview: Hospital transfer point employee
Organization: Rival Care institution
Person to interview: Manager GRC
Focus group elderly people 70+

The sources can effectively inform about the definitions aligned to the dimensions described in the theory. The table below presents an overview of the resources and the dimensions they cover.

Table 7
Overview sources and dimensions covered

<i>Dimensions</i> →	Competitors	New entrants	Suppliers	Buyers	Substitutes	Key resources	Partner networks	Distribution channels	Overall view
<i>Sources</i>									
<i>Insurance company CZ</i>			x				x		
<i>Branche organization Actiz</i>									x
<i>Goudenhart</i>									x
<i>Specialist geriatric medicine</i>						x			
<i>Hospital transfer point employee</i>							x	X	
<i>Rival Care institution</i>	x								
<i>Focus group elderly people 70+</i>				x					

The insurance company is selected as source to interview since it is the most important supplier of GRC care.

Branche organization Actiz is selected since they have contact with all the organizations that deliver GRC and can provide insights in the latest developments and the overall view.

This is also the case for organization Goudenhart, which is an organization that focusses on the developments in short term treatment.

A specialist geriatric medicine is selected since they are essential for an organization for providing GRC and know everything about the substantive area of the care.

The hospital transfer point employee is one of the most important partner in the network of the organization since they are the people that are able to send new clients to the organization. They are also the people that inform the new clients about the GRC in the first place.

The rival care institution is selected since it can be very informative to see how other organizations work in the GRC. The rival care institution that is selected in operating in another region than Attent Zorg, this enhances the possibility that they want to share vulnerable information.

The last source that is selected are the elderly people 70+. They form a group of potential clients in the nearby future. Since we investigate what the future trends in GRC are it is important to know how they would like to receive GRC when necessary. In this case is decided to organize a focus group instead of an interview. They are asked about their preference of receiving GRC. To discuss this topic in a group people let each other think and this increases the output.

However, the dimensions 'substitutes' and 'new entrants' are not covered by a specific source. This because these dimensions are possibilities that may occur in the future but at this point there are no parties that underwrite these dimensions. All sources work closely with all GRC providers and are likely to be up to date with new developments. They can share their thoughts about the future developments. This ensures that the necessary information of the dimensions that have to researched will be obtained. It is also important to mention that all the dimensions will be questioned to all sources. This means that the crosses only refer to the main information the source can give, however the sources may have also important information concerning the other dimensions. The interview questions are formulated on the basis of the definitions of the dimensions against the background of the case.

Desk research

In addition, it is also necessary to perform desk research, in order to retrieve information about the future of the GRC and to obtain current figures and facts about the GRC.

The desk research consists of analysing existing digital data (Eriksson & Kovalainen, 2016). Two documents are analysed:

- De Jong, M. (2012). *Het kleine zorgpadenboek voor de revalidatiesector*. Woerden: CC Zorgadviseurs
- Franssen, L. (2018, Februari 28). Geriatrische revalidatiezorg in ontwikkeling. Retrieved from: <https://www.mijngezondheidsgids.nl/geriatrische-revalidatiezorg-ontwikkeling/>

The first report gives insight in an important substantive component of GRC; the 'care paths'. The second report gives insight in the current situation of GRC and particular developments.

Data analysis

During the data analysis the obtained data will be analysed and based on the results scenarios are generated. During the data analysis the analysing stage of the TAIDA methods is performed. The stages imaging and deciding will be described in part 3.3 of the methodology section.

With the tracking done, the second step is the analysing phase. This phase is about identifying drivers and consequences in order to understand how the identified tracks interact. After the analysis, scenarios have to be generated based on the changes that are identified.

All the interviews and the focus group are transcribed. To analyse the data the table mentioned above will be used. Per source will be noted what the most important findings per dimension are. The last

column of the table forms the conclusion column in which all the most important findings are summed-up.

Table 8
Table to analyse the data

<i>Dimensions → Sources</i>	Competitors	New entrants	Suppliers	Buyers	Substitutes	Key resources	Partner networks	Distribution channels	Conclusion
<i>Insurance company CZ</i>									
<i>Branche organization Actiz Goudenhart</i>									
<i>Specialist geriatric medicine</i>									
<i>Hospital transfer point employee</i>									
<i>Rival Care institution</i>									
<i>Focus group elderly people 70+</i>									

The next step is to distinguish the outcomes that can be labelled as ‘certainty’ and ‘uncertainty’.

The certainties are outcomes that will definitely benefit when the organization takes them into account. These findings are marked **green** in the table.

The uncertainties are the outcomes from which it is unknown how beneficial they will be in the future. However based on the findings it might be interesting investments. These uncertainties form the scenarios. The information in the table that led to the construction of the uncertainties/scenarios are marked **red**.

The outcome of a source is marked green when the source is certain about the particular statement and this statement is also relevant for the organization.

The outcome of a source is marked red when the source has an important opinion or vision about the future developments of the GRC and this opinion/ vision can also be interesting for the organization. Every source is questioned by all dimensions, however some sources were especially selected to cover particular dimensions. Therefore, their opinion on these dimensions have received special attention.

Another important condition to be selected as certainty or uncertainty is that the certainty/uncertainty must be mentioned by several sources. This could be easily discovered by looking at the conclusion columns.

In the table in appendix 2 the certainties/uncertainties are marked in the conclusion column and also what pieces of text refer to them in the other columns.

After the scenarios are generated, one scenario has to be selected. In order to select one scenario, it is important to discuss the vision of the organization and determine the desired future of the organization. This is called the imagine stage. Based on the outcomes of this stage one scenario will be selected in the deciding stage. In this stage everything is put together. The future of the environment is tracked and it is clear what the desired future of the organization is. The scenario that contributes to the achievement of the desired future of the organization will be selected.

3.3 Intervention methods

In this research we perform application-oriented research. Therefore, not only research methods are necessary but also intervention methods. The goal of the intervention methods is to plot a way to get the management involved in the analysis and to make the intervention work. It is important to involve

management during the process of developing the scenarios. This ensures that the management has time to think about the scenarios developed and can give their ideas and opinions about the findings that result in the scenarios. This is also necessary to perform the stages imaging and deciding. Management needs time to think about the desired future which influences the decision of which scenario will be worked out in part 2 of the research. It is wise to start thinking about this during the development of the scenarios and not when they are already created. In this part of the research we only cooperate with the management that is directly responsible for the GRC. They have most knowledge about the developments in the GRC and determine the desired future of the organization in this area. Besides it is not necessary yet to cooperate with the other GRC staff since developments in the environment can be determined without the opinion of each employee. To guide the process of the intervention, the 3D model of Achterbergh and Vriens (2018) is used. The model consists of three dimensions; the functional dimension and the social dimension and the infrastructural dimension.

3.3.1 Functional Dimension

The first dimension is the functional dimension. In this research the goal on the functional dimension is to perform a scenario analysis (Achterbergh & Vriens, 2018). In this dimension the scenarios will be generated by doing interviews. This means that in the focus of this dimension is to perform the right steps in order to create the scenarios.

3.3.2 Social dimension

The social dimension of the model contributes to the integration of the change of the behaviour of the people (Achterbergh & Vriens, 2018). The goal of the social dimension to do the scenario planning in such a way that management is involved. It is important to keep the organization informed during the process and the development of the scenarios. Participation of the right people contributes to the success of the intervention. In this part of the research, updates will be given during meetings with the management every other week. When management is involved in the process of the scenario planning, they better understand the outcome of the analysis. Besides, they have the opportunity to think about the approach of the research. There will be asked for their recommendations and their opinion is seen as vary valuable. To carry this out ensures that the management does not feel passed during the process of the scenario planning.

3.3.3 Infrastructural dimension

The infrastructural dimension consists of aspects that are concerned with developing an infrastructure which realizes the functional and social goals of the intervention. There are three infrastructural areas identified: organizational structure of the intervention, HR and technology. In order to realize the functional and social dimension we have to think about how to shape these three areas.

Organizational structure of the intervention

The organizational structure defines who will be involved and what its scope will be. In the first part of the research the focus will be on external relations of the organization, since the information will be retrieved mostly externally. Only the management involved will be updated on the information obtained. The structure of the intervention is the 'expert structure'. Which means that an external specialist intervenes in aspects of the infrastructure (Achterbergh & Vriens, 2018). The external specialist is in this case the researcher.

HR-Measures

The HR tool that will be aligned with the first part of the research is 'participation'. The management will be involved in the process of the scenario planning. They can advise and give their opinion during the scenario planning. The role of the researcher can be compared with the role of an expert consultant. Which focusses on the content and provides a framework in the form of scenarios.

Technology

This area refers to the technology that is used to communicate, research and solving problems during the intervention. The first technology that is necessary to use during the intervention is the theory about the technique of building scenarios. As regards research techniques, data collection techniques in the form of semi structured interviews and a focus group will be applied to obtain the required data. Further communication techniques will be applied on order to inform the management during the process. The communication will take place through organized meetings where dialogues will take place.

3.4 Research methods and Intervention methods

The chosen strategies in the research methods and the strategies chosen in the intervention methods do not contradict each other. The research methods which describes how the data will be collected and analysed does not impede the intervention methods. In fact, the two methods reinforce each other in some parts. Since the in the research methods describe how the data collection and scenario planning will be performed and the functional goal of the intervention methods is to generate scenarios. Besides participation of the management described in the social dimension also contributes to the understanding of the outcomes generated by the research methods.

3.5 Ethics

We perform a research in close cooperation with an organization. It is important to address research ethics during the investigation. In all probability we speak to a lot of different employees within the company and external parties and conduct interviews with them. At the beginning the goal of the research has to be clear. Besides, it is important to guarantee confidentiality and anonymity. You have to keep in mind employees and external parties trusted you while conducting the interview. You have to be careful with informing about the results and have to think about what possible implications of the findings are in the organization.

Before the data collection:

In order of the participation of the interviewee and other people that contribute to the research their consent will always be requested by the researcher. After the participant permitted to contribute they have the freedom to withdraw from the research at any time. As regards data collection the researcher will guarantee that the contribution of the participants is confidential and anonymous. This will be appointed to the participants before they participate. Also the storage of the data obtained shall only be on secured platforms. Besides, the participants will be told how the findings might be applied in the organization. In this research it can lead to a change of strategy according to GRC in the organization.

After the data collection:

All participants will be informed of the results. However, this might lead to conflicting ethical issues since their might be sensitive results in the rapport about the organization and some of the participants are external parties. In consultation with the organization we cooperate with, only the non-sensitive results that are useful for the particular external party will be shared. This will be appointed to the party before they participate in the research.

Chapter 4 - Results

4.1 Introduction

In this chapter we will describe the findings obtained by the interviews with the sources. In the analysis of the interviews we discovered several certainties and uncertainties/trends. First of all, we give an overview of the important information each source has provided per subject.

Based on these findings we will describe the certainties, which are prospective developments that we are relatively certain of and are good to take into account. Secondly, we will describe the discovered uncertainties/trends which possibly could have great impact on the focal question.

4.2 Overview important information

To give a clear overview of the information that is obtained by interviewing the sources we will use the table showed in the methodology section. For each source will be described what they said about each subject. The final column will be the conclusion which enumerates the most important information the source provided. The completed table can be found in appendix 2. In table 9 we shortly list the most important outcomes per source.

Table 9

Overview important information per source

Insurance company	<ul style="list-style-type: none"> • Care paths must be present for each target group the organization wants to deliver GRC to. • Location of the organization close to client is more important than specialization of the organization in GRC. • If there are doubts about the triage of the clients, observation beds can be used. • Great supporter of ambulatory GRC. • Purchasing conditions for hospitals increases the intake of GRZ. Hospital stay in hospitals should be shorter.
Branche organization Actiz	<ul style="list-style-type: none"> • Client prefers rehabilitation close to home. • Support ambulatory GRC. • Hospitals consider it important that they can easily relocate the client to GRZ. Organization that offers GRC has to be flexible. • Rehabilitation climate in the organization is important. • Purchasing conditions for hospitals increases the intake of GRZ. Hospital stay in hospitals should be shorter.
Goudenhart	<ul style="list-style-type: none"> • Hospitals send clients to the organization where is place. • Clients prefer an organization close to home and that offers good therapy. • Organization prefers internal triage. • Health professionals like the dynamic work place that comes along with working in GRC. • Purchasing conditions for hospitals increases the intake of GRZ. Hospital stay in hospitals should be shorter.
Specialist geriatric medicine	<ul style="list-style-type: none"> • Clients select organizations on the basis of geography. • The biggest annoyance of clients are other people on their department. • Health care professionals like the dynamic work place that comes along with GRC. • Important to create care paths on the basis of functioning of the client.
Hospital transfer point employee	<ul style="list-style-type: none"> • Sometimes hard to do the triage right at the hospital • Prefers to cooperate with large organizations that offer GRC. Better quality more expertise. • Ambulatory GRC seems to be upcoming • Clients prefer an organization to rehabilitate close at home • Health care professionals like the dynamic work place that comes along with GRC. • Organizations need to become more flexible to handle the high turnover.
Rival Care institution	<ul style="list-style-type: none"> • Use the indication ZZZP9 for vulnerable clients. • Observation beds allow the organization to do the triage internal. • Hospital send clients where is a place at that moment. • Crisis beds are a solution with the increasing demand of GRC. • Start your own chain. Specialize and reply to the demand in GRC. • Experiment with ambulatory GRC. • Oncological palliative group is a growing target group in GRC.
Focus group elderly people 70+	<ul style="list-style-type: none"> • Quality of rehabilitation and geography both important for selecting organization. • Like to be surrounded by people with the same problem and that act at the same level. This stimulates them to rehabilitate.

4.3 Certainties

During the analysis of the interviews and according to the outcomes three certainties are discovered. *Care Paths, Indication ZPP9 and observation beds*. The need of Care paths and observation beds are mentioned by several sources directly or indirectly. Indication ZPP9 was only mentioned by one source; the rival care institution. However, since this can be seen as an important source and the emphasis that the source putted on this subject Indication ZPP9 can be determined as a certainty.

4.3.1. Care Paths

A care path can be defined as a complex intervention to realize the common decision-making and organization of care processes for a specific group of patients during a defined time frame (De Jong, 2012). A care path can be seen as the description of successive steps, decision moments and criteria in the care process for a patient group with a specific care request. It is a realization of a care program with the aim of ensuring qualitative and efficient care (De Jong, 2012).

It is important for organizations that offer GRC to work with extensive care paths. Some insurance companies state that care paths are already a minimum requirement for GRC purchasing. The care paths are developed by target group. They describe which type of care is will be used for the target group and when this type of care will be used in the process of GRC. It also describes what the inclusion criteria of clients are and what the outflow criteria of the clients are. This ensures that you substantiate and structure the care you provide. Care paths have to make the provided care more effective. Something insurance companies aim for. Also care paths based on performance of the client make it easier to predict the progress of the process. That makes it easier to indicate when new beds are released and this improves the cooperation with the transfer bureau of the hospital.

4.3.2 Indication ZPP9

Since the organization already works with WLZ indications it is beneficial to work with ZPP9 indications next to GRZ. ZPP9 refers to restorative treatment with nursing and care. Clients with a ZPP9 indication may receive 4.5 hours of therapy per week and the organization get paid per day the client receives care. In terms of content it does not differ much from the GRC. However, it is wise to give weak clients, of whom it is doubtful whether they ever have the possibility to go home, a ZPP9 indication instead of placing them in the GRC. There might be a chance that these clients are not able to return home, but insurance companies keep a close eye on how much percentage of GRC clients return home after treatment. When a large percentage of GRC clients are not able to go home this might have bad consequences for the organization. By giving doubtful clients a ZPP9 indication you can still treat them like you do in the GRC. However, there is more time for the treatment and if after the treatment appears that the client cannot go home, this does not affect the outgoing GRZ percentage. This reduces pressure for the client and pressure for the organizations.

4.3.3 Observation beds

Currently only the specialists and nurses in the hospital can sent someone to the GRC. This means that it is not possible for general practitioners to send clients from their home situation to the GRC, the specialists elderly care (SE) can not change the ELV indication into a GRC indication when this is needed. This causes that hospitals have a hard time to find a place to recover when the hospital and the SE disagree about the indication. To get the patient with the right indication in the right place, the observation beds are introduced. The observation beds allow the organization to provide patients who are difficult to tread and vulnerable with the correct indication and appropriate care and treatment. They can use a short and delineated observation period to determine this indication. After the observation period it is possible for the organization to determine a GRC, ELV or ZPP9 indication. The care path of the analysis is up to 12 days. From day 1 the analysis of the patient starts. Within 4-7 days the first

multidisciplinary conversation takes place, called the multidisciplinary analysis. When the indication is clear, this is requested and the care path will stop. When there are still doubts about the indication the analysis can be extended with 5 days. After these days a final decision should be made.

Not all insurance companies work with the observation beds yet. However, the results of the insurance companies that already work with it are good. Which makes it very likely that more health insurers will invest in this method.

4.4 Uncertainties/Trends

There are 2 uncertainties/trends discovered during the analysis of the interviews. In literature was mentioned that the most profitable way to build scenarios is to pick out two important trends and consider them together in a scenario matrix. This results in four different scenarios where both trends are combined. However, the trends we discovered are two different kind of trends the organization can select to invest in. The trends are not interrelated and have to be seen as two separate strategic decisions which both request different plans and infrastructural conditions. For this reason, we will describe the trends separately from each other. We will outline what the scenario contains and what the pros and cons of the scenarios are.

4.4.1 Scenario 1: Ambulatory GRC

The first possible scenario is ambulatory GRC. Ambulatory GRC means that the GRC does not take place in the institution but the clients live at home and receive their care and therapy at home. There are several reasons to invest in ambulatory GRC. First of all the insurance companies really support this idea since it reduces costs. Secondly, it meets the wishes of the clients. From research it becomes clear that the client's choice for a place to rehabilitate is mainly based on geography. They want to be as close as possible to the place they live. When GRC is ambulatory they can stay home and they do not have to worry that they have to rehabilitate at a place far from home. This is also in line with the vision of the organization: to provide care familiar and close. Also the problem of living with other people, which can cause irritation is solved by providing ambulatory GRC. From a medical point of view, the approach of the treatment is immediately clear people live at home. The intention of GRC is to let people do as much as possible by themselves. Clients do this more automatically when they have to live at their own place and are not surrounded by people who can help all the time. Another advantage is that the places available in the GRC are not dependent on the amount of beds in the institution anymore. It is dependent on how many people work at the GRC department of the organization and how many people they can treat. Which means that when the demand increases only more personnel is needed and not more locations or beds. Expansion is easier. This is beneficial for the transfer bureau of the hospital, since it makes it easier for them to find GRC care for the client. Ambulatory GRC solves problems that occur at this moment, such as a shortage of places and it probably reduces costs. With this idea you unburden the chain and start your own branch.

Besides, some factors are still unclear and need to be sorted out before ambulatory care can start. At this point insurance companies are willing to help, however there are bureaucratic rules that need to be change before ambulatory GRC is possible. Also clients feel stimulated when they are surrounded by other with the same problems. When they live at home they do not have contact with other clients. This aspect has to be taken into account while formulating an ambulatory GRC trajectory.

4.4.2 Scenario 2: Crisis beds in the GRC

Often hospitals are in great need of GRC places in organizations. There are too many clients for the number of available places. Also general practitioners have to deal with crisis cases and need to send their patients somewhere. To unburden the transfer bureau of the hospitals, the general practitioners and shortening the hospital stay duration of patients, the organization can invest in creating crisis beds.

These crisis beds are meant for people that enter the first aid of the hospital but do not need medical treatment and do not have to stay in the hospital but need rehabilitation. In that case these people can be sent to a crisis bed. With the aging of the next years and the pressure on the hospitals to shorten the duration of the patients in the hospital it is very likely that these requests will come more often. When choosing to invest in crisis beds it is important to cooperate with the hospitals and general practitioners in the area. When a crisis bed is necessary, the client must be referred directly to the organization.

A difficulty when implementing this scenario is to find a way how the empty beds will be covered financially. Besides it is important to have good connections with the organizations in the network that are able to send the clients to the GRC. It depends on these organizations how many clients are coming to your organization. Also when other organizations also start to create crisis beds in their organization their might be too less clients for the amount of crisis beds.

4.5 Selected scenario

After generating the two scenarios, both scenarios are discussed with the management. To select one scenario the stages imagine and deciding must be followed. During the deliberation of what scenario should be picked we discussed the desired future of the organization and the developments in the environment. After discussing the vision of the organization and the two generated scenarios one scenario was selected. The selected scenario is *Ambulatory GRC*. This scenario is picked since it anticipates the future demand of society and the future demand of the organization. The scenario is an undeveloped area, what gives the organization the opportunity to be a pioneer and forerunner. It is also in line with the vision of the organization: Familiar and Close. In addition, the organisation notices during the GRC process at this moment that for a large group of GRC rehabilitants it would be possible to rehabilitate at home and this would even benefit their rehabilitation In the case of ambulatory GRC they are forced to act more independently since there are not always healthcare providers available. Another reason why the organization has chosen this scenario is because various parties have indicated that they are enthusiastic about the idea of ambulatory GRC. All the parties that mentioned to be enthusiastic are parties that influence the future of the care and are well aware of the developments in the field of GRC. This gives the organization even more confidence to choose ambulatory GRC.

Also the organization already has a home care department. This can be very beneficial for implementing ambulatory GRC. They have the experience in the logistic part of delivering care at home and are in possession of the necessary flexibility, nevertheless they are in possession of the right knowledge.

The goal of the organization when starting Ambulatory GRC is to deliver the GRC at the client’s home. In the table below is shown what this entails.

Table 10
Meaning of Ambulatory GRC

Ambulatory GRC means:

- | |
|--|
| <ul style="list-style-type: none"> • <i>Client stays in his own home while receiving GRC.</i> • <i>Client receives therapy at home.</i> • <i>Client receives care at home.</i> • <i>Therapists and other care givers in the GRC need to travel to their client to carry out GRC.</i> |
|--|

Part 2 Redesign of the organization

Introduction to part 2

The goal of part 2 of this research is to give substance to the selected scenario; **Ambulatory GRC**. The aim is to provide an answer on subquestion 2: *What is the required organizational structure and human resource management and what design can be developed in order to successfully implement the strategic decision?* This strategic decision mentioned in the question is Ambulatory GRC.

The result of this part will be a redesign concerning the structure of the organization and the human resource management. In order to reach this goal this part of the research consists of three chapters. In the first chapter of this part, chapter 5, we will outline the theoretical foundations. This is about the infrastructure of the organization focussed on the structure and the human resource management. In chapter 6, the methodology section, is described how we obtained the results and finally in chapter 7 the results will be presented in the form of a redesign.

Chapter 5 – Theoretical background: Redesign structure and HR

5.1 Introduction

In this chapter we will describe the theoretical background for the second part of this research. The goal is to discuss conceptual frameworks that are necessary to design structure and human resources standards. The theory will be focussed on the infrastructural conditions of the organization. The infrastructure of an organization consists of three conditions; the structure of the organization, which refers to defining and allocating tasks and responsibilities, the human resources management, which refers to recruiting and developing skilful, knowledgeable, motivated employees and the technology used in the organization (Achterbergh & Vriens, 2010). The goal when designing the infrastructural conditions of the organization is that the infrastructure is able to realize the transformation processes and their operational regulations.

This research is limited to redesign the first two conditions; the structure of the organization, and the human resources management of the organization. First of all, we are going to look at the structure. The topics that will be covered are: how structures can be defined (Section 5.2), what the parameters are to determine what good and bad structures are and we will look into the design rules to redesign a structure. Secondly, we are going to look at the human resources (Section 5.3). In this research we only focus on the parameters skills, knowledge and motivation and we will outline how to design human resources management measures.

5.2 Organizational structure

The organizational structure are the conditions in the organization with respect to the division of work. This refers to defining and allocating tasks and responsibilities (Achterbergh & Vriens, 2010). In this research the work of De Sitter (1994) is selected as base of redesigning the organizational structure. De Sitter is far more detailed about organizational redesign than for example authors as Thompson (1967) or Mintzberg (1983) who also researched this topic. The detailed description of De Sitter (1994) about redesigning organizations contributes to the intention of the second part of this research: the redesign of the organizational structure. In order to design an organizational structure two issues have to be taken into account; design rules, which explain when is a structure a good structure and the design precedence rules, which explain how a structure should be built. First the design rules are discussed and secondly the design precedence rules will be discussed.

5.2.1 Design rules

De Sitter (1994) specifies how a structure should be designed to keep an organization viable. The role of the structure and the design of it will be explained by figure 3.

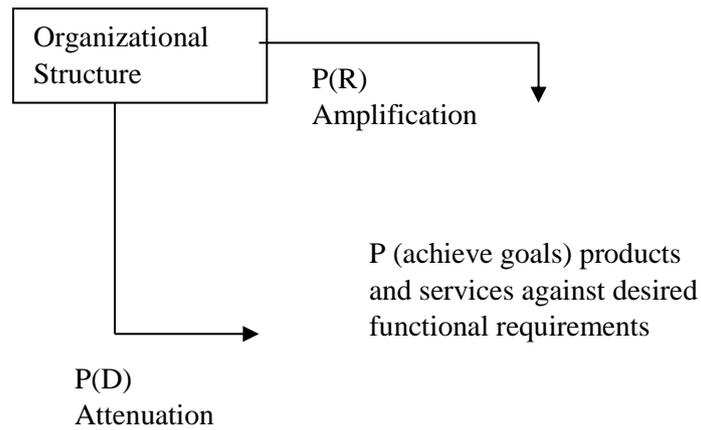


Figure 3: Role of structure and the design

Goals: products and services against desired functional requirements

First of all, it is important to formulate the goal of the organization, which means what are the products and services the organization wants to deliver (primary processes). In order to reach the goal the organization should meet some functional requirements (De Sitter, 1994). Three categories of external functional requirements are distinguished. These external functional requirements should be met to ensure that the organization achieves its goals. These external requirements can be converted into internal functional requirements. These internal requirements are ought to meet in order to meet the external requirements. The categories of external functional requirements are: *the quality of organization, the quality of work* and *the quality of working relations* (De Sitter, 1994).

These categories consist of external requirements which can be translated into internal requirements needed to meet the external requirements. On the basis of the improvement of these three categories should a redesign be designed. The internal functional requirements should be formulated on the basis of an 'air castle'. Which means that the current organization structure and activities do not have to be taken into account and that there is no need to take into account the feasibility of the formulations while the functional demands are formulated (De Sitter, 1994).

An overview of all the functional requirements are shown in table 11 below.

Table 11

External functional requirements and Internal functional requirement

External functional requirements		Internal functional requirements
Quality of Organization	Order flexibility	Short production-cycle time Sufficient product variations Variable mix of products
	Control over order realization	Reliable production and production time Effective control of quality
	Potential for innovation	Strategic product development Short innovation time
Quality of work	Low levels of absenteeism Low levels of personnel turnover	Controllable stress-conditions; Opportunities to (1) be involved, (2) learn, and (3) develop
Quality of working relations	Effective communication	Shared responsibility participation in communication

Note. Reprinted from: “*Synergetisch produceren: Human resources mobilisation in de productie; een inleiding in structuurbouw*”, by De Sitter, L., 1994, p.42, Assen: Van Gorcum.

P(D): attenuation (decreasing the chance of disturbances)

Attenuation refers to the degree to which an organizational structure decreases the probability of the occurrence of disturbances and the sensitivity to the dispersion of disturbances (Achterbergh & Vriens, 2010). Disturbances are caused by many relationships and many orders per relation. Therefore, in order to decrease the chance on disturbances a structure should be design with as few relationships and orders as possible.

P(R): amplification (increasing the number of regulatory activities)

Amplification refers to the regulatory potential built into an organizational structure to actively deal with virtual or actual disturbances (Achterbergh & Vriens, 2010). In order to amplify the regulatory potential of a structure make sure problem and control power are organized as close together as possible.

5.2.1.1 How to design a structure that attenuates P(D) and amplifies P(R).

The level of attenuation and amplification can be seen as the structures controllability. In order to evaluate the controllability of a structure De Sitter (1994) defined 7 parameters. Each parameter captures a relevant characteristic of the organizational structure and has a specific effect on the controllability. These parameters can be used to evaluate the ability of the structure to attenuate and amplify. When these parameters in the organization have ‘low-values’ they positively contribute to the attenuation and amplification of the organization which increases the chances to obtain the fulfilment of the functional requirements.

The 7 parameters can be distinguished into three groups: A group of parameters that describes the production structure (the grouping and coupling of primary processes and their relation to orders). The second group describes the control structure (the grouping of regulatory transformations into tasks). The third group, consisting of one parameter, describes the ‘separation’ between the operational and the regulatory transformations (Achterbergh & Vriens, 2010).

Parameters describing the production structure (Achterbergh & Vriens, 2010).

Parameter 1: the level of functional concentration

Functional concentration as a parameter refers to “the grouping of operational tasks with respect to orders”. A maximum value of functional concentration means that all operational tasks *of the same type* are concentrated into specialized departments, where they are performed with respect to all orders. This means that functional concentration has a maximum value when all operational tasks of the same type, are coupled to all orders. A minimum value of functional concentration means that all operational tasks (*of a different type*) required for realizing some order are grouped together into a ‘production-flow’. This means that the level of functional concentration is minimal when all tasks, necessary for the production of some order-type, are only coupled to this specific order-type – and grouped together into a production-flow. Figure 4 presents a structure which has a high value of functional concentration and figure 5 presents a structure that has a low value of functional concentration (Achterbergh & Vriens, 2010).

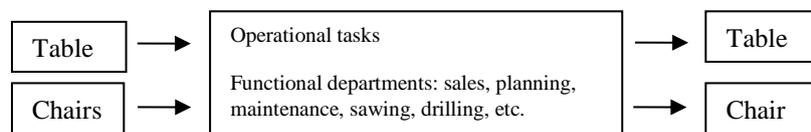


Figure 4. High value of Functional concentration: all operational tasks are coupled to all two order-types. Reprinted from “*Organizations conducting experiments*”, by Achterbergh, J., & Vriens, D., 2010, p.231, Dordrecht: Springer.

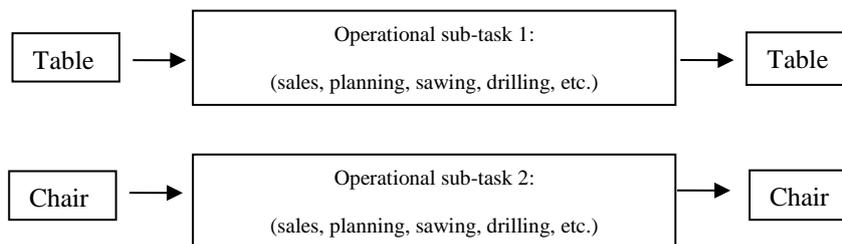


Figure 5. Low value of Functional concentration: all order-types have their own set of operational tasks. Reprinted from “*Organizations conducting experiments*”, by Achterbergh, J., & Vriens, D., 2010, p.232, Dordrecht: Springer.

Parameter 2: the level of differentiation of operational transformations

The second parameter to describe the production structure is called the level of differentiation of operational transformations. Three types of operational tasks can be differentiated: ‘making’, ‘preparing’, and ‘supporting’. The level of differentiation of operational tasks is ‘maximal’ if operational sub-tasks are grouped into ‘make’, ‘prepare’, and ‘support’ tasks, and minimal if operational tasks contain make, prepare and support sub-transformations (Achterbergh & Vriens, 2010).

Parameter 3: level of specialization of operational transformations

The level of specialization of operational transformations refers to ‘how much tasks are split up into sub-tasks’. The value of this parameter increases when operational tasks become more specialized and these specialized transformations become separate tasks. For example, the operational tasks: doing the laundry can be specialized into smaller sub-tasks: ‘sorting out’, ‘cleaning’, ‘hang the laundry to dry’. All these actions can become separate tasks, performed by individual employees. The value of this parameter decreases when all the different actions are integrated into one task (Achterbergh & Vriens, 2010).

Parameter 4: the level of separation between operational and regulatory transformations

Separation between operational and regulatory transformations in tasks is maximal if operational transformations are grouped into tasks that are maximally stripped from their regulatory potential and regulatory transformations are grouped into tasks separated from its operational aspect. In this case, ‘operational tasks’ depend for regulation on separate ‘regulatory tasks’. Then the parameter has high value. Separation is minimal if a task consists of both operational sub-transformations and the regulatory sub-transformations needed to regulate them. Then the parameter has low value (Achterbergh & Vriens, 2010).

Parameters describing the control structure

Parameter 5: the level of differentiation of regulatory transformations into aspects

The level of differentiation is maximal if the three types of regulation, control or strategic regulation; regulation by design, and operational regulation are grouped into different tasks. The level of differentiation of regulatory tasks is minimal if these three forms of regulation are combined into one task (Achterbergh & Vriens, 2010).

Parameter 6: the level of differentiation of regulatory transformations into parts

This parameter focusses on the division of every regulatory transformation into a ‘monitoring’, ‘assessing’, and ‘acting’ part. The value of this parameter is maximal if one differentiates regulation into ‘monitoring’, ‘assessing’, and ‘acting’ and assigns these sub-transformations to separate regulatory tasks. The value of this parameter is minimal if these regulatory aspects are integrated into one task (Achterbergh & Vriens, 2010).

Parameter 7: the level of specialization of regulatory transformations

This parameter refers to the level of dividing regulatory transformations into small sub-transformations. The value of this parameter increases as the decomposition of a particular regulatory transformation increases, and as these regulatory sub-transformations become separate tasks. For instance, operational regulation is divided into several regulatory sub-transformations: product quality, efficiency, personnel and each of these specialized transformations becomes a separate task. The value of the parameter. Table 12 summarizes the parameters and which type of parameter it is (Achterbergh & Vriens, 2010).

Table 12
Parameters and type of parameter

Parameter	Parameter type
1. Level of functional concentration (relative to orders)	
2. Level of differentiation of operational transformations in tasks	Parameters to describe production structure
3. Level of specialization of operational transformations in tasks	
4. Level of separation of operational and regulatory transformations in tasks	Parameter to describe the separation between the production and control structure
5. Level of differentiation into aspects of regulatory transformations in tasks	
6. Level of differentiation into parts of regulatory transformations in tasks	Parameters to describe the control structure
7. Level of specialization of regulatory transformation in tasks	

Note. Reprinted from “Organizations conducting experiments”, by Achterbergh, J., & Vriens, D., 2010, p.234, Dordrecht: Springer.

5.2.2 Design precedence rules

When starting the actual structure building the design precedence rules have to be taken into account. To ensure all the relevant design precedence rules are taken into account, both the theory of De Sitter (1994) and the theory of Amelsvoort, Kuipers and Kramer (2010) are applied. These two theories are basically the same, since the theory of Amelsvoort et al. (2010) is based on the theory of De Sitter (1994). However, we refer to both theories, since sometimes the explanation of one of them is more easy to use. In this part the two theories will be combined, resulting in a complete and clear overview of the steps that have to be taken to design a structure.

There are three steps that have to be performed when building an organizational structure.

- Step 1: Outside-in approach (functional requirements formulated to create a utopian situation (bouwen van een luchtkasteel))
- Step 2: Design production structure (macro to micro)
- Step 3: Design control structure (micro to macro)

The first step when starting structure building is to apply the outside in approach. During the scenario planning the developments in the environment of the organization, concerning GRC are examined. As a result of which we were able to determine the external demand. After picking one scenario that addresses the demand there has to be determined what the goal of the organization is and what this goal entails. Therefore, the primary processes have to be defined. What is the actual job that the organization wants to carry out to the client and which tasks have to be performed? This also involves vision on what the organization wants to mean for the client in practice. The goal has to be reached regarding the three categories of essential organizational variables: quality of organization, quality of work and quality of working relations. The external and internal functional requirements that belong to these categories are already described in theory. In this step the internal functional requirements should be formulated on the basis of an ‘air castle’.

When the first step is performed the steps to design the actual structure follow.

When designing a new structure there are two structure types that can be distinguished. *The production structure* which refers to the division and coupling of operational activities and the *control structure* which refers to the division and coupling of administrative and regulatory activities (Van Amelsvoort et al., 2010; De Sitter, 1994).

When designing a new structure, it is of great importance to first focus on the production structure and secondly on the control structure. The production and the control structure are built from three parts: macro, meso, micro.

In the production structure the macrostructure is about the division of the organization in relatively large units. The entire system is taken into consideration and the design question is how this system can best be divided into relatively independent macro-units. The meso structure is about a finer division of these units, for example project groups. The micro structure is about the division at the level of individual workstations. The micro design of the production structure is about the internal structure of the task groups (Van Amelsvoort et al., 2010).

When designing the production structure, you have to design from macro to micro. Regarding the control structure it works the other way around, there you design from micro to macro.

Concluding, when designing a structure it is first of all important to keep the level of the parameters low in order to increase the chances to obtain the fulfilment of the functional requirements and secondly it is important to follow the steps of the design precedence rules while creating a design.

5.3 Human resources management

Given the chosen scenario and the changes in the organizational structure in terms of new tasks and operational regulations there is need for a well suited human resource management strategy. This new strategy has to be formulated in order ensure that the right employees are present within the organization for the scenario to succeed. Human resources management refers to recruiting and developing skillful, knowledgeable, motivated employees (Achterbergh & Vriens, 2010). These three variables; knowledge, skills and motivation, are the parameters of the infrastructural component 'human resources' (Van Laar, 2019). We will use these three parameters to determine what a suitable employee has to meet. Below we will first describe the three parameters. Secondly a methods to design human resource measures will be described.

5.3.1 Parameters in Human Resource Management

Parameter: Knowledge

Knowledge can be defined in two ways. First of all knowledge can be defined as “the whole of what one has learned through study or practice; the whole of what someone knows” (Van Laar, 2019). The second definition of knowledge is “a (through learning) personal capacity that enables someone to perform a certain task”. Personal capacity is defined as “the product of the information, experience, skills and attitude which a person has at a particular moment”. In this research the second definition of knowledge will be used, since it already clearly points to the question we want ourselves to ask. Which personal capacities do the employees need to have that enables them to perform the tasks required in ambulatory GRC?

Parameter: Skills

A general definition of skill is 'ability' of 'agility' or the ability to perform certain actions competently (Van Laar, 2019). The concept skilful is usually used to determine actions that people can perform easily and precisely (Van Laar, 2019). We can conclude that knowledge is a more comprehensive term and is mostly associated with the verb 'to know'. Skilful/skill is part of the term knowledge and mostly associated with the verb 'being able to'.

Parameter: Motivation

Besides the importance of employees to have the right knowledge & skills, it is important that they are motivated to do the job. Motivation in general can be defined as: number of factors (including instincts and motives) through which stimulated behaviour and is directed.

“When speaking of motivation specifically related to work it can be defined as: a set of energetic forces that originates both within as well as beyond an individual's being, to initiate work-related behaviour, and to determine its form, direction, intensity, and duration” (Van Laar, 2019, p.165).

This definition indicates that motivation contains of forces that employees encourages to act. These forces determine what the employee wants to achieve how they want to achieve this and how hard he will work to achieve and when he will stop with his efforts (Van Laar, 2019).

Motivation can be divided in two forms: intrinsic motivation and extrinsic motivation. Intrinsic motivation is accompanied with involvement. There are four characteristics of jobs that lead to intrinsic job motivation (Van Laar, 2019):

- The job has to be meaningful and includes a variety of different activities, that need different skills and abilities.
- The job offers the employee the opportunity to develop new abilities and skills and to learn new things.
- The job comprises activities that together form a complete task, which ensures that the employee feels responsible for the results.
- The job knows a lot of freedom and autonomy regarding the way it is performed.

Extrinsic motivation has an external basis. An employee takes a certain action, because he wants to achieve a certain distinguished result, such as obtaining a reward or promotion or preventing a negative assessment or dismissal (Van Laar, 2019).

5.3.2 How to design human resource management measures.

In order to design Human resource management measures we use the model of Van Laar (2019).

According to this model there are 3 stages in the HR-flow that have to be attended: Inflow, Flow and Outflow. In each stage there are several instruments that can be used to affect the stage. These instruments can ensure that each parameter reaches its requested value.

The instruments are: recruitment, selection, assessment, remuneration, education, training, coaching, career development, management development and dismissal. In the table below is shown which instrument can affect what stage.

Table 13

HR- instrument coupled to HR-stages

HR-flow	HR-instrument
Inflow	Recruitment and selection
Flow	Assessment Remuneration Education & Training Coaching Career development & Management development
Outflow	Dismissal

Note. Reprinted from “*Shared services, oplossing of probleem? Onderzoek naar de invloed van de inrichting van de organisatiestructuur op de performance van shared services*”, by Van Laar, H., 2019, p.171, Nijmegen: Radboud Universiteit.

Chapter 6 – Methodology

6.1 Introduction

In this part of research only intervention methods are used to obtain the results. The goal of the intervention is to achieve the functional goal and social goal. The functional goal is to create an optimal redesign to implement ambulatory GRC. The social goal is to involve the employees involved by implementing and carrying out the scenario in order to create understanding of the idea. It is important to involve them in the process of the development of a redesign to succeed ambulatory GRC. This ensures that they know that their opinion and knowledge are crucial and required to formulate infrastructural conditions. Based on these goals the infrastructural dimensions of the intervention are initiated: structure, HR and technology. The intervention consists of one focus group and one reflection workshop. The participants of the focus group and the reflection workshop is the staff directly related to the GRC. In the first focus group the scenario is introduced and the goal is to generate information of how the structure and HR should be designed in order to realize the scenario. In the following reflection workshop the design is presented based on the first focus group and the participants have the opportunity to ask questions and comment on this design. It is important to notice that the intervention is not only a way the gather empirical data. First of all, the goal of the intervention is making the employees think about the way of working in the selected scenario and secondly to gather their ideas and opinions about ambulatory GRC. Also in this part of the research the 3D model of Achterbergh and Vriens (2018) is used to guide the process of the intervention.

6.2 Intervention methods

6.2.1 Functional Dimension

The first dimension is the functional dimension. In this research the goal on the functional dimension is to optimize as much as possible the quality of the redesign and its implementation (Achterbergh & Vriens, 2018). The functional goal is to generate input to redesign the infrastructural conditions. In this dimension the focus is to perform the right steps to obtain the right information and to guide the participants of the focus group by asking the right questions and involve them in the creation of the design.

6.2.2 Social dimension

The social dimension of the model contributes to the integration of the change of the behaviour of the people (Achterbergh & Vriens, 2018). It is important to keep the organization and the participants of the focus group informed during the process and the development of the required design. In this part of the research the management will still be updated every other week. In addition, also the other employees involved managing the GRC have to know that their opinion is taken into account. The first focus group contributes to the feeling of involvement. However, after the first design and recommendations are formulated we will ask again for their feedback and opinions in the reflection workshop. This ensures that the final design is as complete as possible and increases the chances of understanding for certain choices.

6.2.3 Infrastructural dimension

The infrastructural dimensions consist of aspects that are concerned with developing an infrastructure which realizes the functional and social goals of the intervention. The redesign of infrastructural conditions is a process itself, which requires infrastructural conditions. There are three infrastructural areas identified: organizational structure of the intervention, HR of the intervention and technology used in the intervention.

Organizational structure of the intervention

The organizational structure defines who will be involved and what its scope will be. In the second part of the research the focus will be on internal relations of the organization, since it is about the infrastructural requirements (structure and HR) of ambulatory GRC. Besides the management involved also the employees that are involved managing GRC will be updated and taken into account in the process. Also in this part of the research the structure of the intervention is the 'expert structure'. Which means that an external specialist intervenes in aspects of the infrastructure (Achterbergh & Vriens, 2018).

HR-Measures

The HR tool that will be aligned with the second part of the research is equal to the tool that is used in the first part of this research. This means that also 'participation' will be used as a HR tool in the second part. The management and the important employees concerned will be involved in the process of development of infrastructural requirements. They can advise and give their opinion during the process of development. The meetings to update the management will continue during the development of the redesign. Besides a focus group and reflection workshop will be organized to ensure the involvement of the GRC staff. Also in this part the role of the researcher can be compared with the role of an expert consultant. Which focusses on the content and provides a framework in the form of a redesign.

Technology

This area refers to the technology that is used to communicate, research and solving problems during the intervention. The first technology that is necessary to use during the intervention is the theory about the technique of determine structures and parameters determining the recruitment and selection process. Besides one focus-groups and one reflection workshop will be applied for obtaining the required data. However, again, it is important to mention that the focus-group/workshop are not only used to obtain empirical data, but are also a means to make the employees think of working with ambulatory GRC.

In the focus group two topics will be discussed: the organizational structure necessary to implement ambulatory GRC and the human resource management necessary to implement ambulatory GRC. These topics will be treated on the basis of the following questions. The structural requirements will be determined on the basis of two questions:

- *What are the main tasks (primary processes) needed to realize ambulant GRC?*
- *How will you regulate these tasks operationally?*

The human resource management requirement will be determined on the basis of questions related to the parameters. However, there is one question important to ask first:

- *What new functions are necessary to succeed the selected scenario?*

When that question is answered, the focus will be on the parameters that guide the recruitment and selection process. Three questions are developed:

- *Knowledge: What knowledge must an employee have in a certain function to be able to offer ambulatory GRC?*
- *Skills: What skills should an employee have in a certain job in order to be able to offer ambulatory GRC*
- *Motivation: What motivation is required for an employee to work in GRC and how do you ensure that employees are motivated to work in ambulatory GRC?*

After the focus group the first version of the redesign is evaluated in the reflection workshop. The participants do have time to read the first version of the redesign before attending the workshop. During the workshop they have the opportunity to ask questions and comment on the content.

In addition, we also used literature in the field of human resources. The following research is used:

- Van der Veen, M. (2016). *Beroepscompetentieprofiel Verzorgende in de Geriatrische Revalidatiezorg (GRZ)*. Den Haag: Adviescommissie Arbeidsmarkt & Opleidingen.

Further communication techniques will be applied on order to inform the management during the process but also to guide the focus-group and obtain the rights answers on the questions. In the meetings where the management will be informed the communication will be in in form of a dialogue. However, during the focus-group the communications will be between the participants and the researcher will lead the conversation on the basis of a presentation. In the reflection workshop the communication will be in form of a dialogue again.

Chapter 7 – The Design

7.1 Introduction

The goal of this chapter is to process the results of the focus group and to create an organizational redesign. The chapter is divided into 4 parts. Section 7.2 starts with looking at the scenario from an outside in approach, and follows with the designs of the production structure and the control structure. In section 7.3 the human resource management is presented. Section 7.4 finishes with an overview of the general findings. Following, in section 7.5 the results of the reflection workshop on the design will be presented.

7.2 Redesign of the structure

In the following part the precedence design rules will be applied to come up with a new design for the structure of ambulatory GRC. Paragraph 7.2.1 starts with looking at the functional requirements regarding the outside-in approach. Thereafter in paragraph 7.2.2 the production structure will be determined and in paragraph 7.2.3 a part will be devoted to the control structure. The paragraphs of the production structure and the control structure have the similar way of argumentation. Each paragraph starts with results of the focus group. In this part the ideas about the particular structure that came up in the focus group will be explained. In the section that follows the created redesign is presented. This redesign is based on the ideas that are mentioned during the focus group. However to design a structure that involves a critical view on the ideas mentioned in the focus group, this redesign is also created from a business administration point of view and takes the theory into account. This ensures that the ideas mentioned in the focus group are taken into account but the redesign also meets the requirements an organizational design should meet according to theory. The production structure starts at macro level followed by meso level and finally the micro level is determined. The control structures starts with determining the micro level, followed by the meso level and ends at macro level.

7.2.1 Outside- in approach

The first step of the design precedence rules is applying the outside- in approach. In this stage the products and services the organization want to deliver are formulated and the activities that are necessary to do deliver the products and services are formulated. How well these products and services can be delivered depend on the realization of the internal functional requirements that help to realize the external functional requirements, which increase the chance of obtaining the goals of the organization.

The goal of the organization is to offer Ambulatory GRC to all clients that receive GRC and for whom it's safe to rehabilitate at home. This means that the client can live at their own homes and receive therapies and care at the place they live. Apart from the treatments that are consciously organized on location, for example because the approach of the treatment is to meet fellow sufferers.

There are a few concrete activities that have to be performed when ambulatory GRC is carried out. We can state that all the activities can split up in five main actions:

1. Intake
2. The preparation of the treatment plan.
3. Carrying out rehabilitation program
4. Client dismissal
5. After care

The first activity that has to be performed is the intake of the client. During the intake, it is determined whether the GRC is the right place for the client. In this stage the indication is assigned to the client.

The client can be directly admitted to the GRC, although the choice can also be made to first place the client in an observation bed or to assign the indication ZZP9. The second activity in line is the preparation of the treatment plan. During this activity the treatment plan must be drawn up. The treatment plan states what kind of treatment (which types of therapy and what types of care) the client needs and how many hours per week. When the treatment plan has been drafted the third activity; the actual rehabilitation program, has to start. This means that the necessary therapies have to be carried out to the client and the care the client needs must be delivered at the homes of the clients. Next, when the client is ready to stop with the rehabilitation program, since he is doing well or the conclusion is that the client cannot take care of himself anymore, the clients gets dismissed and leaves to go home or to a nursing home. After the dismissal of the client there must be considered if after care is needed.

These activities have to be performed against the desired functional requirements. In theory we described the three categories of external functional requirements and their external functional requirements which can be translated into internal functional requirements. The following parts describes how these requirements can be defined for the organization and what internal functional requirements should be met.

The first category is the quality of organization.

The first external functional requirement that goes with this category is order flexibility. For the organization to reach order flexibility it is important to have a short production cycle time. This means that the team should be able to quickly respond to new applications of GRC clients and unforeseen emergencies. The second external functional requirement in this category is control over order realization. Therefore, the organizations should have reliable production and production time and effective control of quality. Which means that the organization should know when they have place for new clients and have to ensure the quality of the care is steady and good. The third external functional requirement is this category is potential for innovation. This means that the organization must be able to quickly reply to the change in demand in GRC.

The second category is quality of work.

Which contains the external requirements low levels of absenteeism and low levels of personnel turnover. Therefore, the organizations should have controllable stress conditions and opportunities to be involved, learn and develop. To reach that the organization should allow their employees to help determine which care is provided to the clients and how. The employees in the organization should also be able to learn and develop. The care they provide must remain varied and challenging.

The third and last category is quality of working relations.

The external functional requirement in this category is effective communication. Therefore, it is important that there is shared responsibility for the tasks they do and participation in communication. This means that every healthcare professional should be responsible for a part of the care they provide to the client. Also the communication between all the different healthcare professionals that are related to the GRC should be easy.

7.2.2. Production structure

To design a new production structure is special in this case, since a new activity is going to be performed by an organization that already exists. This means that a part of the design problem is how the new activity relates to the existing structure. It is for example an option to build the new activity into an existing task, but it is also an option to create a new flow in the organization that performs the new activity. To facilitate the understanding of the design, we first discuss the existing organization. Against this background we can explain the ideas of the focus group and the theory-based design.

Existing organisation

GRC Department

At the moment, the GRC is provided from several nursing homes of the organization. There are special GRC departments within these nursing homes. In these departments are several healthcare professionals and therapists working. The nurses/carers are responsible for the care the client receives. They try to create a rehabilitation climate on the department. Which means that they nurse clients if necessary, but also let them do as much as possible by themselves. The therapists present in the department are responsible for the therapy given to the clients. Rehabilitation always takes place under the responsibility of a rehabilitation doctor. The nursing staff, therapists and doctors together form a multidisciplinary team.

Homecare department

The homecare department is currently organized in different regions from neighbourhood teams. This means that every team consisting of several healthcare professionals is responsible for their own neighbourhood. The homecare department offers several types of care varying from domestic support to medical specialist care.

Ideas from focus group

The ambulatory GRC can be organized from the clinical GRC department, that already exists in the organization. They have the right expertise and abilities to be able to provide GRC. However, they are not yet familiar with the logistical issue that comes with ambulatory GRC. These logistical issues refer to the fact that the therapists and healthcare professionals have to travel to each of the client's homes to carry out GRC. To ensure that the logistical requirements of Ambulatory GRC can also be met, the GRC will be combined with the home care department of the organization. They are already familiar with offering care at home and therefore the logistical organization of it. Besides, the actions performed by the nursing staff within the GRC also seem to be very similar in some cases to the actions that the nursing of the home care must perform. Therefore, the nurses in the GRC and in Home Care possess the same abilities, which makes that GRC nurses can perform home care and vice versa. Both teams of nurses can be joined together. A combination of these two departments is the desired end result. At this moment the clients of the home care department are divided per neighbourhood and each neighbourhood has its own team of nurses. This can be continued when the GRC and home care are merged.

There are three important roles needed in the fulfilment of ambulatory GRC; Therapists, nurses and planners. The therapists only focus on the GRC clients. The therapists that are involved at the GRC are a physiotherapist, an occupational therapist, a speech therapist, a psychologist and a specialist in elderly care.

The nurses have to work with GRC clients as well with home care clients. They help the client by their general daily life operations (GDL care), perform nursing actions when necessary and offer personal care. The planners are responsible for the routes that every nurse has to travel in the neighbourhood. In addition, they also have to make sure that the therapists are not at the same time with a client as the

nurses. Besides the communication between the therapists and the nurses is very important but they can perform their tasks independently from each other.

Redesign from Business administration point of view

From Macro level to Meso level to Micro level.

The baseline for the redesign of the organization on macro level will be the order flow. The order flow of Ambulatory GRC will be clients divided by neighbourhood. These clients can be home care clients as well as GRC clients. This order flow is semi-homogeneous, which means that the 'products' in this case speaking of clients are different, however they receive in great extent the same services. Each neighbourhood is coupled to a particular team that operates in this neighbourhood. The nurses in a team take care of the clients in the neighbourhood they operate in. These clients can be both GRC clients or homecare clients. Despite the interference of home care, ambulatory GRC can be seen as a stand-alone order flow. They are still two different types of care. This affects the level of functional concentration. The same nurses are responsible for both types of care; home care and GRC. Therefore, the value of the level of the functional concentration will increase. What negatively affects the controllability (attenuation and amplification) of the organization. However, the level of functional concentration is countered by working in neighbourhood teams. Each team is responsible for their own neighbourhood. This ensures that not all nurses are responsible for all order types, which reduces the level of functional concentration.

At the meso level we are going to look at tasks in the primary process that can be performed independently by different teams. Since the nurses are responsible for both the GRC and the homecare in a neighbourhood team and the therapists are only responsible for the GRC clients there are two different options to design teams. Before we describe the two team options we start describing which tasks are dedicated to the therapists and which tasks are dedicated to the nurses at the moment. This makes it easier to describe what tasks remain for each function in each team option (micro level).

Therapists

There are five different therapists and one doctor working in the GRC; a physiotherapist, an occupational therapist, a speech therapist, a psychologist and a specialist in elderly care. The therapists/doctor are each responsible for their own expertise and therapy pathway. The therapists are not mutually dependent on each other and only focus on clients in the GRC. However, they together compile the care plan/treatment procedure for the client. Together they determine which therapies the client needs and determine the plan of action. When they determined this they all start carrying out their own therapy plan.

Nurses

The nurses that carry out daily GRC care and home care. GRC care is still another type of care than home care, although the same employees are able to do both kind of jobs and there are many similarities. The tasks of the nurses will be described from a GRC perspective. The GRC nurse performs the following main tasks (Van der Veen, 2016):

- Assisting the client and the informal caregiver with training aimed at achieving rehabilitation goals.
- Coordinating the care for the client in collaboration with the therapists that guides and treats the client during rehabilitation.

Team options

1. Classical team formation: Multidisciplinary team with classical task division

This design is like the classic design of the GRC teams. A multidisciplinary team. Each team consists of therapists, a doctor and healthcare providers (nurses and caretakers). They compile the care plan of the client during a multidisciplinary consultation. The whole GRC treatment takes place under the responsibility of a specialist geriatric medicine. The therapists in the team are responsible for the therapy the GRC client receives. Each therapist is responsible for its own type of therapy. The healthcare providers are responsible for the general daily life operations (GDL care), the nursing actions and the personal care of the GRC clients and the home care clients in one neighbourhood. Since the amount of therapy the client receives is most likely not enough to assign a separate doctor and therapists per neighbourhood each doctor and therapists is a member of several neighbourhood teams. In each team there is someone responsible for the planning. They can use handy planning software to make this easier.

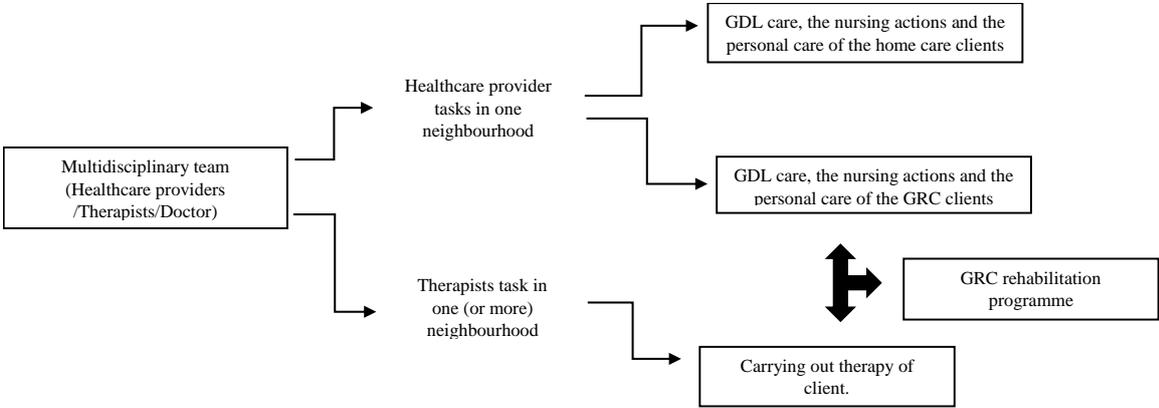


Figure 6. Team option one. Classical team formation: Multidisciplinary team with classical task division

2. Classical team formation, but different division of tasks

Broad healthcare providers supported by therapists

In this team option the team also forms a multidisciplinary team which consists of healthcare providers, a doctor and therapists. The types of therapy that the client receives and the plan of action are determined by means of a multidisciplinary consultation. In this option, the complete GRC treatment also takes place under the responsibility of a specialist geriatric medicine. However, the division of tasks differs according to the therapists and the healthcare providers. Since the healthcare providers play a huge role in the trajectory of GRC of a client it is important that the healthcare providers actively stimulate the forms of therapy that the client receives. They must be trained in such a way that they can partly take over the role of the therapist. Also the therapists are still responsible for their form of therapy the client receives and they still visit the clients to offer the therapy. However, the amount of therapy that a client receives from a therapist can be reduced, since the nurses are also able to train the client. This means that the therapists receive a more supervising and coordinating instead an actual executive role. Therapist have to visit less often clients which means they can support multiple neighbourhood teams. Also in this type of team there is one team member per neighbourhood team responsible for the planning.

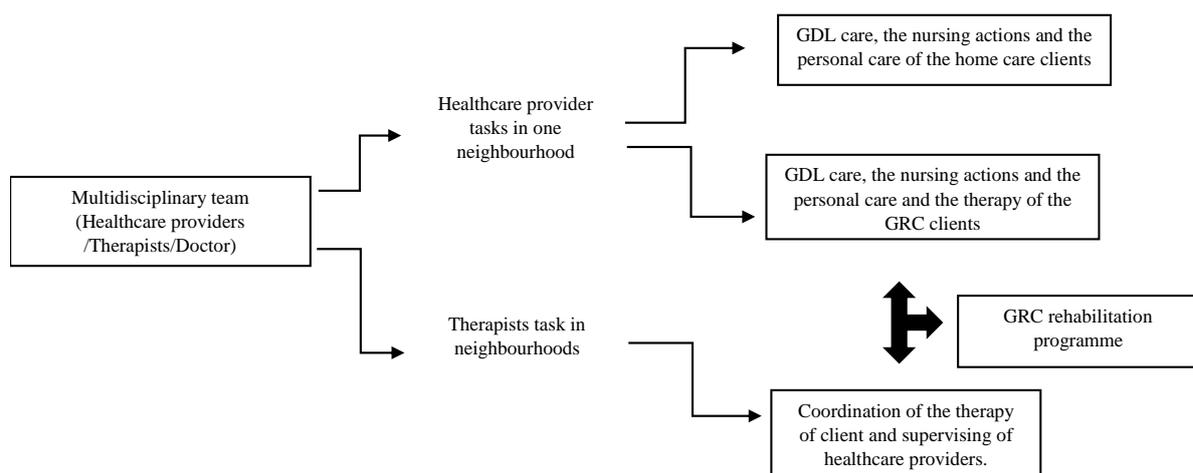


Figure 7. Team option two. Classical team formation, but different division of tasks

Given the two team options each activity has to be performed and coordinated. Per activity will be described how each activity is performed and coordinated in both teams and we will also mention the points that differ between the two team options.

1. Intake

The intake will be carried out by the specialist geriatric medicine. He/she will determine if the client can rehabilitate directly via the GRC, if it is wise to first place the client on an observation bed, or to assign a different indication such as ZZP9 to the client.

2. The preparation of the treatment plan.

The treatment plan will be determined during a multidisciplinary consultation. The specialist geriatric medicine, the therapists and one or more healthcare providers take part of the conversation. A healthcare professional must be present for every neighbourhood where a client is discussed who lives there. They all together determine which therapy is needed for each client and what care will be provided. What therapy and what care will be assigned to the client will be based on the developed care paths.

3. Carrying out rehabilitation program

During the GRC process of a client each therapists and healthcare provider visit the clients at their homes to provide GRC. It is important that the moments the client receives care and the moments the client receives therapy do not overlap. To avoid this fixed time blocks can be used for scheduling therapy. Around these blocks the care can be planned. However advanced planning technology can also ensure that there is no overlap. In that case, fixed blocks may not be necessary. During the rehabilitation program communication between the healthcare professionals and the therapists is very important to stay up to date about the state of the client. Multidisciplinary consultation can be arranged to discuss the progress of the client. In addition, the progress of the rehabilitation process can be reported and viewed by the practitioners.

It could be the case that the therapists are not only responsible for clients in the GRC but also for other clients in the nursing homes and in ambulatory GRC traveling from client to client takes a lot more time. This is something that has to be taken into account while scheduling the therapists. In team option two it is probably less an issue since the therapists have a more supervising role and have to travel less themselves to the clients to offer therapy.

4. Client dismissal

During a multidisciplinary consultation will be determined if the clients can get dismissed. The specialist geriatric medicine will have final responsibility in this. During this multidisciplinary consultation will be determined if the client is able to stay home after stopping GRC and/or after care is needed.

5. After care

It could be necessary to organize after care when the client is dismissed from GRC. After care means that the clients can live at home but still needs to receive care. Since the healthcare providers that offer GRC also are responsible for the home care, after care can be easily set up. The same healthcare providers can visit the client to provide care, but now to provide home care instead of GRC.

To realize what ambulatory GRC means for clients, therapists and healthcare providers, we will look at the situation from an inverse social perspective. This means that we will describe Ambulatory GRC from the point of view of the client, the therapists and the healthcare providers.

Clients' point of view

Providing ambulatory GRC means that the clients can live at their own home, in their own familiar environment during the rehabilitation process. The client performs the practice sessions in his own environment which benefits the ability to function independently again in its own environment. Besides the client gets more stimulated to do things at their own from the beginning since there are not always healthcare professionals available. When providing ambulatory GRC the clients are less in contact with fellow sufferers. This can be experienced as a downside for some clients, since they find it stimulating to talk to fellow sufferers. Group sessions can be organized for them that take place once in a while.

Therapists' point of view

When providing ambulatory GRC the therapists do not work from one central location. They have to travel to each GRC client. Therefore, it takes a lot more time for them to provide the therapy, especially when they have to travel between several neighbourhoods. In team option two, where the therapists have a more coordinating and supervising role travel time takes less time since they visit the clients less themselves. However, the coordinating and supervising role requires some new skills and another way of working. In any case, therapists will expect a new way of working when implementing Ambulatory GRC.

Healthcare providers' point of view

The healthcare providers of the Home Care department and the GRC department will be merged. This requires to perform different tasks for the healthcare providers of both departments. They are both responsible for a broad client group. The healthcare providers from the GRC department have to travel to their clients now instead of working from one central location. The healthcare providers from the home care department are already used to traveling to their clients to provide care. Besides they have to keep in mind the difference between the home care clients and the GRC clients. In the case of the home care clients a more caring role must be assumed. However, while providing care to GRC clients the healthcare providers have to create a rehabilitation climate in which they stimulate the client to do more themselves.

As described all the actions should be performed against the functional requirements. To ensure order flexibility it is important that each team has enough personnel so that they are able to respond flexibly to new demand. Ofcourse there is a limit with regard to the ability to handle new care questions. The organization must determine when they are satisfied with the number of clients that they can handle at the same time.

To obtain low levels of absenteeism and low levels of turnover it is important that all the healthcare professionals have the opportunity to be involved. In both teams every healthcare professional fulfils its own role during the rehabilitation programme. Concerning the opportunities to learn and develop the healthcare professionals are more challenged in team option two since they are also responsible for the therapy. However, in both the options the healthcare professionals are responsible for the homecare and the GRC, something that is new. This ensures that the care they have to provide becomes more versatile. This stimulates the development and learning opportunities of the healthcare professionals.

In both team options there all the team members have shared responsibilities. However, in team option two the healthcare professionals have more responsibilities towards the therapy the client receives than in option one. The participation in communication is in both team options equally important. The multidisciplinary team must make sure they always communicate with each other mutually, since the care plan is constituted during multidisciplinary consultations.

In both team options the level of differentiation of operational transformations is low, since the planning is done by the teams themselves. This makes that the operational tasks of the teams contain make, prepare and support subtransformations.

However, the level specialization of operational transformations differs per team option. In team option one, the classical design of the team, the level of specialization is higher than in team option two. In team option one the therapists are only responsible for carrying out the therapy to the client. The nurses have to stimulate that they practice during the care they provide but they do not explicitly take over providing therapy. In team option number two it is also a task of the nurse to provide therapy to the client. Besides the therapists themselves they provide a large part of the therapy to the client. This ensures a lower level of specialization of operational transformation.

It is important to notice the functional concentration of the therapists. In both teams they are responsible for the therapy in several neighbourhoods and it could be possible that the therapists are also responsible for the therapy in the nursing homes. This increases the level of functional concentration. In team option two is this less a problem than in option one, since in option two also the nurses can partly take over the therapy. When option one is implemented it is important to hire more of the same therapists when the demand of ambulatory GRC increases.

Conclusive we can state that team option two is in many ways more beneficial than team option one. The functional requirements are better realized in team option two, since the healthcare professionals have more responsibility and this option stimulates development and learning opportunities better. Also looking at the parameters, team option two ensures lower level parameters since the healthcare providers can take over a part of the therapy. It will also reduce costs to make healthcare professionals partly responsible for the therapy instead of just therapists.

7.2.3 Control structure

Ideas from focus group

The therapists and the nurses are both responsible for all the care-related issues. They determine what kind of therapy a client receives and how many hours a week. The communication between the therapists and the nurses is very important to guarantee good care. It's good to start working with a casemanager. Someone who has an overview of what must happen during the start-up phase of ambulatory GRC. A person who can connect all the parties involved and is fully up to date of what the developments are in the ambulatory GRC.

Redesign from Business administration point of view

From Micro level to Meso level to Macro level

In both team options good understanding of the progress of the client is important to improve the quality of care for each client. Therefore, in both cases, it is important to determine one team member, who is in control of the care a particular client receives. This team member is the client's point of contact and the link between the all the involved parties. Best choice is to give a nurse this task, since they are seeing the client the most.

Also the quality of the care is a factor the teams are responsible for. The care paths, mentioned in the results of the scenario panning as 'certain' is a way to maintain quality. The team members of the multidisciplinary team can be held responsible to create these care paths and keep them up to date, since they have close contact with the clients. Regarding quality standards the nursing team has to strive to reduce care for a client. The given care must be justified by means of a prepared care plan or must be indicated in the care path.

Since GRC is a developing area and Ambulatory GRC is still undeveloped it is important to work with a casemanager. A director that connects all the parties that are involved by offering GRC. Especially at the start of the ambulatory GRC clients have a lot of questions, but things can also be unclear for employees. Besides, when you offer GRC at home there are a lot of external parties that the organizations has to cooperate with. The casemanager needs to have an overview of all parties and has to connect them. This also improves the strategic changes that have to be made. The strategic decisions are made on macro level. This is done by the management of the GRC. However, all the strategic decisions will be made in close operation with the employees that perform the care given in the GRC. This to ensure that the link between the strategic decisions and the execution are close to each other and do not work against each other.

To ensure control over order realization it is important to know when there is room to include a new GRC client in a neighbourhood team and to make sure the quality of the care they deliver is steady and good. In order to estimate more easily when current clients have completed rehabilitation the organization has to work with extensive care paths. These care paths also ensure more control of quality since they know better which treatments to apply to each client.

Looking at the parameters we have to mention that the level of separation between the operational and regulatory transformation differs. The regulatory tasks to perform the operational tasks are partly devoted to the teams and not separated from the operational structure. The care related issues are directly coupled to the teams, the management of the teams is coupled directly to de operational tasks and one case manager coupled to the GRC keeps the overview. However, other regulations such as design, some operational regulations and strategic regulations are not directly coupled to operational transformations, which causes that this parameter has quite a high value. When both structures work closely together and ensure good communication, this separation can be beneficial. The employees that perform the operational task do only have to focus on the GRC care. The level of differentiation of regulatory transformations into aspects is low. The three forms of regulation: strategic regulation; regulation by design, and operational regulation are all performed by the board. They determine their decisions in close cooperation with the teams that carry out the tasks. The level of differentiation of regulatory transformations intro parts is also quite low. Monitoring and assessing the regulatory transformations is done by the board of the GRC. However, the acting part is performed by the teams that carry out the care. Contrary the level of specialization of regulatory transformations is quite high. Although everything is determined in cooperation with every board member there are many regulatory sub transformations. Quality, efficiency and personnel are all separated tasks.

7.3 Human Resources Management

In this section the goal is to explain the human resource management which is necessary to implement Ambulatory GRC in the organization. The focus of this Human resource management section is on the merging of the home care department and the nursing department. This merger takes place in both team options and requires a new approach in de the field of human resource management. The two team options given in the redesign of the production structure differ on the division of other tasks, but these were not discussed during the focus group. Therefore, the requirements in the field of HR for these different divisions of tasks will not be covered in this section.

In theory several HR instruments are described. However, in order to In order to bring together the GRC department and the home care department within the organization, we only use two particular HR-instruments. Recruitment and selection during the inflow stage and Education and training during the Flow stage. We will first start by describing what is necessary with regard to knowledge, skills and

motivation. At the end of the section we will give an overview of how the necessary HR instruments will be used.

When realizing the ambulatory GRC the focus of the human resource management will be on the nursing team. The team of therapists does not change as regards the type of employees or does not request other knowledge, skills or motivation. Since the nursing team consists of nurses from the clinical GRC department and nurses from the home care department some investments have to be made to get these two groups at the same level. At the start of ambulatory GRC retraining or courses might be necessary for the employees that already work for the organization. In the long term in the recruitment period can be selected on particular knowledge, skills and motivation. In the end, in the organizations a function in the as nurse at the home care means also a job as GRC nurse and vice versa.

Knowledge

A certain expertise is requested when performing GRC care. The GRZ nurse applies knowledge about syndromes and the course of rehabilitation processes in the daily care of the client. The knowledge of the nurses coming from the home care department does not differ very much from the medical knowledge the nurses have that already worked on the GRC department. This means that the investment with regard to extra training to improve medical knowledge is likely to be unnecessary. However, some nurses will have to refresh the memory to be able to perform certain actions.

Skills

There are several skills a GRC nurse has to have in order to deliver successful GRC care. In this paragraph we list the skills the nurses have to have and the result that comes along when the employee uses this skill, based on early research. And we list the skills *Attent Zorg* likes a nurse to have, since these skills matches the culture of the organization. There is some overlap between these skills.

Research based skills and the result achieved by using these skills:

- **Motivation:** The GRC nurse connects with the client and encourages him or her to work on rehabilitation goals. The rehabilitation goals of the client are the mean goal and the client is facilitated as much as possible to reach this goal.
- **Alertness & flexibility:** GRC nurses observe the development and signals in time that the rehabilitation does not go according to plan. When the client reacts differently than expected on the rehabilitation process, this is noticed in time and the rehabilitation programme can be changed.
- **Communication:** The GRZ carer makes contact with the client and aligns the communication goals to the experience and expertise of the client. For the client it is clear how the rehabilitation is going to happen and he or she feels understood.
- **Professionalism:** In consultation with the client, caregivers and practitioners, the GRZ carer makes considerations and choices regarding the care that the client needs. The client experiences that care is provided by skilled staff and knows where he stands.
- **Coordinate:** The GRC nurse align the changes in care for the client with the colleagues in the multidisciplinary team and the nursing team.
- **Hospitality:** The GRC nurse welcomes the client and shows them that they get support for the goals they set themselves. The client feels welcome and becomes stimulated to rehabilitate.

Besides these research-based skills, the employees have to fit in the culture of the organization itself. Therefore, the organization asks their employees to be: independent, enterprising, flexible, reflective, pro-active and positive critical. They have the role of coach instead of carer, since they have to stimulate

the client to improve his/her condition. The requirements of Attent Zorg do not contradict the skills that are formulated in the research. They fit with the research based skills and complement each other.

Motivation

The motivation is an important aspect when selecting GRC personnel. They need to have the intrinsic motivation to improve the functioning of the client. This is also in line with the vision that is requested a employee to have according to research. *A GRC nurse works according to the vision that the rehabilitation of a large part exists of self-working of the client. This ensures that the client experiences an unambiguous approach of the employees who accompany him in the rehabilitation and is constantly aware of his own responsibility of the rehabilitation process.* We do not expect it to be difficult to find this motivation since the combination of GRC and home care provides more variation and extra challenge in the job. Thereby there is some extrinsic motivation to fulfil as well home care as GRC care, since it makes it more easy to reach a certain number of working hours per week in fewer days. Given this information in the table 14 shows the necessary HR instruments and how they can be used.

Table 14
HR instruments and how they can be used

HR INSTRUMENTS USED	WHAT THE HR INSTRUMENTS ARE USED FOR
INFLOW: RECRUITMENT & SELECTION	Select new employees on the basis of: <ul style="list-style-type: none"> - Knowledge about medical issues and performing actions in GRC & homecare - The skills: Motivation, Alertness & flexibility, Communication, Professionalism, Coordinate, Hospitality. - Motivation to improve the functioning of the client.
FLOW: EDUCATION & TRAINING	Personnel that already works in the GRC department or the homecare department can receive education when they lack knowledge to do each others job and can follow a training to develop the right skills in order to perform ambulatory GRC.

7.4 General findings

In this part we would like to mention the general findings that came up during the research. These are unexplored factors that require further investigation before they can be regulated, or particular tasks can be included in the structure to deal with these factors.

First of all, a thing that needs to be discussed is the medical responsibility of the client. From a legal perspective the general practitioner is responsible for the client when they are at home. This means that when ambulatory GRC is implemented the GP gets more responsibility and extra tasks. It may be that there is no support for this, from the GP. In cooperation with the GP A Specialist Elderly care (SE) can be consulted, become co-practitioner, or even get the full responsibility. Anyway, close cooperation with the GP is necessary to realize ambulatory GRC. However, there are already two arguments for the SE to play a major role treatment process: SE, is GRC specific more competent than a GP and from legal perspective of GRC, the client has a right to be treated by a SE.

The second thing that needs to be discussed is medication responsibility. There are several ways to ensure the clients receives the right medicine. However, it is important to determine who is responsible for the prescription of the medicine and who delivers the medication. It is most likely to maintain the process that is already used in the home care department.

Thirdly, a thing that has to be discussed is the home automation (domotica) that plays a role when vulnerable clients live at home. There needs to be determined what types of home automation need to be used and during the first pilot group a constant evaluation is needed if these resources are sufficient enough. This can also play a role in the subject of medication safety.

Another important factor that has to be taken into account is the informal caregiver (mantelzorger). In order to prevent overburdening of the immediate environment and informal caregiver, there must be a fixed point of contact and it has to be clear who this is.

Also it is important to realize that ambulatory GRC might not be possible for every client. Therefore, it is necessary to create crisisbeds. These beds are free for people who really can not stay at home. To optimize the process of determining if someone is able to go home, the observation beds described in the certainties of part 1 can be used. Also the indication ZZP9 can be a handy tool to cover yourself.

And last but not least, the financing possibilities have to be determined. This has to be examined and determined in collaboration with the insurance company.

7.5 Results of reflection workshop

During the reflection workshop we reflected with the GRC staff on the Redesign from Business administration point of view. The discussion was especially about the structure part of the redesign. The most important discussion points/remarks will be described and their effect on the redesign will be explained.

First of all, not only the nursing team is responsible for different types of care (GRC and Home care) also the therapists are responsible for different types of care. The Law long-term care (WLZ) and the GRC. However, a given set of hours per week to work in GRC are dedicated to the therapists. In the production structure this comment is taken into account when evaluating the functional concentration of the therapists and how this is affected when they have to travel to carry out the therapy in the GRC.

Secondly at this moment in the GRC the nurses and the team of therapists are seen as one team; the multidisciplinary team. They work together as one team to the final goal of the client. The members of this team strive to work more closely together and like to see that in the future every therapist and nurse working in the GRC can take over parts of each others disciplines. This means that also the therapists take care of the nursing actions. In the future they want to become closer. The question is if this is possible when home care is also the responsibility of healthcare providers. This discussion point was very important and has led to the creation of team option 2 in the redesign.

Further the nursing team and the team of therapists are dependent of each other looking at the planning. Also the therapists are mutual dependent on each other according to the planning. In the future agendas of employees will be coupled to the agenda of the clients, which makes planning easier. However, planning is still too much work for the teams to do it by themselves which makes that planners are still necessary. Also fixed periods for therapy and other care are a good starting point to realize the planning. Although some clients need care outside the fixed periods. The fixed periods for therapy and other care are described in the explanation of the tasks. With an eye on the value level of the parameters it has been decided to let the teams make their own planning. When in practice it takes too much time the decision can be made to do this otherwise.

Chapter 8 - Conclusion & reflection

In this chapter, a concluding and summarizing answer will be given to the two main questions pertaining to the two different parts of this research. This chapter is divided into two sections. In section 8.1 the conclusion is given by answering the main questions. In section 8.2 we reflect on the research and outcomes and the theoretical and practical implications are discussed.

8.1 Conclusion

This research consisted of two parts; the strategic analysis and the infrastructural redesign. The aim of the first part of this research was to make a strategic external analysis to examine what the developments are in the GRC. Based on these outcomes different strategic scenarios are formulated. One strategic scenario was selected by the organization and formed the basis of part two of this research; the infrastructural redesign.

In part two of this research an infrastructural redesign was created in the area of structure and HR. During focus groups we investigated which infrastructural conditions the organization has to comply to in order to successfully implement the selected scenario. Based on these outcomes a design of the organizational structure was developed and the requirements regarding human resource management were determined.

The main questions devoted to these two parts were:

Main questions associated to part 1:

*What strategic scenarios can be developed based on the strategic analysis and which scenario fits
Attent Zorg en Behandeling best?*

Main questions associated to part 2:

*What is the required organizational structure and human resource management and what design
can be developed in order to successfully implement the strategic decision?*

This research is no theoretically focussed research but applied research. The research is part of an intervention. The aim of this research was to provide an answer on the two questions by performing a theoretical exploration, performing empirical research and performing intervention methods.

Answer to part 1

In part one of this research the theoretical exploration gave insight in how scenarios could be developed according to theory. In this research the TAIDA method is used to develop scenarios. The TAIDA method also formed the basis of the methodology section of part 1 and included intervention-oriented methods. Secondly the theoretical exploration gave insight in the definition of a strategic analysis and the concepts that are necessary to perform an external analysis. The goal of a strategic analysis is to discover how the environment of the organization develops and how the organization should adapt to these developments in the future. During the theoretical exploration several models are compared that contains concepts that allow to look at the external environment. However, none of the models provided all the concepts that were necessary to get a complete picture of the environment and contribute to the purpose of scenario planning. Therefore, the model of Porter (1995) is used as basis model and concepts of the business model canvas by Osterwalder and Pigneur (2010) have been added. The dimensions that were ultimately used are: *rivalry among competitors in the industry, new entrants, suppliers, buyers, substitutes, partners in network, key resources and the distribution channel*. In order to use the dimensions in this research all the definitions of the dimensions are formulated against the background of the case in this research.

The empirical research in part one is based on the theoretical exploration. In order to create the scenarios the TAIDA method is applied during the empirical research. First start with Tracking by doing the interviews. Based on the chosen dimensions in the theoretical section the sources to interview were selected. All sources together covered all selected dimensions. Based on the second step of the TAIDA method the analysis, the interviews and focus groups were analysed. Based on the interviews with the sources and the focus group the situation of the GRC in the area of *Attent Zorg* is determined. A division can be made within the outcomes between certainties, things the organization definitely should do according to the situation, and uncertainties which became the scenarios. The certainties are: *Care Paths, Indication ZPP9 and observation beds*. The uncertainties/scenarios are: *Crisisbeds & Ambulatory GRC*.

After execution of the last two steps of the TAIDA method: Imaging and Decision the organizations choose to select the scenario *Ambulatory GRC* to implement.

Ambulatory GRC means that the clients can stay home while receiving GRC. The clients receive therapy and care at home. For the therapists and other care givers this means that they have to travel to their clients to carry out GRC.

Answer to part 2

In part two of this research the theoretical exploration gave insight in how organizational structures and human resource management should be designed. In order to get theoretical insights in how organizational structures should be designed design rules and design precedence rules are combined. Concerning redesigning the human resource management we made use of theory about the parameters that determine what a suitable employee has to meet; the right knowledge, skills and motivation. In addition, we also described the methods that are used to design human resource measures. These measures concern measures that can be applied in the three stages of the HR-flow: Inflow, Flow and Outflow. By making use of intervention methods is examined how these design principles can be applied to the organization, in order to implement Ambulatory GRC. A focus group was organized to discuss the subjects, necessary to redesign a new structure and human resource management. On the basis of the results of the focus group and the theoretical insights a redesign from a business point of view is created (section 7.2) and a plan concerning Human resource management (section 7.3).

In the redesign of the production structure two team options are formulated. Team option 1: The classical team formation: Multidisciplinary team with classical task division and team option 2: The classical team formation, but with different division of tasks. Broad healthcare providers supported by therapists. In both team options five main action can be distinguished: Intake, preparation of treatment plan, carrying out rehabilitation programme, client dismissal and after care. The two team options differ in the division of the responsibility of the therapy. In team option 1 only the therapists are responsible for the therapy. In team option 2 the therapists have a more coordinating and supervising role and the healthcare providers carry out a large part of the therapy to the client. Looking at the realization of the functional requirements and the value of the parameters team option 2 is the best option to select.

As regards the control structure it is important to determine one healthcare provider who is in control of the care a particular client receives. In addition, it is important to work with a case manager, especially at the start of ambulatory GRC. This case manager has an overview of all the parties involved when offering ambulatory GRC.

As to the human resource management the focus is on the merging of the home care department and the GRC department. During the inflow stage new healthcare providers have to be selected on the basis of the right knowledge of both homecare and GRC. The skills formulated the new healthcare providers should have are: Motivation, Alertness & flexibility, Communication, Professionalism, Coordinate, Hospitality. In addition, they should have the motivation to improve the functioning of the client. During

the flow stage of HR the healthcare providers that are already working in the GRC or Home care can receive education to obtain the necessary knowledge and can follow a training to develop the requested skills.

8.2 Reflection

In this section, a reflection is given on the results, we look at the theoretical implications and practical implications of the research. This section will start with a reflection on the quality of the research and the limitations. After that, we go into the theoretical implications and finish with the practical implications.

8.2.1 Quality of the research

In order to evaluate the quality of the research the four aspects of Lincoln and Guba (1985) are used (Eriksson & Kovalainen, 2016). The four aspects they propose are: dependability, transferability, credibility and confirmability.

Dependability is concerned is with the responsibility for offering information to the reader, that the process of research has been logical, traceable and documented (Eriksson & Kovalainen, 2016). Dependability in this research is achieved by giving a comprehensive explanation of the methodological choices. Both parts of the research contain extensive methodological chapters.

Transferability. The idea of transferability is not about generalization, but more of whether some sort of similarity could be found in other research contexts and how results would apply in other context (Eriksson & Kovalainen, 2016). Already in the first chapter of the research it is made clear that the research is focused on the development of geriatric rehabilitation care which takes place in a healthcare environment. This is made clear in every chapter and outcomes are also focused on this field. This makes it clear in which situations the outcomes are applicable.

Credibility refers to a good reconstruction of the construction of the realities of the sources. This means that the researcher has to be familiar with the topic. The question that has to be asked is: Can any other researcher, on the basis of your materials, come relatively close to your interpretations or agree with your claims (Eriksson & Kovalainen, 2016)? In this research the credibility is achieved by carefully selecting the sources in cooperation with the organization in this research. They were able to mention which sources are important to speak with to get a clear picture of the development in the environment of GRC. This ensures all the most important parties to speak with are included in the research. Every source is questioned by all dimensions, however some sources were especially selected to cover particular dimensions and were more aware of the developments in this particular dimension. Therefore, their opinion on these dimensions have received special attention.

Conformability is about linking findings and interpretations to the data in ways that can be easily understood by others (Eriksson & Kovalainen, 2016). To reach conformability in this research the questionnaire of the interviews is attached. In addition, all the interviews and the focus groups are transcribed and attached to the document. In a separate table the outcomes of the interviews are processed per source and per dimension. The outcomes of each interview that led to the final results are marked in colours that refer to the results to which they belong.

8.2.2 Limitations

Despite the focus on the punctuality and quality in making choices during the process of the research, there are some limitations of this research. Therefore, this section will shed light on the limitations of the research.

Firstly, the lack of time was a factor that influenced the end result. In the first part of the research all sources made time in their busy schedule to cooperate with this research. Due to lack of time it was not possible to schedule an appointment again. Therefore, the first part of the research is not an iterative process. It could be beneficial to discuss some findings again with some sources. It also benefited the investigation if certain topics could be discussed in more detail in a second appointment. In the second part of the research lack of time was also a limitation. It would have been good to organize several focus groups in which the structure and the human resource would have been discussed. This had produced probable qualitative improvements in the design of the infrastructural elements.

Secondly, in order to find out what the clients consider as important when they receive GRC a focus group was organized. However, an even clearer and more generalizable picture had been obtained if we had set out a quantitative study among a larger group of (potential) clients.

Third, the demographics of the sources form a limitation. It was most valuable to speak with sources that operate in the direct area of the organization and know a lot about the GRC. However, some parties that were important to speak with did not operate in the direct area of the organization. They did know a lot of the GRC but not about the area the organization operates in.

8.2.3 Practical implications

As for practical implications this research contributes to the start of ambulatory GRC within a healthcare organization. Possible design options to start ambulatory GRC are given and the human resource management for ambulatory GRC are described. Important to mention that these options are especially possible for healthcare organization that deliver GRC and home care. However, in section 7.4 (general findings) are a lot of elements described that are not clear yet and which are important to discover before actually starting GRC. Project groups must be established that focus on these elements and discover how to handle this.

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Appendix 1 - Questionnaire

Rivalry among competitors.

(Other healthcare institutions in the region of the organization that offer GRC as well)

1. Door welke partijen wordt de GRZ voornamelijk aangeboden?
2. Zijn er partijen die de GRZ domineren in de omgeving van Arnhem?
3. Op welke manieren kiezen organisaties ervoor om de GRZ in te richten in hun organisatie?
4. Zijn bepaalde manieren van organiseren succesvoller gebleken dan andere?
5. Hebben cliënten of partijen die GRZ inschakelen voorkeuren voor bepaalde zorg instellingen die GRZ bieden en waar komt dat door?

New entrants

(Other parties that enter the market to offer GRC)

6. Merk je dat er nieuwe ontwikkelingen zijn op het gebied van aanbieders in GRZ en welke ontwikkelingen zijn dit?

Powerful suppliers

(Organizations/persons in the network that are crucial to deliver GRC and can take more value to themselves by maintaining higher prices)

7. Waar baseren zorgverzekeraars hun keus op wie ze wel of geen GRZ laten inkopen?
8. Wat levert een cliënt gemiddeld op binnen de GRZ en wat kost een cliënt gemiddeld?
9. Wat is de juridische organisatie structuur waar binnen zijn GRZ vaak wordt uitgevoerd?

The power of buyers

(Persons that receive or are going to receive GRC and can forcing down the prices, demanding better quality of better service.)

10. Wat zijn factoren die cliënten belangrijk vinden bij het kiezen voor een organisatie als ze GRZ nodig hebben?
11. Wat zijn factoren die cliënten in het specifiek als negatief ervaren wanneer ze GRZ hebben ontvangen?
12. Geloof je meer in centraliseren of decentraliseren van de GRZ?
13. Denkt u dat het beter is om de GRZ uit te voeren op een afdeling waar allemaal dezelfde soort patiënten zijn of allemaal verschillende soorten patiënten?
14. Denkt u dat een kleine instelling met alleen GRZ fijner is of een grotere instelling? (Klein betekent wel dat er geen restaurant aanwezig zal zijn en ook andere faciliteiten minder)
15. Op welke manier bent / wordt u geïnformeerd over het aanbod van GRZ?
16. Op welke manier zou u geïnformeerd willen worden over het aanbod van GRZ?

The threat of substitutes

(A substitute that performs the same or a similar function as the GRC, by a different means)

17. Zijn er andere vormen van zorg die ingezet kunnen worden als vervanging van GRZ?

Partner networks

(External persons/organizations the organization cooperates with that perform activities necessary to deliver GRC)

18. Welke partijen zijn betrokken wanneer GRZ wordt ingezet?
19. Zijn er organisaties of voorzieningen / functies die onmisbaar zijn wanneer GRZ wordt gegeven?
20. Zie je vaak samenwerkingsverbanden tussen organisaties als het gaat om het aanbieden van GRZ?

Key resources

(Assets required to deliver GRC)

21. Wat zijn redenen voor verpleegkundige om te kiezen voor het werken in de GRZ?

22. Wat maakt de GRZ aantrekkelijk voor het personeel om in te werken?
23. Wat maakt de GRZ onaantrekkelijk voor het personeel om in te werken?

Distribution Channels

(Channels concerning the distribution of the GRC)

24. Als andere partijen, zoals ziekenhuizen, een organisatie moeten benaderen voor GRZ, waar baseren de keus dan op?
25. Zijn er factoren die een belangrijke rol spelen bij het kiezen voor een bepaalde organisatie?
26. Hoe beïnvloed de inkoop voorwaarden van het ziekenhuis de uitstroom naar GRZ?

Appendix 2 - Results Scenarios

Appendix 3 - Results Focus group

Appendix 4 - Transcript interviews and focus group.

