Healthcare collaborations
A qualitative study about the best practices in a collaboration between a hospital and a home care organization
Abstract

Even though previous research has defined the needed attributes, little is known about the required practices to achieve and sustain successful healthcare collaboration. This study aims to fill this gap by studying this specific collaboration using the strategy-as-practice perspective. Using this perspective, three expected best practices that are implied by the presence of multiple indicators can be elaborated. Two other main factors can be developed as well. The research uses a qualitative case study design embracing the analysis of documents and a set of interviews among project leaders, geriatrics and management in home care organizations as representatives (N=12). The analysis shows the expected best practices and factors indeed can be seen as best practices and main factors for a successful healthcare collaboration in the light of the strategy-as-practice concept. The most important aspects of a successful healthcare collaboration turn out to be: collective action, interaction, governance, interdependency and trust.

Keywords: healthcare collaboration, Transmural Care Bridge (TCB), strategy-as-practice, best practices, collective action, interaction, governance, trust and interdependency.
Preface

Six years ago, I started the double degree program in Law and Business Administration at the Radboud University Nijmegen. I am very happy that I took this opportunity, because it provided me a lot of different insights over the years. In my fifth year of University, I choose the master Strategic Management in combination with the Master Business Law. The analytical and theoretical knowledge I acquired during these masters will be beneficial for the rest of my career.

This thesis will be the first step to my working career. The writing of it was a period of intense learning in which I developed my academic skills. I look back on a process in which I developed myself as a person and as researcher.

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Kind regards,

Anke Goossens

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1. Introduction

In this chapter, the research question will be explained. Also, a research background of the research question will be given in order to understand the theoretical and practical relevance of this study. Finally, the thesis structure will be outlined.

1.1 Research background

Imagine you are hospitalized, the most important thing you want is to get better and go home as soon as possible. This is easy, when you can take care of yourself. However, for vulnerable elderly, a hospitalization is a radical event that mostly leads to function loss. Most elderly go home in a state worse than they were before their hospitalization (Buurman et al., 2016). There is a big risk of complications for elderly. They mostly have problems moving, taking care of themselves and remembering things after their hospitalization. Elderly depend on home care after their hospitalization. This would mean vulnerable elderly are not allowed to go home when no aftercare is available. A guided transition from the second to the first line of healthcare is necessary. The first line of healthcare includes the care that is available for everyone, like home care. The second line involves care that requires a reference, like hospital care. This transition from the second to the first line is mostly insufficiently orientated in The Netherlands. The problems patients are experiencing are opposite medicine advice, a missing discharge planning, inadequate follow-up and difficult discharge instructions (Buurman et al., 2016). These problems are crucial for vulnerable elderly that cannot take care of themselves.

It was necessary to develop new clinical practices based on a collaboration. A collaboration with potential partners can help to reach the goals of both parties, to achieve advantages and to reduce disadvantages (Child et al., 2005; D’Amour et al., 2008; Henneman et al., 1995). In other words, there was need for a new collaboration between hospitals and home care organizations. It was necessary to support the transition of vulnerable elderly together. This is the reason why a new collaboration was created, named ‘De Transmurale Zorgbrug’ or in English: ‘Transmural Care Bridge’ (after: TCB) (Buurman et al., 2016). The TCB is based on the ‘transitional care concept’, that represents the situation in which a patient leaves one care setting and moves to another one. It ensures the safe transitions between those different care settings (Buurman et al., 2016). A new element in the TCB is the proactive way to search for vulnerable elderly. This happens with the use of multiple screening techniques, that focuses on function loss, illness and geriatric conditions of elderly, e.g. the comprehensive geriatric assessment. When the requirements of those screenings are present, a person comes
eligible for the process of the TCB. The TCB combines proactive hospital care for vulnerable elderly with a transmural intervention guided by a home caregiver, who guides the patient from hospital to their home situation and ensures systematic aftercare. It contains a bridge between the second and the first line in healthcare. It consists of two areas: the hospital and a patient’s home. **Figure 1**, included in **Appendix 1**, shows the process of this project.

The TCB focuses on the recovery of vulnerable elderly at home after their hospitalization (Buurman et al., 2016). It is a combination of treatment, support and de-escalation, focusing on restoring the patient’s own control (Buurman et al., 2016). It is a close collaboration between a hospital and a home care organization, with the goal to improve the quality of healthcare for vulnerable elderly and decrease the mortality rate. Due to this collaboration, hospital stays became shorter, the mortality rate is decreasing and the quality of healthcare is increased after hospitalization (Buurman et al., 2016). This means the collaboration is fulfilling its purpose.

### 1.2 Central question

The TCB shows there is already an existing collaboration between hospitals and home care organizations. The relationship between hospitals and home care organizations in a healthcare collaboration is important for the proper functioning of this collaboration. The TCB has shown this relationship was successful. This is why this study will take the TCB as an example to study a successful healthcare collaboration in general. By examining the TCB, the succeeding and failing factors can be studied. The best practices for the TCB that helped to achieve and sustain the successful healthcare collaboration can be studied. This will be examined on the basis of the strategy-as-practice concept, that implies the doing of strategy. These best practices can be applied to the process of a healthcare collaboration between hospitals and home care organizations in general. The difficulty of the TCB is that multiple parties are involved, namely: hospitals, home care organizations, general practitioners and health insurance organizations. This study will only focus on the relationship between a hospital and a home care organization.

Following from the above, the following question has been formed:

"**What are the best practices for a successful healthcare collaboration between a hospital and a home care organization?**"
This main question leads to the following sub questions:

**What is a healthcare collaboration?**

A healthcare collaboration is a complex process that brings healthcare organizations together. It is defined as the joint communicating and decision-making process with the expressed goal of satisfying the patient’s wellness and illness needs while respecting the unique qualities and abilities of each professional. Furthermore, it is an interdisciplinary collaboration. It is through an interdisciplinary collaboration that the different roles interact and strive for the improvement of the quality of healthcare. This concept will be further explained and linked to the strategy-as-practice concept.

**What is the strategy-as-practice concept?**

This strategy approach is focused on what actually takes place in the activities that deal with the thinking and doing of strategy. It focuses on what the doing of strategy contains and how it forms strategy. In other words, it explains the practices that creates a strategy process. The strategy-as-practice concept relies on organizational and other practices that can both affect the process as well the outcome of strategies. This concept will be explained and used to elaborate the best practices for a successful healthcare collaboration.

**What are the best practices for a successful healthcare collaboration?**

Practices can be studied to understand how strategic activity is constructed. The concept helps to understand what practices will lead to a successful healthcare collaboration. It focuses on how the doing of strategy contributes to the organizational performance. This study will research what strategic practices parties have to establish to achieve and sustain a successful healthcare collaboration. These practices can be seen as best practices based on the strategy-as-practice concept. In other words, this study helps to uncover what strategic practices must be done for a successful collaborative performance.

1.3 Theoretical and practical relevance

The goal of this study is to gain more insight in a collaboration between a hospital and a home care organization. Due to the increasing attention and demand for elderly care in society and the success of the TCB, this study takes the transmural care bridge as an example to study a successful healthcare collaboration between a hospital and a home care organization in
A healthcare collaboration between a hospital and a home care organization

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1.4 Thesis structure

In the next chapter, the theoretical background will be discussed. This chapter is divided in four subchapters. First, the concept of a healthcare collaboration will be explained. Second, the strategy-as-practice concept will be set out and it will be clarified how this concept can be used to understand the process of a healthcare collaboration. In the third subchapter, nine propositions have been elaborated based on this concept. The propositions explain the expected best practices, implied by different indicators and other main factors that will help to achieve and sustain a successful healthcare collaboration. This chapter will end with a concluding note.
and the proposed conceptual model. Chapter three will outline the epistemology, ontology and methodology of this study. It will outline which methods are used to collect the data and how the collected data is used to examine the propositions. Furthermore, the used cases will be defined. This chapter ends with an explanation of the analysis of results and the research ethics. The results will be explicated in the fourth chapter based on quotes by respondents. These results will be discussed based on the theoretical framework in chapter five and the propositions will be tested. This study ends with the conclusion, followed by the limitations, implications and recommendations in chapter six.
2. Theoretical background

In this chapter, the theoretical framework will be discussed and used to answer the subquestions. This chapter is divided in four subchapters. First, the concept of a healthcare collaboration will be set out. Second, the strategy-as-practice concept will be explained and it will be clarified how this concept can be used to understand the process of a healthcare collaboration. Hereafter, the expected strategic best practices and other main factors that will help to achieve and sustain a successful healthcare collaboration will be elaborated. This chapter ends with a concluding note and the proposed conceptual model.

2.1 A healthcare collaboration

In this subsection, the concept of a healthcare collaboration will be clarified. It will outline the problems that can occur due to a breakdown in collaboration. Furthermore, it will clarify the need for clinical and strategic practices that will help to achieve and sustain a successful healthcare collaboration.

2.1.1 An interdisciplinary collaboration

A collaboration is regarded the defining feature of alliances, that is the voluntary arrangement between firms involving sharing, exchanging or developing products, technologies or services (Kretschmer & Vanneste, 2017). Collaboration is defined as: "a process in which autonomous actors interact through formal and informal negotiation, jointly creating rules and structures governing their relationships and ways to act or decide on the issues that brought them together" (Thomson & Perry, 2006, p. 23). It is a process that involves mutually beneficial interactions and shared norms. However, a more constructive description of a healthcare collaboration will better assist its process in practice (Petri, 2010). A healthcare collaboration is a complex process that brings healthcare organizations together that are generally from different professional disciplines (D’Amour et al., 2005; Petri, 2010). A healthcare collaboration is an interdisciplinary collaboration (Fewster & Velsor, 2008; Houldin et al., 2004). An interdisciplinary collaboration is defined as the joint communicating and decision-making process with the expressed goal of satisfying the patient’s wellness and illness needs while respecting the unique qualities and abilities of each professional (D’Amour et al., 2005; Henneman et al., 1995; Houldin et al., 2004; Petri, 2010). Furthermore, it is a complex relationship because it is a developing and evolving process (Lindeke & Sieckert, 2005; Petri, 2010). It is an interactive and dynamic process that transforms over times (Child et al., 2005;
D’Amour et al., 2005).

Many collaborations are formed when organizations think they can benefit from their complementarities, like knowledge and expertise, because a collaboration is the act and process that contains the establishment of new value or knowledge (Child et al., 2005; Henneman et al., 1995; Wagner & Boutellier, 2002). Learning is mostly the main motive for entering a collaboration (Doz, 2017). When parties are dedicated to the idea of mutual learning, their relationship will progressively evolve (Child et al., 2005). The Managerial Grid, added in Figure 2, included in Appendix 1, shows a collaborative approach maximizes the outcomes and results for both parties (Child et al., 2005). It will be realized if both partners look out for each other’s interests as well as for their own. An interdisciplinary collaboration is necessary in the healthcare sector to achieve the desired goals and outcomes (Bronstein, 2003). It is through an interdisciplinary collaboration that the different roles interact and strive for the improvement of the quality of healthcare (Wells et al., 1998). An interdisciplinary collaboration causes that parties can learn from each other due to information sharing across multiple disciplines. It can approve a better approach of the problem and the understanding of their common goals and shared interests (Fewster & Velsor, 2008). Healthcare organizations are confronted with the need for an interprofessional collaboration. They need each other, because the outcomes of the successful collaboration are greater than the sum of the individual actions alone (Bronstein, 2003; Houldin et al., 2004; Thomson & Perry, 2006).

Nevertheless an interdisciplinary collaboration is an essential element in healthcare, it is a complex phenomenon and can cause problems (Bronstein, 2003; Gulati et al., 2012; Petri, 2010). Problems can occur due to a breakdown in collaboration (Kretschmer & Vanneste, 2017). Such breakdown can arise by failures in cooperation or in coordination (Gulati et al., 2012; Patru et al., 2015). Cooperation is defined as: "joint pursuit of agreed-on goals in a manner corresponding to a shared understanding about contributions and payoffs" (Gulati et al., 2012, p. 6). It refers to the adjustment of motives explaining why partners are willing to work together. Cooperation is not guaranteed because both partners have their own goals (Kretschmer & Vanneste, 2017). "Alliance partners essentially remain independent economic actors, retain control over their own resource-allocation decisions, have different and possibly conflicting strategic objectives" (Gulati et al., 2012, p. 8). Cooperation is the alignment of interests (Patru et al., 2015).

Coordination is defined as: "the deliberate and orderly alignment or adjustment of partners’ actions to achieve jointly determined goals" (Gulati et al., 2012, p. 12). It refers to the
adjustment of actions so parties know how to work together when they want to do so (Kretschmer & Vanneste, 2017). It is not guaranteed because they don’t know how to work together or they fail to anticipate correctly to the other party in the collaboration. Parties must expose themselves and have to take the other party into account during the process of decision-making. Moreover, problems can arise because of the differences between the objectives of partners and their strategic and cultural differences (Child et al., 2005; Gulati et al., 2012). Coordination is the alignment of actions (Patru et al., 2015).

This means organizing healthcare services requires not only the implementation of structures but also clinical and strategic practices to guide a successful collaboration and to overcome its problems (D’Amour et al., 2008). Previous research has defined and conceptualized the attributes required for a successful healthcare collaboration (Bronstein 2003; Petri, 2010; San Martin-Rodriguez et al. 2005). Bronstein (2003) set out five core components of interdisciplinary collaboration: professional activities, flexibility, interdependency and collective ownership of goals. Petri (2010) defined the attributes: trust, open communication, awareness and acceptance of the responsibilities, roles and skills of the participants. San Martin-Rodriguez et al. (2005) determined the following attributes: trust, communication, the willingness to collaborate and mutual respect. Attributes are the characteristics of the concept (Petri, 2010; Wagner & Boutellier, 2002). They are the identifying elements that have to be present for the concept to occur (Henneman et al., 1995). They make it possible to identify situations and describe the concept in actual activities (Petri, 2010; Wagner & Boutellier, 2002). In contrast to the attributes, little is known about the practices required to achieve and sustain a collaboration between partners (Patru et al., 2015). The strategy-as-practice concept will be used to study these strategic practices. This concept will be explained in the next subchapter.

2.2 Strategy-as-practice

In this subsection, the concept of strategy-as-practice will be set out and it will be clarified how this concept can be used to understand the process of a healthcare collaboration.

2.2.1 The concept

From a strategy-as-practice perspective, strategy is defined as "a situated, socially accomplished activity, while strategizing comprises those actions, interactions and negotiations of multiple actors and the situated best practices that they draw upon in accomplishing that activity" (Jarzabkowski et al., 2007, p. 8). The complication of this broad interpretation is that
it includes all types of activities. It is difficult to resolve which one is not strategic. An approach to deal with this complication is to focus on only those activities that involve strategic practices (Jarzabkowski & Spee, 2009). The strategy-as-practice perspective takes only these activities into account (Jarzabkowski et al., 2007; Jarzabkowski & Spee, 2009; Whittington, 2006). Therefore, an activity is strategic when it is substantial for the strategic directions and outcomes of an organization (Jarzabkowski et al., 2007; Jarzabkowski & Spee, 2009; Vaara & Whittington, 2012).

The outcomes of strategic processes and organizational outcomes depend on the way strategy is created and implemented (Jarzabkowski et al., 2007; Jarzabkowski & Spee, 2009; Patru et al., 2015; Vaara & Whittington, 2012). This means strategy is more than just organizational. It refers to the doing of strategy (Whittington, 1996). The strategy-as-practice concept contains a shift from the core competences to the practical competences of the manager as a strategist (Patru et al., 2015; Whittington, 1996). The concept is an alternative to the individualistic decision-making models in the field of strategic management (Vaara & Whittington, 2012). Practice-based analyses of organizations are becoming more important because of their special capacity to understand how organizational action is enabled and constrained by prevailing organizational and societal practices (Golsorkhi et al., 2010). "Thus strategy-as-practice, while it may not adopt the same approach to firm performance as traditional, economics-based strategy research, can explain organizational level and strategizing process outcomes and hence contribute to our understanding of why and how organizations perform the way they do" (Jarzabkowski & Spee, 2009, p. 26). The concept frames strategy as a social process involved with a variety of organizational actors (Patru et al., 2015). It is concerned with the managerial activity, how strategists strategize and how they act and interact in the strategy-making process (Patru et al., 2015; Whittington, 1996). The concept is more focused on what actually takes place in the activities that deal with the thinking and doing of strategy (Golsorkhi et al., 2010; Patru et al., 2015). Furthermore, it focuses on the doing of strategy and how the practices create the strategy process (Patru et al., 2015; Whittington, 2006).

2.2.2 Core themes

The strategy-as-practice concept contains three core themes: practitioners, praxis and practices (Golsorkhi et al., 2010; Jarzabkowski & Spee, 2009; Vaara & Whittington, 2012; Whittington, 2006). Practices shape the praxis that is done by the practitioners (Jarzabkowski
et al., 2007; Jarzabkowski & Spee, 2009). Practitioners refer to the strategists that make, shape and execute strategies (Golsorkhi et al., 2010). They are the role of the actors involved that ensure the creation of practices (Vaara & Whittington, 2012; Whittington, 1996). They include those that are directly involved by the making of strategy or those that indirectly influence the strategy process (Jarzabkowski & Spee, 2009).

Praxis refer to the actual activities in which strategy is accomplished (Golsorkhi et al., 2010; Jarzabkowski & Spee, 2009). It is the stream of activities in which strategy is achieved (Vaara & Whittington, 2012). It is substantial for the direction and outcome of an organization (Jarzabkowski et al., 2007). “Praxis draws on that interconnection between what people are doing, their interactions, and what is going on in their context in terms of an organizational strategic direction” (Jarzabkowski & Spee, 2009, p. 9). Praxis are all the activities that concern the formulation and implementation of strategy (Whittington, 2006). It is the work required for making and executing strategy (Golsorkhi et al., 2010; Jarzabkowski & Spee, 2009).

Practices are the symbolic, material and social tools through which strategy is done (Jarzabkowski & Spee, 2009; Vaara & Whittington, 2012). Practices refer to shared routines of behaviour that include norms, traditions and procedures for thinking and acting (Whittington, 1996; Whittington, 2006). Practices are used to analyse how strategy-as-practice is constructed and how the practices are used to shape praxis at different levels, because they are multilevel (Jarzabkowski et al., 2007). Practices can be organization-specific, this means they are embodied in the operating procedures, routines and cultures that shape the strategy. Practices can also be extra-organizational, as the routines of the environment or norms set by an industry (Whittington, 2006). It is the behaviour that contains the doing of strategy (Golsorkhi et al., 2010).

These three themes do not necessarily have to be combined (Whittington, 2006). This study will mostly focus on the concept of practices, since it relates to the doing of strategy and it is used to shape the actual activity that is being accomplished. Practices can be studied to understand how strategic activity is constructed (Jarzabkowski et al., 2007; Jarzabkowski & Spee, 2009; Whittington, 2006).

2.2.3 Strategy-as-practice linked to a collaboration

The strategy-as-practice concept relies on organizational and other practices that can affect the process and outcome of strategies (Vaara & Whittington, 2012). The process of a healthcare collaboration can be linked to the strategy-as-practice concept, since this concept
delves deeper into what is actually going on (Jarzabkowski et al., 2007; Jarzabkowski & Spee, 2009; Patru et al., 2015; Vaara & Whittington, 2012; Whittington, 2006). The strategy-as-practice approach can concretize what actually takes place in the healthcare organizations when strategy work is being done (Patru et al., 2015). It focuses on how the doing of strategy contributes to organizational performance (Jarzabkowski & Spee, 2009; Vaara & Whittington, 2012). Even though organizations are helpful in supporting collaborations, they cannot guarantee a collaboration will succeed. It might fail due to failures in cooperation and coordination (Gulati et al., 2012; Patru et al., 2015). Organizing healthcare services requires clinical and strategic practices to achieve and sustain the collaboration and to overcome its problems (D’Amour et al., 2008). The strategy-as-practice concept can help to uncover what strategic practices must be done for a successful collaborative performance. In other words, what the best practices are to help to achieve and sustain a successful healthcare collaboration.

In the next subchapter, the expected strategic best practices and other main factors that will help to achieve and sustain a successful healthcare collaboration will be elaborated based on multiple different theories.

2.3 Practices in a healthcare collaboration

Even though previous research has defined the needed attributes, little is known about the required practices to achieve and sustain successful healthcare collaboration. Attributes are the identifying elements that has to be present for the concept to occur. Practices are the symbolic, material and social tools through which strategy is done. They show how organizations develop their strategy and shape their actual activities. In other words, organizations have to establish these strategic practices to achieve and sustain a successful healthcare collaboration. In this subchapter, these expected strategic best practices and other main factors will be elaborated and explained.

2.3.1 Collective action: common goals, shared interests and mutual benefits

Healthcare organizations are societal systems. In fact, they are groups that want to work together towards a specific collective action, namely a better patient care (D’Amour et al., 2008; Thomson & Perry, 2006). A collective action is the basis for a collaboration (Bryson et al., 2006; D’Amour et al., 2005). The perspective helps to understand the process of a collaboration because a collaboration can be seen as a collective undertaking (Thomson & Perry, 2006). A collective action refers to an action that has been taken together by a group that tries to achieve
a common purpose together (D’Amour et al., 2005; San Martín-Rodríguez et al., 2005; Thomson & Perry, 2006). Purpose is the reason, task, vision or result for the collaboration (Mattessich & Monsey, 1992). This means the involved parties should have common goals, shared interests and mutual benefits in the collaboration (D’Amour et al., 2005; D’Amour et al., 2008; Houldin et al., 2004).

Common goals refer to the existence of the same goals and their appropriation and recognition by the team (D’Amour et al., 2008). Sharing and identifying common goals is essential for a collective undertaking (Bronstein, 2003; Fewster & Velsor, 2008; Gulati et al., 1996; Wells et al., 1998). Parties should be able to acquire and explicitly develop common goals (San Martin-Rodriguez et al., 2005; Wagner & Boutellier, 2002). Shared interests refer to the achievement of shared aims and objectives (Fewster & Velsor, 2008; Houldin et al., 2004). Parties should strive for shared interests rather than their self-interests (Das & Teng, 2000; San Martin-Rodriguez et al., 2005). They should focus on common patient care interests rather than individual intentions (Petri, 2010). Furthermore, benefits refer to the outcome of the collaboration. It is important parties ensure that both parties experience mutual benefits and both parties have something to gain (Bryson et al., 2006; Crosby & Bryson, 2005; Das & Teng, 2000; Thomson & Perry, 2006). This will be accomplished by achieving their common goals and shared interest, due to obtaining higher mutual benefits or reducing their common damage (Thomson & Perry, 2006).

Problems in a collaboration can occur due to failures in cooperation (Gulati et al., 2012; Kretschmer & Vanneste, 2017; Patru et al., 2015). It is the alignment of interests (Patru et al., 2015). Cooperation entails a goal-directed collective action (Gulati et al., 2012). The root causes for failures in cooperation are the presence of self-interests (Gulati et al., 2012; Kretschmer & Vanneste, 2017). Furthermore, when parties only achieve individual goals and benefits, the collaboration is likely to fail given the complexity of its process (Thomson & Perry, 2006). A collaboration brings a change from one situation in which parties act independently to another situation in which they must adjust to one another to obtain mutual benefits or reduce their common damage (Child et al., 2005; Thomson & Perry, 2006). Parties want to work together to provide a better patient care, but at the same time they want to retain their independence and autonomy (D’Amour et al., 2008; Kretschmer & Vanneste, 2017). Parties, in fact, share a dual identity: they want to maintain their own identity and at the same time they are striving towards their collaborative identity. This creates a tension between their collective-interests and their self-interests (Emerson et al., 2011; Thomson & Perry, 2006). To overcome this tension,
partners need to justify their involvement in the collaboration in terms of a contribution to their own aims and should never forget the collaboration is all about the quality of patient care (D’Amour et al., 2008). In a healthcare collaboration, being able to act upon the needs of patients is a central objective on which both parties can agree (D’Amour et al., 2008; Fewster & Velsor, 2008).

The presence of common goals, shared interests and mutual benefits is necessary to ensure parties are united and strive towards a collective action (Lindeke & Sieckert, 2005; Petri, 2010). A collective action is the basis for an enduring and effective collaboration, because of the diversity of viewpoints and backgrounds, since a healthcare collaboration is a prolonged and complex process (D’Amour et al., 2008; Houldin et al., 2004; Thomson & Perry, 2006). Without the presence of a collective action, the collaboration is likely to fail. Parties will try to collaborate, but it won’t work out because they will only maintain their self-interests, own goals and own benefits instead of the collective ones.

Taken this into account, the following proposition can be formed:

**Proposition 1:**

*There is a positive relationship between a collective action as practice and the success of a healthcare collaboration. The presence of a collective action is implied by the existence of a common goal, shared interests and mutual benefits within a collaboration.*

2.3.2 Interaction: communication, information sharing, negotiation and discussion

It is through an interdisciplinary collaboration that different disciplines interact and strive for the improvement of the quality of healthcare (Wells et al., 1998). Interaction leads to a more effective collaboration (Miller & Shamsie, 1996). Interaction is defined as the process of perceptions, verbal and non-verbal communication and the two-way exchange of meaningful information between parties (Fewster & Velsor, 2008; Mattessich & Monsey, 1992; Rice et al., 2010). An effective and open communication is important for the success of a collaboration (Bender et al., 2013; D’Amour et al., 2005; Henneman et al., 1995; Petri, 2010; Rice et al., 2010). It indicates that the intended verbal and nonverbal messages are successfully transmitted between parties (Bronstein, 2003; Lindeke & Sieckert, 2005). Furthermore, it ensures role awareness. (D’Amour et al., 2008). Role awareness contains the knowledge, perspectives and skills of the other party (Petri, 2010). The role responsibilities and expertise of both parties should be understood and recognized (Bronstein, 2003). It is important that parties know what
they can expect of each other (D’Amour et al., 2008; Petri, 2010). In other words, both parties should have a clear understanding of what their responsibilities and expectations are.

A two-way exchange of meaningful information between partners is useful to promote the collaborative relationship (Madhok, 1997; Mattessich & Monsey, 1992; Rice et al., 2010). It admits the advancement to processes for the sharing of information (Crosby & Bryson, 2005; San Martin-Rodríguez et al., 2005). The sharing of information refers to the existence and appropriate use of information channels to allow fast and complete exchanges of information between professionals (D’Amour et al., 2008). It increases the understanding of the shared problem and gives parties the information they need to successfully do their job (D’Amour et al., 2008; Lindeke & Sieckert, 2005; Thomson & Perry, 2006). Furthermore, a complete information sharing makes mutual knowledge sharing possible (San Martin-Rodríguez et al., 2005). Collaborators have the need to learn (Child et al., 2005; Doz, 2017). The need to learn involves the need to share new knowledge, capabilities and skills (Doz, 2017). It is required because of the complexity of the collaboration process and to create value through co-specialization of these contributions (Bryson et al., 2006; Lindeke & Sieckert, 2005; Madhok, 1997). Knowledge sharing needs to be created because parties must understand each other’s contributions to effectively integrate them (Doz, 2017). It contains meaningful information that can help parties to get to know each other and to learn from each other (San Martin-Rodríguez et al., 2005).

Problems in a collaboration can occur due to failures in coordination (Gulati et al., 2012; Patru et al., 2015). It is the alignment of actions (Patru et al., 2015). The root causes for failures in coordination is bounded rationality (Kretschmer & Vanneste, 2017). This implies partners do not have a complete understanding of the collaboration and their collaborator, resulting in difficulties in anticipating to the other party (Emerson et al., 2011; Fewster & Velsor, 2008). To overcome this failure, parties should ensure role awareness and guarantee mutual knowledge sharing for the goodness of both parties (Thomson & Perry, 2006). This requires close interaction by an effective and open communication and complete information sharing (Doz, 2017).

Taken this into account, the following proposition can be formed:

**Proposition 2:**

There is a positive relationship between interaction as practice and the success of a healthcare collaboration.
To promote the understanding of the results, this proposition is split into two parts.

**Proposition 2a:**

The presence of interaction is implied by the existence of open and honest communication and complete information sharing within a collaboration.

In order to maintain symmetry between the involved parties in this relationship, collaborative interaction is required (D’Amour et al., 2005). Additional terms to interaction are negotiation and respectful disagreement (Petri, 2010; San Martin-Rodriguez et al., 2005). The outcomes of the healthcare collaboration are directly influenced by the way a collaborative relationship is negotiated (Lindeke & Sieckert, 2005). Negotiation is part of the interaction process and contains the willingness to give and take (D’Amour et al., 2005; Wells et al., 1995). Negotiation is defined as the process of interaction by which collaborators strive for the most effective outcome through action jointly decided upon (Ness, 2009). Effective and open communication and information sharing allows parties to constructively negotiate (Henneman et al., 1995; Petri 2010; San Martin-Rodriguez et al., 2005). Both parties should participate in the process, because joint problem-solving and cohesiveness are desired results of a collaboration (Henneman et al., 1995; Lindeke & Sieckert, 2005; Petri, 2010). However, parties will not always agree. This means there should be room for respectful disagreement in this process. In other words, there should be room for discussion (Houldin et al., 2004; Lindeke & Sieckert, 2005). The room for discussion makes sure the ideas of both parties are welcome (D’Amour et al., 2008; Lindeke & Sieckert, 2005). Respectful disagreement enriches the process of interaction (Houldin et al., 2004; Petri, 2010). It enables the possibility to make adjustments to practices and to coordinate the problems (D’Amour et al., 2008).

In order to overcome failures in coordination, parties should be willing to negotiate (Gulati et al., 2012). Parties must negotiate the details of how and when to collaborate, how to structure their interactions and how to evaluate the outcomes (Bryson et al., 2006; Houldin et al., 2004). While negotiating, collaborators bargain about their contributions and interests (Petri, 2010). This means parties negotiate what they want and can offer the collaboration (Petri, 2010; Thomson & Perry, 2006). This means there should be room to do so and requires room for discussion to make adjustments to practices. Without room for negotiation and room for discussion, the healthcare collaboration may become ineffective.

Taken this into account, the following proposition can be formed:
Proposition 2b:

The presence of interaction is implied by the existence of room for negotiation and discussion within a collaboration.

2.3.3 Governance: shared authority and central leadership

Within the context of a collective action, governance can be defined as an element of rules and norms jointly created to regulate individual and group behavior (Emerson et al., 2011; Thomson & Perry, 2006). Governance is a set of monitoring and coordinating activities that allows the survival of the collaboration, because it is the process that influences decisions and actions (Bryson et al., 2006; D’Amour et al., 2008; Emerson et al., 2011). Collaborators must understand how to jointly make decisions about the rules that will govern their individual and group behavior (San Martin-Rodriguez et al., 2005; Thomson & Perry, 2006). Parties need to create a governance structure for reaching agreements through shared power arrangements (Crosby & Bryson, 2005; Thomson & Perry, 2006). Shared power arrangements are seen as "sets of implicit or explicit principles, norms, rules and decision-making procedures" (Crosby & Bryson, 2005, p. 18). Power should not be concentrated in the hands of one party, because unequal power will negatively influence the outcome of an interdisciplinary collaboration (D’Amour et al., 2005; D’Amour et al., 2008). All collaborators must be able to take part in the decision-making process.

The choice of governance structures influences the effectiveness of the collaboration (Bryson et al., 2006). A governance structure is the formal contractual structure used by collaborators to formalize the collaboration (Gulati & Singh, 1998). The types of governance structures can include: "(1) self-governing structures in which decision-making occurs through regular meetings of members or through informal, frequent interactions; (2) a lead organization that provides major decision-making and coordinating activities; and (3) a network administrative organization, which is a separate organization formed to oversee network affairs" (Bryson et al., 2006, p. 49). In a healthcare collaboration the first mentioned governance structure will lead to the most effective collaborative outcome. An interdisciplinary collaboration brings different disciplines together that strive towards a collective action (Petri, 2010). It requires that collaborators frequently interact (Wells et al., 1998). This governance structure ensures parties have regular meetings or have frequent interaction and that power is not concentrated in the hands of one party.

More specifically, governance can be defined as the means by which order is achieved
in a relationship, in which potential conflicts could threaten to disturb opportunities that can realize mutual gains (Ness, 2009). Such order is achieved through the implementation of mechanisms, also mentioned as social and formal controls, like hierarchical elements (Gulati & Singh, 1998; Ness, 2009). Governance enables the mechanisms to monitor and coordinate behavior (Bryson et al., 2006). Collaborators are more confident about the collaboration when they feel they have a level of control over the other party, it thus necessitate more formal governance in the form of hierarchical governance structures (Das & Teng, 1998; Gulati et al., 2012). This can be distinguished in terms of the degree of hierarchical elements parties embody and the extent of control and coordination features. Alliances with more hierarchical features are capable to provide greater control and coordination (Gulati & Singh, 1998). Furthermore, it can manage uncertainty because it enables further interaction (Gulati & Singh, 1998; Ness, 2009). Hierarchical features are often referred to as authority (Emerson, 2011; Ness, 2009). Elements of authority can include joint teams or working groups, joint procedures and administrative rules and the establishment of decision rights (Ness, 2009). All these features of hierarchy are obtained by contracts or arrangements between organizations, such as shared power arrangements (Crosby & Bryson, 2005; Ness, 2009).

In order to overcome failures in coordination, shared authority should be present. These failures can be caused by the immobility of existing structures, like differences in decision-making. Shared authority can facilitate coordination, because it enables both parties to control the collaboration (Gulati et al., 2012). Furthermore, each form of governance structure requires different degrees of coordination of and control over the activities in the collaboration (Bryson et al., 2006; Ness, 2009). Shared authority, like joint teams or working groups, is necessary to assure the use of the self-governance structure that ensures joint decision-making through regular meetings and frequent interactions (Bryson et al., 2006).

Taken this into account, the following proposition can be formed:

**Proposition 3:**

*There is a positive relationship between governance as practice and the success of a healthcare collaboration.*

To promote the understanding of the results, this proposition is split into two parts.
Proposition 3a:

The presence of governance is implied by the existence of shared authority within a collaboration.

One driver of collaborative governance is leadership (D’Amour et al., 2005; Emerson et al., 2011). A managerial choice is critical for matching the best type of governance structure to its conditions (Bryson et al., 2006). Leadership is shared by the collaborators and is subject to an agreement (D’Amour et al., 2008). Developing collaborative practices is a challenge and can be facilitated by leaders who know how to convey the practices and how to motivate professionals to take them up (San Martin-Rodriguez et al., 2005). Being aware of the best practices can directly lead to a better management (Crosby & Bryson, 2005; Patru et al., 2015). A successful development of a collaboration depends on the efforts of two leaders: at a strategic level and at operational level (Patru et al., 2015).

The position of leadership at a strategic level refers to a project director. In other words, the leader of collaboration on which the economic success of the collaboration depends (Bryson et al., 2006; Child et al., 2005). The project leader can be a member of one of the collaborators or may be from an independent organization (Emerson et al., 2011). Leaders should be impartiality, showing the willingness not to favour only one particular solution and focussing on collaborative problem solving (Emerson et al., 2011). This function is necessary to develop and guide the process of an interdisciplinary collaboration (Bender et al., 2013; D’Amour et al., 2008). A leader at strategic level knows how to create an organizational setting that fosters the collaboration between parties (Bender et al., 2013; Crosby & Bryson, 2005; San Martin-Rodriguez et al., 2005; Wagner & Boutellier, 2002).

The second position of leadership refers to gatekeepers, also known as managers from both sides of the collaboration that ensure the interaction between two parties (Bryson et al., 2006; Child et al., 2005). It refers to the managers who actually execute and implement the agreements in practice in their own organization (Patru et al., 2015). This function is necessary because collaborators cannot rely on only one centralized direction (Bryson et al., 2006). The leaders at operational level need to navigate and implement decisions and actions from strategic level to operational ones in their own organization (Patru et al., 2015).

Coordination failures can be caused by the immobility of existing processes between collaborators (Das & Teng, 2000; Gulati et al., 2012). It refers to differences in operational actions and management (Mattessich & Monsey, 1992). Furthermore, coordination failures can
be caused by underlying cultural differences. Parties have different cultures, because their disciplines are rooted in different frameworks (Fewster & Velsor, 2008). These failures can be overcome by a central leader that will control and coordinate the collaboration (Gulati et al., 2012; Patru et al., 2015). It refers to the existence of a clear and explicit function at two levels: at strategic level that guides the collaboration and at operational level to implement and navigate decisions and actions from strategic level to operational ones in their own organization (Bryson et al., 2006; Child et al., 2005; D’Amour et al., 2008). An interdisciplinary collaboration necessitates central leadership (D’Amour et al., 2008; Petri, 2010).

**Proposition 3b:**

The presence of governance is implied by the existence of central leadership within a collaboration.

### 2.3.4 Trust and interdependency

A healthcare collaboration is a process in which interdependent professionals interact and are structuring a collective action towards patients’ healthcare (San Martin-Rodriguez et al., 2005). The patient’s health problems require the expertise of multiple professionals and that is why different disciplines must work together. It can provide a better approach of the problem (Fewster & Velsor, 2008). This means the involved parties should be interdependent rather than autonomous (D’Amour et al., 2008). Interdependency is the mutual dependence of the involved parties (D’Amour et al., 2005). Dependency in a social relation is the reverse of power (Child et al., 2005).

Interdependency can be linked to the resource dependency theory (D’Amour et al., 2005). The resource-dependence perspective focuses on the need of resources (Child et al., 2005). It accentuates that value can be created through optimal resource boundary by uniting and utilizing valuable resources (Das & Teng, 2000). Resources can be classified in two categories: property-based and knowledge-based resources (Miller & Shamsie, 1996). Property-based resources refers to the legal properties owned by organizations, i.e. human and physical resources (Das & Teng, 2000). Knowledge-based resources are the intangible skills and know-how of organizations (Das & Teng, 2000; Miller & Shamsie, 1996). Knowledge-based resources are not easy to imitate in contrast to property-based resources. When resources and competences are not sufficiently and immediately available, it will increase the reason to enter a collaboration (Child et al., 2005; Das & Teng, 2000). "Collaborations are a useful
vehicle for enhancing knowledge in critical areas of functioning where the requisite level of knowledge is lacking and cannot be developed within an acceptable timeframe or cost" (Madhok, 1997, p. 43). The key motivation to enter a collaboration is thus the expectation to gain the skills or resources that are necessary to receive valued returns. The specific need will differ, but all subjects can be classified as specific resource, skill or imbalance (Child et al., 2005). This means parties have different but complementary resource needs. The organizations are not able to achieve their objectives alone. In other words, they are interdependent on each others’ knowledge and skills. Healthcare organizations need each other, because the outcomes of the successful collaboration are greater than the sum of the individual actions alone (Bronstein, 2003; D’Amour et al., 2005; Houldin et al., 2004; Thomson & Perry, 2006). This means interdependency should be present for a healthcare to be successful (Bronstein, 2003; D’Amour et al, 2008; Henneman et al., 1995; Petri, 2010; Thomson & Perry, 2006).

Furthermore, a collaboration requires trust to succeed (Child et al., 2005). Trust refers to the willingness of parties to relate with each other in the belief that their actions will be beneficial rather than harmful, even though it cannot be guaranteed (Child et al., 2005; Das & Teng, 1998; Jones & George, 1998). It means being confident that your partner will commit valuable resources and competences to transactions with the possible risk that the partner might take advantage of the commitment or the inability of partners to accomplish its part of the collaboration (Bryson et al., 2006; Thomson & Perry, 2006). Trust reduces uncertainty (D’Amour et al., 2008). When trust is missing, collaborators will try to avoid a collaboration and hold their responsibility over their clients as long as possible (D’Amour et al. 2008; Houldin et al., 2004). There should be trust in each others’ abilities and competences to hand over responsibilities (San Martin-Rodriguez et al., 2005). Mutual trust is an essential attribute for the development and success of an interdisciplinary collaboration (Bender et al., 2013; Bronstein, 2003; D’Amour et al., 2005; Henneman et al., 1995; Lindeke & Sieckert, 2005; Petri, 2010).

Taken this into account, the following proposition can be formed:

**Proposition 4a:**

*There is a positive relationship between the existence of the two factors interdependency and trust and the success of a healthcare collaboration.*
Trust can be linked to the expected best practices: collective action, interaction and governance. First of all, the practice of collective action can evolve trust. When parties have shared interests and benefits they want to perform in a way that contributes to a common goal (Das & Teng, 1998; Jones & George, 1998; Thomson & Perry, 2006). They are prepared to take risks more quickly when they share common goals, shared interests and mutual benefits (Child et al., 2005). The sharing of these elements promotes high confidence between parties because they can assure each other of their real objectives and intentions (Jones & George, 1998). In the nonexistence of trust, parties will be more restrained by the fear of self-interests, this means one party cares more about its own aims and benefits from the collaboration than those of its collaborator (Gulati et al., 2012; Kretschmer & Vanneste, 2017). This improves trust (Jones & George, 1998). The other way around, a collective action depends on trust (Thomson & Perry, 2006). Trust reduces the uncertainty that the other party will take advantage of the collaboration (D’Amour et al., 2008; Jones & George, 1998). When there is trust, parties are more likely to put organizational goals ahead because they know the other party will do the same (Child et al., 2005; Jones & George, 1998).

Secondly, the practice of interaction helps to emerge trust (Bender et al., 2003; Fewster & Velsor, 2008; Patru et al., 2015; Wagner & Boutellier, 2002). Trust will evolve over time through continuous interaction, because interaction could ensure mutual understanding (Bryson et al., 2006; Child et al., 2005; D’Amour et al., 2008; Henneman et al, 1995; Jones & George, 1998). Mutual understanding can build trust and facilitate cooperation and coordination (Gulati et al., 2012). When interaction is missing, partners have no foundation to trust each other (Thomson & Perry, 2006). Trust has much to do with predictability (Gulati et al., 2012; Wagner & Boutellier, 2002). Collaborators want to know how their partner behaves in a particular situation (Wagner & Boutellier, 2002). When parties don’t know each other well, they feel like they constantly must take risks and are in a vulnerable position (D’Amour et al., 2008). The collaboration will only succeed when parties have trust in each other’s abilities and competences. They should be willing to hand over their responsibilities and share information (Child et al., 2008). Interaction is an important aspect for establishing trust, because it will break down barriers (D’Amour et al., 2008; Das & Teng, 1998). It increases the understanding of the shared problem and gives parties the information they need to successfully do their job (Lindeke & Sieckert, 2005; Thomson & Perry, 2006). The following four indicators of trust could ensure mutual understanding. An effective and open communication ensures role awareness, it can transfer and clarify the expectations and responsibilities of both parties (D’Amour et al., 2008).
A complete information sharing makes mutual knowledge sharing possible, it ensures meaningful information that can help parties to get to know each other and to learn from each other (San Martin-Rodríguez et al., 2005). While negotiating, collaborators bargain what they want and can offer the collaboration (Petri, 2010; Thomson & Perry, 2006). Discussion enables the possibility to make adjustments to practices and to coordinate the problems (D’Amour et al., 2008). This ensures mutual understanding. The other way around, interaction should be based on mutual trust (Houldin et al, 2004). Trust reduces uncertainty (D’Amour et al., 2008). When there is trust, parties are more willing to interact (Child et al., 2005). It gives the assurance that information and knowledge will be used for a common good and not for own interests (Jones & George, 1998).

Lastly, the practice of governance helps to evolve trust (Das & Teng, 1998). Governance is achieved through the implementation of mechanisms, also mentioned as social and formal controls (Gulati & Singh, 1998; Ness, 2009). Control mechanisms can emerge trust, because parties are more confident over the collaboration when they feel they have control over the other party (Das & Teng, 1998). Parties want to work together to provide a better patient care, but at the same time they still want to carry their independence and autonomy as well (D’Amour et al., 2008; Kretschmer & Vanneste, 2017). This can be ensured by the ability to control the collaboration. A self-governance structure will ensure initial meetings between parties (Ness, 2009). It enables both parties to control the healthcare collaboration instead of only one party and this will increase trust (Ness, 2009; Thomson & Perry, 2006). Furthermore, it will ensure that managers from both sides interact and this enables them to familiarize themselves with each others’ differences (Das & Teng, 1998). The other way around, trust reduces the need to check-up and control the other party, because it reduces uncertainty (Child et al., 2005; D’Amour et al., 2008; Das & Teng, 1998). It will foster the fact that partners are encouraged to place themselves within the powers of one another (Child et al., 2005). Parties should be willing to be vulnerable for the collaboration to be successful (Houldin et al., 2004).

Taken this into account, the following proposition can be formed:

Proposition 4b:

There is a two-way positive relationship between trust and the three practices: collective action, interaction and governance.
2.4 Concluding note and conceptual model

In sum, a healthcare collaboration is defined as the joint communicating and decision-making process with the expressed goal of satisfying the patient’s wellness and illness needs while respecting the unique qualities and abilities of each professional (Henneman et al., 1995; Houldin et al., 2004). It is an interdisciplinary collaboration in which different disciplines interact and strive to the same collective action, namely the quality of healthcare (Wells et al., 1998; Petri, 2010). However, it is a complex phenomenon and can cause problems due to failures in cooperation and coordination (Gulati et al., 2012; Kretschmer & Vanneste, 2017; Patru et al., 2015). This means organizing healthcare services require not only the implementation of structures but also clinical and strategic practices to achieve and sustain a successful healthcare collaboration (D’Amour et al., 2008).

Practices are used to shape the actual activity (Jarzabkowski et al., 2007). They are the symbolic, material and social tools through which strategy is done (Golsorkhi et al., 2010; Jarzabkowski & Spee, 2009). The process of a healthcare collaboration can be linked to the strategy-as-practice concept, since this concept delves deeper into what actually takes place in the healthcare organizations when strategy work is being done (Jarzabkowski et al., 2007; Jarzabkowski & Spee, 2009; Patru et al., 2015; Vaara & Whittington, 2012; Whittington, 2006). It focuses on how the doing of strategy contributes to organizational performance (Jarzabkowski & Spee, 2009; Vaara & Whittington, 2012). The strategy-as-practice concept can help to uncover what strategic practices must be done for a successful collaborative performance. In other words, what the best practices are to help to achieve and sustain a successful healthcare collaboration.

It is expected that there are three best practices, namely: collective action, interaction and governance. These strategic practices could be seen as best practices for a successful healthcare collaboration in the light of the strategy-as-practice concept. They could help to achieve and sustain a successful collaboration. See Table 1 included in Appendix 2 for a clear overview of the descriptions of the best practices. These practices can be implied by the existence of different indicators. Furthermore, it is expected that interdependency and trust should also be present for the healthcare collaboration to succeed. There could be a two-way positive relationship between trust and the three best practices: collective action, interaction and governance. Based on the literature review presented in this chapter, the following model was developed to visualize the expected three best practices, two other main factors and their relationships.
Figure 3: The Conceptual Model of a Successful Healthcare Collaboration

Figure 3 shows the expected three best practices, implied by nine indicators and the expected two other main factors for a successful healthcare collaboration. Influences and relationships between the components are indicated by arrows in the model. In the next chapter the methodology used for collecting the data and to test the propositions will be set out.
3. Methodology

This chapter will outline the epistemology, ontology and methodology of this study. It outlines which methods are used to collect the data and how the collected data is used to examine the previously drawn-up propositions. Furthermore, it gives a presentation of the cases, an explanation of the research analysis. This chapter ends with the research ethics.

3.1 Research strategy

The epistemology, ontology and methods used, should be outlined. Table 2, included in Appendix 2 gives an overview of the possible different positions. Epistemology considers the relationship between reality and theory. It includes how to know what real reality is and what is real knowledge (Guba & Lincoln, 1994). This study follows a post positivism epistemology. It contains that objectivity remains a regulatory ideal. Objectivity is provided by critical conditions, such as whether the findings fit with the pre-existing knowledge and critical communities, such as professionals (Guba & Lincoln, 1994). Ontology contains the nature of reality and whether human interpretations can be independent. It assumes that reality exists but can be imperfectly apprehendable because of basically flawed human intellectual mechanisms. This study makes use of critical realism, "that includes that reality must be subjected to the widest possible critical examination to facilitate apprehending reality as closely to possible" (Guba & Lincoln, 1994, p. 110). The realism ontology and a post positivist epistemology can bring limitations, e.g. they both are subject to falsification. However, these problems will be redressed by using qualitative techniques, that will research in more natural settings, collect more situational information and viewpoints to assist in defining meanings and purposes that people ascribe to their actions (Guba & Lincoln, 1994).

Therefore, this study is conducted as a qualitative and multiple case study design. A qualitative study is often used in the field of healthcare research to describe complex interactions and settings (Sofaer, 1999). It plays an important role in clarifying the meanings, languages and values of the involved parties. Qualitative methods allow participants to speak in their own terminology, rather than in the terms and categories that are made up by others (Sofaer, 1999). Conducting a qualitative method makes it appropriate to make statements about processes over time and provides a better understanding of certain phenomena, organizational cultures and the context of a particular phenomenon (Bleijenbergh, 2013; Sofaer, 1999). Therefore, qualitative research is suitable for investigating multiple causality or describing how several causes of a phenomenon are linked (Bleijenbergh, 2013). It contributes to the
understanding of the situation and can yield opportunities to improve these processes (Merriam, 1998).

A case study is primarily interested in giving detailed descriptions of a phenomenon that occurs in a specific case (Swanborn, 2013). A case study can suggest what to do or not to do in a similar situation (Merriam, 1998). It is an intensive form of research with a focus on perceptions, interactions and decisions of people (Swanborn, 2013). It presents information in a wide variety of ways and from the viewpoint of different groups (Merriam, 1998). "A qualitative case study is an intensive, holistic description and analysis of a single instance, phenomenon or social unit" (Merriam, 1998). The use of a qualitative case study will give a better view of the collaboration. It provides better and more complete insights from the aspects of the parties involved (Bleijenbergh, 2013). It can describe the experiences of the parties involved (Sofaer, 1999). By using a case study, different views and situations are gathered. That is why in this study is chosen to interview parties that already had implemented or are implementing the TCB to study the succeeding and failing factors. These factors can be compared to the propositions that contain the expected best practices for a successful healthcare collaboration. A case study can help to uncover what strategic best practices must be done for a successful collaborative performance.

3.2 Validity, reliability and generalizability

One limitation of qualitative research is that validity and reliability cannot be measured with established metrics. In a qualitative study this will be measured based on the trustworthiness that will be examined by four aspects: credibility, transferability, confirmability and dependability (Merriam, 1998; Shenton, 2004).

Credibility involves the internal validity. It implies that the study is measuring what is actually intended. Dependability associates to objectivity, the use of instruments that are not dependent on a human skill or perception (Shenton, 2004). These two aspects are improved in this study by the use of triangulation, the use of different research methods to show the findings are credible (Shenton, 2004).

Transferability involves the external validity that refers to the extent to which this study can be applied to other situations (Merriam, 1998). The results must be understood within the context of the characteristics of the organisations (Shenton, 2004). This is improved by setting boundaries and contexts in this research.

Confirmability addresses the issue of reliability, the degree of neutrality in the findings
of the study (Shenton, 2004). This means the findings are based on the responses of participants and not on the bias of the researcher. In this study, a clear description of the used methods is given. Also, per question is explained how it is used in this study and the collected results are set out by quotes that are given by respondents to ensure that results are derived from documents and statements of participants.

3.3 Data sample

The data is collected through 12 semi-structured interviews with three different roles per case: project leaders, managers from home care organizations and hospital professionals specified in elderly care, named geriatrics. All the interviewees were part of the implementation process of the TCB. The sampling was purposeful, the respondents were selected to represent these roles. See Table 3, included in Appendix 2 for an overview of the characteristics of respondents that has been interviewed.

By asking respondents open-ended questions about what they think and how they experienced the collaboration, a lot of inside information becomes available (Bleijenbergh, 2013). This will lead to a clear perspective of the experiences of the interviewed parties (Sofaer, 1999). A semi-structured interview will give more detailed information since it tries to explain the phenomenon from the position of the participants (Sofaer, 1999). It ensures social interaction (Bleijenbergh, 2013). Social interaction can be a strength but a weakness as well. It can motivate people to express things in their own terminology (Sofaer, 1999). However, it is possible that respondents give socially acceptable answers (Bleijenbergh, 2013). For this study a semi-structured interview was the best way to gather information about the succeeding and failing factors of the healthcare collaboration and how respondents experienced the process. The social interaction with participants helped to gain more insight and understanding in the sector and the organizational context.

An interview plan based on the theoretical framework was developed to guide the interviews. This guideline is included in Appendix 3. The interviews were retrospective and were held from 22 May 2017 till 25 July 2017. They lasted on average 45 minutes and were held in Dutch, because the participants and the additive documents were in Dutch. A translation of the interview questions to English is available in Appendix 3 as well. All interviews were audio-recorded and fully transcribed.

In addition, more data is collected by analysing written material that is providing more information. Collecting information through different methods will reduce potential biases that
can occur when only one method is used (Merriam, 1998; Shenton, 2004). Relevant documents for this study were: information flyers, factsheets, covenants and infographics.

3.4 Presentation of the cases

The cases contained the healthcare services providing the TCB in different regions in The Netherlands: Zeeland, Amsterdam, Utrecht and Leiden. These regions were selected because they were done implementing or are currently implementing the TCB. A region consists of several hospitals and home care organizations, however only one hospital and one home care organization in one area has been interviewed. As mentioned before, three respondents were interviewed per case. All respondents were part of the implementation process and were important for a complete view of the cases. Interviewing all involved parties per case gave a better view of the differences and motives. All cases had a different time-lapse regarding the TCB: one case has already implemented, two cases were currently implementing and another case was just started to implement the TCB. However, all cases can be used and compared because it concerns the same project. The anonymous code names of the respondents are mentioned in the analysis of the data for verification and confirmation. The first letter refers to the region of the case. The second letter describes the function of the respondent. For a clear overview of the code names see Table 4, included in Appendix 2.

3.4.1. Case I. Region Zeeland

The first case covers region Zeeland. It includes the region above the Westerschelde. It concerns the islands Schouwen Duiveland, Tholen, Walcheren and Bevelanden. There was a trial procedure from 1 December 2014 till 1 December 2015. The pilot of this project was from 19 January 2015 till 16 February 2015. This means they have implemented the TCB. The pilot had a purpose to develop and test the implementation strategies. This case can be used to study the success and failing factors. The interviews are held with the formal project leader of this region (Z.P.), with a clinical geriatric (Z.G.) and the director of an elderly home care organization (Z.M.), it is a cooperation of all the home care organizations in region Zeeland. The differences with the other cases is the size of the working area. Zeeland is a relatively large area. The other cases are mostly limited to one city. In this case it is difficult for healthcare providers to move quickly from one place to another.
3.4.2. Case II. Region Amsterdam

The second case covers region Amsterdam. This project only includes the City of Amsterdam itself. The TCB project has started in Amsterdam as first in The Netherlands. The research took place from January 2010 till the end of 2013. However, the implementation of the project is started in 2015 and is still running. The interviews were held with the first project leader of the Transmural Care Bridge of region Amsterdam (A.P.). This person is the founder of the TCB and researcher of several articles about this project. She has implemented this project from America into The Netherlands, adapted to the local needs. The other interviews were held with an internist elderly care (A.G.) and with a manager quality and care development of an elderly home care organization (A.M.). The differences with other cases is the size of Amsterdam. Amsterdam itself is a big city, where several hospitals are located. It is a complex area because of the many parties involved. This makes it difficult for healthcare providers to move quickly from one place to another.

3.4.3. Case III. Region Utrecht

The third case covers region Utrecht. This project’s area is only Utrecht city itself. There was a trial procedure from January 2014 till the end of 2014. The official start date of the implementation process was in November 2016 and the project is still running. The interviews were held with the current project leader of Utrecht city and region manager of a home care organization (U.P.). Furthermore, with a clinical geriatric (U.G.) and with a region manager of a home care organization (U.M.). The differences with other cases it that this region only contains Utrecht itself. Utrecht is a big city but not that big as Amsterdam. It is possible for healthcare providers to move quickly from one place to another.

3.4.4. Case IV. Region Leiden

The fourth case covers Leiden. This project includes region South-Holland North. This project is relatively new. The date of implementation is 1 December 2017 till the present day, so they have just started the project. The interviews are held with the current project leader of the city Leiden (L.P.). The other interviews are held with a clinical geriatric (L.G.) and with a section manager working at a home care organization (L.M.). The differences with other cases is the novelty of the project. The other cases are further in the implementation phase, this case is just started to implement. However, this case can still be used to study the succeeding and failing factors until the day of today. This case also covers multiple cities around Leiden itself.
Healthcare providers can relatively move quickly from one place to another.

3.5 Data analysis

The entire collected data was analysed in order to draw conclusions. The collected documents and interviews were interpreted by using the method of coding. This contains the labelling of fragments of the texts with concepts (Bleijenbergh, 2013). The data analysis combined two additional strategies, deduction and induction (Bleijenberg, 2013). Deduction is based on the outlined theoretical framework and proposals. Induction ensures there is room left for new elements to emerge.

The relevant theoretical definitions were operationalized (Bleijenberg, 2013; Shenton, 2004). The goal of this study is to gain more insight in this collaboration between a hospital and a home care organization using the strategy-as-practice approach. This approach focuses on how the doing of strategy contributes to organizational performance. It can help to uncover what strategic best practices must be done for a successful collaborative performance. It is expected that there are three best practices, namely: collective action, interaction and governance. These strategic practices could be seen as best practices for a successful healthcare collaboration in the light of the strategy-as-practice concept. These practices can be implied by the existence of different indicators. Therefore, the expected best practices were coded in terms of the indicators that emerged from the theory. Furthermore, the expected main factors interdependency and trust should also be present. These factors are coded as well.

First, the process of open coding has been used, to identify possible emerging themes. To ensure the validity of the indicators, there is continually shifted between the data, validating the indicators, evaluating the healthcare collaboration and looking out for new emerging indicators. The data showed there were no new indicators emerging. Therefore, three practices implied by nine indicators and two other main factors are operationalized to evaluate the process of a successful healthcare collaboration. Appendix 4 presents the operational definition of the nine indicators, representing the best practices and two other main factors for a successful healthcare collaboration. Appendix 5 includes an explanation of how the interview guideline has been used per question to gather the needed information to test the propositions in the theoretical framework based on the operationalization. The data was analysed and interpreted based on the results of coding. Quotes that are used to confirm the analysis of the data in the next chapter were translated from Dutch to English. An overview of the translations is available in Appendix 6 to ensure the reliability. In the result chapter the results of the analysis are set
out and categorized per expected best practice and other main factors. It has been checked per indicator if it was present and of importance for the success of the collaboration. When all the indicators that represent an expected best practice were present and of importance, it can be said that the practice itself is present and will help to achieve and sustain a successful collaboration. Therefore, the practice can be seen as a best practice in the light of the strategy-as-practice concept. Regarding the other expected main factors, when it was present and of importance for a successful collaboration, it can be seen as main practice. In the next chapter, these results will be explained.

3.6 Research ethics

The research ethics has been taken into account in a few ways. First of all, permission was asked for conducting the research at the involved organizations. When permission was given, the respondents were asked to participate in the research and voluntarily agreed. The respondents have been asked if they wanted to remain anonymous. To make sure that the interviews were not deducible to a certain relationship between one specific healthcare organization and a hospital, it was decided to arrange interviews with organizations that were randomly chosen in a specific area. However, it has been checked whether they work together. Before the interview started, permission has been asked for recording the interview. At the end of each interview, respondents were asked if they wanted to add something to the interview and whether in their opinion every important aspect had been treated. Thereafter, each interview has been transcribed. The transcripts include every pronunciation of the respondents, with each hesitations or (re)thinking to ensure the transcripts were literal. To ensure confirmation and verification, the transcripts were sent to the respondents to check the presence of inaccuracies and ambiguities. In the end, the interviewed organizations were handed over a summary of the final research report to communicate the results of this study.
4. Results

In this chapter the results of the analyses will be presented. The results are outlined in different subchapters covering different best practices: collective action, interaction and governance and the two expected other main factors: trust and interdependency. The subchapters are subdivided by the indicators that represent the expected practice.

4.1 Collective action

A healthcare collaboration requires a collective action. It refers to an action that has been taken together by a group that tries to achieve a common purpose together (D’Amour et al., 2005; San Martín-Rodríguez et al., 2005). The involved parties should have common goals, shared interests and mutual benefits in the collaboration (D’Amour et al., 2005; D’Amour et al., 2008; Houldin, 2004).

4.1.1 Common goals

Most respondents [10/12] were convinced that both parties entered the collaboration because of the same motives. "We all attempt to generate optimal care" (A.G.); "We want to provide the patient good healthcare" (U.G.); "The quality of patients’ healthcare" (L.M.); "We all want to provide good healthcare for the patient" (Z.G.). In a healthcare collaboration, being able to act upon the needs of patients is a central objective on which both parties can agree (D’Amour et al., 2008; Fewster & Velsor, 2008). This is confirmed by all interviewees [12/12]. It is mentioned that the hospital and the home care organization have the same goal. "Yes, this is actually the same. The primary goal is the healthcare for elderly, meaning that eventually the goal will also be providing more efficiency in the work of meditators, hospital and home care" (Z.P.); "The goal is to complement the care for the client and this goal is the same" (L.M.); "The final goal is to make it better for the elderly" (A.P.); "To provide appropriate and dignified care for as long as possible" (U.P.); "To provide good healthcare for the patients" (U.G.). This proves that all participants recognized the same common goal regarding the need of their patients.

Sharing and identifying common goals is essential for a collective undertaking (Bronstein, 2003; Fewster & Velsor, 2008; Gulati et al., 1996; Houldin et al., 2004; Wells et al., 1998). Participants stated that the common goal was the main motive to enter the collaboration. It was important for the collective action they undertake. "Well, the most important lesson is that it is essential to keep the final goal in mind. It is surely a thing you have
to repeat" (U.P.); "What is most important, is that we set mutual common goals and pursue them" (A.G.); "Clearly, we have a goal. There is an urge for this that is really needed. This dream was clear, there is a big common goal" (Z.P.). The presence of a common goal makes parties understand they must collaborate to achieve their common goal.

4.1.2 Shared interests

Parties should strive for shared interests rather than their self-interests (Das & Teng, 2000; San Martin-Rodriguez et al., 2005). However, the results showed respondents stated both parties have different interests. The interests for the hospital are the prevention of re-hospitalization [7/12] and the improvement of the quality of healthcare [5/12]. "The number of rehospitalizations" (U.G.); "To prevent rehospitalizations" (Z.P.); "They want to provide qualitative healthcare" (L.P.); "Especially for the patients’ healthcare and the quality the patient experiences" (A.G.). The interest for the home care organization is the improvement of the transfer from the hospital to home to improve the quality of healthcare [12/12]. "Home care organizations and hospitals often speak different languages. It can be difficult to understand each other. The patient will benefit from implementing a project like this, in which a warm transfer is ensured" (L.P.); "The home care organization wants to deliver the highest possible quality of healthcare" (U.P.).

Nevertheless, parties should focus on common patient care interests rather than individual intentions (Petri, 2010). Most participants [10/12] were convinced that parties started the collaboration because of the same interests, namely the quality of patient care. "The interests are different but we agree on the shared interests that we both want to provide good quality of healthcare for the elderly" (Z.M.); "In the end it is all about the patient’s interest" (U.M.); "Everyone wants to deliver good quality of healthcare" (A.P.). Parties had other personal interests, but they found each other on the overarching interest: the quality of healthcare. A few participants indicated that shared interests were necessary to avoid parties pursuing their own interests. "It is important to keep the shared interests in mind. The reason we are working together is that we all want to provide good healthcare for patients. We all want this. If we don’t agree with, it is important to keep this interest in mind. This will ensure we will be at the same level" (U.G.); "It is important to keep the shared interests in mind" (A.P.); "The client was set first. Starting from a different way of thinking provides a lesson. This will ensure us to come further" (L.M.). This shows parties are more inclined to collaborate when shared interests are present because it ensures parties will not pursue their self-interests.
4.1.3 Mutual benefits

Parties should ensure the presence of mutual benefits (Bryson et al., 2006; Crosby & Bryson, 2005; Das & Teng, 2000). All respondents [12/12] stated there is one big mutual benefit, namely the improvement of the quality of healthcare. "I mainly see the benefits: the good transfer of a patient" (A.G.); "I think, mutual benefit is that we both improve the quality of patient’s healthcare" (A.M.); "I think, the advantages are the improvement of the quality of healthcare. Which is better complemented" (U.M.); "We know each other’s work (..) we can adapt to one another" (Z.P.); "If a transfer is really efficient, there will always be a mutual benefit" (L.G.).

Most respondents [11/12] experienced disadvantages as well. They state that the implementation of the collaboration is time-consuming [6/12] and that it is not always easy to implement [5/12]. "It is a new method that we have to adapt to. It always takes time to implement something new" (A.P.); "The disadvantage is that it takes a lot of time to arrange everything properly" (U.G.); "The investments we need to do takes more time" (Z.G.). "It was hard to process the differences" (Z.P.); "The changes were difficult to process" (L.M.).

Disadvantages and advantages should be equal for both parties (Das & Teng, 2000). Participants experienced that the advantages and disadvantages exist for both parties and not for only one party [7/12]. More important, they experienced that the advantages outweigh the disadvantages. "Both parties should not come out worse, otherwise it will repulse at a given moment" (L.M.); "In the end, I think that we have a better idea of what is going on and that can save time" (A.P.); "The challenge is how to achieve a higher goal with equal or lower costs. (..) The more proactive we are, I think, the easier that a goal can be achieved. In the end we will have high-quality, appropriate and affordable care" (U.P.). It became clear that participants experienced that mutual benefits are important for the collaboration. It shows the reason and usefulness to collaborate, namely that mutual benefits can arise as result of the collaboration.

4.2 Interaction

Interaction leads to a more effective collaboration (Miller & Shamsie, 1996). Interaction is defined as the process of perceptions, and verbal and non-verbal communication and the two-way exchange of meaningful information between parties (Fewster & Velsor, 2008; Mattessich & Monsey, 1992; Rice et al., 2010). Additional terms to effective and open communication are negotiation and respectful disagreement (Petri, 2010; San Martin-Rodriguez et al., 2005).
4.2.1 Communication

An effective and open communication is important for the success of a collaboration (Bender et al., 2013; D’Amour et al., 2005; Henneman et al., 1995; Petri, 2010; Rice et al., 2010). It indicates the intended verbal and nonverbal messages are successfully transmitted between parties (Bronstein, 2003; Lindeke & Sieckert, 2005). The interviews showed there are two levels of communication in this collaboration: the external communication between parties and internal communication within parties.

The first level of communication implies the expectations and responsibilities between parties. All parties [12/12] stated they feel the same level of responsibility to make this collaboration successful and to ensure a good quality of healthcare. "We are both responsible for good healthcare for our patients. We are responsible for good communication with each other as well" (Z.G.); "We both have the social task to organize good and dignified care" (U.P.); "We both have the same responsibility to ensure good healthcare" (A.G.). A few respondents [3/12] stated they are only responsible for their own part of their job. However, this is to ensure the other party can do its job as well. "Our main responsibility is to do our own job so the other party can do his job as well" (Z.M.); “We are both responsible for our own part of the job” (Z.P.); "There is a clear border, when a patient is discharged from the hospital, the responsibilities are with the other party" (A.P.). This proves parties’ responsibilities are clear and the same. They feel the same responsibility to ensure a good quality of healthcare.

Even though parties made appointments in a covenant (covenant documents), parties’ expectations are not that clear. A brief overview of parties’ expectations within a case is included in Appendix 7. It shows most respondents do not clearly understand what the other party expects of them. A notable fact is that the expectations of the hospitals in the eyes of home care organizations are clearer for both parties than the expectations of the home care organization in the eyes of hospitals. Examples of this fact can be obtained from Appendix 7.

The second level includes the internal communication. A few respondents stated the knowledge about the project itself was not clear [4/12]. They stated it is important to communicate the obtained successes and to celebrate them. This is with the aim parties know that the collaboration is working. "What went wrong was that people did not know what the project was about and what was expected of them. Agreements were made at managerial level, but not at organizational level (...) it is nice that there are covenants, but things were not clear at the organization level" (A.M.; covenant documents); "Communication is very important: newsletters, something in the newspaper. You have to come up with something that shows your
successes on a regular basis. Create successes and celebrate them" (Z.P.); "We gave a presentation once. (..) Everyone could indicate what their ideas were but nobody ever heard of it again. That annoys us" (Z.G.); "The success of the collaboration. (..) To achieve successes and to celebrate them. (..) We should not only look at what went wrong" (U.P.). This shows the importance of internal communication about the project itself. Parties need to know what to do, whether they are doing well and whether the collaboration leads to the desired collective action.

It can be stated that communication between parties is not optimal. This is confirmed by half the respondents [6/12]. They stated there is still lack of communication or communication is complicated. "Communication is quite complicated" (Z.P.); "The communication is complex" (A.G.); "I think we can improve the communication" (Z.G.); "People did not know what it was all about and what was expected of them" (A.M.). Despite the fact that communication is not that optimal, all respondents [12/12] state communication is crucial for the collaboration. "Good communication is crucial" (A.G.); "The most important thing is to ensure ongoing communication" (A.M.); "I think that communication can be improved. (..) Communication among parties but also the presentation of the project itself" (Z.G.); "Clear communication is an important lesson: to make it clear what we are doing" (Z.P.). Communication ensures the awareness of roles. It can be said that the two levels of communication entail that there also are two levels of awareness: external as well as internal. External role awareness contains the transfer and clarification of the expectations and responsibilities between parties. Parties must know what they can expect of each other. Internal role awareness refers to the transfer and clarification of expectations and responsibilities within parties. It implies that parties must know what they should do, whether they are doing well and whether the collaboration leads to the desired collective action.

4.2.2 Information sharing

The sharing of information refers to the existence and appropriate use of information channels to allow fast and complete exchanges of information between professionals (D’Amour et al., 2008). The results showed the sharing of information takes place in different ways. Via vocal communication by telephone [12/12], vocal communication when participating in a working group [12/12] and sometimes by a visit of a home caregiver in the hospital [6/12]. Also, all parties [12/12] use a letter of resignation that goes along with the patient and other parties [6/12] also use Point, an electronic program. A brief overview of the channels used to
share information within a case is included in Appendix 8. This shows there is vocal and written sharing of information. The interviews showed that within every separate case, each respondent experienced the same channels of communication. Examples of this fact can be obtained from Appendix 8.

Most respondents experienced the sharing of information is improved but still experienced a lack of complete information exchange [9/12]. Notable is that the managers from home care organizations and geriatrics experienced there was lack of complete information sharing about a patient’s transfer. "I think that the transfers have become a lot better (..) but it can always be better" (U.G.); "The intention is present, but it does not always happen" (U.M.); "It is certainly missing (..) I think they just do not have that information" (Z.G.); "That the information is no longer shared. That no good transfer forms are made up anymore" (Z.M.); "I think quality can be improved" (L.G.). On the other hand, project leaders thought the sharing of information was complete [2/4] or they did not know for sure [2/4]. "Yes, I think so, if they are satisfied about the content, I do not know" (A.P.); "Yes, that is why we created the flowchart" (Z.P.).

The sharing of information increases the understanding of the shared problem and gives parties the information they need to successfully do their job (D’Amour et al., 2008; Lindeke & Sieckert, 2005; Thomson & Perry, 2006). This is confirmed by the respondents. Parties were trying to fix the incompleteness because it is of importance for the collaboration [12/12]. Parties made transfer documents together that contain the letter of resignation. They tried to find out what is of importance for the other party [12/12]. "We created a working document, in which we both created our own part, which we discussed with each other" (L.M.); "We made the transfer documents in that way (..) what exactly should be in that transfer" (Z.P.); "A transfer document (..) in which anything important for the continuation of the policy is included" (A.G.).

Knowledge sharing needs to be created because parties must understand each others’ contributions to effectively integrate them (Doz, 2017). It contains meaningful information that can help parties to get to know each other and to learn from each other (Doz, 2017; San Martin-Rodríguez et al., 2005). This is confirmed by the respondents [12/12]. In two cases, respondents organized trainings for both hospital- and home caregivers with the purpose to get to know each other. In that way, they can find out what kind of information is needed for the counterparty. "It is very important to give a trainings. (..) Schooling nurses from the hospital and home care organizations together, is an enormous added value, because they get to know each other's perspectives" (A.P.); "When this happens often and you see each other multiple times, you will
get to know each other. This ensures the exchange of that kind of things” (A.M.); “We also give trainings (..) to make them to get to know each other” (U.M.). Also, in one case they made a central point where parties can report a situation in which the collaboration was not functioning properly (U.P.; U.M.; U.G.). They used that information to improve the completeness of information exchanges and to learn from their mistakes.

The sharing of information assures the transfer of mutual knowledge, meaningful information that helps parties to get to know each other and learn from each other.

4.2.3 Negotiation

Negotiation is defined as the process of interaction by which collaborators strive for the most effective outcome through jointly decided actions (Ness, 2009). Parties should be able to participate in this process (Henneman et al., 1995; Lindeke & Sieckert, 2005; Petri, 2010). All participants [12/12] experienced they can participate at an equal amount. "They all have something to say about their responsibilities" (Z.P.); "They certainly have something to say about it. There should be an option to do so" (A.P.); "Yes, I think that both parties have just as much to say” (U.G.); "Yes, they are equal" (U.M.).

Parties must negotiate the details of when and how to collaborate, what they want and can offer the collaboration, how to structure their interactions and how to evaluate the outcomes (Bryson et al., 2006; Houldin et al., 2004; Petri, 2010; Thomson & Perry, 2006). This is confirmed by all the respondents [12/12]. "We must look together what is feasible, what is real. Sometimes it turns out to be not feasible" (A.G.); "All parties have to make the possibilities clear in advance. (..) We should be honest about it“ (Z.M.); "We have to indicate early when it will not work out (..) because we are all learning and we should be honest to each other what we need to do our job” (A.M). Parties negotiated what they can offer the collaboration while they made the transfer documents together. "They all have something to say for what they are responsible. (..) We are working together to create a document that is supported by everyone" (Z.P.); "We are jointly writing plans (..) it will be clear how we should do this the best way, we make a document with the lessons learned” (L.P.). This shows negotiation is important to clarify what can be offered to the collaboration by parties.

4.2.4 Discussion

There should be room for respectful disagreement in this process, because different parties will not always agree on all subjects (Houldin et al., 2004; Lindeke & Sieckert, 2005).
The room for discussion makes sure the ideas of both parties are welcome (D’Amour et al., 2008; Lindeke & Sieckert, 2005).

All the respondents [12/12] experienced there is room for discussion in the collaboration. "Yes, I think that it should always be there. There is good discussion and bad discussion. I think you should be able to have a positive discussion, to see if you can learn from the things you did and how to improve this at the same time to improve the care for vulnerable elderly" (A.G); "Yes, there is certainly room for discussion (...) what are the possibilities" (A.M.); "We discuss with each other what is going on and how we can solve it. We are trying to reach an agreement" (U.G.); "The discussions are present" (Z.G.).

Respectful disagreement enriches the process of interaction (Houldin et al., 2004; Petri, 2010). It enables the possibility to make adjustments to practices and to coordinate the problems (D’Amour et al., 2008). This is confirmed by the respondents [9/12]. They stated that there should be room to make adjustments to the pre-fixed arrangements to better fit the actual and specific situation. "Sometimes we have to change the original plan. (...) We have been way too good, acted too much according to the rules. We have to tailor it" (Z.P.); "We have made local adjustments and we have done that in mutual consent" (U.G.); "It is all about the feasibility" (U.P.); "It should be possible to be able to make local additional agreements" (U.M.). This means it is important that there is room for discussion. This ensures the possibility to make adjustments to practices.

4.3 Governance

Governance can be defined as the means by which order is achieved in a relationship, in which potential conflicts could threaten to disturb opportunities that can realize mutual gains (Ness, 2009). Such order is achieved through the implementation of mechanisms, also mentioned as social and formal controls, like shared authority (Gulati & Singh, 1998; Ness, 2009). One driver of collaborative governance is leadership (D’Amour et al., 2005; Emerson et al., 2011). A managerial choice is critical for matching the best type of governance structure to its conditions (Bryson et al., 2006).

4.3.1 Shared authority

Parties need to create a governance structure for reaching agreement on their activities through shared power arrangements (Crosby & Bryson, 2005; Thomson & Perry, 2006). Power should not be concentrated in the hands of one party, but all collaborators must be able to take
part in the decision-making process (D’Amour et al., 2008). There should be shared authority, like joint teams or working groups. Shared authority enables the presence of the self-governance structure, in which decision-making occurs through regular meetings or frequent interactions (Bryson et al., 2006). Furthermore, it ensures shared control.

This is confirmed by the respondents. Each case [4/4] had a working group that includes all involved parties to jointly make decisions. All respondents stated that they are able to participate in this working group [12/12]. "We have a kind of consultation every three months in which all parties are involved" (A.G.); "We have a team (...) that meets once in a while (...) to see how things are going, what the problems are and what is going well" (U.G.); "We have set up a working group in which people are coming together" (Z.M.); "Once a month there is a working group" (L.G.); "We had a working group in which they looked at the details" (Z.P.); "Everyone comes together (...) you can decide to do things differently, as long as joint conclusions can be made" (A.P.); "I have recently set up a working group (...) in which they are going to brainstorm together" (U.P.).

It is shown that parties make use of the self-governance structure, because decision-making occurs during regular meetings and frequent interactions. The self-governance structure is ensured by elements of shared authority, because parties make use of working groups in which all involved parties can participate. This means shared authority is present and important to ensure joint decision-making and it enables both parties to control the collaboration.

4.3.2 Central leadership

Central leadership refers to the existence of a clear and explicit function at two levels: at strategic level that guides the collaboration and at operational level to implement and navigate decisions and actions from strategic level to operational ones within an organization (Bryson et al., 2006; Child et al., 2005; D’Amour et al., 2008; Patru et al., 2015). The positions of leadership at strategic level refers to a project director. In other words, the leader of collaboration on which the economic success of the collaboration depends (Bryson et al., 2006; Child et al., 2005). The interviews showed a project leader is present in each case [12/12]. The most important task of this function is to lead up and drive on the collaboration [9/12], the planning of meetings and being the chairman of that meeting [6/12] and being the point of contact for both parties [3/12]. Most of the respondents [7/12] stated that they experience the collaboration did not function properly without a project leader, because they missed the guiding function. "At a certain moment there was no more subsidy for a project leader and we
immediately saw that the project was less productive because it was difficult to keep people involved" (Z.M.). "A project leader is very important, especially in such an area, you have to incentivize, because there are so many parties and because it is such a complicated project (...) a problem can be that the incentive is no longer there" (Z.P.); "The project leader leaving forms a great risk. it is the risk of delusion and failure of the project" (L.G.); "We did not really have a project leader (...) we sometimes missed a person who provided incentives" (U.M.). This means there is need for a project leader to guide the action.

The project leader can be a member of one of the collaborators or may be from an independent organization (Emerson et al., 2011). The cases showed there are two different preferences for a project leader. Two cases made use of an external project leaders [Zeeland; Leiden], an independent person who looks at the collaboration from the outside. The project leaders of the other cases are internal ones [Amsterdam; Utrecht]. This means this function is filled in by one person that is chosen out of the involved parties. It is striking that despite there are two different types of project leaders, all project leaders [4/4] stated it is better to have an internal project leader that is chosen out of one of the parties. "It is actually better, if one of the parties has a committed person, who is important for everyone. Someone who is also accepted by the parties and who provide incentives" (Z.P.); "We have searched for an external project leader, but nobody wanted to fulfil this role, because there are a lot of different working methods" (U.M.); "The person involved had his own idea about how everything should be executed. (...) He came from a completely different organization, (...) the hospital world is a whole different world" (Z.G.). An internal project leader knows the working area of that specific collaboration and has more insight in the working field. This means there is need for central leadership in the sense of an internal project leader that guides the collaboration.

The position of leadership at the operational level refers to gatekeepers, also known as managers from both sides of the collaboration that ensure the interaction between two parties (Bryson et al., 2006; Child et al., 2005). It refers to the managers who actually execute and implement the agreements in practice in their own organization (Patru et al., 2015). The operational managers need to navigate and implement decisions and actions from strategic level to operational ones in their own organization (Patru et al., 2015). This is confirmed by the respondents [6/12]. "Every organization has its own mandated person (...) who serves as a point of contact for the organization. Those persons are coming together in the working group" (L.P.); "Both parties have contact persons (...) which come together once every two months to interact" (U.G.); "We had our peak at the moment when there was someone in the hospital who
felt involved and responsible for it. At that moment the collaboration went well” (Z.M.); ”We have one person per party in the working group (..) they can ensure further distribution in the organization. This means these people (..) should have some mandate and also some authority to ensure the spread within the organization. If this is not the case (..) we can agree upon certain points, but if no one keeps his promises, it won’t work out” (U.M.). Furthermore, the project leaders on strategic level [4/4] stated it is better that parties are working bottom-up instead of top-down. They stated that it is better to retain knowledge at lower level. ”Also make sure it is done in practice (..) that you see how it goes (..) bottom-up” (Z.P.); ”A project leader is seen as the person arranging everything. This is not the case, if I leave in a year, the project will fail. They have to perform themselves” (L.P.); ”When working bottom-up, the greatest successes will be present. (..) Know how to put the right people in the right places” (U.P.); ”We have learned we should maintain knowledge at lower level, (..) because it is the problem owner. (..) You don’t have to start pulling everything” (A.P.). This shows there is need for a central leader at operational level to implement and navigate the decisions and actions from strategic ones to operational level.

One problem of the collaboration is that new people enter and leave the involved parties and thus the collaboration. ”Due to changes in the board of the hospital, nobody knew how to fill in the lists. There was lack of internal control” (Z.M.); ”They want a contact point in the home care organization and we want one in the hospital. When one is present, someone leaves the organization and it all ends” (A.M.). A solution for this problem has not yet been found by the respondents.

4.3.3 Differences

Parties have different cultures, because their disciplines are rooted in different theoretical frameworks (Fewster & Velsor, 2008). Most participants stated they experience differences between their organizations [10/12]. ”Yes, sometimes we get annoyed by that (..) but the other party gets annoyed about us sometimes as well” (U.G.); ”Of course there are differences (..) when we are coming together, we feel those differences” (U.P.); ”It is notable that the home care organization (..) does not have an idea about the processes in a hospital (..) system of how it works, what has to be done, what rules and protocols there are (..) and the culture of responsibility, the hierarchy in the hospital” (L.P.); ”I think that a lot of people here in the hospital do not have an idea of what the home care nurse is doing in the home situation” (A.P.). These differences could be overcome by central leadership which will guide the
A healthcare collaboration between a hospital and a home care organization (Gulati et al., 2012; Patru et al., 2015). However, only one respondent stated it is the role of the project leader to deal with the differences between parties. "Good leadership is to create synergy, this means bridging the differences. For me as chairman it is the challenge to bring (...) that together" (U.P.). More participants stated [7/12] they can handle the differences by ensuring good interaction and by making sure that parties learn from their differences. "If you communicate about it, it will come a long way" (L.P.); "We knew those differences from each other (...) but this can all be discussed" (U.M.); "It clarifies why we should transfer that information correctly" (A.P.); "That's one of the things we have discussed" (U.G.). Interaction can help to overcome the differences.

4.4 Trust and interdependency

A healthcare collaboration is a process in which interdependent professionals interact and are structuring a collective action towards patients’ healthcare (San Martin-Rodriguez et al., 2005). This means the involved parties should be interdependent rather than autonomous (D’Amour et al., 2008). Also, a collaboration requires trust to succeed (Child et al., 2005). Trust refers to the willingness of parties to relate with each other in the belief their actions will be beneficial rather than harmful, even though it cannot be guaranteed (Child et al., 2005; Das & Teng, 1998; Jones & George, 1998). According to the theoretical framework, there could be a two-way positive relationship between trust and the three best practices: collective action, interaction and governance.

4.4.1 Interdependency and trust

Interdependency can be linked to the resource dependency theory (D’Amour et al., 2005). This implies that parties have different but complementary resource needs, classified in two categories: property-based and knowledge-based resources (Child et al., 2005; Miller & Shamsie, 1996). Participants unanimously stated they are interdependent on each others’ knowledge-resources [12/12]. "We must work together to provide the right patient care. We depend on each other, we cannot provide the entire chain on our own" (L.G.); "Ultimately, the collaboration is especially essential for the patient, because the transfer from one place to another is of high importance" (Z.M.); "Yes, very much. The patient goes from one place to another" (Z.P.); "We have to deliver good healthcare when the patient goes home and when no home care is available, the patient would not be able to go home. (...) On the other hand, home care organizations depend on us for good information" (U.G.); "We cannot do this without
them" (Z.G.); "Without home care organizations, we cannot do this project, they need information from the hospital and vice versa" (A.P.); "We really need each other to reach the goal" (A.G.). A patient goes from one place to another and the parties need to collaborate to make this transfer succeed. They depend on each others’ knowledge and skills. The results showed all respondents recognized the importance of the collaboration because they are interdependent. Interdependency makes parties comprehend that they need each other and they need to collaborate.

Furthermore, a collaboration requires trust to succeed (Child et al., 2005). Trust means being confident that your partner will commit valuable resources and competences to transactions with the possible risk that the partner might take advantage of the commitment or the inability of partners to accomplish its part of the collaboration (Bryson et al., 2006; Thomson & Perry, 2006). Most respondents [9/12] indicated there is mutual trust between parties. "I think there is a lot of trust" (L.M.); "There is a lot of trust that there is a possibility to make it better for the vulnerable elderly together" (L.P.); "You can trust that the other party performs the tasks that you have assigned to him or her" (U.G.); "There is trust that everyone is really committed to do this right" (A.M.). Three other respondents stated there was lack of trust. "Mutual trust is not ensured and sometimes things are being said that should not been said very often" (A.G.); "There is a lack of trust of the home care organization to the hospital because it is the question if there is commitment in the hospital. Also, it is questionable if they get their jobs done (...) However, trust is increased by the end of the project" (Z.M.); "Sometimes there is less trust" (Z.P.). More important, all participants [12/12] declared that trust is crucial for a successful collaboration. "Mutual trust is very important (...) when this is missing (...) it will not work well" (A.G.); "Without trust we won’t not succeed" (U.P.); "We cannot collaborate when trust is missing" (U.G.); "Trust is extremely important for the collaboration. (...) No effort would be shown when there is no trust from the home care organization to the hospital, which results in a lower probability of success" (L.P.); "One must be convinced the other party is doing its best for patient care" (Z.G.); "Yes, otherwise one cannot work together" (Z.P.); "Mutual respect and understanding (...) to get along with each other" (A.P.). This shows trust increases the willingness to collaborate since it reduces uncertainty. It turns out that the collaboration will not succeed without trust.

4.4.2 Trust

According to the theoretical framework, there could be a two-way positive relationship
between trust and the three best practices: collective action, interaction and governance. First of all, parties are prepared to take risks more quickly when they share common goals, shared interests and mutual benefits (Child et al., 2005). A collective action can improve trust (Jones & George, 1998). This is confirmed by most respondents [8/12]. They argued there is trust, because both parties strive to the same collective action. "In my opinion, there is trust because everyone is really committed to do this well" (A.M.); "Yes, it is coming from an intrinsic motivation" (U.M.); "There is consensus for what they want to do and a lot of trust in that they can improve it for vulnerable elderly together" (L.P.); "We achieve more based on trust (...) we have to find each other on the content" (Z.M.); "When suddenly own interests emerge, it can be seen that there is lack of trust" (L.G.). This shows the practice of collective action influences trust. The other way around, there are no results that prove trust influences a collective action. This means there is a one-way relationship proven between the practice of collective action and trust.

Secondly, trust will evolve over time through continuous interaction, because interaction could ensure mutual understanding (Bryson et al., 2006; Child et al., 2005; D’Amour et al., 2008; Henneman et al, 1995; Jones & George, 1998). Interaction is an important aspect of establishing trust, because it will break down barriers (D’Amour et al., 2008). All parties state it is important to have continuous interaction for the development of trust [12/12]. "It means when multiple interaction takes place (...) trust will evolve naturally (...) it is important to hear the opinions of parties" (A.P.); "You should talk to each other, to ensure you will not lose trust in each other" (A.G.); "There are clear agreements (...) regarding that there is trust" (U.G.); "There is trust (...) we can confront each other" (U.M.). The respondents that experienced a lack of trust [2/3] stated that trust ex post was increased by continuous interaction. "In the end, they did share it. We came together. (...) If we cannot fully trust each other it will not work. At the end of the project, trust has been increased" (Z.M.); "Mutual trust is very important, when this is missing it won’t work. (...) In that case it is particularly a lack of knowledge" (A.G.); "Sometimes there was less trust (...) but in consultations we have discussed this" (Z.P.). The other way around, parties are more willing to interact when there is trust (Child et al., 2005). It gives the assurance that information and knowledge will be used for a common good and not for own interests (Jones & George, 1998). Participants experienced there is more room to interact when trust is present [6/12]. "That is trust (...) you should be able to find each other, you should be able to confront each other. The openness and trust must be present" (U.M.). "Mutual trust and understanding (...) to get along with each other" (A.G.). This means
there is a two-way positive relationship proven between the practice of interaction and trust.

Lastly, governance is achieved through the implementation of mechanisms, also mentioned as social and formal controls (Gulati & Singh, 1998; Ness, 2009). Control mechanisms can emerge trust, because parties are more confident about the collaboration when they feel they have control over the other party (Das & Teng, 1998). Only three respondents stated there is a relationship between trust and governance. "One must have the idea the other party is doing its best for patient care" (Z.G.); "You can trust the other party performs the tasks that you have assigned to him or her" (U.G.); "I think there is huge trust (...) parties are not competitors" (L.M.). Only a weak effect of trust on the practice of governance is found. The other way around, trust reduces the need to check-up and control the other party, because it reduces uncertainty (Child et al., 2005; D’Amour et al., 2008; Das & Teng, 1998). There are no results that can confirm this statement. This means there is no relationship proven between trust and governance.
5. Discussion

In this chapter the results of the analyses will be discussed based on the elaborated theoretical framework. This chapter is divided by the best practices: collective action, interaction and governance and by the two other main factors: trust and interdependency. Also, the propositions mentioned in chapter two will be tested at the end of each subchapter.

5.1 Collective action

The presence of common goals, shared interests and mutual benefits is necessary to ensure that parties are united and strive towards a collective action (Petri, 2010). A collective action is the basis for collaboration (D’Amour et al., 2008; Thomson & Perry, 2006). The analyses of the results showed all indicators representing the best practice of collective action were present. The presence of a common goal made parties understand they had to collaborate to achieve their common goal. Participants stated that a common goal is the basis for an enduring and effective collaboration. This is in line with the theory (Bronstein, 2003; Fewster & Velsor, 2008; Gulati et al., 1996; San Martin-Rodriguez et al., 2005; Wagner & Boustellier, 2002; Wells et al., 1998). Secondly, the analysis showed both parties had different interests, but they found each other on the overarching interest: the quality of healthcare. Parties were more inclined to collaborate when shared interests are present because it ensures parties will strive to shared interests rather than their self-interests. This is consistent with the theory that parties should focus on a common patient care rather than their individual interests (Das & Teng, 2000; Emerson et al., 201; Petri, 2010; San Martin-Rodriguez et al., 2005; Thomson & Perry, 2006). Lastly, the results showed that participants experienced mutual benefits. They also experienced disadvantages, but the mutual benefits outweigh them. It became clear that mutual benefits are important for the collaboration. It shows the reason and usefulness to collaborate, because mutual benefits can arise as result of the collaboration. This is consistent to the theory (Bryson et al., 2006; Crosby & Bryson, 2005; Das & Teng, 2000).

As expected by the theoretical framework, the data proves the presence of the following three indicators is necessary to overcome failures in cooperation (Gulati et al., 2012; Petri, 2010). Common goals, shared interests and mutual benefits ensure the alignment of interests. It helps parties to see why they should be willing to work together.

Regarding proposition 1, the results showed common goals, shared interests and mutual benefits should be present, since these are of importance for the success of the collaboration. The three indicators representing collective action as practice are present and of importance.
This means that there is a positive relationship between collective action and the success of the collaboration. That is, the practice of collective action helps to achieve and sustain a successful collaboration. It can be seen as a best practice, in the light of the strategy-as-practice concept. In conclusion, proposition 1 can be fully accepted.

5.2 Interaction

Interaction could lead to a more effective collaboration (Miller & Shamsie, 1996). The analyses of the results showed that all indicators representing the best practice of interaction were present. The results showed there are two levels of communication in this collaboration: the external communication between parties and internal communication within parties. Despite communication was not that optimal, parties were eager to improve it. They stated that communication is very important to make the collaboration workable. It is necessary to ensure the awareness of roles. This is consistent with the existing theory (Bender et al., 2013; D’Amour et al., 2005; Henneman et al., 1995; Petri, 2010; Rice et al., 2010). It can be said that the two levels of communication entail that there also are two levels of awareness: external as well as internal. External role awareness contains the transfer and clarification of the expectations and responsibilities between parties. Parties must know what they can expect of each other. Internal role awareness represents the transfer and clarification of expectations and responsibilities within parties. It implies that parties must know what they should do, whether they are doing well and whether the collaboration leads to the desired collective action. This is an addition to the theoretical framework.

The analysis showed the sharing of information is important to ensure the transfer of mutual knowledge. It ensures meaningful information that can help parties to get to know each other and learn from each other. Respondents experienced there is lack of information sharing. They were trying to fix this incompleteness by making transfer documents together and by organizing training days to ensure they get to know each other and can learn from each other. Respondents stated it is crucial to have complete information sharing to improve the collaboration. This is consistent to the theory (Bryson et al., 2006; Child et al., 2005; Doz, 2017; Lindeke & Sieckert, 2005; Madhok, 1997).

Regarding proposition 2a, the results showed communication and information sharing should be present, since these are of importance for the success of the collaboration. Proposition 2a can be accepted. However, these indicators only represent one part of the practice of interaction. To fully accept proposition 2, negotiation and discussion should also be present.
The discussion regarding these indicators is presented below.

The analysis confirmed negotiation clarifies what can be offered to the collaboration by parties. Participants stated it was important to negotiate and to be clear about what parties can contribute to the collaboration. This is in line with the existing theory (Lindeke & Sieckert, 2005; Ness, 2009; Petri, 2010; Thomson & Perry, 2006).

Furthermore, the analysis proved there should be room for discussion because it enables the possibility to make adjustments to practices. It became clear there should be room to make local additional agreements based on case-specific needs. This is consistent with the theory because it ensures the ideas of both parties are welcome (D’Amour et al., 2008; Houldin et al., 2004; Lindeke & Sieckert, 2005; Petri, 2010).

Regarding proposition 2b, the results showed negotiation and discussion should be present, since these are of importance for the success of the collaboration. Proposition 2b can be accepted.

As expected by the theory, the data proves the presence of the indicators: communication, information sharing, negotiation and discussion is necessary to overcome failures in coordination (Gulati et al., 2012; Petri, 2010). It ensures the alignment of actions. It helps parties to know how to work together when they want to do so (Kretschmer & Vanneste, 2017). The four indicators representing interaction as practice are present and of importance. This means that there is a positive relationship between interaction and the success of the collaboration. That is, the practice of interaction helps to achieve and sustain a successful collaboration. It can be seen as a best practice, in the light of the strategy-as-practice concept. In conclusion, proposition 2 can be fully accepted.

5.3 Governance

The analysis of the results showed the two indicators representing the best practice of governance were present. The analysis showed parties make use of the self-governance structure, because decision-making occurs during regular meetings and frequent interactions. As expected by the theoretical framework, parties prefer the self-governance structure in a healthcare collaboration, because it ensures frequent interactions between parties. This structure is ensured by the implementation of elements of shared authority. Parties make use of working groups in which all involved parties can participate. This means shared authority is present and
important to ensure joint decision-making. It enables both parties to control the collaboration. This is in line with the theoretical framework (Bryson et al., 2006; D’Amour et al., 2008; Emerson, 2011; Ness, 2009).

Regarding proposition 3a, the results showed shared authority should be present, since it is of importance for the success of the collaboration. Proposition 3a can be accepted. However, shared authority only represents one part of the practice of governance. To fully accept proposition 3, central leadership should also be present. The discussion regarding this indicator is presented below.

One driver of collaborative governance is leadership (D’Amour et al., 2005; Emerson et al., 2011). The analysis showed there is need for leaders at two levels. The first one is a leader at strategic level: a project leader that guides the collaboration. The second one refers to leaders at operational level: managers who implement and navigate decisions and actions from strategic level to operational ones within their own organization. The results showed participants prefer an internal project leader over an external one. An internal project leader knows the working area of that specific collaboration and has more insight in the working field. Furthermore, participants stated that the operational level manager is important, because better results can be achieved when parties work bottom-up and knowledge remains at lower level. Parties have to fulfil their own duties. The operational manager should be able to co-decide strategic decisions. Furthermore, joint decision-making should be possible. This is in line with the theory (Bryson et al., 2006; Child et al., 2005; Crosby & Bryson, 2005; Patru et al., 2015; San Martín-Rodriguez et al., 2005; Wagner & Boutellier, 2002).

Not in line with expectations, it is not the job of the central leader to deal with differences in cultures. This is not coherent with the outlined theory (Gulati et al., 2012; Patru et al., 2015). It is through interaction that parties get to know each other, can learn from each other and can deal with differences. The practice of governance could ensure further interaction. This would be in line with the theory (Gulati & Singh, 1998; Ness, 2009). Coordination also contains how interactions are organized between partners (Gulati et al., 2012). Interaction can take place through the use of self-governance structures, by using elements of shared authority such as working groups in which joint decision-making occurs. Furthermore, a central leader could guide the working groups and ensure effective interaction.

Regarding proposition 3b, the results showed central leadership should be present, since it is of importance for the success of the collaboration. Proposition 3b can be accepted.
As expected by the theory, the data proves the presence of the indicators: shared authority and central leadership is necessary to overcome failures in coordination (Gulati et al., 2012; Petri, 2010). It ensures the alignment of actions, because it provides greater control and coordination (Gulati & Singh, 1998). The two indicators representing governance as practice are present and of importance. This means that there is a positive relationship between governance and the success of the collaboration. That is, the practice of governance helps to achieve and sustain a successful collaboration. It can be seen as a best practice, in the light of the strategy-as-practice concept. In conclusion, proposition 3 can be fully accepted.

5.4 Trust and interdependency

Interdependency can be linked to the resource dependency theory that implies that parties have different but complementary resource needs (D’Amour et al., 2005). The analysis showed participants unanimously recognized they are interdependent. Parties stated they depend on each other’s knowledge-based resources: knowledge and skills. The results showed that interdependency makes parties comprehend they need each other and they need to collaborate. This is consistent with the resource dependency theory (Bronstein, 2003; Child et al., 2005; D’Amour et al., 2005; Das & Teng, 2000; Madhok, 1997; Miller & Shamsie, 1996; Thomson & Perry, 2006).

A collaboration requires trust to succeed (Child et al., 2005). The analysis showed most respondents experienced trust is present in the collaboration. All respondents stated trust is important for the collaboration to succeed because it reduces uncertainty and influences the willingness to collaborate. This is coherent with the theory (Bender et al., 2013; Bronstein, 2003; D’Amour et al., 2005; Henneman et al., 1995; Lindeke & Sieckert, 2005; Petri, 2010).

Regarding proposition 4a, the results showed trust and interdependency should be present, since these are of importance for the success of the collaboration. This means that there is a positive relationship between these factors and the success of the collaboration. That is, they help to achieve and sustain a successful collaboration. They can be seen as a main factors. In conclusion, proposition 4a can be fully accepted.

On the relationship between trust and the best practices: collective action, interaction and governance, two relations are found. Only a one-way positive relationship of the practice of collective action influencing trust is proven. A two-way positive relationship between trust and the practice of interaction is present. Parties argue there is trust, because both parties strive
to the same collective action. This is in line with the theory (Gulati et al., 2012; Jones & George, 1998; Kretschmer & Vanneste, 2017; Thomson & Perry, 2006). It is notable that participants anonymously indicated that trust and the practice of interaction influence each other. Parties state it is crucial to have continuous interactions to develop and ensure trust. It will increase mutual understanding. The other way around, parties stated there is more room to interact when there is trust. This is in line with the theory (Bryson et al., 2006; Child et al., 2005; D’Amour et al., 2008; Henneman et al, 1995; Jones & George, 1998). Lastly, only a small relationship of trust influencing the practice of governance is proven. This relationship can therefore not be fully accepted.

Regarding proposition 4b, the results showed there is only a one-way positive relationship of the practice of collective action influencing trust. A two-way relationship between trust and the practice of interaction is proven. They positively influence each other. Lastly, only a weak effect of trust on the practice of governance is found, meaning this relationship cannot fully be accepted. In conclusion, proposition 4b can only be accepted partially.
6. Conclusion

In this chapter the final conclusion will be set out. This chapter ends with the limitations, policy and managerial implications and practical recommendations of this research.

6.1 Final conclusion

This research aimed to gain more insight in a healthcare collaboration between a hospital and a home care organization. This study has taken the TCB as an example for researching a successful healthcare collaboration in general. The best practices for the TCB that helped to achieve and sustain the successful healthcare collaboration have been studied. These practices can be applied to a healthcare collaboration between hospitals and home care organizations in general. Therefore, the following research question was formulated in this thesis:

"What are the best practices for a successful healthcare collaboration between a hospital and a home care organization?"

A healthcare collaboration is an interdisciplinary collaboration (Fewster & Velsor, 2008; Houldin et al., 2004). It is through an interdisciplinary collaboration that the different roles interact and strive for the improvement of the quality of healthcare (Wells et al., 1998). Nevertheless an interdisciplinary collaboration is an essential element in healthcare, it is a complex phenomenon and can cause problems due to failures in cooperation and coordination (Bronstein, 2003; D’Amour et al., 2005; D’Amour et al., 2008; Gulati et al., 2012; Houldin, 2004; Kretschmer & Vanneste, 2017; Lindeke & Sieckert, 2005 Petri, 2010). This means organizing healthcare services requires not only the implementation of structures but also clinical and strategic practices to guide a successful collaboration and to overcome its problems (D’Amour et al., 2008). Previous research has defined and conceptualized the attributes required for a successful healthcare collaboration (Bronstein 2003; Fewster & Velsor, 2008; Houldin, 2004; Petri, 2010; San Martin-Rodriguez et al. 2005). In contrast to the attributes, little is known about the practices required to achieve and sustain a collaboration between partners (Patru et al., 2015). Practices are the symbolic, material and social tools through which strategy is done (Golsorkhi et al., 2010; Jarzabkowski & Spee, 2009). Practices relate to the doing of strategy and are used to shape the actual activity that is being accomplished (Jarzabkowski et al., 2007). The process of a healthcare collaboration can be linked to the strategy-as-practice concept, since this concept delves deeper into what is actually going on (Jarzabkowski et al., 2007; Jarzabkowski & Spee, 2009; Patru et al., 2015; Vaara &
Whittington, 2012; Whittington, 2006). It can concretize what actually takes place in the healthcare organizations when strategy work is being done (Patru et al., 2015). The concept focuses on how the doing of strategy contributes to organizational performance and how the practices create the strategy process (Jarzabkowski & Spee, 2009; Patru et al., 2015; Vaara & Whittington, 2012; Whittington, 1996). It can help to uncover what strategic practices must be done for a successful collaboration. In other words, what the best practices are to help to achieve and sustain a successful healthcare collaboration.

Nine propositions have been elaborated based on this concept. The propositions explain the expected best practices, implied by different indicators and other main factors that will help to achieve and sustain a successful healthcare collaboration. The first seven propositions explained there is a positive relationship between the presence of the practices and the success of a healthcare collaboration. It is expected that there are three best practices, namely: collective action, interaction and governance. These practices could be seen as best practices for a successful healthcare collaboration in the light of the strategy-as-practice concept. The expected best practices can be implied by the existence of different indicators. Furthermore, the eighth proposition implies there is a relationship between the existence of the two factors trust and interdependency and the success of a healthcare collaboration. The last proposition states there is a two-way positive relationship between trust and the expected three best practices: collective action, interaction and governance.

To answer the main question and test the propositions, this study was set up as a case study. By using a case study, different views and situations were gathered. The data is collected through 12 semi-structured interviews within 4 different areas with project leaders, managers from home care organizations and hospital professionals specified in elderly care, named geriatrics. The results are set out per best practice:

Collective action: The presence of a collective action is implied by the existence of a common goal, shared interests and mutual benefits within a collaboration. A common goal makes parties understand they must collaborate to achieve their common goal. In addition, parties are more inclined to collaborate when shared interests are set ahead of self-interest. The presence of mutual benefits shows the reason and usefulness to collaborate. The three indicators: common goals, shared interests and mutual benefits are necessary to overcome failures in cooperation. It ensures the alignment of interests. The three indicators representing a collective action as practice are present and of importance. This means that there is a positive relationship between collective action and the success of the collaboration. That is, the practice
of interaction helps to achieve and sustain a successful collaboration. It can be seen as a best practice, in the light of the strategy-as-practice concept.

**Interaction:** The presence of interaction is implied by the existence of communication, information sharing, negotiation and discussion within a collaboration. First, communication ensures the awareness of roles. There are two levels of awareness: external as well as internal. External role awareness contains the transfer and clarification of the expectations and responsibilities between parties, what they can expect of each other. Internal role awareness represents the transfer and clarification of expectations and responsibilities within parties. It implies that parties must know what they should do, whether they are doing well and whether the collaboration leads to the desired collective action. Second, the sharing of information assures the transfer of mutual knowledge, meaningful information that helps parties to get to know each other and learn from each other. Third, negotiation clarifies what parties can offer the collaboration. Lastly, discussion enables the possibility to make adjustments to practices. The four indicators are necessary to overcome failures in coordination. It ensures alignment of actions. The four indicators representing interaction as practice are present and of importance. This means that there is a positive relationship between interaction and the success of the collaboration. That is, the practice of interaction helps to achieve and sustain a successful collaboration. It can be seen as a best practice, in the light of the strategy-as-practice concept.

**Governance:** The presence of governance is implied by the existence of shared authority and central leadership within a collaboration. Parties make use of the self-governance structure, ensured by the implementation of elements of shared authority, because parties make use of working groups. This means that decision-making occurs during regular meetings and frequent interactions with all parties involved. Shared authority is present and important to ensure joint decision-making and shared control. A successful development of a collaboration depends on the effort of two central leaders: at strategic level and at operational level. The first one is a project leader that guides the collaboration. The second one refers to managers who implement and navigate decisions and actions from strategic level to operational ones in their own organization. It turned out it is not the function of the central leader to deal with differences in cultures. It is through interaction that parties get to know each other, can learn from each other and can deal with these differences. The presence of these indicators helps to overcome failures in coordination. It ensures alignment of actions. The two indicators representing governance as practice are present and of importance. This means that there is a positive relationship between governance and the success of the collaboration. That is, the practice of governance helps to
achieve and sustain a successful collaboration. It can be seen as a best practice, in the light of the strategy-as-practice concept.

**Interdependency and trust:** Interdependency makes parties comprehend they need each other and they need to collaborate. Trust reduces uncertainty and increases the willingness to collaborate. The results showed trust and interdependency should be present, since it is of importance for the success of the collaboration. This means that there is a positive relationship between these factors and the success of the collaboration. That is, they help to achieve and sustain a successful collaboration. They can be seen as a main factors. Furthermore, the results showed there is only a one-way positive relationship of the practice of collective action influencing trust. There is trust because parties strive to the same collective action. A two-way positive relationship between trust and the practice of interaction is proven. Continuous interactions develop and ensure trust because it increases mutual understanding. The other way around, parties stated that they experience more room to interact when there is trust. Lastly, only a weak effect of trust on the practice of governance is found, meaning this relationship cannot fully be accepted.

In conclusion, the following model has been made to summarize the findings.

![Figure 4: The Model of Results of a Successful Healthcare Collaboration](image-url)
Figure 4 shows the results found for the three best practices, implied by nine indicators and the two other main factors for a successful healthcare collaboration. Influences and relationships between the components are indicated by arrows in the model.

6.2 Limitations

The results and conclusion of this research can be seen as the outcomes of best practices for a successful healthcare collaboration. The TCB is a successful healthcare collaboration aimed at providing the best care for vulnerable elderly, making the transfer from hospital to their homes. Due to the increasing attention and demand for elderly care in society and the success of the TCB, this study took the transmural care bridge as an example to study a successful healthcare collaboration in general. The research outcomes found can be interpreted in the light of the TCB and applied to a collaboration between a hospital and a home care organization in general.

Several limitations, shortcomings and opportunities for further research have been found. One limitation of this study is that the TCB does not fit within one specific framework. It is adjusted to the specific conditions of each case. Even though it is a strength that parties can make adjustments due to discussion, this can be a limitation for this research. In this research, the comparison of four different regions has been made. All cases had a different time-lapse regarding the TCB: one case has already implemented, two cases were currently implementing and another case just started to implement the TCB. Furthermore, this study took the transmural care bridge as an example to study a successful healthcare collaboration in general. However, the TCB is aimed at providing the best care for vulnerable elderly. The scope of a healthcare collaboration between hospitals and home care organizations in general can be broadened to other patients. Other practices might then be needed for success.

Secondly, multiple parties are involved in this collaboration. This study is limited to interviewing only one person per involved party. Only three persons per case are interviewed. However, several hospitals and home care organizations are involved. To broaden this research, it would have been good to interview more involved persons and parties. Also, the studied collaboration is even more complex than stated in this work because GPs and health insurances are also involved. Even though they meet each other in the same working groups and joint meetings and the biggest part of this research can be applied to this collaboration in general, it only studies the collaboration between a home care organization and a hospital. Further research can be done on the collaboration between all those parties.
Lastly, the results showed governance might assure that interaction takes place. There might be a relationship between the other best practices. It is possible they can influence each other. This would be in line with the theory that a certain minimum of coordination is required for cooperation and vice versa (Gulati et al., 2012; Kretschmer & Vanneste, 2017). Further research can be conducted on other relationships between the best practices and how they influence each other based on this theory. Further research can also be conducted on the relationships between trust and governance. Not enough results were collected to fully accept a relationship between these two.

6.3 Policy and managerial implications

A few managerial and policy implications can be given per best practice:

Collective action: Policy makers should ensure that the goals, interests and benefits of both parties are clearly understood. They should take them into account and consider them when creating the final policy. This can help to ensure the presence the common goals, shared interests and mutual benefits of parties that represent a collective action. In the process of policy making, it became clear project leaders and operational managers repeatedly needed to clarify and remind parties they are striving towards a collective action. It is important parties keep this in mind. Otherwise, they will still strive towards their own goals, interests and benefits.

Interaction: This study showed that there are two levels of communication entailing that there also are two levels of awareness: external as well as internal. External role awareness contains the transfer and clarification of the expectations and responsibilities between parties. Internal role awareness refers to the transfer and clarification of expectations and responsibilities within parties. Policy makers and managers should ensure the internal communication. Policies and agreements can be made at policy level. However, it became clear that most of the time the agreements were not clear at lower level. The intention and the successes of the collaboration should be clear within the organization. Parties must know what they should do, whether they are doing well and whether the collaboration leads to the desired collective action. Managers should ensure internal role awareness. It is important to celebrate the obtained successes. Organizing trainings for both parties can help with that. Furthermore, policy makers should ensure there is room to make local adjustments at a lower level.

Governance: The analysis showed there is need for leaders at two levels: at strategic level and at operational level. The first one is a project leader that guides the collaboration. The second one refers to managers who implement and navigate decisions and actions from strategic
level to operational ones in their own organization. It became clear that a project leader is necessary to drive on the collaboration and the planning of meetings and being the chairman of that meeting. A central leader should ensure shared authority is present by organizing joint teams or working groups. It is necessary for the use of the self-governance structure that ensures decision-making through regular meetings and frequent interactions. As chairman, the project leader should ensure the presence of optimal interaction. This will help to make joint decision-making effective. In this study an internal project leader is preferred above an external one. An internal project leader knows the working area of that specific collaboration and has more insight in the working field. Parties should make sure the project leader is democratically chosen by all involved parties and has some power to guide the collaboration. This will ensure the project leader is impartially. The operational managers should ensure they have some mandate and also some power to ensure implementation of agreements within their own organization. These are necessary to implement decisions and actions from strategic level to operational ones in their own organization. Furthermore, more successes can be achieved by working bottom-up. Lower managers should be able to co-decide strategic decisions. Furthermore, joint decision-making should be possible. This can be ensured by the use of the self-governance structure, due to the use of shared authority, like joint teams or working groups.

**Interdependency and trust:** Policy makers and managers should both ensure the best practices are respected and present. This will help to the increase the awareness of interdependency and trust.

### 6.4 Recommendations

A few practical recommendations can be given per best practice.

**Collective action:** In this study parties stated they are striving for the same collective action. They experience they have common goals, shared interests and mutual benefits. To keep this in mind, parties should look at the whole of the collaboration. They should see themselves as part of the collective chain instead of performing their own parts’ duties. This would lead to parties being too much inclined to realize their own interests. Furthermore, parties stated subsidy money is important for the TCB. Subsidy is needed to fulfil the project’s goals, but parties’ interests might be shifted by the money involved. When money is in the game, parties mostly forget the real reason why they started the collaboration in the first place. Parties should put the collaboration on the first place and remuneration should be seen as an extra.

**Interaction:** Parties make use of different channels and software for the transfer of
information. There should be one specific and clear form of software to make it easier to share the needed information. This is a very difficult point in the medical world as a whole due to privacy laws. Further research can be done on how parties can ensure a patient’s privacy and at the same time make the sharing of information easier. A lot of progress can be made at this point. Furthermore, the results showed interaction is the most important practice for a successful collaboration and helps to reduce differences in process and structures. Parties should make sure their interaction is optimal by ensuring the four indicators: open and honest communication, complete information sharing, negotiation and discussion. It is important to continuously interact, i.e. by repeated calls, an ICT program, a letter of resignation or a visit by a home caregiver.

**Governance:** Regarding shared authority, it became clear the parties waited till the project leader had organized joint meetings or a working group. Also, they stated they missed the guiding function when the project leader was not present. Parties could also arrange these meetings themselves. They should not be depending on the project leader. It is important because it makes joint decision-making possible. Furthermore, participants stated central leadership is difficult to manage due to changes of persons within the project. Parties should ensure a better internal transfer of knowledge from the person that leaves to the person that takes over his position. Contractual arrangements can diminish the problem of position takeovers.

**Interdependency and trust:** Interdependency is most self-evident. Parties are aware they are interdependent. It became clear trust can be increased by continuous interaction and striving towards a collective action. When parties ensure these best practices, it will also positively influence trust.

In conclusion, a collaboration is a complex phenomenon. When parties take the studied best practices implied by different indicators and main practices into account, it will help to achieve and sustain a successful collaboration. The provided recommendations and implications further facilitate the success of the healthcare collaboration.
References


 Appendices

Appendix 1: Figures
This appendix includes figures that will help to understand or summarize this study.

Figure 1: The process of the Transmural Care Bridge
A figure made by ‘Stichting Effectieve Ouderenzorg’ that represents the process of the Transmural Care Bridge.
Figure 2: The managerial grid of negotiating possibilities

Blake and Mouton (1964) integrated these five possible approaches into a matrix that they called the Managerial Grid, illustrated in this figure.

Source: adapted from Child et al., 2005.
Appendix 2: Tables

This appendix includes tables that will help to understand or summarize this study.

Table 1: Description of the best practices in a healthcare collaboration

<table>
<thead>
<tr>
<th>Best practices</th>
<th>Collective action</th>
<th>Interaction</th>
<th>Governance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>An action that has been taken together by a group that has a common purpose. It means both parties should have common goals, shared interests and mutual benefits. Common goals refer to the recognition of same goals. Shared interests refer to the achievement of shared aims and objectives. Mutual benefits refer mutual outcomes of the collaboration.</td>
<td>Process of perceptions. It is implied by communication, information sharing, negotiation and discussion. Communication ensures role awareness, it clarifies the expectations and responsibilities of both parties. Information sharing makes mutual knowledge sharing possible, meaningful information that helps parties to get to know each other and learn from each other. Furthermore, there should be room to negotiate to clarify what parties can and cannot offer the collaboration and the room for discussion that enables it to make adjustments to practices.</td>
<td>It is a set of monitoring and coordinating activities that allows the survival of the collaboration, because it is the process that influences decisions and actions. Governance is implied by shared authority and central leadership. Shared control is a control mechanism, that includes joint teams or work groups. It assures the use of the self-governance structure that ensures decision-making through regular meetings and frequent interactions. Central leadership refers to the existence of a clear and explicit function at strategic level that guides the collaboration and a function at operational level to implement and navigate decisions and actions from strategic level to operational ones in their own organization.</td>
</tr>
<tr>
<td></td>
<td>Positivism</td>
<td>Post positivism</td>
<td>Critical theory et al.</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Ontology</strong></td>
<td>Naïve realism – &quot;real&quot; reality but apprehendable</td>
<td>Critical realism – &quot;real&quot; reality but only imperfectly and probabilistically apprehendable</td>
<td>Historical realism – virtual reality shaped by values; crystallized over time</td>
</tr>
<tr>
<td><strong>Epistemology</strong></td>
<td>Dualist/objectivist; findings are true</td>
<td>Modified dualist / objectivist; critical tradition/ community; findings probably true</td>
<td>Transactional/ subjectivist; value mediated findings</td>
</tr>
<tr>
<td><strong>Methodology</strong></td>
<td>Experimental/ manipulative; verification of hypotheses; chiefly quantitative methods</td>
<td>Modified experimental/ manipulative; critical multiplism; falsification of hypotheses; may include qualitative methods</td>
<td>Dialogic/ dialectical</td>
</tr>
</tbody>
</table>

*Source: adapted from Guba & Lincoln, 1994.*
### Table 3: Characteristics of respondents

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Sex</th>
<th>Function</th>
<th>Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>Women</td>
<td>Project leader</td>
<td>Zeeland</td>
</tr>
<tr>
<td>#2</td>
<td>Women</td>
<td>Geriatric</td>
<td>Zeeland</td>
</tr>
<tr>
<td>#3</td>
<td>Women</td>
<td>Manager</td>
<td>Zeeland</td>
</tr>
<tr>
<td>#4</td>
<td>Women</td>
<td>Project leader</td>
<td>Amsterdam</td>
</tr>
<tr>
<td>#5</td>
<td>Men</td>
<td>Project leader</td>
<td>Utrecht</td>
</tr>
<tr>
<td>#6</td>
<td>Women</td>
<td>Manager</td>
<td>Amsterdam</td>
</tr>
<tr>
<td>#7</td>
<td>Men</td>
<td>Geriatric</td>
<td>Amsterdam</td>
</tr>
<tr>
<td>#8</td>
<td>Women</td>
<td>Manager</td>
<td>Leiden</td>
</tr>
<tr>
<td>#9</td>
<td>Women</td>
<td>Project leader</td>
<td>Leiden</td>
</tr>
<tr>
<td>#10</td>
<td>Men</td>
<td>Manager</td>
<td>Utrecht</td>
</tr>
<tr>
<td>#11</td>
<td>Men</td>
<td>Geriatric</td>
<td>Leiden</td>
</tr>
<tr>
<td>#12</td>
<td>Women</td>
<td>Geriatric</td>
<td>Utrecht</td>
</tr>
</tbody>
</table>

### Table 4: Overview of codename respondents

<table>
<thead>
<tr>
<th>Region</th>
<th>Function</th>
<th>Codename</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zeeland</td>
<td>Project leader</td>
<td>Z. P.</td>
</tr>
<tr>
<td>Amsterdam</td>
<td>Geriatric</td>
<td>A. G.</td>
</tr>
<tr>
<td>Utrecht</td>
<td>Manager in home care</td>
<td>U. M.</td>
</tr>
<tr>
<td>Leiden</td>
<td></td>
<td>L.</td>
</tr>
</tbody>
</table>
Appendix 3: Guideline interview
This appendix includes an interview plan based on the theoretical framework that was developed to guide the interviews. The interview is held in Dutch, because all interviewed participants were Dutch. The English translation is included as well.

Introduction


English: At this moment I am working on my master’s thesis of Strategic Management at Radboud University. My thesis is about the improvement of guidance of vulnerable elderly from the hospital to home. More specifically, I want to study the collaboration that arises, namely: the hospital and home care. I want to study which aspects this collaboration must include to succeed, because of the strategic vision of my thesis. Given the fact the transmural care bridge is an existing collaboration, I want to take this as the starting point. I will only study the collaboration between the hospital and home care, I will not include any other parties in my thesis. The interview will last about an hour and will consist of 41 questions.

General person

1. Wat is uw functie? / What is your function?
2. Waar bent u werkzaam? / Where are you working?
3. Wat is uw opleiding? / What is your level of education?

General process

4. Bent u bekend met het begrip en het proces van transmurale zorgbrug voor ouderen? / Are you familiar with the concept and process of the transmural care bridge for the elderly?
5. Wat vindt u van het project transmurale zorgbrug? / What do you think of the transmural care bridge project?
6. Met welk gebied/ziekenhuis/stad heeft u te maken (gehad)? / Which area / hospital / city do/did you have to deal with?
7. Wat was de officiële startdatum van dit implementatieproces? / What was the official start date of this implementation process?
8. Sinds wanneer heeft u te maken met dit project? / Since when are you part of this project?
9. Wat is uw rol in het project? / What is your role in this project?

Collective action
10. Waarom bent u begonnen met dit project? / Why did you start this project?
11. Waarom is de implementatie van dit project belangrijk gezien vanuit het ziekenhuis? / Why is the implementation of this project important for the hospital?
12. Waarom is de implementatie van dit project belangrijk gezien vanuit de thuiszorg? / Why is the implementation of this project important for the home care organization?
13. Zijn het ziekenhuis en de thuiszorg deze samenwerking aangegaan vanuit hetzelfde belang? / Did the hospital and home care organization start this collaboration because of the same interest?
14. Bent u ervan overtuigd dat beide partijen vanuit dezelfde drijfveren handelend dit project zijn aangegaan? / Are you convinced that both parties have entered this collaboration because of the same motives?
15. Wat is het uiteindelijke doel van dit project? / What is the final goal of this project?
16. Is dit doel voor het ziekenhuis en voor de thuiszorg hetzelfde? / Are the goals for the hospital and the home care organization the same?
17. Zijn er gemeenschappelijke voordelen of juist nadelen? / Are there common advantages/disadvantages?
18. Zijn er voordelen die voor enkel één partij optreden? / Are there advantages that that arise for only one party?
Interaction

19. Wat zijn de verwachtingen en verantwoordelijkheden naar de thuiszorg vanuit het ziekenhuis? / What are the expectations and responsibilities of the home care organization in the eyes of the hospital.

20. Wat zijn de verwachtingen en verantwoordelijkheden naar het ziekenhuis vanuit de thuiszorg? / What are the expectations and responsibilities of the hospital in the eyes of the home care organization.

21. Hebben het ziekenhuis en de thuiszorg in dezelfde mate verantwoordelijkheden in deze samenwerking en waarom? / Do the hospital and home care have the same level of responsibilities in this collaboration and why?

22. Op welke wijze verloopt de communicatie tussen het ziekenhuis en de thuiszorg? / How do the hospital and the home care work communicate?

23. Hoe wordt informatie gedeeld tussen het ziekenhuis en de thuiszorg? / In what way is information being shared between the hospital and the home care organization?

24. Heeft u het idee dat alle nodige informatie wordt gedeeld en waarom? / Do you have the idea that all necessary information is shared and why?

25. Hebben beiden partijen even veel inspraak en waaruit blijkt dit? / Can both parties participate at an equal amount and why?

26. Is er plek voor eventuele discussie? / Is there room for discussion?

Governance

27. Op welke wijze verloopt de handhaving tussen het ziekenhuis en de thuiszorg? / How is governance between the hospital and home care organization provided?

28. Zijn er in de praktijk eventuele cultuur, proces of structuur verschillen gebleken? En hoe is hier mee omgegaan? / Are there any differences in culture, process or structure appeared in practice? How have they been handled?

29. Wat is uw rol in deze communicatie en handhaving van het project? / What is your role in the communication and governance function of this project?
**Interdependency and trust**

30. Is er sprake van vertrouwen vanuit het ziekenhuis naar de thuiszorg? / Does the hospital trust the home care organization?

31. Is er sprake van vertrouwen vanuit de thuiszorg naar het ziekenhuis? / Does the home care organization trust the hospital?

32. Waaruit komt dit gevoel voort en hoe wordt hiervoor gezorgd? / What causes this feeling and how is this ensured?

33. Is dit vertrouwen belangrijk voor de samenwerking en waarom? / Is trust important for the collaboration and why?

34. Zijn het ziekenhuis en de thuiszorg afhankelijk van elkaar en waarom? / Are the hospital and home care organization interdependent and why?

**Implementation**

35. Mochten het ziekenhuis en thuiszorg opnieuw de kans krijgen om een soortgelijke samenwerking aan te gaan, verwacht u dan dat ze dit zouden doen? Wat zou er anders gaan? / When the hospital and the home care organization should get another chance to enter a similar collaboration, do you expect them to enter this collaboration? What would be different?

36. Wat liep er goed tijdens de periode van implementatie tot op heden? / What went well during the period of implementation to date?

37. Wat ging er mis tijdens de periode van implementatie tot op heden? / What went wrong during the period of implementation to date?

38. Wat zijn de belangrijkste lessen die uit de implementatie volgden? / What are the most important lessons following from the implementation?

39. Wat zijn in uw oog de belangrijkste punten voor het slagen van deze samenwerking? / What are, in your opinion, the most important aspect for the collaboration to succeed.

40. Heeft u voorbeelden van mogelijke problemen waar de samenwerking in de toekomst tegenaan kan lopen? / Do you have any examples of possible problems that can arise for the collaboration in the future?
End

41. Welke belangrijke punten zijn naar u mening nog niet aan bod zijn gekomen? / Which important aspects have not yet been discussed?

Dutch: Als u verder geen vragen meer heeft, waren dit voor zover de vragen. Wilt u een transcript van dit interview ontvangen om te controleren op eventuele onjuistheden en wilt u een kopie van mijn onderzoek wanneer deze is afgere? Hartelijk dank voor uw tijd en uw participatie aan dit interview.

English: I will conclude this interview if you have no further questions. Would you like to receive a transcript of this interview to check for any inaccuracies and would you like a copy of my research when it is completed? Thank you very much for your time and your participation in this interview.
Appendix 4: Operationalization

This appendix presents the operational definition of each indicator of the best practices for a successful healthcare collaboration, that are separated into measurable factors.

<table>
<thead>
<tr>
<th>Practices</th>
<th>Indicators</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Collective action</strong></td>
<td>Common goal</td>
<td>This indicator is related to professional values in the form of a common goal. The common goal for a healthcare collaboration mostly can be specified as the quality of healthcare.</td>
</tr>
<tr>
<td></td>
<td>Shared interests</td>
<td>Parties should keep shared interests in mind, otherwise private interests will emerge. It is the reasons why they started the collaboration.</td>
</tr>
<tr>
<td></td>
<td>Mutual benefits</td>
<td>Parties should focus on mutual benefits. In a healthcare collaboration this should be the improvement of the quality of healthcare.</td>
</tr>
<tr>
<td><strong>Interaction</strong></td>
<td>Communication</td>
<td>It indicates that the intended verbal and nonverbal messages are successfully transmitted between parties. It ensures the awareness of roles, it clarifies the expectations and responsibilities of both parties. Both parties should have a clear understanding of what their responsibilities and expectations are.</td>
</tr>
<tr>
<td></td>
<td>Information sharing</td>
<td>The existence and appropriate use of information channels to allow fast and complete exchanges of information between professionals. It assures mutual knowledge sharing, meaningful information that helps parties to get to know each other and learn from each other. It increases the understanding of the shared problem and gives parties the information they need to successfully do their job.</td>
</tr>
<tr>
<td></td>
<td>Negotiation</td>
<td>Negotiation is defined as the process of interaction by which collaborators strive for the most effective outcome through jointly decided actions. Parties bargain about their contributions and interest. This includes that parties negotiate what they want and can offer the collaboration.</td>
</tr>
</tbody>
</table>
### Discussion
Discussion can make it possible to make adjustments to practices and coordinate problems that occur. Both parties should have freedom to disagree. The room for discussion makes sure that both parties can participate in the interaction process.

### Governance

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shared authority</strong></td>
<td>It is a hierarchical control mechanism. Power should not be concentrated in the hands of one party, but all collaborators must be able to take part in the decision-making process. Elements of authority can include joint teams or work groups. It assures the use of the self-governance structure that ensures decision-making through regular meetings and frequent interactions.</td>
</tr>
<tr>
<td><strong>Central leadership</strong></td>
<td>It refers to the existence of a clear and explicit function at strategic level that guides the collaboration and a function at operational level to implement and navigate decisions and actions from strategic level to operational ones in their own organization.</td>
</tr>
</tbody>
</table>

### Other factors

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interdependency</strong></td>
<td>Interdependence is the state of depending on someone or something. Parties have different but complementary resource needs. The organizations are not able to achieve their objectives alone. Parties are interdependent on their knowledge and skills. Healthcare organizations need each other, because the outcomes of the successful collaboration are greater than the sum of the individual actions alone.</td>
</tr>
<tr>
<td><strong>Trust</strong></td>
<td>Trust means the willingness of parties to relate with each other in the belief that their actions will be beneficial rather than harmful, even though it cannot be guaranteed. It means being confident that your partner will commit valuable resources and competences to transactions with additional risks. It reduces uncertainty.</td>
</tr>
</tbody>
</table>
Appendix 5: Operationalization and the interview guideline

This appendix includes an explanation of how the interview guideline has been used per question to gather the needed information to test the propositions in the theoretical framework based on the operationalization.

General information

First, the general questions 1 till 9 were used to gain more background information about the person and the organization itself.

Collective action

Questions 10 till 18 are used to test proposition 1:

There is a positive relationship between a collective action as practice and the success of a healthcare collaboration. The presence of a collective action is implied by the existence of a common goal, shared interests and mutual benefits within a collaboration.

This proposition will test the first best practice: collective action. The indicators of this practice are: common goals, shared interests and mutual benefits. The following questions are used.

Shared interests:

10. Why did you start this project?
11. Why is the implementation of this project important for the hospital?
12. Why is the implementation of this project important for the home care organization?
13. Did the hospital and home care organization start this collaboration because of the same interest?

These four questions contain the indicator ‘shared interests’. Question 11 looks at the interests of the hospital and question 12 looks at the interests of the home care organization. The answers of these questions will be compared. Questions 13 tests whether parties thought they had the same interest. This question can be compared to the conclusion of questions 12 and 13. Out of these questions can be concluded whether parties have shared interests.

Common goal:

14. Are you convinced that both parties have entered this collaboration because of the
same motives?

15. What is the final goal of this project?

16. Are the goals for the hospital and the home care organization the same?

Question 14, 15 and 16 involve the indicator ‘common goal’. Question 14 contains the initial goal the party had before they entered the collaboration. Question 15 includes the current goal in the collaboration. Question 16 asks whether parties think they have the same goal. These answers will be compared. Following from these outcomes a comparison of the goals can be made. The existence of common goal can be tested.

Mutual benefits:

17. Are there common advantages/disadvantages?

18. Are there advantages that arise for only one party?

These questions are asked regarding the indicator ‘mutual benefits’. These questions can be used to test whether mutual benefits or mutual disadvantages exist within the collaboration.

Interaction

Questions 19 till 26 are used to test proposition 2:

There is a positive relationship between interaction as practice and the success of a healthcare collaboration.

This proposition tests the second best practice: interaction. To promote the understanding of the results, this proposition is split into two parts.

Questions 19 till 24 are used to test proposition 2a:

The presence of interaction is implied by the existence of open and honest communication and complete information sharing within a collaboration.

This proposition tests the second best practice: interaction. It involves the indicators: communication and information sharing. The following questions have been used:

Communication:

19. What are the expectations and responsibilities of the home care organization in the eyes of the hospital.

20. What are the expectations and responsibilities of the hospital in the eyes of the home care organization.
21. Do the hospital and home care have the same level of responsibilities in this collaboration and why?

22. How do the hospital and the home care work communicate?

These questions involve the indicator ‘communication’. They test the openness and honesty of the communication. Communication ensures role awareness, it clarifies the responsibilities and expectations of the other party. When communication is open and honest, the expectations and responsibilities should be clear. By making a comparison of the answers to these questions, it can be tested whether the parties involved experienced the same expectations and responsibilities.

Information sharing:

23. In what way is information being shared between the hospital and the home care organization?

24. Do you have the idea that all necessary information is shared and why?

Question 23 and 24 involves the indicator ‘information sharing’. The sharing of information assures the transfer of mutual knowledge, meaningful information that helps parties to get to know each other and to learn from each other. The answers to these questions can be compared to test whether there were any differences between parties in the experience of completeness of information sharing. It is important both parties experience that information useful for the collaboration is exchanged.

Questions 25 and 26 are used to test proposition 2b:

The presence of interaction is implied by the existence of room for negotiation and discussion within a collaboration.

This proposition tests the second best practice: interaction. It involves the indicators: negotiation and discussion. The following questions have been used:

Negotiation:

25. Can both parties participate at an equal amount and why?

This question involves the indicator ‘negotiation’. From this question it can be concluded whether both parties experience they are able to participate in the negotiation process and whether they experience they are heard in the collaboration. Both parties should be able to negotiate about what they can and cannot offer the collaboration.
Discussion:

26. Is there room for discussion?

This question involves the indicator ‘discussion’. From this question it can be concluded whether both parties experience that there is room for discussion. It can be tested whether they believe that their ideas are welcome and whether they can make adjustments to practices. When this is the case, it means there is room for discussion in the collaboration.

Governance

Questions 27 till 29 are used to test proposition 3:

There is a positive relationship between governance as practice and the success of a healthcare collaboration.

This proposition tests the last best practice: governance. To promote the understanding of the results, this proposition is split into two parts.

Questions 27 is used to test proposition 3a:

The presence of governance is implied by the existence of shared authority within a collaboration.

This proposition tests the last best practice: governance. It contains the indicator: shared authority. The following question is used:

Shared authority:

27. How is governance between the hospital and home care organization provided?

This question involves the indicator ‘shared authority’. It shows what type of governance-structure parties make use of and how authority is implemented in the collaboration. From the answers it can be concluded whether or not shared authority is present within the collaboration.

Questions 28 and 29 are used to test proposition 3b:

The presence of governance is implied by the existence of central leadership within a collaboration.

This proposition tests the last best practice: governance. It involves the indicator: central leadership. The following questions are used:
Central leadership:

28. Are there any differences in culture, process or structure appeared in practice? How have they been handled?

29. What is your role in the communication and governance function of this project?

These questions involve the indicator ‘central leadership’. Question 28 is an open question. Based on the theory it can be concluded that the problems regarding those differences can be controlled by a central leader. The answers to this question show whether this function works properly to dissolve differences. Question 29 can be used to test whether the interviewed person is involved as central leader. Also, the involvement of parties can be compared to those of commensurate functions in other organizations, because persons with the same function are interviewed in the different cases. It can be concluded central leadership exists on two levels in the organization: at strategic and operational level.

Trust and interdependency

Question 30 till 35 are used to test proposition 4a and proposition 4b:

Proposition 4a:

*There is a positive relationship between the existence of trust and interdependency and the success of a healthcare collaboration.*

Proposition 4b:

*There is a two-way positive relationship between trust and the three practices: collective action, interaction and governance.*

These propositions test the presence of the factors ‘trust and interdependency’. The following questions are used:

30. Does the hospital trust the home care organization?
31. Does the home care organization trust the hospital?
32. What causes this feeling and how is this ensured?
33. Is trust important for the collaboration and why?
34. Are the hospital and home care organization interdependent and why?

Questions 30 and 31 tell whether parties experience trust in their collaboration. Questions 32 and 33 ask how parties experience and implement trust. It involves the importance of trust for the collaboration and why parties might think it is important. The answers to these questions
will be compared to the theory and it might be concluded that there is a relationship between the best practices and trust. Question 34 asks whether parties think they are interdependent. It might be concluded that interdependency is necessary for a successful collaboration.

Implication
Question 35 to 41 are questions about the implementation process. These questions might gather additional information or emerging factors that are needed for a successful healthcare collaboration. Also, when comparing these answers, it can be tested whether parties experience the same progress in the collaboration.
Appendix 6: Translation quotes

This appendix includes quotes that are used to confirm the analysis of the data in this study are translated from Dutch to English. It contains the translation to ensure the reliability.

<table>
<thead>
<tr>
<th>English</th>
<th>Dutch</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;We all attempt to generate optimal care&quot;</td>
<td>&quot;We trachten allemaal om optimale zorg te genereren&quot;</td>
</tr>
<tr>
<td>&quot;We want to provide the patient good healthcare&quot;</td>
<td>&quot;We een goede zorg voor de patiënt willen leveren&quot;</td>
</tr>
<tr>
<td>&quot;The quality of patients’ healthcare&quot;</td>
<td>&quot;De kwaliteit van cliëntenzorg&quot;</td>
</tr>
<tr>
<td>&quot;We all want to provide good healthcare for the patient&quot;</td>
<td>&quot;We willen met z’n allen dat er goede zorg voor die patiënt wordt geleverd&quot;</td>
</tr>
<tr>
<td>&quot;Yes, this is actually the same. The primary goal is the healthcare for elderly, meaning that eventually the goal will also be providing more efficiency in the work of meditators, hospital and home care&quot;</td>
<td>&quot;Ja dit is eigenlijk hetzelfde. Dus voornamelijk zorg voor die ouderen zal het primaire doel zijn en dus ook uiteindelijk meer &quot;efficiency&quot; in het werk van hun bemiddelaars, het ziekenhuis en de thuiszorg&quot;</td>
</tr>
<tr>
<td>&quot;The goal is to complement the care for the client and this goal is the same&quot;</td>
<td>&quot;Het doel is gewoon de zorg beter op elkaar te laten aansluiten voor de cliënt en dat is hetzelfde doel&quot;</td>
</tr>
<tr>
<td>&quot;The final goal is to make it better for the elderly&quot;</td>
<td>&quot;Het uiteindelijke doel wel is om het beter voor de ouderen te maken&quot;</td>
</tr>
<tr>
<td>&quot;To provide appropriate and dignified care for as long as possible&quot;</td>
<td>&quot;Om zo lang mogelijk die passende en menswaardige zorg te geven&quot;</td>
</tr>
<tr>
<td>&quot;To provide good healthcare for the patients&quot;</td>
<td>&quot;Dat je goede zorg voor patiënten levert&quot;</td>
</tr>
<tr>
<td>&quot;Well, the most important lesson is that it is essential to keep the final goal in mind. It is surely a thing you have to repeat&quot;</td>
<td>&quot;Nou ja de belangrijkste les is dat je het doel echt voor ogen moet blijven houden. Het is toch wel een ding wat je moet herhalen&quot;</td>
</tr>
<tr>
<td>&quot;What is most important, is that we set mutual common goals and pursue them&quot;</td>
<td>&quot;Wat het belangrijkste is (..) is dat we wederzijdse gemeenschappelijke doelen opstellen en die ook nastreven&quot;</td>
</tr>
</tbody>
</table>
"Clearly, we have a goal. There is an urge for this that is really needed. This dream was clear; there is a big common goal"

"Je hebt natuurlijk het doel, het is gewoon echt heel erg nodig. Die droom was wel duidelijk, er was een enorm gemeenschappelijk doel"

---

**Shared interests**

<table>
<thead>
<tr>
<th>English</th>
<th>Dutch</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;The number of rehospitalizations&quot;</td>
<td>&quot;Het aantal heropnames&quot;</td>
</tr>
<tr>
<td>&quot;To prevent rehospitalizations&quot;</td>
<td>&quot;Om het aantal heropnames te voorkomen&quot;</td>
</tr>
<tr>
<td>&quot;They want to provide qualitative healthcare&quot;</td>
<td>&quot;Ze willen kwaliteit van zorg verlenen&quot;</td>
</tr>
<tr>
<td>&quot;Especially for the patients’ healthcare and the quality the patient experiences&quot;</td>
<td>&quot;Vooral voor de patiëntenzorg en de kwaliteit die hij of zij daarvan ondervindt en ervaart&quot;</td>
</tr>
<tr>
<td>&quot;Home care organizations and hospitals often speak different languages. It can be difficult to understand each other. The patient will benefit from implementing a project like this, in which a warm transfer is ensured&quot;</td>
<td>&quot;De thuiszorg en de ziekenhuizen (...) die hebben vaak een andere taal en zijn voor elkaar moeilijk te begrijpen. Door het inzetten van een project, zoals dit, waarin je vooral voor de warme overdracht zorgt (...) daar heeft de patiënt natuurlijk heel veel baat bij&quot;</td>
</tr>
<tr>
<td>&quot;The home care organization wants to deliver the highest possible quality of healthcare&quot;</td>
<td>&quot;De thuiszorg wil (...) een zo hoog mogelijke kwaliteit van zorg&quot;</td>
</tr>
<tr>
<td>&quot;The interests are different but we agree on the shared interests that we both want to provide good quality of healthcare for the elderly&quot;</td>
<td>&quot;Ja het zijn echt twee andere belangen. Maar je vindt elkaar op het belang dat je die kwetsbare ouderen een goede kwaliteit van leven wilt bieden&quot;</td>
</tr>
<tr>
<td>&quot;In the end it is all about the patient’s interest&quot;</td>
<td>&quot;Uiteindelijk gaat het wel hier om het cliëntbelang&quot;</td>
</tr>
<tr>
<td>&quot;Everyone wants to deliver good quality of healthcare&quot;</td>
<td>&quot;Iedereen wil dat er een goede zorg wordt aangeboden&quot;</td>
</tr>
<tr>
<td>&quot;It is important to keep the shared interests in mind. The reason we are working together is that we all want to provide good healthcare for patients. We all want this. If we don’t agree with, it is important to keep this interest in mind. This will ensure we will be at the same level&quot;</td>
<td>&quot;Het is van belang dat je het gezamenlijk belang denk ik voor ogen houd, waar doen we het voor. We doen het om goede zorg voor patiënten te leveren en dat willen we allemaal. Ja, dus als je het een keer niet met elkaar eens bent, uhm, is het belangrijk om dit iedere keer als uitgangspunt te nemen en daarna na te denken en dan kom je al heel snel weer op een lijn&quot;</td>
</tr>
</tbody>
</table>
"It is important to keep the shared interests in mind"

"The client was set first. Starting from a different way of thinking provides a lesson. This will ensure us to come further"

"Het is belangrijk om het gezamenlijk belang te blijven inzien"

"De klant heel erg centraal stond (...). Het is een les dat je dan veel verder komt, om vanuit een andere denkwijze te starten"

---

**Mutual benefits**

"I mainly see the benefits: the good transfer of a patient"

"I think, a mutual benefit is that we both improve the quality of patient’s healthcare"

"I think, the advantages are the improvement of the quality of healthcare. Which is better complemented"n

"We know each other’s work (..) we can adapt to one another"

"If a transfer is really efficient, there will always be a mutual benefit"

"It is a new method that we have to adapt to. It always takes time to implement something new"

"The disadvantage is that it takes a lot of time to arrange everything properly"

"The investment you need to do takes more time"

"It was hard to process the differences"

"The changes were difficult to process"

"Both parties should not come out worse, otherwise it will repulse at a given moment"

"In the end, I think that we have a better idea of what is going on and that can save time"

---

"Ik zie voornamelijk voordelen: de goede overdracht van de patiënt"

"Een gemeenschappelijk voordeel is denk ik dat je allebei de kwaliteit verhoogt van je zorg"

"De voordelen zijn denk ik dat je naar betere zorg kan, dat het beter op elkaar is afgestemd voor beiden"

"Je kent elkaars werk (..) je kunt aansluiten op wat de ander heeft gedaan"

"Als een overdracht echt efficiënt verloopt, er sowieso een gemeenschappelijk voordeel is"

"Kijk het is wel een nieuwe werkwijze die je moet aanleren dus als je iets nieuws moet implementeren kost dat altijd tijd"

"Het nadeel is dat het veel tijd kost om het allemaal goed te regelen"

"Het kost meer tijd, de investering die je moet doen"

"Het was moeilijk te organiseren"

"Die veranderingen zijn moeilijk om te verwerken"

"Maar beiden partijen moeten er niet slechter van worden want dan gaat het verdringen op een gegeven moment"

"Uiteindelijk denk ik wel dat je gewoon beter in beeld hebt wat er dus aan de hand is en dat dit dan ook weer tijd kan besparen"
"The challenge is how to achieve a higher goal with equal or lower costs. (..) The more proactive we are, I think, the easier that a goal can be achieved. In the end we will have high-quality, appropriate and affordable care"

"Dus de uitdaging zit het hem er vooral in hoe kunnen we met gelijke dan wel lagere kosten, een hoger doel halen (..), hoe meer proactief je bent denk ik, hoe makkelijker dat doel te halen is. Dus dan heb je hoogwaardige zorg, passende zorg en betaalbare zorg"

**Communication**

"We are both responsible for good healthcare for our patients. We are responsible for good communication with each other as well"

"Je bent wel allebei verantwoordelijk voor goede zorg voor je patiënten. Maar ook voor goede communicatie met elkaar"

"We both have the social task to organize good and dignified care"

"We hebben allebei de maatschappelijke opdracht om goede waardige zorg te organiseren"

"We both have the same responsibility to ensure good healthcare"

"Je hebt dezelfde verantwoordelijkheid omdat je een kwaliteit van goede zorg wilt waarborgen"

"Our main responsibility is to do our own job so the other party can do his job as well"

"Je bent vooral verantwoordelijk naar elkaar toe om je eigen organisatie goed te doen zodat de ander ook z’n werk kan doen"

"We are both responsible for our own part of the job"

"Je bent verantwoordelijk voor je eigen deel van je werk"

"There is a clear border, when a patient is discharged from the hospital, the responsibilities are with the other party"

"Er zit wel een duidelijke scheidingslijn wanneer iemand wordt ontslagen gaan de verantwoordelijkheden gewoon over"

"What went wrong was that people did not know what the project was about and what was expected of them. Agreements were made at managerial level, but not at organizational level (..) it is nice that there are covenants, but things were not clear at the organization level"

"Wat er misging is eigenlijk ook dat mensen niet wisten waar het nou over ging en wat er van ze verwacht werd. Of er wordt ergens op bestuurlijk niveau afgesproken, maar niet op uitvoeringsniveau (..) want het is wel leuk dat er allemaal convenanten zijn, maar de werkvloer weet daar vaak weinig vanaf"

"Communication is very important: newsletters, something in the newspaper. You have to come up with something that shows your successes on a regular basis. Create successes and celebrate them"

"Communicatie is erg belangrijk: dus nieuwsbrieven, iets in de krant. Je moet regelmatig met iets komen dat je successen laat zien, dus successen creëren en ze vieren"
"We gave a presentation once. (..) Everyone could indicate what their ideas were but nobody ever heard of it again. That annoys us"

"We hebben een keer een presentatie gegeven (..) iedereen kon daar aangeven wat de ideeën waren, maar niemand heeft er ooit nog wat van gehoord en dat is voor ons dan irritant"

"The success of the collaboration. (..) To achieve successes and to celebrate them. (..) We should not only look at what went wrong"

"Het slagen van de samenwerking (..) dat je successen gaat krijgen en dat je successen gaat vieren (..) dat je niet alleen kijkt naar wat er fout is gegaan"

"Communication is quite complicated"

"Communicatie is best wel ingewikkeld"

"The communication is complex"

"De communicatie is complex"

"I think we can improve the communication"

"Ik denk dat het vooral in de communicatie wel beter kan"

"People did not know what it was all about and what was expected of them"

"Wat er misging is eigenlijk ook dat mensen niet wisten waar het nou over ging en wat er van ze verwacht werd"

"Good communication is crucial"

"Goed met elkaar blijven communiceren is van cruciaal belang"

"The most important thing is to ensure ongoing communication"

"Dus het belangrijkste is met elkaar blijven communiceren"

"I think that communication can be improved. (..) Communication among parties but also the presentation of the project itself"

"Ik denk dat de communicatie wel beter kan (..) de communicatie onderling, maar ook het bekendmaken van het project zelf"

"Clear communication is an important lesson: to make it clear what we are doing"

"Ook de duidelijke communicatie is een belangrijke les: waar ben je mee bezig, duidelijk maken"

---

**Information sharing**

"I think that the transfers have become a lot better (..) but it can always be better"

"Ik denk wel dat de overdrachten een stuk beter zijn geworden (..) maar het kan altijd beter"

"The intention is present, but it does not always happen"

"De intentie is er wel, maar het gebeurt niet altijd"

"It is certainly missing (..) I think they just do not have that information"

"Er ontbreekt zeker wel wat (..) ik denk dat ze die informatie gewoon niet hebben"

"That the information is no longer shared. That no good transfer forms are made up anymore"

"Dat die informatie niet meer met elkaar gedeeld wordt, dat er geen goede overdrachtsformulieren meer worden gemaakt"
"I think quality can be improved"
"Ik denk dat hier nog wel iets aan kwaliteit verbeterd kan worden"

"Yes, I think so, if they are satisfied about the content, I do not know"
"Ja dat denk ik wel, of ze inhoudelijk tevreden zijn weet ik niet"

"Yes, that is why we created the flowchart"
"Jazeker, we hebben daar dat stroomdiagram voor gemaakt"

"We created a working document, in which we both created our own part, which we discussed with each other"
"We hebben een werkdocument gemaakt, waarin we allebei ons eigen stuk hebben gemaakt en die met elkaar hebben besproken"

"We made the transfer documents in that way (..) what exactly should be in that transfer"
"We hebben de overdracht wel zo gemaakt (..) wat nou precies in die overdracht moest staan"

"A transfer document (..) in which anything important for the continuation of the policy is included"
"Een overdrachtsbrief (..) waarin alles wat van belang is voor het continueren van het beleid staat"

"It is very important to give trainings. (..) Schooling nurses from the hospital and home care organizations together, is an enormous added value, because they get to know each other's perspectives"
"Verder is het heel belangrijk om die scholing te geven. (..) Je echt wel een enorme meerwaarde hebt van verpleegkundigen uit het ziekenhuis en de thuiszorg samen te scholen omdat je elkaars perspectieven ook leert kennen"

"When this happens often and you see each other multiple times, you will get to know each other. This ensures the exchange of that kind of things"
"Kijk als dat maar vaak genoeg gebeurt en je elkaar vaak genoeg ziet, dan leer je elkaar ook kennen en dan ga je ook dat soort dingen uitwisselen"

"We also give trainings (..) to make them to get to know each other"
"We zijn ook met opleidingen bezig (..) zodat ze elkaar leren kennen"

---

**Negotiation**

"They all have something to say about their responsibilities"
"Ja ze hebben natuurlijk allemaal wat te zeggen waarvoor ze verantwoordelijk zijn"

"They certainly have something to say about it. There should be an option to do so"
"Ze hebben er zeker wat over te zeggen, want ze moeten de ruimte hebben"

"Yes, I think that both parties have just as much to say"
"Ja ik denk dat allebei de partijen wel evenveel inspraak hebben"

"Yes, they are equal"
"Ja, iedereen is gewoon gelijkwaardig aan elkaar"
"We must look together what is feasible, what is real. Sometimes it turns out to be not feasible"

"Dan denk ik dat je, nou ja, samen (...) moet kijken, wat is haalbaar, wat is reëel, maar soms is dat niet haalbaar"

"All parties have to make the possibilities clear in advance. (...) We should be honest about it"

"Je moet vooraf goed spreken met alle partijen wat de mogelijkheden zijn (...) en dat je daar dan ook eerlijk in moet zijn tegenover elkaar"

"We have to indicate early when it will not work out (...) because we are all learning and we should be honest to each other what we need to do our job"

"Maar ook vroegtijdig aan de bel trekken als het niet gaat lukken (...) dat we allemaal lerende zijn en gewoon eerlijk aan elkaar aangeven van wat heb je nou nodig om het goed te kunnen doen"

"They all have something to say for what they are responsible. (...) We are working together to create a document that is supported by everyone"

"Ze hebben natuurlijk allemaal wat te zeggen waarvoor ze verantwoordelijk zijn (...) dus je bent samen bezig om een document te maken waar iedereen achter staat"

"We are jointly writing plans (...) it will be clear how we should do this the best way, we make a document with the lessons learned"

"Ja, dat we gezamenlijke plannen schrijven (...) we gaan kijken hoe we dit het beste moeten doen, dus we maken een document met lessons learned"

**Discussion**

"Yes, I think that it should always be there. There is good discussion and bad discussion. I think you should be able to have a positive discussion, to see if you can learn from the things you did and how to improve this at the same time to improve the care for vulnerable elderly"

"Ja, ik denk dat die er altijd moet zijn. Dan heb je goede discussie en slechte discussie. Ik denk dat je een positieve discussie moet kunnen voeren met elkaar, om te kijken of je kunt leren van de dingen zoals je ze gedaan hebt en hoe je dat dan tegelijk kunt verbeteren om de zorg voor kwetsbare ouderen beter te borgen"

"Yes, there is certainly room for discussion (...) what are the possibilities"

"Ja plek voor discussie is er zeker (...) van wat zijn ook de mogelijkheden"

"We discuss with each other what is going on and how we can solve it. We are trying to reach an agreement"

"We discussiëren met elkaar wat er nou aan de hand is en hoe we dat kunnen oplossen en proberen daarin overeenkomst te krijgen"

"The discussions are present"

"Die discussies zijn er natuurlijk wel"

"Sometimes we have to change the original plan. (...) We have been way too good, acted too much according to the rules. We have to tailor it"

"Soms moet je (...) van het oorspronkelijke plan afstappen (...) we zijn veel te braaf geweest, teveel volgens de regels. Dus je moet het echt op maat maken"
"We have made local adjustments and we have done that in mutual consent"  "We hebben ook alle lokale aanpassingen gedaan en die hebben we in gezamenlijk overleg gedaan"

"It is all about the feasibility"  "Het gaat uiteindelijk om de maakbaarheid"

"It should be possible to be able to make local additional agreements"  "Dat je op lokaal niveau echt aanvullende afspraken moet kunnen maken"

**Shared authority**

"We have a kind of consultation every three months in which all parties are involved"  "We hebben een soort overleg eens in de drie maanden, waarbij alle partijen zitten"

"We have a team (..) that meets once in a while (..) to see how things are going, what the problems are and what is going well"  "We hebben een team (..) die een keer in de zoveel tijd (..) samenkomt om te kijken hoe het loopt, waar de problemen lopen, wat goed loopt"

"We have set up a working group in which people are coming together"  "We hadden een werkgroep ingericht waar voor de praktijk mensen met elkaar om tafel zaten"

"Once a month there is a working group"  "Daar is een keer per maand zo 'n werkgroep"

"We had a working group in which they looked at the details"  "We hadden (..) een werkgroep praktijk en die ging echt om tafel kijken tot in de details"

"Everyone comes together (..) you can decide to do things differently, as long as a joint conclusions can be made"  "Iedereen komt samen aan tafel (..) je kunt heel veel dingen samen beslissen om dat anders te doen, zolang er maar echt samen tot een conclusie kan worden gekomen"

"I have recently set up a working group (..) in which they are going to brainstorm together"  "Ik heb nu een werkgroep in het leven geroepen (..) die gaan samen nadenken"

**Central leadership**

"At a certain moment there was no more subsidy for a project leader and we immediately saw that the project was less productive because it was difficult to keep people involved"  "Maar op een gegeven moment waren de gelden voor de projectleiding op en dan zie je ook gelijk dat het project gelijk minder productief is omdat je mensen niet goed bij de les kunt houden"
"A project leader is very important, especially in such an area, you have to incentivize, because there are so many parties and because it is such a complicated project (...) a problem can be that the incentive is no longer there"

"The project leader leaving forms a great risk. It is the risk of delusion and failure of the project"

"We did not really have a project leader (...) we sometimes missed a person who provided incentives"

"It is actually better, if one of the parties has a committed person, who is important for everyone. Someone who is also accepted by the parties and who provide incentives"

"We have searched for an external project leader, but nobody wanted to fulfil this role, because there are a lot of different working methods"

"The person involved had his own idea about how everything should be executed. (...) He came from a completely different organization, (...) the hospital world is a whole different world"

"Every organization has its own mandated person (...) who serves as a point of contact for the organization. Those persons are coming together in the working group"

"Both parties have contact persons (...) which come together once every two months to interact"

"We had our peak at the moment when there was someone in the hospital who felt involved and responsible for it. At that moment the collaboration went well"
"We have one person per party in the working group (...) they can ensure further distribution in the organization. This means these people (...) should have some mandate and also some authority to ensure the spread within the organization. If this is not the case (...) we can agree upon certain points, but if no one keeps his promises, it won’t work out”

"We hebben wel per partij iemand in de werkgroep (...) die kan dan verder verspreiding in de organisatie zoeken. Dat betekent ook wel dat de mensen (...) wel enig mandaat hebben en ook wel wat gezag om dat binnen de organisatie verder uit te spreiden. Als je dat niet hebt (...) dan kun je nog zo mooi afspraken maken, maar als niemand zich er dan aan houdt dan schiet het niet op"

"Also make sure it is done in practice (...) that you see how it goes (...) bottom-up”

"Zorg ook dat het voldoende in de praktijk gebeurt (...) dat je ziet hoe het gaat (...) dus bottom-up”

"A project leader is seen as the person arranging everything. This is not the case, if I leave in a year, the project will fail. They have to perform themselves”

"Mensen zien de rol als projectleider als die gaat alles voor ons doen en alles voor ons regelen. Maar nee, want als ik het allemaal regel en ik ben over een jaar weg, dan verstopt het in niets. Ze moeten het zelf doen”

"When working bottom-up, the greatest successes will be present. (...) Know how to put the right people in the right places”

"Van bottom-up zijn de grootste successen te vieren (...) dat je de juiste mensen op juiste plek weet te zetten”

"We have learned we should maintain knowledge at lower level, (...) because it is the problem owner. (...) You don’t have to start pulling everything”

"We hebben geleerd dat je de kennis vooral bij de afdeling moet laten (...) die is ook probleemeigenaar (...) niet dat je alles moet gaan trekken”

"Due to changes in the board of the hospital, nobody knew how to fill in the lists. There was lack of internal control”

"Door de wisselingen in het bestuur van het ziekenhuis wist eigenlijk niemand meer goed hoe de lijsten ingevuld moesten worden. Daar ontbreekt het ook aan een stukje interne aansturing”

"They want a contact point in the home care organization and we want one in the hospital. When one is present, someone leaves the organization and it all ends”

"Want dan willen ze een contactpersoon in de thuiszorg en wij in het ziekenhuis en dat wordt dan even gedaan en dan gaat er iemand weg en dan zakt het allemaal weer in”

Differences

"Yes, sometimes we get annoyed by that (..) , but the other party gets annoyed about us sometimes as well”

"Ja en daar kun je wel eens geïrriteerd door raken (..) maar de andere partij is ook wel eens geïrriteerd over ons”

"Of course there are differences (..) when we are coming together, we feel those differences”

"Tuurlijk zijn er verschillen (..) als je hier aan tafel zit, dan voel je de verschillen wel”
"It is notable that the home care organization (..) does not have an idea about the processes in a hospital (..) system of how it works, what has to be done, what rules and protocols there are (..) and the culture of responsibility, the hierarchy in the hospital"

"Je merkt heel erg dat de thuiszorg (..) niet zoveel ideeën heeft van hoe die processen in een ziekenhuis lopen (..) ook de hele systemen van hoe werkt het dan, wat moet er allemaal gedaan worden, aan welke regels en protocollen is men allemaal gebonden (..) en de cultuur van aanspreken, de hiërarchie in het ziekenhuis"

"I think that a lot of people here in the hospital do not have an idea of what the home care nurse is doing in the home situation"

"Ik denk dat heel veel mensen hier in het ziekenhuis niet echt een idee hebben hoe het met de wijkverpleegkundige er in de thuissituatie aan toe gaat"

"Good leadership is to create synergy, this means bridging the differences. For me as chairman it is the challenge to bring (..) that together"

"Goed leiderschap is 'creëer synergie', en dat betekent overbrug de verschillen. Dus voor mij als voorzitter is het de uitdaging om (..) dat bij elkaar te brengen"

"If you communicate about it, it will come a long way"

"Als je echt vooral daarover communiceert, dan komt het een heel eind"

"We knew those differences from each other (..) but this can all be discussed"

"Dat wisten we wel van elkaar, die verschillen (..) maar op zich is dat allemaal wel te bespreken"

"It clarifies why we should transfer that information correctly"

"Dat je dan ook ziet van daarom moet ik die informatie goed overdragen"

"That's one of the things we've discussed"

"Dat is een van de dingen waarover we gediscussieerd hebben"

---

**Interdependency and trust**

"We must work together to provide the right patient care. We depend on each other, we cannot provide the entire chain on our own"

"Je moet daarin samenwerken om de patiënt de juiste zorg te leveren. Daarin ben je van elkaar afhankelijk, die hele keten kun je niet in je eentje doen"

"Ultimately, the collaboration is especially essential for the patient, because the transfer from one place to another is of high importance"

"Uiteindelijk is de samenwerking vooral heel essentieel voor de cliënt, want de overdracht van de een naar de andere situatie is wel heel belangrijk"

"Yes, very much. The patient goes from one place to another"

"Jazeker, heel erg zelfs. De patiënt gaat van plek een naar de volgende plek"
"We have to deliver good healthcare when the patient goes home and when no home care is available, the patient would not be able to go home. (...) On the other hand, home care organizations depend on us for good information"  

"We have to deliver good healthcare when the patient goes home and when no home care is available, the patient would not be able to go home. (...) On the other hand, home care organizations depend on us for good information"

"We cannot do this without them"  

"Ja we kunnen niet zonder ze"

"Without home care organizations, we cannot do this project, they need information from the hospital and vice versa"  

"Zonder thuiszorg kan je dit project sowieso niet doen, zij hebben informatie nodig uit het ziekenhuis en visa versa"

"We really need each other to reach the goal"  

"Je hebt elkaar heel erg nodig om het doel te bereiken"

"I think there is a lot of trust"  

"Volgens mij is er echt heel veel vertrouwen"

"There is a lot of trust that there is a possibility to make it better for the vulnerable elderly together"  

"Er is veel vertrouwen in dat ze het samen beter kunnen maken voor kwetsbare ouderen"

"You can trust that the other party performs the tasks that you have assigned to him or her"  

"Ja je mag er wel op kunnen vertrouwen dat de andere partij de taken die je hem of haar hebt toegedeeld ook uitvoert"

"There is trust that everyone is really committed to do this right"  

"Het vertrouwen is er wel dat iedereen zich echt wilt inzetten om dit goed te gaan doen"

"Mutual trust is not ensured and sometimes things are being said that should not been said very often"  

"Wederzijds vertrouwens is er niet per definitie en er wordt ook heel vaak iets over elkaar gezegd wat niet gezegd zou moeten worden"

"There is a lack of trust of the home care organization to the hospital because it is the question if there is commitment in the hospital. Also, it is questionable if they get their jobs done (...) However, trust is increased by the end of the project"  

"Het vertrouwen vanuit de thuiszorg naar het ziekenhuis is heel laag omdat het daar vooral de vraag is of er wel dan echt commitment is vanuit het ziekenhuis en gaan ze het wel dan voor elkaar krijgen (...) aan het einde van het project is vertrouwen wel gestegen"

"Sometimes there is less trust"  

"Soms was er wel wat minder vertrouwen"

"Mutual trust is very important (...) when this is missing (...) it will not work well"  

"Wederzijds vertrouwen is heel erg belangrijk (...) als dat ontbreekt (...) het niet altijd zo even goed werkt"

"Without trust we won’t not succeed"  

"Zonder vertrouwen kom je nergens"
"We cannot collaborate when trust is missing"

"Trust is extremely important for the collaboration. (...) No effort would be shown when there is no trust from the home care organization to the hospital, which results in a lower probability of success"

"One must be convinced the other party is doing its best for patient care"

"Yes, otherwise one cannot work together"

"Mutual respect and understanding (...) to get along with each other"

"In my opinion, there is trust because everyone is really committed to do this well"

"Yes, it is coming from an intrinsic motivation"

"There is consensus for what they want to do and a lot of trust in that they can improve it for vulnerable elderly together"

"We achieve more based on trust (...) we have to find each other on the content"

"When suddenly own interests emerge, it can be seen that there is lack of trust"

"It means when multiple interaction takes place (...) trust will evolve naturally (...) it is important to hear the opinions of parties"

"You should talk to each other, to ensure you will not lose trust in each other"

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"Zeker, als je geen vertrouwen hebt, kun je ook niet samenwerken"

"Vertrouwen is extreem belangrijk voor de samenwerking (...) stel je voor als de thuiszorg het niet vertrouwt dat het vanuit het ziekenhuis beter gaat worden (...) wat voor energie zouden ze er dan nog in gaan steken (...) dan is de kans op slagen een stuk minder"

"Je moet toch het idee hebben dat de andere partij z’n best doet voor de patiëntenzorg"

"Ja, anders kun je echt niet werken"

"Wederzijds respect en begrip (...) met elkaar verder te komen"

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**Trust**

"In my opinion, there is trust because everyone is really committed to do this well"

"Yes, it is coming from an intrinsic motivation"

"There is consensus for what they want to do and a lot of trust in that they can improve it for vulnerable elderly together"

"We achieve more based on trust (...) we have to find each other on the content"

"When suddenly own interests emerge, it can be seen that there is lack of trust"

"It means when multiple interaction takes place (...) trust will evolve naturally (...) it is important to hear the opinions of parties"

"You should talk to each other, to ensure you will not lose trust in each other"

"In my opinion, there is trust because everyone is really committed to do this well"

"Ja, want het is vanuit een intrinsieke motivatie"

"Dat er een enorme consensus is voor wat ze willen doen en alleen maar veel vertrouwen in dat ze het samen beter kunnen maken voor kwetsbare oudere patiënten"

"Dat we daar meer bereiken op basis van vertrouwen (...) je moet elkaar op de inhoud vinden"

"Dan komen ineens eigen belangen in het spel en zie je dat vertrouwen ineens niet zo groot is"

"Dat betekent dat je heel veel overlegt (...) dan ontstaat het vertrouwen vanzelf (...) het is belangrijk om de mening van partijen te horen"

"Je moet het gesprek met elkaar aan gaan, zodat je het vertrouwen in elkaar niet verliest"
"There are clear agreements (..) regarding that there is trust"

"There is trust (..) we can confront each other"

"In the end, they did share it. We came together. (..) If we cannot fully trust each other it will not work. At the end of the project, trust has been increased"

"Mutual trust is very important, when this is missing it won’t work. (..) In that case it is particularly a lack of knowledge"

"Sometimes there was less trust (..) but in consultations we have discussed this"

"That is trust (..) you should be able to find each other, you should be able to confront each other. The openness and trust must be present"

"Mutual trust and understanding (..) to get along with each other"

"One must have the idea the other party is doing its best for patient care"

"You can trust the other party performs the tasks that you have assigned to him or her"

"I think there is huge trust (..) parties are not competitors"

"Mutual trust is very important, when this is missing it won’t work. (..) In that case it is particularly a lack of knowledge"

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"I think there is huge trust (..) parties are not competitors"
Appendix 7: Expectations

This appendix includes a summary of the expectations of parties.

The expectations of the home care organization in the eyes of the hospital.

<table>
<thead>
<tr>
<th>Case</th>
<th>Geriatrics</th>
<th>Manager home care</th>
<th>Project leader</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amsterdam</td>
<td>Implement the policy of the hospital in the home situation</td>
<td>Experts</td>
<td>Deliver good care</td>
</tr>
<tr>
<td>Utrecht</td>
<td>Implement the policy of the hospital in the home situation</td>
<td>The timely visit of a home care giver in the hospital</td>
<td>Different</td>
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<tr>
<td>Zeeland</td>
<td>Deliver the care that has been agreed</td>
<td>Deliver the care that has been agreed</td>
<td>Deliver the care that has been agreed</td>
</tr>
<tr>
<td>Leiden</td>
<td>Provide good care that connects with the care of the hospital</td>
<td>A better adjustment to one another</td>
<td>The timely visit of a home care giver in the hospital</td>
</tr>
</tbody>
</table>

The expectations of the hospital in the eyes of the home care organization.

<table>
<thead>
<tr>
<th>Case</th>
<th>Manager home care</th>
<th>Geriatric</th>
<th>Project leader</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amsterdam</td>
<td>Timely information about the hospital discharge of a patient</td>
<td>A complete transfer of knowledge, that it is possible to implement the policy of the hospital in the home situation</td>
<td>The timely and complete sharing of information</td>
</tr>
<tr>
<td>Utrecht</td>
<td>Timely information about the hospital discharge of a patient. The timely and complete sharing of information</td>
<td>Timely information about the hospital discharge of a patient. The timely and complete sharing of information</td>
<td>Different</td>
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<tr>
<td>Zeeland</td>
<td>Delivery of clients</td>
<td>Sending a patient home with a reasonable condition</td>
<td>Timely information about the hospital discharge of a patient</td>
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<tr>
<td>Leiden</td>
<td>The timely and complete sharing of information</td>
<td>The timely and complete sharing of information</td>
<td>Good communication and fulfil the agreed appointments</td>
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</table>
Appendix 8: Information channels

This appendix includes a summary of the information channels used.

<table>
<thead>
<tr>
<th>Case</th>
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<th>Manager home care</th>
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</thead>
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<td>Letter of resignation</td>
<td>Letter of resignation</td>
<td>Letter of resignation</td>
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<tr>
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<td>Visit home caregiver</td>
<td>Visit home caregiver</td>
<td>Visit home caregiver</td>
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<tr>
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<td>Letter of resignation</td>
<td>Letter of resignation</td>
<td>Letter of resignation</td>
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<td>Letter of resignation</td>
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<td>Telephone</td>
<td>Telephone</td>
<td>Telephone</td>
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<tr>
<td></td>
<td>Letter of resignation</td>
<td>Letter of resignation</td>
<td>Letter of resignation</td>
</tr>
<tr>
<td></td>
<td>Visit home care giver</td>
<td>Visit home care giver</td>
<td>Visit home care giver</td>
</tr>
</tbody>
</table>