Master Thesis

Studying BeRoEmD's strategic business model and network in the Dutch health care sector to assert the care group's future viability and performance.

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Abstract

This thesis investigated the strategy and network relations for BeRoEmD. BeRoEmD is a care group in the region of ‘s Hertogenbosch. Care groups have taken a prominent role in coordinating and mediating within the chronic health care sector. A sector that deserves more attention, considering over a third of the Dutch population suffers from at least one chronic disease as of 2014, sixty-five per cent when only considering the elderly. Traditional health care organization is not equipped to facilitate this chronic care and therefore, a new approach was taken with the help of care groups starting 2007. Now, ten years after introducing these organizational constructs, Care group BeRoEmD wants to ascertain its strategy and the network positioning.

To meet the goal of strengthening BeRoEmD’s strategy and network, this thesis is structured in two parts. The first part is dedicated towards a formal evaluation of BeRoEmD’s strategy and the second part aims to diagnose the network BeRoEmD is part of. To formally evaluate the strategy product of BeRoEmD, this research combines 8 business models available in literature into a conceptual business model for this thesis. This business model is used to evaluate the completeness plus internal and external consistency of BeRoEmD’s strategy. The second part is dedicated to diagnosing the network. To diagnose the network for BeRoEmD, Beer’s viable systems model was used to define activities of the network and their distribution among actors within that network. Research methods for both parts of this research are comparable. A qualitative approach is taken in the form of a case study. Data is triangulated in the form of strategic documents, semi-structured interviews and an interactive stakeholder meeting was organized.

Results of this study indicate a high degree of completeness for BeRoEmD’s strategy, but certain inconsistencies that impact the ability to achieve desired strategic outcomes. Implications from these inconsistencies predominantly reside in financial limitations and ambiguity towards whom is considered customer for BeRoEmD. The network diagnosis results in a new core value statement for the network, upon which all parties can agree. Moreover the distribution of operational activities and regulatory activities is established, in which a dominant role can be found for BeRoEmD in the regulation area. BeRoEmD would benefit from a more solid mandate from other parties in order to perform these activities to everybody’s satisfaction.

Keywords: Strategy, network, business models, viable systems model, chronic health care

Preface

This research is conducted and written for my master of Science (MSc) in Business Administration (Organizational Design and Development) studies at the Radboud University in Nijmegen. The research was carried out in collaboration with care group BeRoEmD. A chronic health care organization located in ‘S Hertogenbosch, The Netherlands in the period of April 2017 – June 2018. After a slow start, this collaboration was, in my opinion, enjoyable, fruitful and based on mutual respect towards one another.

I would like to take this opportunity to thank my supervisors, dr. J.M.I.M. Achterbergh from the Radboud Faculty of Management and Monique Weisse from BeRoEmD. Jan has supported me along the entire way. Through rough times in the beginning, and he continued doing so all the way, even though he had to deal with his increasing workloads at the management faculty. Thank you for your patience, valuable input and insights you have provided me with during this process. Monique, thank you for our productive meetings, your patience and making me feel equal and valued in our dealings.

On a more personal note, I would like to thank some of my closest relatives and friends. First and foremost, Rosalie Adolfs, my significant other, who has supported me all the way. You have helped me more than you can probably fathom, even though you also made matters difficult for me on occasion as well! You motivated me, you pushed me, you brightened my day whenever I was down. Moreover, you helped transcribe my interviews, a horrendous task. Furthermore, I would like to thank my parents, for always believing in me. You might not always have understood what I was doing, as the first family member getting into university, but you encouraged me. Lastly, close friends, with whom I muddled through this thesis side by side and the ones that encouraged me from the sidelines. You know who you are.

For the readers, I hope you find this thesis informative, enjoyable and a nice read that contributes to the understanding strategy and networks within of the chronic health care system.

Roy van Amsterdam
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List of abbreviations

Abbriviation	Description
BeRoEmD	Berlicum, Rosmalen, Empel, Den Bosch
HIS	Huisarts Informatie Systeem (general practitioner information system)
KIS	Keten Informatie Systeem (chain information system)
GP	General Practitioner
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardio Vascular Disease
CCM	Chronic Care Model
VSM	Viable Systems Model
POH	Praktijk Ondersteuner Huisarts

Chapter 1 Introduction

This research studies the strategy and network of care group BeRoEmD as part of the chronic disease healthcare system in the Netherlands.

§1.1 Background and problem statement

Over the past decades, advances in science, medicine and general knowledge about human life have increased average human life expectancy (Global Health Observatory, n.d.). Due to prolongation duration of life we are dealing with an ageing population. With ageing certain ails and illnesses start to become more prominent, like diabetes, COPD and cardio vascular risks. A common denominator between these diseases is their chronic nature. A chronic disease is characterized as *"an irreversible illness without reasonably chances of full recovery persisting for a longer period of time that can generally not be prevented or cured by medication, nor do they just disappear"* (Regionaal Kompas Volksgezondheid Brabant, 2013) Treatment of chronic diseases require continuous or repetitive care. In 2014, In the Netherlands, thirty-two per cent of the population suffered from at least one chronic disease. This number is set to rise to forty per cent by the year 2030 (RIVM, 2014). The numbers are even more staggering among the elderly. Over fifty per cent of the population over 65 years of age suffers from at least one chronic disease and one in three people over the age of 75 is diagnosed with multi-morbidity; having more than one chronic disease simultaneously (Regionaal Kompas Volksgezondheid Brabant, 2013). These numbers indicate the growing impact chronic diseases has on our healthcare system. The treatment of chronic diseases demands a more prominent role in healthcare systems (Bodemheimer, Wagner, & Grumbach, 2002). However, traditionally healthcare systems have been primarily focused on providing acute care; active but short term-treatment of severe injuries or illnesses. This is in contrast to the care required for chronic diseases. Therefore traditional healthcare was not well equipped to facilitate high quality chronic care efficiently, causing extreme rises in overhead costs and workload (Christensen, Grossman, & Hwang, 2009). Thus, to facilitate chronic care, healthcare was in dire need of a different approach.

Several solutions aimed towards providing high quality chronic care have since been developed. Most of these solutions aim to integrate different forms of healthcare as the integration of healthcare services seems to '*allow for opportunities to improve the quality and affordability of chronic care"* (Duivenboden & Althuis, 2014; Wagner, et al., 2001). For example, Germany uses the *Gesundes Kinzigtal*, a population based approach organizing care across health sectors (Busse & Stahl, 2014). The United Kingdom released several integrated care pilots with different approaches (Busse & Stahl, 2014; Richards, et al., 2008). In 2007, the Netherlands introduced a bundled payment system with care groups (Busse & Stahl, 2014).

A care groups is a legal entity in which healthcare providers are united (InEen, n.d.). *"In the bundled payment system care groups act as intermediaries between health insurers and health care professionals negotiating the content and price of a comprehensive package of chronic care, the resulting agreements of which are captured in bundled payment contracts"* (Busetto, Luijkx, Huizing, & Vrijhoef, 2015). The Dutch care group business model is a derivation of the Chronic Care Model (CCM) aimed at providing and improving chronic care. (Wagner, et al., 2001). The CCM addresses six components that should be present and well-designed in order to achieve high quality care: the health system, self-management support, delivery system design, decision support, clinical information system, community (Wagner, et al., 2001). By 2014, over 75 per cent of all general practitioners in the Netherlands were affiliated with a care group (Hansen, Bakker, Batenburg, & Schellevis, 2014). Moreover, care groups have a care coverage of roughly 14.8 million people or 87 per cent of the Dutch inhabitants in 2016, a 2 per cent rise compared to 2015 (InEen, 2017). These numbers show that care groups have attained a significant role in the Dutch health care system and thus the system benefits most with them functioning properly. *"Previous research has demonstrated improved outcomes of integrated care initiatives, however it is not clear why and when integrated care works"* (Busetto, Luijkx, Huizing, & Vrijhoef, 2015). Moreover, the Dutch bundled payment systems initially seems to have resulted in higher costs compared to the German and English solutions (Busse & Stahl, 2014). However, prognoses hint overall costs will simmer down over time (InEen, 2017). More research on the functioning and design of care groups will help pinpoint the positive and negative effects of integrated care as a whole, but also give insights to particular care groups on their performance.

BeRoEmD (an acronym for the region it covers) is one of the care groups in the Netherlands. BeRoEmD was founded in 2008 and since then coordinates chronic care in the region of Berlicum, Rosmalen, Empel and 's Hertogenbosch. Since the start of the bundled payment system in 2007, the system has been undergoing constant changes and development that BeRoEmD had to cope with (e.g. expansion of diseases incorporated, healthcare legislation). Now, almost ten years later, BeRoEmD wishes to assert its existence and viability within the chronic care system. Therefore, in association with BeRoEmD, this study aims to research the role and efficacy of care groups, and in particular that of BeRoEmD, in the chronic care system of the Netherlands.

§1.2 Research Goal and Question

The goal of this research reads as follows:

> *<u>Research goal:</u>*
> *to contribute to the practical challenges of care group BeRoEmD by gaining insights in the formal correctness of care group's strategy and the network(s) of the care group.*

Moreover, this research will contribute to extending the debate on the effectiveness and outcomes of integrated care as the solution to the growing demand and pressure of chronic diseases. Additionally, this case study can serve as relevant insights to other care groups in similar situations to further improve the overall quality of chronic healthcare in the Netherlands.

In order to attain the goal of this research, the following research question and sub questions have been formulated:

> *<u>Research question:</u>*
> *What is the strategy and network for care group BeRoEmD in the Dutch health care system for chronic care, to what extent is that strategy correct / robust, and how does that network perform?*

This research question can be divided into 2 parts, whereas the first part is focussed on the strategy related aspects of the research question and the second part is focussed on the network aspects:

1. Strategic aspects:
    a. *What does existing literature say about formal correctness of strategy?*
    b. *What is BeRoEmD's strategy?*
    c. *To what extent is the strategy of BeRoEmD formally correct?*
2. Network aspects:
    a. *What does existing literature say about networks and network performances?*
    b. *What is the network for BeRoEmD and how does that network perform?*
    c. *To what extent does the network of BeRoEmD perform as desired?*

§1.3 Practical relevance

This study in conducted in association with BeRoEmD. Therefore, practical relevance is primarily focussed at this particular care group. An in-depth analysis of her own business model, network and structure will enable BeRoEmD to strategically better match the activities of the care group's viability and efficacy. Insights in the network BeRoEmD is part of and how it is positioned in the network can lead to strengthening that positioning. Lastly and most importantly, aligning the gained insights on strategy and network will strengthen the organization's viability and processes.

Additionally, research indicates further integration of care can lead to improved processes and patient outcomes (Busetto, Luijkx, Huizing, & Vrijhoef, 2015). However, as mentioned in the previous paragraph, the exact reasons and methods are still unclear. Some elements of integrated care are problematic or under researched. Building upon previous research with the care group and its stakeholders will provide more insights into this relation and benefit BeRoEmD.

Moreover, BeRoEmD's request to study its role, business model and network is applicable to the bigger picture of the chronic healthcare in the Netherlands. A report by *het Rijksinstituut voor Volksgezondheid en Milieu* (RIVM) states there are conflicting views on the role and what tasks are considered the responsibility of a care group in the Netherlands and further research is demanded (Til, Wildt, & Struijs, 2010). The rise in healthcare costs is a major political, policy and social issue. Not only costs generated by the general practitioner, but especially follow-up costs make primary care pivotal in this system (InEen, 2017).

§1.4 Scientific relevance

This research's scientific relevance can be found in three aspects. First of all, in recent years management and economic literature paid increasing attention to Business models and business model innovation; it suggests that business model innovation is the key to a business success (Chesbrough, 2010). However, most of these studies have been focused on commercial organizations, whilst this study researches the care group business model of BeRoEmD in the public sector. This study will further the knowledge on business models as a source of business success in the public sector. Providing insights on the importance of essential elements to a commercial organization to a public organization. Other aspects of business model theory might be more, or in other ways, important for the success of a care group. After review of available models,

this research proposes a combined model aiming to help researchers evaluate a formal strategy product for both commercial and public organizations.

Second, the Dutch bundled payment system for chronic care and the adoption of the care group business model in order to coordinate chronic care has been a topic of research for nearly ten years now. However, practice has been very dynamic and each care group has taken its own route in tackling the problems it had to face. Moreover, earlier research is inconclusive on multiple occasions within this topic. For example, Previous research has demonstrated improved outcomes of integrated care initiatives, although it is not yet clear why and when integrated care works or how the benefits come to be (Busetto, Luijkx, Huizing, & Vrijhoef, 2015). Also reports show total costs per patient have actually increased compared to before the introduction of the bundled payment system (Busse & Stahl, 2014). Which is the opposite of what this solution should be. Especially considering the German and UK solution have resulted in saving total costs. Furthermore, the care groups under study by Busetto et al (2015) only partially achieve incorporation of the CCM elements, whilst full incorporation would lead to a stronger business model (Wagner, et al., 2001). Combining the literature on chronic care models and business models in general within care groups will further the base of knowledge in this area.

Third, in the network part of this research, this thesis tests a recently published framework that aims to aid researchers in analyzing the network's quality of work and quality of care. Adding to the usability of this framework and testing it on a similar context as was done by the original authors.

§1.5 Research Structure

This research will be structured in two parts; a strategic part and a network part. The goal of each part is to answer the corresponding set of sub-questions. The preceding strategic part will underpin the successive network part.

The strategic and network parts follow the same procedure; First both parts start with a review of relevant literature followed by constructing a conceptual framework. Second, a methodological section explains the methods concerning research design, operationalisation, data collection and data sources. Third, a section will present the findings of data collection and perform corresponding analysis with the help of the constructed conceptual framework. Fourth, a section draws conclusions for that part of the research.

After individually concluding both parts, a final concluding chapter will bundle gained insights to a whole. This chapter is devoted to the conclusions of this thesis and discussion on the research's implications, limitations, possible shortcomings and notes for future research.

A brief summary of each part's content:

1) The first part will be aimed at organizational strategy and strategizing with the goal to evaluate BeRoEmD's strategy. A theoretical overview details how strategy can be formally evaluated with the help of business models as a way of capturing said strategy.
2) The second part is directed at the network of BeRoEmD and that network's performance. Therefore, we dive into system theory and the viable systems model that enables evaluation of a network with the help of a recently developed role and value module tool.

Part 1 Strategy

Being the first of this two-part research, the goal of part one is to perform an evaluation on the strategy by BeRoEmD. Therefore, first a review of relevant literature will be conducted followed by the argumentation for using the Business Model Canvas and components of the Chronic Care Model to assess BeRoEmD's strategy. The theory section of Part 1 will also be used to elaborate on the concept and history of care groups and introducing intervention methodical tools. Secondly, the methodological chapter will discuss the methods of operationalization and data collection. Third, findings will be presented and assumptions based on the established theoretical framework will be reviewed against the collected data. Finally, conclusions concerning the strategy for BeRoEmD will be drawn in a final chapter.

Chapter 2 Conceptual underpinnings: strategy

§2.1 Introduction

The goal of this theory chapter is to provide the theoretical tools that enable this research to properly evaluate the strategy of BeRoEmD, Thus this chapter constitutes the theoretical framework of the concepts needed to evaluate the strategy of a care group. The first section explains the Dutch bundled payment system and the therefrom derived coordinating organizational model called *care groups* (2.1). Secondly, ways of organizational strategy and strategizing are reviewed along with the use of business model theory to capture said strategy (2.2). Subsequent, the third section merges these theories on care groups and strategy for the use of this thesis (2.3). Lastly, the concluding section presents the conceptual framework to evaluate BeRoEmD's strategy product (2.4).

§2.1 Care groups: Origin & characterisation

The focal point of study in this thesis is to evaluate the strategy of a care group, in particular care group BeRoEmD. For the understanding of the reader, this section will first provide insights in the origination of care group. The first section provides an overview of how and why care groups came into existence. Moreover understandings and the defining of care groups are discussed; what are considered to be key characteristics, tasks and issues for a care group in the Netherlands.

Origin

As mentioned in the introduction, several factors have caused general life expectancy to rise for modern society. Due to the increased life expectancy, our population is ageing (CBS, 2016). Ageing brings about an aggregation of illnesses that require continuous and most often infinite care (e.g. diabetes, asthma, cardio

vascular problems). In contrast to severe injuries or illnesses that require direct yet short term-treatment, these diseases are of a more chronic nature. Traditional healthcare systems, set to cater acute care, were not well suited to provide this chronic care (cost-)efficiently. Therefore the traditional healthcare systems required adaptation to cope with treating chronically diseased patients.

In many cases, the solution is sought through the integration of care (Busse & Stahl, 2014; Wagner, et al., 2001). Integrated care is *"an organizational process of coordination that seeks to achieve seamless and continuous care, tailored to the patient's needs, and based on a holistic view of the patient"* (Mur-Veeman, Hardy, Steenbergen, & Wistow, 2003, p. 227). Despite that the exact effects of integrated care are still to be further researched, integrating care is argued to be a necessity to the improve care, patient experience, efficiency, and to save cost (Busse & Stahl, 2014; Dijk, et al., 2013; Golden, & Hannam, 2015; InEen, 2017; Kruis, Boland, Assendelft, & Gussekloo, 2014; Richards, et al., 2008). For that reason, the Netherlands began experimenting with a bundled payment approach for diabetes patients in 2007 leading to the creation of care groups.

Defining

In the bundled payment care system, care groups act as intermediaries between health insurers and health care professionals (mainly primary care). Care groups "*negotiate the content and price of a comprehensive package of chronic care, the resulting agreements are captured in bundled payment contracts"* (Busetto, Luijkx, Huizing, & Vrijhoef, 2015). The care group is responsible for the co-ordination and provision of contracted care in a particular region (Til, Wildt, & Struijs, 2010). A care group can either provide care itself or sub-contract other providers (e.g. dietician). Over the period of 2008 to 2010, other chronic diseases were added to the bundled payment system, expanding the role of care groups; chronic obstructive pulmonary disease (COPD), asthma, cardio vascular diseases (CVD), and depression. By 2016, the Dutch national primary care association InEen identified 130 active care groups that provided care for one or more chronic diseases (InEen, 2017). Many have attempted to capture the definition of care groups. The most comprehensive definition is given by Duivenboden and Althuis:

> "*Care groups are organizations (predominantly primary care providers) whom conclude contracts with health insurance companies to coordinate and perform chronic care in a particular region with the objective to improve the quality of care*." (Duivenboden & Althuis, 2014, p. 9)

Characterization

Still, many conflicting interpretations on the defining of care group aspects exist (i.e. role, tasks, mission and vision, procedures, partners, etc.). The rapid increase in numbers of care groups with each its own interpretation of the organization has both led to differences and commonalities between and among care

groups in the Netherlands (De jong-van Til, Lemmens, Baan, & Struijs, 2012). Common trends can be found in development on organizational level by expanding offered care programs, growth of support staff members, focus on increasing transparency and quality of the provided care. The latter often with the help of benchmarking and the appointing quality managers within the organization.

Not only commonalities, but also differences can be found in the inclusion of the provided care programs. In 2016, all questioned care groups offer care for diabetes, roughly ninety per-cent of the care groups cater to COPD, and CVD is least represented by nearly seventy-five per-cent of the care groups (InEen, 2017). This is, however, an significant increase for COPD and CVD compared to 2011, whereas COPD was covered by half and CVD by only a quarter of the care groups investigated respectively.

Additionally, the role of the patient varies between care groups in both perceived importance and realization (De jong-van Til, Lemmens, Baan, & Struijs, 2012). Care groups have different approaches to the role a patients has in his or her own disease. This can either relate to the active role, as in what can the patient actively do or change in his lifestyle to help combat the disease or to the degree of involvement. Involving and informing the patient can strengthen the patients understanding of his condition, but requires time and effort from the care provider. Not all care groups assess doing this as its responsibility.

Another striking difference between care groups is the adoption and usage of IT resources. IT enables care groups, health insurers, care providers and patients to exchange data and generate reflective information. However, there is a discrepancy in systems and usage; General Practitioner work with a *Huisarts Informatie Systeem* (HIS) since before the introduction of care groups. Care groups tend to work with *Ketenzorg Informatie Systeem* (KIS). Connecting one another has proven difficult so far, as well as the variety of KIS in use by care groups using its preferred functions.

A final point of attention found is the relationships between players on the healthcare market, mainly between care groups and insurers. Contract negations are considered troublesome from the care group's perspective in many cases due to the power play tactics exacted by the insurers (Nederlandse Zorgautoriteit, 2014).

In Sum

Care groups are the Dutch solution to integration of chronic healthcare. A care group organization's activities encompass concluding contracts with health insurance companies and to coordinate and to perform chronic care in a particular region of the country. With the main goal being to improve the quality of the provided care for the patient. Each care group caters chronic care towards its own region with partners (e.g. general practitioners, physicians, etc.). Also a care group can chose which chronic illnesses to provide care for. Care groups started as organizations aimed at providing chronic care for diabetes, but developments towards providing care for other forms of chronic care as well followed after the pilot years.

This had led to a general understanding and consensus of what a care group is and what its activities entails. However, multiple interpretations on the concept still reside, leading to commonalities and differences amongst the care groups in the Netherlands. Most care groups have adopted more chronic diseases than diabetes and most care groups have been working on, or at least acknowledged, developing the organizational structure leads to further improvement of chronic care. Differences exist in the role care groups assume in the chronic care chain, usage and adoption of IT resources, and patient involvement into the care process.

To underpin BeRoEmD's interpretation of the care group, its activities, role and relations, an investigation into strategy should provide insights as to what strategic choices leads to attaining the highest quality of care.

§2.2 Strategy - Business models

Part one of this thesis is aimed at evaluating the strategy of a care group. The notion of *strategy* can be understood in many different ways and can pertain different aspects or goals. I will first introduce to the reader what is understood by strategy for this section in accordance to the nature of this thesis. Followed by an in-depth review of aspects of strategy that are aimed at evaluating and an exploration of available tools to do so.

Strategy

Strategy is a much-discussed topic in management literature in all its forms and derivatives. Quinn defined strategy as "*the pattern or plan that integrates an organization's major goals, policies, and action sequences into a cohesive whole"* (Quinn, 1980, p. 3). Porter noted strategy is "*the creation of a unique and valuable position, involving a different set of activities than your competitors"* (Porter, 1996, p. 68). Implying creation is a conscious, deliberate choice. Subsequently, the purpose of a strategy is "*to define what the organization will and will not do*" (Christensen, 1997, p. 142). Moreover, strategy is "*all that which relates to the long-term prospects of the company and has a critical influence on its success or failure*" (Agarwal & Helfat, 2009, p. 281). Thus, strategy is "*a contingent plan of action designed to achieve a particular success by choosing a particular logic of the firm, way to operate and particular way to create value*" (Casadesus-Masanell & Ricart, 2010, p. 196 & 203).

From these characterizations of strategy, certain aspects (taking action, planning, patterns) indicate strategy is an active process. Other aspects (goals, policies, explanation) imply strategy is a product of that process. Implying strategy can be regarded as both a process and a product. Moreover, literature identifies two approaches to strategy (or change); planned versus emergent. The approach of planned change is based on the works of Kurt Lewin (Bamford & Forrester, 2003); "*Planned change views strategy as a process that moves from one fixed state to another through a series of pre-planned steps and can, therefore, be analyzed by constructs"* (Bamford & Forrester, 2003, p. 547). Most notably Lewin's own *action research* approach prescribing a three-step model (unfreeze, change, refreeze) to change (Lewin, 1951).

Supporters of emergent change, however, argue that strategy can never be fully planned. Emergent change is a reaction to the planned strategy approach stating the complete process of change is too prescriptive and complex to be fully planned. Due to being less prescriptive yet more analytical, emergent change is "*better suited to manage achieve broader understandings in complex environments*" (Bamford & Forrester, 2003, p. 548). With rising complexity, an organization has to deal with higher levels of uncertainty. Due to the nature of emergent change, this approach is more capable of reacting dynamically during the process of strategy.

In sum, it can be argued the process of strategy can never be fully planned, nor can it be completely emergent. Making strategy a continuous process of actions, planning and adjusting. This process delivers the strategy product and that product is subsequently the subject of the strategy process again.

Evaluation

Corresponding, evaluating strategy can have different goals (figure 1). First off, we already differentiated that strategy can be considered as either the *process* of formulating strategy or as the final *product* of strategy. Second, we can evaluate a strategy either on its *contents* or we can do so *formally*. Content-wise, the quality of a strategy is subjected to evaluation. Formal evaluation, assesses to what extent protocols, guidelines and elements have been applied or followed. The combination of these options leads to the matrix shown in figure 1, resulting in four modes of evaluating strategy.

Evaluating strategy	Process	Product
Content-wise	Is every aspect of our strategy well-discussed and debated over?	Is the end product a good strategy?
Formally	How did the strategy come to be and have we taken the correct processual steps in formulating it?	Is the end product as it should be according to format; topics, concepts?

Table 1: Strategy evaluation matrix

This thesis is focused on **formally** evaluating the **product** of strategy for BeRoEmD (figure 1 - bottom-right). A formal-product evaluation focuses on whether the end-product of an organization's strategy process contains the correct format, topics and concepts as prescribed in strategic literature. It is vital to investigate what are considered elements of this correct format and how they should find its resonance in a strategic evaluation. While performing a formal product evaluation, we want to analyze the strategy's completeness as well as its consistency. Completeness can be reviewed by assessing whether all parts that comprise a solid strategy are present and well thought about. Consistency can be assessed on two levels. First off, consistency within components of strategy to assess if all data (sources) present the same strategy towards that certain component or if there's conflict findings. (e.g. both data sources state profit maximization should be a main goal vs. one source states profit maximization should be the main goal whilst another source states CSR policies should be given higher priorities than profit maximization). Second, consistency among the various components of strategy can be evaluated to assess whether the strategy components match the others (e.g. a company promoting high CSR operations, whilst turning out to be heavily polluting its area of operations

and underpaying its employees clearly presents a mismatch somewhere in the strategy). In order to properly evaluate both completeness and consistency of a formal strategy product, it must first be clear what is considered an adequate formal strategy product. That's why the latter sections of this chapter will review several strategic tools aimed at formal-product evaluation.

The formal-product evaluation is used in the case of BeRoEmD for two reasons; First and foremost, because BeRoEmD requested this kind of evaluation. Second, this thesis consists of three parts; strategy, network and organizational structure. Evaluating the formal product of BeRoEmD's strategy is required for the subsequent parts. The knowledge and the overview of strategy will underpin upcoming network evaluation. Together, network and strategy evaluation shall serve as possible design parameters to the organizational structure.

In order to properly evaluate BeRoEmD's strategy, tools are needed that suit a formal strategy product evaluation. We have characterized strategy as a continuous process with both deliberate (planned) and reactive (emergent) properties. With the process delivering the product of strategy. This product is what literature often times refers to as a B*usiness Model*. Evaluating such business models can play a central role in explaining firm performance (Afuah & Tucci, 2001). No matter what the sector, there are criteria that enable one to determine whether or not one has designed a good business model (Teece, 2010). Therefore, evaluating the business model as the formal product of BeRoEmD's strategy is considered a well-suited approach.

Tools to evaluate strategy: Business Models

The term business model has become more popular since the mid-1990's, but its usage dispersed. "*At a general level, the term business model has been referred to as a statement, a description, a representation, an architecture, a conceptual tool or model, a structural template, a method, a framework, a pattern, and a set*" (Zott, Amit, & Massa, 2011, p. 1022). Thus, business models yield exactly the strategy aspects that are open for a formal and product focused strategy evaluation. Taking a closer look into business models, the most relevant definitions in the contexts of this study are shown in the figure below:

Author(s), Year	Definition
Casadesus-Masanell & Ricart, 2010	A business model is a reflection of the firm's realized strategy (p. 195)
Teece, 2010	A business model articulates the logic, the data and other evidence that support a value proposition for the customer, and a viable structure of revenues and costs for the enterprise delivering that value (p. 179)
Johnson, Christensen, & Kagermann, 2008	Business models consist of four interlocking elements, that, taken together, create and deliver value. These are customer value proposition, profit formula, key resources, and key processes. (p. 52)
George & Bock, 2011	a business model is the design of organizational structures to enact a commercial opportunity (p. 24)

Figure 1: Overview definitions for the concept *Business Model*

Combining these definitions leads to the conclusion that a business model is not solely a value proposition, a revenue model, or a network of relationships by itself; it rather is all of these elements together (Zott, Amit, Massa, 2011). *"A good business model thus yields value propositions that are compelling to customers, achieves advantageous cost and risk structures, and enables significant value capture by the business that generates and delivers products and services"* (Teece, 2010, p. 174).

Distinguishing strategy from business model, a strategy is a dynamic set of initiatives, activities, and processes. Whereas the business model is a static configuration of organizational elements and its activity's characteristics. Note the emphasis on dynamic versus static nature. A strategy may be reflexive, initiating change within the organization that impacts the emergent strategy. A business model is inherently non-reflexive due to its static nature (Bock & George, 2011). Therefore, strategy is choosing the particular business model through which the organization will operate, whilst the business model itself refers to "*the logic of the organization, the way it operates and how it creates value"* (Casadesus-Masanell & Ricart, 2010). If the business model doesn't produce the expected value, strategy can adapt. Producing in a new strategy product that changes the business model or uses a different model entirely.

If we consider the business model a translation or reflection of an organization's strategic choices, the business model is the end product of an organization's strategy that is open to formal evaluation. In the upcoming section, an overview of several established business models interpretations will be presented.

Each model will be discussed by briefly explaining core goals, elements, as well as advantages and disadvantages attributed by literature to the model. Resulting in the constructing of the conceptual framework that enables evaluation of BeRoEmD's formal strategy product.

Overview of feasible Business Model Tools

This section will present feasible business model representations found in literature. Starting from the most simplistic models to more complex models. Key insights and elements found in each model are used to construct the conceptual framework.

Compiled defining (Zott, Amit, Massa)

As mentioned above, compiling the various definitions of term *business model* leads to the conclusion that it consists of at least a *value proposition, a revenue model,* and *a network of relationships* (Zott, Amit, & Massa, 2011)

➔ Business Model elements taken into consideration

- Customer value proposition
- Profit Formula
- Key resources

Key components (George & Bock)

The first 'model' to be discussed is actually more prescriptive than it is a model. George and Bock define a business model as "*the design of organizational structures to enact a commercial opportunity" (p.107),* stating a business model should at least contain: 1) a resource structure; 2) a transactive structure; and lastly 3) a value structure (George and Bock, 2011, p. 99).

➔ Business Model elements taken into consideration

- Resource structure
- Transactive structure
- Value structure

Driving Forces (Christensen)

Next up is another prescriptive definition of business models by Christensen. He states: *"business models consist of four interlocking elements, that, taken together, create and deliver value. These are customer value proposition, profit formula, key resources, and key processes."* (Johnson, Christensen, & Kagermann, 2008, p. 3).

➔ Business Model elements taken into consideration

- Value proposition
- Revenue model
- Network of relationships

Five Forces Model (Porter)

In an attempt to simplify micro-economics Porter identified five forces that can help explain organizational performance (Porter, 1980). The model can be used to assess what forces or threats affect the industry an organization is part of and assess ones strategic position within this industry in order to increase profitability and competitiveness (Porter, 1996). Porter's five forces model was one of the first models used in strategic management in the 1980's and has since become a staple in most academic books and courses on strategy.

The model is attributed to be relatively abstract and highly prescriptive in nature (Grundy, 2006). However, the model never really gained popularity among practice. Possibly due to its abstractness and inflexibility. Later, the model was revised with a sixth force to strengthen the model. Resulting in the six forces that can help assert an organizations strategic positioning (Porter, 1996).

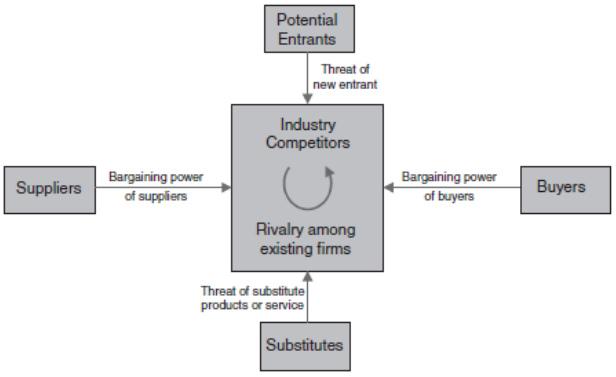


Figure 2: Porters 5 forces model (Porter, 1980)

➔ Business Model elements taken into consideration:

- Bargaining power of Buyers
- Bargaining power of suppliers
- Entry barriers
- Rivalry among existing competitors
- Threat of substitutes
- Threat of complementary products

Stakeholder Mapping (*Ackerman & Eden)*

Ackerman and Eden focus more on a stakeholder perspective with regards to strategic management (Ackerman & Eden, 2011). Mapping stakeholders on a two-dimensional matrix based on their degree of power over the organization and their interest in the organization (figure 3). Furthermore they make differentiate between three kinds of stakeholders: 1) internal stakeholders, like employees; 2) connected stakeholders, like business partners; 3 external stakeholders, like parties not directly involved but somehow touched by the organization.

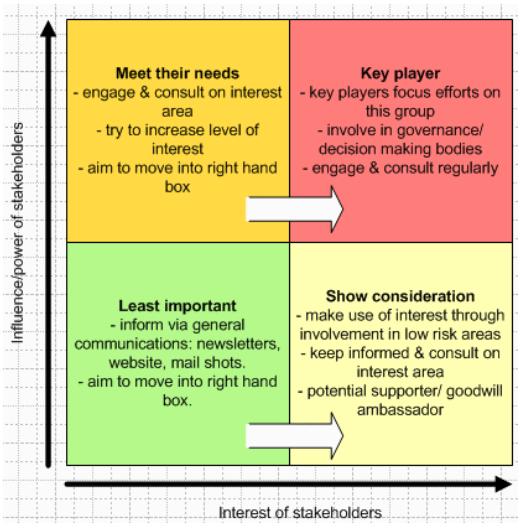


Figure 3: Stakeholder Mapping matrix

➔ Business Model elements taken into consideration:

- Critical success factors
  - Financial perspective
  - Customer perspective
  - Internal perspective
  - Learning & improvement perspective
- Critical measures

[redacted]

- External stakeholders

[redacted]

Balanced Scorecard (Kaplan & Norton)

Next up for consideration is the balanced score card. The balanced scorecard is a town-down reflection of company's mission and strategy that helps managers to look forward by integrating external and internal measures (Kaplan & Norton, 1993). Using the balanced scorecard helps users choose the fitting measures suiting their strategic goals. It does so by providing four different perspectives on strategy from which to distill measures; *1) financial (stakeholder) perspective; 2) performance for customers perspective; 3) internal processes perspective; 4) internal & improvement perspective* (Kaplan & Norton, 1993, p. 7). For each perspective, the critical factor(s) for succes should be identified. After finding those critical success factors, suitable critical measurements can be chosen that help attain the values that match strategic goals.

The balanced scorecard method can be a strong strategic tool, but it has quite some requirements for success. It requires all that are involved in the process to understand the theory behind the model, which can be a lengthy task. Not every participant in the strategic process is as well versed in academic literature as the

next person. Besides theoretical knowledge, the model assumes complete information is present. However, it can be argued that often we are not capable to process hundred per cent of the information. We rather operate on *bounded rationality*; The notion *that our rationality is limited by time, tractability of the agent, and our own cognitive limitations* (Barros, 2010, pp. 460-461). Lastly, it can be argued the model focusses too much on competitiveness compared to other values. Other goals to an organization are given a significantly smaller role, which result in the risk of forgetting other important strategic aspect in the process. This might especially be relevant for a care goup, as it mainly provides a public service.

Business Model Canvas

Last of the descriptive models is the Business Model Canvas (BMC). The BMC creates a *"shared language for describing, visualizing, assessing, and changing business models"* (Osterwalder & Pigneur, 2010, p. 18). The model does this in a highly visual fashion with the help of nine building blocks. These blocks guide the user through key components and complementary components in the process of strategizing with primary focus on the value proposition of the organization. Moreover the model aims at creating a common language among its users. Making the model highly practical in its use for making or assessing strategy. One drawback that can be identified is that the model does not account for social value.

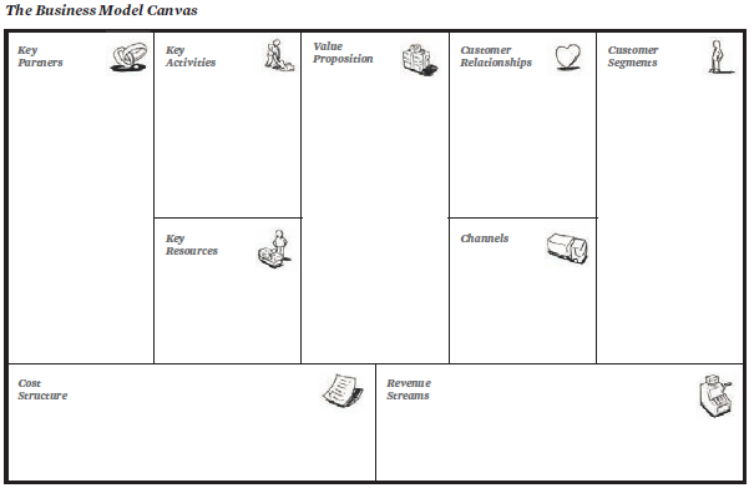


Figure 4: Business Model Canvas as taken from Osterwalder & Pigneur, 2010, p. 50.

➔ Business Model elements taken into consideration:

- Value proposition
- Key activities
- Partner network
- Key resources
- Client segments
- Client relationships
- Distribution channels

Causal Loop diagrams and stock & flow models

Group model-building literature provides two more tools; causal loop diagrams and stocks & flows modelling (figure 6 & 7 respectively). *"Causal loop diagrams may be used to get an initial idea of central concepts and their relationships."* (Rouwette & Alberto Franco, 2015, p. 45). Creating these diagrams reveals processes within the organization and their causal relation to one another.

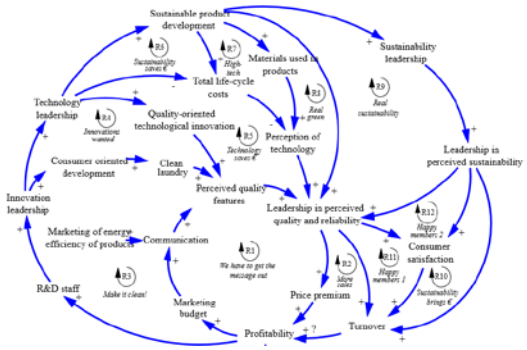


Figure 6: causal loop diagram example

Stocks & flows models take this a step further by adding a high amount of calculating power, creating what is known as *formal quantitative models*. Both methods rely on *working with small groups to support system conceptualization, model formulation, and decision making*. (Andersen & Richardson, 1997, p. 107).

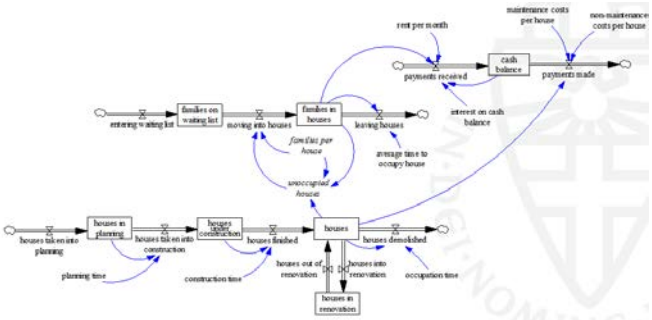


figure 7: stock & flows model example

➔ Business Model elements taken into consideration:

- Causal relations
- Feedback loops
- Group model-building characteristics

Compiling all of the elements found in the strategic literature on business models above leads to the list of elements that can be used in constructing a business model as shown on the next page.

List of BM elements identified	
Author / model	**Elements named**
George & Bock	Resource Structure
	Transactive Structure
	Value Structure
Zott, Amit & Massa	Value Proposition
	Revenue model
	Network of relationships
Christensen: Driving forces	Customer value Proposition
	Profit formula
	Key resources
	Key processes
Porter: 6 Forces	Competition in industry
	Potential of new entrants
	Power of suppliers
	Power of customers
	Threat of substitutes
	Complementary products
Balanced Scorecard	Critical success factors
	Financiel perspective
	Customer perspective
	Internal processes perspective
	Learnings & growth perspective
	Critical measures
Stakeholder mapping	Power of stakeholders
	Interest of stakeholders
	Internal stakeholders
	Connected stakeholders
	External stakeholders
Business Model Canvas	Key partners
	Key activities
	Key resources
	Value Proposition
	Revenue flows
	Customer Relationships
	Distribution channels
	Cost structure
	Customer Segments
Causal Looping and stocks & flows model	Feedback loops
	Causal relations
	Group model building

Table 2: compilation of business elements identified in literature

Table 2 shows all elements that have been identified from the discussed feasible business models, resulting in a compiled list of business model elements identified. A total of 39 elements were gathered. However, some elements resemble doubles from one model to another model or at least seem to overlap with other elements within the compiled list. Therefore, all elements received a verbatim label (e.g. all elements directed at value were named Value; Value structure → Value). This analysis resulted in a list of 15 unique elements. Some of these unique items still seemed to overlap or did not fit accordingly to the goal of this thesis, requiring a second iteration of relabeling the business model elements.

A second iteration of labelling resulted to distinguish 11 elements from which a business model should constitute according to this thesis. For a more in-depth analysis and depiction of this process This research refers the reader to *Appendix 2: Analysis of business model elements*. The final set of elements that are deemed highly relevant when evaluating a firm's strategy are:

Business Model Element	**Defining/understanding**
Value	The core idea of what value the organization provides, or aims to provide with its operations.
Activities / Processes	Relates to all key activities and processes going on within the organization related to attaining or providing the value
Resources	All resources that are exploited by the organization.
Partners	Parties the organization regards to as partners. For instance, suppliers, joint ventures, or other complementary organizations
Competitors	Parties the organization regards to as possible rival or threat to the organization.
Customers	*Segments:* Who are your customers? And can they be segmented into groups?
	Relations: What kind of relationship do you want / have with your customers, how do you culture / maintain this?
Financial aspects	*Revenue structure:* All financial aspects related to the revenues created by the organization.
	Cost Structure: All financial aspects related to costs being made by the organization.
Channels	*Communication:* all modes of communication within the organization itself, but also all communication that is outbound.

	Also pertains the how and why a message is communicated
	Information: All modes of information streams for the organization, both inbound and outbound. What information systems are being used.
	Distribution: All modes of distribution from supplier to customer. Explains what channels are being used and why.
External	*Developments:* Regards to developments outside of the organizations environment that can be relevant to the organization. (e.g. governance or new laws that relate to the organization).
	Threats: Possible threats to the organization that should be monitored that are not directly linked to competitors.
Learning	Relates to how learning is incorporated within the organization and how this knowledge is attained, shared, and retained.
Measurement	Aimed at measuring performances, what is the norm, current value and possible gap between these. Key performance indicators (KPI) can be used to present an overview of these measurements.

Table 3: Business Model elements to constitute strategic evaluation framework

§2.3 Connecting the Chronic Care Model

In the preceding paragraph, a set of general business model elements has been identified and defined to enable a formal and product evaluation of strategy. However, this thesis is aimed at care group BeRoEmD, an organization in the health-care sector. Therefore, the goal of this section is to investigate health-care specific strategy aspects that should be incorporated in a strategic evaluation for BeRoEmD. This section addresses earlier strategic research on health-care in the form of the Chronic Care Model by Wagner as well as previously conducted research into care groups in the Netherlands and how this can be incorporated in the business model elements summed up in the previous section.

The creation of the care group business model was based on the chronic care model constructed by Wagner as a response to the rapidly growing number of people requiring chronic care due to chronic ilnesses. *"The model does not offer a quick and easy fix; it is a multidimensional solution to a complex problem"* (Bodemheimer, Wagner, & Grumbach, 2002, p. 1776). It states chronic care is primarily perfomed in the primary care settings (i.e. general practitioners), yet takes place in three dimensions; 1) the entire community of chronicaly ill, 2) the health care system and it's payment structures; 3) the providing organization. High quality chronic care can only be achieved by positive and productive interactions between these dimensions. Therefore, Wagner identifies six essential components that should enable qualitative solutions to chronic care (Wagner, et al., 2001, pp. 73-76):

1. *community resources and policies:* stressing the importance of community linkages and resources available to the providing organization
2. *health care organizations:* Deals with the structure, goals and values of the providing organization as well as partners, insurers and other relations.
3. *self-management support:* The patient has to live with the illness for many years. Therefore, he should learn to manage the ilness himself; diet, medication use, exercise, measuring values himself, other lifestyle aspects. Chronic care providers should support and enhance the self-managing capabilities of the patient.
4. *delivery systems design:* Refers to the structure of medical practice. Providing organizations should be organized in practice teams with a clear division of labour and capable of planned managing of chronic care.
5. *decision support:* The use of evidence based clinical practices guidelines delivers standards to chronic care and these should be integrated into daily practice. Also, communication lines are to be short and accessible.
6. *clinical information systems:* The final element refers to computerized information systems and states these systems serve three purposes. 1) as a reminder system; 2) as feedback system to care providers; 3) as registries for planning individual and population-based care.

These six components are considered to be interdependent, meaning one element can help enhance another and vice versa. For example, effectively utilizing the community resources can help a patient's awareness and thereby his self-management skills.

Earlier research by Busetto, Luijkx, Huizing, & Vrijhoef (2015) has tried to translate the CCM Components onto the Dutch care group system for diabetes care (figure 7).

Their conclusions show not all components were represented equally or represented at all among surveyed care groups in the Netherlands. No aspects of the Dutch integrated care model seems to meet the *community* component. Additionally, the component self-management support received significantly less attention that the other component (Busetto, et al., 2015).

CCM component	Dutch integrated care for type 2 diabetes
Health system	Care groups and bundled payment system
Self-management support	Patient involvement
Delivery system design	Health professional cooperation and task substitution
Decision support	Evidence-based care protocols
Clinical information system	Shared clinical information system
Community	

Figure 8: Dutch care group system translation of the CCM components (adapted from Busetto, Luijkx, Huizing, & Vrijhoef, 2015)

Moreover, Busetto et al. (2015) investigated barriers and facilitators to the implementation of integrated care (Appendix 1). At all levels both barriers and facilitators were identified. Most notably, economic, political and IT-related barriers were discussed most frequently. Indicating those barriers are currently the most pressing issues among care groups (Busetto, Luijkx, Huizing, & Vrijhoef, 2015).

The components of the chronic care model and their translation to Dutch care groups along with the most notable findings regarding barriers and facilitators should be incorporated in the evaluation of BeRoEmD's formal strategy product. They form the connection between strategic input and the core business of a care group. This research argues that most of the CCM components can be connected to the already existing business model elements in the framework, because they are an interpretation of what values should be given to the various elements derived from the more general attempts at defining a business model. Therefore, table 4 details how the six CCM components are linked to the business model elements that are identified in the previous section.

Chronic Care Model components	**Relation to the business model**
Community resources and policies:	This component focusses on community linkages and resources available to the care group. Therefore, it relates to almost all of the business model elements. It emphasizes on bringing together you *customers*, *partners*, and possibly even *competitors*, to share *resources* and *information* via chosen *channels*. It can be considered an *activity* to the care group aimed at providing a certain *value* to the chronic health-care system.
Health care organizations:	In the Netherlands we have chosen the care group model as a way of organizing our chronic health-care within the bundled payment system. Basically, this refers to the organizational structure of the care group itself. Thus relates to how the organization structures all the elements of its business model. Part 3 of this thesis is focused on evaluating and possibly adjusting the organization's structure.
Self-management support:	This component relates to the self-reliance capabilities of chronic care patients, as the patient has to learn how to manage his illness for a longer period of time. In order to successfully enable the patient, the patient has to be actively involved in his own care. If the patient is regarded to as the *customer* for the business model, he can be identified by what type of illness the patients suffers from (*segment*) and what *relationship* the organization should engage in. Besides customer, the *channel* elements should also be actively considered in self-management support.
Delivery systems design:	The component that refers to the actual providence of medical practice components. This can be linked to the *value* and *activities* elements within the model. The value element structures what the organization delivers to the patient. Whereas the activities element explains how this is done.

Decision support:	This component describes evidence based care protocols / guidelines to deliver high standards to chronic care that should be incorporated into daily practice. This component is a combination of how *activities* are structured, with the help of *measurement*, *learning* and *information* elements.
Clinical information systems:	This component links directly to the *channels* and *measurement* elements. These two elements provide systems to share information, how this information can be shared, prescribe the information input and possible output.

Table 4: linkage of Chronic care to business model elements

For this thesis the components are considered to give direction in valuing and/or structuring the strategic elements. Moreover, the aforementioned barriers and facilitators found by Busetto et al (2015) add another layer of consideration towards the model, as they relate to known problems related to the chronic care components with regards to the chronic care sector. When evaluating BeRoEmD's strategy with the help of the business model elements, these insights on chronic care taken from the CCM plus their barriers and facilitators should be researched within the generic strategic elements.

§2.4 Conceptual Framework

The goal of this conceptual chapter was to enable the formal evaluation of care group BeRoEmD's strategy product. Therefore, first I elaborated on the origins and the definition of care groups, followed by a characterization of care groups in the Netherlands. Secondly, strategic aspects were discussed; the nature of strategy and ways of evaluating a formal product of strategy by means of business models theory. Third, a connection between care groups and strategy was made by discussing the chronic care model by Wagner and earlier research identifying barriers and facilitators to these components in the Dutch integrated care system. This final section of the first chapter will construct the conceptual framework for evaluating BeRoEmD's formal strategy product.

The conducted literature review resulted in a final selection of 12 business model elements that describe an organization's strategic model gathered from various existing business model representations. The original models discussed all featured at least some of the final elements. All of the elements from the compiled definition (4/4), key components (3/3), and Driving forces (4/4) were included in the final list of elements. However each of these business models are considered too narrow on their own. Porter's 6 forces

model (4/6), the Balanced scorecard (4/6), and the Stakeholder model (3/5) are each represented fairly high in the ending set of elements. However, all three of these models do not seem to capture the entirety of the goal for this thesis. Each model centers around its own point of view, resulting in strong focus towards some of the elements, yet neglecting others. The Business Model Canvas (8/9) is also highly represented in the final set of business model elements. Finally, the quantitative causal looping and formal models do not make the final cut. These models do not match the goal of charting and evaluating the formal strategy product of BeRoEmD. In fact, they would overshoot this goal.

Due to the high representation of the final elements and the highly visual design of the Business Model Canvas, this model is chosen as a basis for constructing the model. The original model is expanded with the complementing elements taken from the other business models. This results in the model as shown on the next page (figure 8).

Besides the business model elements, section 3 of this chapter expresses the relevance of incorporating the Chronic Care model components into the strategic evaluation for BeRoEmD. In order to properly evaluate BeRoEmD's strategy product, the 6 components and their translated implications towards chronic care in the Netherlands by Busetto, et al. (2015) are incorporated into the business model canvas elements. Formal evaluation should review wether these components are, at a bare minimum, present. Or favourably, all adequatly and evenly represented in the strategy as drafted by BeRoEmD.

Combining all of the above mentioned demands for conducting a formal product evaluation of strategy leads to the conceptual model as depicted on the next page in figure 9. This conceptual business model can be used as a basis for data collection and as a visual representation of the gathered data. The basis with nine building blocks from the business model canvas is used and extended with the elements *competitors, external* and *learning.* Thus, in total, this model is comprised of 11 business model elements, where some elements have subcategories added. The customer element is divided in segments and relations. This research aims to assess what customers can be differentiated and how they are managed. The channels element is divided in distribution and communication. Finally, the financial element is split into a cost structure and revenue structure. At the very bottom of this model, room is left for findings that become apparent during research, yet do not seem to fit any of the existing elements.

The following chapter discusses the goals and ways of data collection.

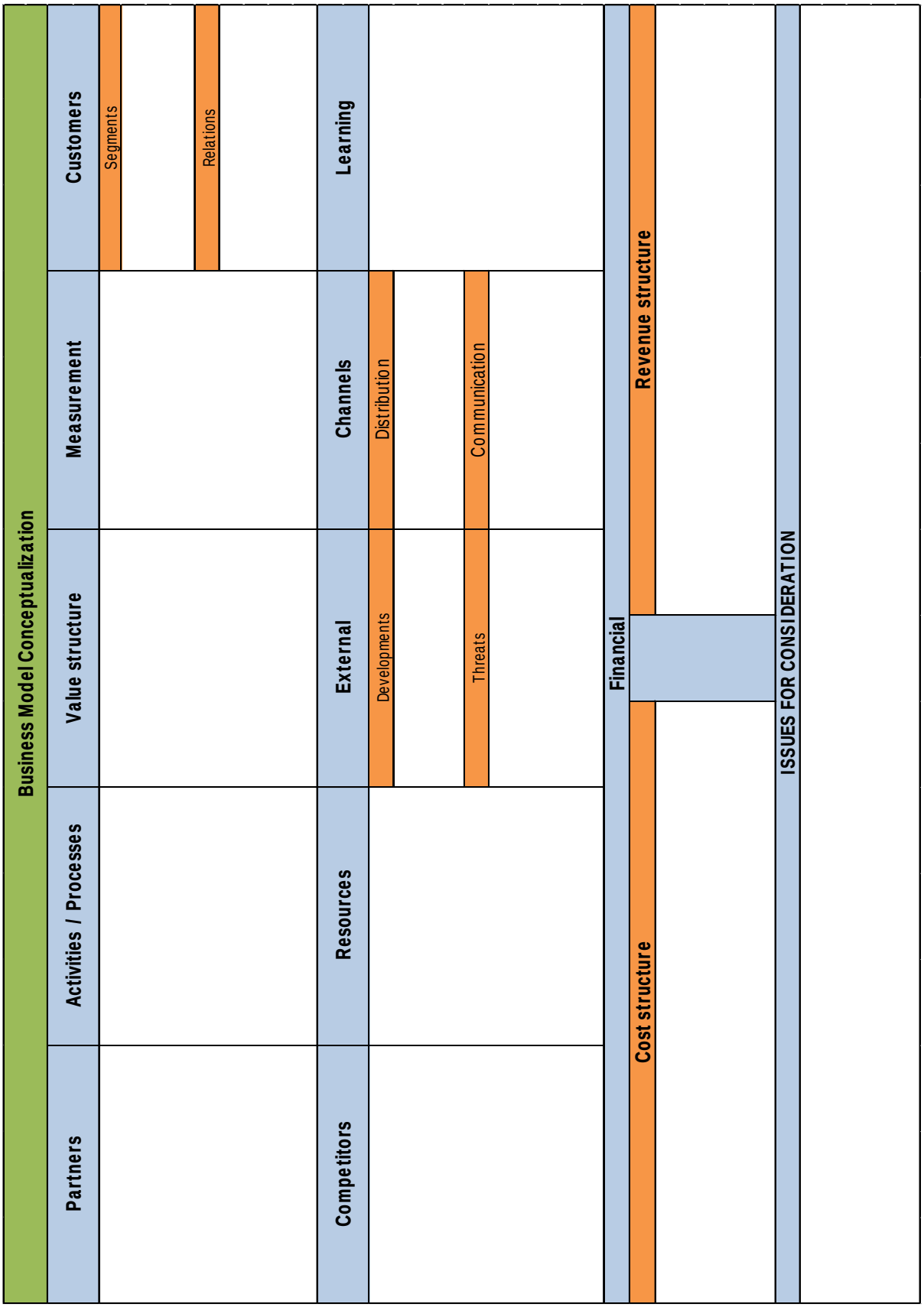


figure 9: Graphical depiction of this research's conceptual business model for evaluating a formal product of strategy

Chapter 3 Methodology

§3.1 Introduction

The goal of this chapter is to outline the methodology of this part of the research. First, the research design is described (3.1). Second, the selected data sources are discussed (3.2). Followed by a section on research methods elaborating the operationalisation, data collection- and data analysis methods (3.3). A fourth section is devoted to establishing the assessment criteria for qualitative research and how this research intends to ensure these criteria (3.4).

§3.2 Research Design

A research strategy is a set of key decisions from which a number of other decisions will follow (Verschuren & Doorewaard, 2010). First, a researcher has to question himself whether he wants to attain a deep understanding of the object under investigation, or rather a broad overview. In other words, this is a choice between *depth* and *breadth.* Second, a choice between *quantification* or *qualification* must be made. Quantitative studies focus primarily on calculations, tables and numbers, whilst quantitative studies use a more verbal and contemplative approach. The third question a researcher must consider deals with his degree of connection with the field; *empirical* versus *desk research.* These three choices guide the researcher in designing a research. Verschuren and Doorewaard (2010) subsequently sum up five research approaches: *survey*, *experiment*, *case study*, *grounded theory approach*, and *desk research*. Each of these five approaches is an accumulation of the abovementioned key decisions.

The goal of the first part of the research is to formally evaluate BeRoEmD's strategy. Hence the research design has to be aligned to this goal. A case study is deemed best suited towards attaining depth, whilst performing a qualitative and empirical study. A case study is *"a research strategy in which the researcher tries to gain a profound and full insight into one or several objects or processes that are confined in time and space"* (Verschuren & Doorewaard, 2010, p178). A case study is further characterised by a small number of research units, intensive data generation, a selective (i.e. strategic) sample, open observation on site, qualitative data and research methods.

In this part of the research, a case study approach is followed with care group BeRoEmD as the sole object of research. Data is gathered with the help of document analyses and supplementary open interviews underpinned by the conceptual framework conceived in chapter 2. Enforcing *triangulation of methods* by using multiple methods of collecting data. Furthermore, *triangulation of sources* is sought through the various sources in the form of different documents and interviews with two important respondents from BeRoEmD.

§3.3 Research methods

This section contains the detailed explanation of methods used during this part of the research. First, a section is devoted to operationalising the conceptual framework constructed in chapter 2. Second, this part of the research's ways of data collection as discussed. This section explains what methods of collection that are applied and why they are congruent towards the goal of this research design. Third, data analysis is detailed, explicating the process of analysing the collected data.

§3.2.1 Operationalisation of conceptual framework

In order to research BeRoEmD's strategy in a formal-product kind of view, chapter 2 devised a conceptual framework by analysing existing literature on business models. For the list that defines all elements and the conceptual model itself this research refers back to figure 9 and figure 10 respectively. This section will use the theoretical understandings of chapter 2 and translates them to useable operational definitions. Before data collection, the following concepts of care group BeRoEmD and formal strategy product are operationalised to know what is meant by these terms in this thesis.

Care group BeRoEmD

BeRoEmD is the focal object under investigation in this research. This organization has all the characteristics of the organizational form defined as *care group*. For this research, BeRoEmD will be regarded to as one of the care groups in the Netherlands with all of the accompanying characteristics and aspects as described in section 2.1. An organogram detailing the organizational structure can be found in Appendix 3 (Supporting data research methods).

Formal strategy product

Strategy is the contingent plan that integrates an organization's major goals, policies and actions. This can also be regarded to as the logic of the firm and in what way the organization intends creates value. The outcome of this process can is considered the strategy product of a firm and it is possible to capture said strategy with the help of a business model. The business model is thereby the formal product of strategy that is open to evaluation. For this research, a conceptual business model was designed containing all relevant elements that serves as a blueprint for what should constitute a formal strategy (table 3).

Object under investigation	**Elements**	**Defining**	**Values**
	Value	The core idea of what value the organization provides, or aims to provide with its operations.	What is the core value proposition of BeRoEmD? What is the mission/vision statement?
	Activities /	Relates to all key activities and	What activities / processes

Formal strategy product *(business model)*	*Processes*	processes going on within the organization related to attaining or providing the value	are present within BeRoEmD?
	Resources	All resources that are exploited by the organization.	What resources are present within or to BeRoEmD?
	Partners	Parties the organization regards to as partners. For instance, suppliers, joint ventures, or other complementary organizations	Who are the key partners to BeRoEmD?
	Competitors	Parties the organization regards to as possible rival or threat to the organization.	Who are considered competitors to BeRoEmD?
Formal strategy product *(business model)*	*Customers*	*Segments:* Who are your customers? And can they be segmented into groups? *Relations:* What kind of relationship do you want / have with your customers, how do you culture / maintain this?	*Segments:* Who are BeRoEmD's customers? And can they be segmented into groups What kind of relationships does BeRoEmD have with its customers?
	Financial aspects	*Revenue structure:* All financial aspects related to the revenues created by the organization. *Cost Structure:* All financial aspects related to costs being made by the organization.	How does BeRoEmD create revenue? What are costs to BeRoEmD?
Formal strategy product *(business*	*Channels*	*Communication:* all modes of communication within the organization itself, but also all communication that is outbound. Also pertains the how and why a message is communicated *Information:* All modes of information streams for the organization, both inbound and outbound. What information systems are being used. *Distribution:* All modes of distribution from supplier to	Via what channels does BeRoEmD communicate? What mediums are employed to create and to store knowledge? What are BeRoEmD's

model)		customer. Explains what channels are being used and why.	ways of distribution?
Formal strategy product *(business model)*	*External*	*Developments:* Regards to developments outside of the organizations environment that can be relevant to the organization. (e.g. governance or new laws that relate to the organization). *Threats:* Possible threats to the organization that should be monitored that are not directly linked to competitors.	What are relevant external developments for BeRoEmD? What developments are considered potential threats to BeRoEmD?
	Learning	Relates to how learning is incorporated within the organization and how this knowledge is attained, shared, and retained.	How does BeRoEmD facilitate, foster, and stimulate learning of and within the organization?
	Measurement	Aimed at measuring performances, what is the norm, current value and possible gap between these. Key performance indicators (KPI) can be used to present an overview of these measurements.	What measurement tools does BeRoEmD use / employ?

Table 5: Formal strategy product operationalization

§3.2.2 Data collection

For this part of the research, two types of data-collection methods are applied; document analysis and interviews.

Document analysis

The document analysis method is used to collect a large amount of data with regard to the strategy of BeRoEmD. Making use of this method enables the researcher to study copious amounts of data on his own behalf to gain better understanding of the object under investigation. For this part of the research, documents pertaining strategy have been requested from the management of BeRoEmD. These documents are sensitive and confidential for BeRoEmD. Handling and analysis of these documents should be conducted accordingly.

Interview

design

The purpose of conducting interviews is twofold. In the first place it serves the purpose to of a controlling method towards the document analysis. Secondly it serves to expand the knowledge gained by the prior document analysis. The intent is to start with one interview in which both purposes are met, if it becomes clear that one session does not provide enough clearance, data or other grounds are found that deem extra interviews a necessity, a follow-up will be conducted.

Protocol

In order to ensure proper conduct of each interview, general rules and procedures applied to interviewing are contained in the interview protocol. This research strives to abide the following protocol before, during and after conducting interview(s):

After mutual agreement from both the respondent and researcher, a face-to-face interview is scheduled at a location of the respondents choosing. If required, additional details or information will be sent to the respondent in a timely manner beforehand. Before starting the interview, permission will be asked to make an audio recording of the interview accompanied by explaining the goal of the interview. The interviews will be open to semi-structured natured and are held in Dutch. During the interview, the researcher will take an enquiring attitude towards the respondent. Gathering as much relevant information about the topics addressed as possible. At the end of the interview, the respondent will be asked for his/her recollection of the interview and if important topics were missed, under- or over-discussed or any other issues that need to be addressed. After the interviews, the audio-recording is saved and later transcribed. A draft version of the transcript will be sent to the respondent for approval. When the respondent indicates the transcript is complete and correct, it is to be used for data-analysis together with notes taking during the interview. A transcript book containing all transcripts will be a separate attachment to this thesis.

§3.2.3 Data analysis

After collecting all of the mentioned data, the data will be analysed. BeRoEmD's formal strategy product is the focal object under investigation in this part of the research. An analysis will be conducted towards the formal correctness of this strategy once all data has been collected. By compiling the collected data into a matrix, an overview of BeRoEmD's strategy will be made. Enabling evaluation of the formal correctness of the strategy per strategic element. First assessing whether all strategic elements that should be present according to the conceptual model are present in BeRoEmDs strategy. Followed by evaluating if the data

shows internal consistency within the element and external consistency among the business model elements or if any discrepancies can be identified.

§3.4 Data sources

The previous paragraph detailed plans for data collection. This section shows the final collection of data sources. The care group BeRoEmD, or more specifically the strategy of care group BeRoEmD, is the object under investigation in this part of the research. Thus, BeRoEmD will constitute as the data source for this research. A number of strategical documents were provided by the management of the care group. These are presented in chronological order in table 1.

Document title	**Abbreviation for further use**
Report Brainstorm strategy day BeRoEmD (2013)	SD1
Strategic document: Internal analysis (2015)	SD2
Strategic document External Analysis (2015)	SD3
Realistic future scenarios BeRoEmD (2016)	SD4
Impactanalysis v1 (2016)	SD5
Report future plans (2017)	SD6

Table 6: list of documents provided by BeRoEmD for document analysis with regard to the strategy part of this research

After conducting independent document analyses, several interviews have been conducted. An overview of these interviews can be found in table 2.

N.	**Interviewee (function)**	**Date**	**Duration (minutes)**	**Abbreviation**
1.	Manager BeRoEmD	20-12-2017	100	IMW1
2.	Director BeRoEmD (former)	20-12-2017	35	ITB1
3.	Director BeRoEmD (current)	17-01-2018	60	IMW2

Table 7: list of conducted interviews with regard to the strategy part of this research

§3.5 Assessment criteria qualitative research

When assessing qualitative research, two approaches can be distinguished. The positivists strive towards the criteria of *validity*, *reliability*, *generalizability*, and *objectivity*. Whereas the naturalists stress qualitative research should be assessed by the criteria of *credibility*, *transferability*, *dependability*, and *confirmability*. In my opinion, there is no good or wrong in striving for either of these criteria. In fact, both of the

approaches and coherent criteria match the dual nature of this thesis; In the first place this thesis is an academic research paper that should strive for the positivists criteria. Besides that, due to the link with practice all aspects of a practise-based intervention methodological paper suit the naturalistic criteria. Therefore, both sets of criteria are deemed relevant assessment criteria that should be upholded in this thesis. The following sections first introduce both approaches in a general sense, followed by how they are applied to assert the quality of this research in the section below.

Positivistic criteria: validity, reliability, generalizability,* and *objectivity

The first set of criteria towards assuring the quality of this thesis is based on the positivists approach:

1. *Validity:* The first and foremost criteria in the positivists approach to assesses the quality of research is the validity criteria. Validity deals with diminishing the chance of making systematic errors in the research. Validity can be divided into internal and external validity (Vennix J. , 2011). The internal validity can be ascertained prior to the data collection process by calibrating the collection methods in line with the object under investigation. The external validity focusses on the applicability of the results outside of the researched sample group (Vaus, 2001). This form of validity is hard to ascertain beforehand and thus can be better determined after data collection and analyses have been applied (Vennix J. , 2011).
2. *Reliability:* Reliability concerns the stability of the research and concerns with diminishing the chance for random errors in the research. Therefore, a research must be independent from the researcher and repeatable. This implies that a research should produce the same, or at least similar, findings when repeated.
3. *Generalizability:* This criteria deals with transferring applicability of the research onto other cases or contexts.
4. *Objectivity:* The researcher should strive to be as objective as possible. Not subjecting the research with his own background, opinions and thoughts.

Naturalistic criteria: credibility, transferability, dependability,* and *confirmability.

The second set of criteria used in assessing qualitative research is the naturalistic approach that states one should strive for and assure *trustworthiness* of the research Guba (1981). The naturalistic approach constructs four criteria in preference to the positivists criteria (Lincoln & Guba, 1985):

1. *Credibility* (in preference to internal validity): Deals with embedding trust and confidence that findings are congruent with reality. Credibility is considered the most important naturalistic criteria

2. *Transferability* (in preference to external validity & generalizability): Relates to applicability of the findings to other similar contexts or studies.
3. *Dependability* (in preference to reliability): Findings should be consistent and other researchers are able to repeat the study.
4. *Confirmability* (in preference to objectivity): a degree of neutrality or the extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation, or interest.

After assessing both sets of criteria, quite some overlap can be identified between the two. It becomes clear that both sets generally strive towards similar goals, but chose to use slightly different phrasing and method descriptions. More sets of criteria can be found in qualitative assessment literature. However, adding on more criteria would only result in more overlap and dilute the researcher's focus. It is my goal to uphold a combination of the abovementioned positivists and naturalists criteria. Table 4 presents how this research intends to do so.

Assessment criteria	**Intent to uphold criteria**
Validity & Credibility	In order to attain internal validity, this research has conducted an extensive literature study on the topic of strategy, more specific business models in chapter 2. This was done to construct the conceptual framework that forms the basis of an adequate measuring tool guiding the data collection methods. Moreover, this research makes use of both strategic documents and interviews to triangulate collection methods and strengthen the validity of acquired data. In order to attain credibility of the research, a prolonged engagement approach is taken, in combination with member checking methods. This means that the research spans over a longer period of time and findings are being checked with members of the object of observation for congruency. Besides these methods, the researcher also has periodical meetings with his supervisor to discuss progress and steps taken in the research. With regard to external validity, the analysis of collected data will be written out and followed.
Reliability & Dependability	To ensure reliability and dependability, the research is grounded in existing theory concerning strategy and business models. Moreover, all steps are described extensively. This way, the repeatability of research is high and will result similar findings.
Generalizability & transferability	This research strives to some extent of generalizability & transferability, in the context of care groups in the Netherlands. However, this study is conducted with care group BeRoEmD in particular and therefore most suited towards this care group's specific circumstances. Thus, although theory is generalizable towards more care groups in the Netherlands, most findings will be exclusive towards BeRoEmD
Objectivity & confirmability	The researcher will try his best to remain objective during this research. Personal connections, affiliations and opinions are to be left out of the research and research conduct.

Table 8: Assessment criteria for qualitative research and respective techniques this research applies to meet the criteria.

Chapter 4 Findings & Analyses

§4.1 Introduction

This chapter will present the findings for the strategy part of this research. The goal of this part was to evaluate the formal strategy product of BeRoEmD. In order to do so, BeRoEmD's strategy had to be charted, which can be seen as an accessory goal that serves purpose towards the second part of this research. Before presenting the findings, a section is devoted to reviewing the process of data collection (4.1). The following section orderly presents the findings of the data collection process for all of the business elements incorporated in the conceptual model in conjunction with analysing the results in the form a formal product evaluation of BeRoEmD's strategy by assessing completeness and consistency within each element (4.2). A third section is used to evaluate consistency among each and all of the business model elements to further assess whether BeRoEmD's strategy is formally correct or that gaps and/or inconsistencies can be identified (4.3).

§4.2 Data-collection process review

This section will be used to critically reflect on the process of data collection. This process consisted of two phases; first a document analyses phase, followed by a series of interviews.

For the document analysis, strategic documents were requested and received from the management of BeRoEmD. In total, six documents were gathered and available for analysis (see table 1, p 37). The goal of this phase was to link as much of the available data to the conceptual business model framework in clear fashion to the researcher, broadening understanding of BeRoEmD's strategy. Some of the documents provided clear cut information easily linkable to elements of the business model. Others were deemed more ambiguous, or even superfluous.

The interview phase served two goals as stated in the previous chapter. First it was meant as a means to control the researchers understanding of the data collected during the document analysis phase. Moreover, to verify with BeRoEmD's management this gathered understanding. Secondly, the interviews could serve to expand the data. Both as a whole and on topics that were unclear beforehand. The first interview was conducted with the manager of the care group. A time constraint of 2 hours was set and the interview was structured very open. In that way a lot of topics could be discussed in freedom. This resulted in very rich data on several topics and elements for analysis. However, some setbacks of this strategy are to be named. Due to the open nature, a clear structure and order of questioning was lacking. Resulting in discussing some topics more in-depth than others. Even lacking time for the (at the time assessed) less relevant elements. Due to acknowledging these setbacks, a second interview with the manager was deemed appropriate to close the gaps.

The second interview was conducted with the chairman of the board for the care group. The manager was also (still) present during this interview, but the researcher focused his line of questioning towards the director. Again, the nature of this interview was open. The interview was primarily directed towards the discussion on what is to be considered BeRoEmD's customer. However, we drifted a little off-topic later on in the interview.

The third interview was the follow-up interview with the manager. The purpose of this interview was to enable the respondent and interviewer to discuss the remaining topics, reaffirm certain assumptions made after a preliminary review of the earlier collected data and to encourage the respondent to share anything she deemed relevant but was yet unspoken about.

§4.3 Findings & Analyses

This section presents the findings from the data collection process in conjunction with analysing the formal product of strategy by BeRoEmD. Data from all sources has been gathered into a raw data document and, subsequently, compiled into a compacted data matrix. For a full overview of the collected data, This research refers the reader to Appendix 4: Raw strategy data matrix and to the transcript book.

The presenting and analyses procedures will be as follows. In the subsequent section all of the business model elements will be discussed in succession. First, for each of the elements, the associated part of the data matrix is presented. This data matrix shows the element, summarizes the findings for that item and presents what all data sources reported with regard to the item (table Q presents a legend explaining all symbols in the data matrix). Second, following this data matrix is the researchers interpretation and elaboration of the data's core meanings. Third, this part of the strategy findings as interpreted are analysed on formal product completeness and the internal consistency within the element. Moreover the findings are tested on external consistency with the preceding elements in order to assess overall consistency of BeRoEmD's strategy. Lastly, a separate paragraph summarizes the findings on completeness as well as internal and external consistency for all elements combined.

Symbol	**Explanation**
+	Data source mentions finding in agreement to majority of sources
++	Data source mentions finding prominently compared to other sources
//	Data source mentions finding, but is unclear / has no opinion
-	Data source mentions finding, but disagrees with other sources
DNM	Data source did not mention finding

Table 9: legend of symbols used in strategy data matrix.

Value(s)

"The core idea of what value the organization provides, or aims to provide with its operations."

Business Model Element	Findings	Data source								
		SD1	SD2	SD3	SD4	SD5	SD6	IMW1	ITB	IMW2
Value	Assist in providence of high quality (primary) care	+	+	+	+	+	+	+	//	+
	Efficient organisation & coordination of care	DNM	+	+	+	DNM	+	+	+	+
	Full Transparancy	+	+	+	+	DNM	+	+	DNM	+
	Patients should feel safe in the entire process	DNM	+	+	+	DNM	+	+	DNM	DNM
	Stimulate professional autonomy	+	+	+	+	DNM	+	++	//	+
	Multidisciplinary care	+	+	++	+	DNM	+	++	+	+
	Subsitute care for secondary care	DNM	DNM	+	DNM	DNM	DNM	+	DNM	+
	Increase Self-management support	DNM	DNM	DNM	DNM	DNM	++	+	DNM	+
	Ensure accessibility and the continuity of care	DNM	DNM	DNM	+	DNM	DNM	++	+	DNM

Figure 10.1 Values findings element from compiled data matrix.

BeRoEmD has released a mission statement in 2009. This statement is referred to in sources SD2, SD3, SD4, IMW1 and IMW2. Evaluation of the statement in both SD2 in 2015 and the interviews conducted with the manager state that the mission statement is still in line with BeRoEmD's current value proposition. BeRoEmD strives to provide high-quality, targeted and local primary care for chronic diseases. BeRoEmD wants to work towards a multi-disciplinary care environment. It is important to guarantee professional autonomy for all parties involved and to stay connected with the entire work field and practice. Management also values pro-active attitude. The care group strives to lead and take responsibility within its environment towards issues. This could be facilitating other parties, learning, organising and developing solid care programs. Noteworthy is that the value of being a multi-disciplinary care organization has become a more prominent value over the years.

The findings for the element *values* are considered internally consistent within the element itself. No real inconsistencies can be found within this element. What can be found is a shift of emphasis over time for some of the values. Multi-disciplinary care programs have gotten more attention in recent years for instance.

Key Activities

"Relates to all key activities and processes going on within the organization related to attaining or providing the value"

Business Model Element	Findings	Data source								
		SD1	SD2	SD3	SD4	SD5	SD6	IMW1	ITB	IMW2
Key Activities	Negotiate, close and carry out care agreements	+	++	++	+	DNM	DNM	+	+	+
	Organize and coordinate care provision for chain partners	+	+	+	+	+	+	+	+	+
	Education and schooling	+	+	DNM	DNM	+	+	DNM	DNM	+
	Information provision	DNM	//	DNM	DNM	DNM	+	+	+	+
	Monitor performances	DNM	+	DNM	DNM	DNM	DNM	+	DNM	+
	Start, organize, adapt care programs	DNM	//	DNM	+	+	+	+	+	+
	Provice supporting services to partners	+	+	DNM	+	+	+	+	+	+
	Regional cooperation	DNM	+	DNM	+	+	//	+	+	+
	Employ	+	+	+	DNM	//	//	+	DNM	+

Figure 10.2 Key activities findings element from compiled data matrix..

A primary set of activities can be found for BeRoEmD along with some additional activities. BeRoEmD's key activities are the negotiation, concluding of contracts and coordinating the executing of contracted care. This results in three distinguishable contracts with distinct relations. First is the *zorginkoopovereenkomst*, a contract between the insurer and general practitioner. Second, the *verzekeringsovereenkomst*, a contract between insurer and patient. Third, the *geneeskundige behandelovereenkomst*, a contract between patient and general practitioner. BeRoEmD is closely involved in the first and second agreements. Alongside closing these contracts, BeRoEmD is the organization that organizes and coordinates the health care providence, making sure patients are provided with adequate care by the GP and/or other chain partners. Additional key activities for BeRoEmD are to provide and select education and schooling activities for its employees and partners, monitor performance of the care group as a whole, for individual partners and care programs.

The findings for *key activities* are considered to be internal consistent with the possible exception of the employment activity. The activities BeRoEmD wishes to enact complement each other well. The findings are mentioned in at least three or more sources and no contradictions were found. Findings in SD5 and SD6 on the employer activity indicate that the size of staffing personnel might be insufficient to support all other activities.

The findings show externally consistent with the value element. The key activities are in line with the values the care group wants to express/attain. Again, the activity of being an employer caused some debate among the data, relating to the size of staffing personnel. Sources 5 and 6 state that the care group, in its current size and form, lack the manpower to attain aforementioned values. Other sources do not seem to worry about this.

Key Resources

"All resources that are exploited by the organization"

Business Model Element	Findings	Data source								
		SD1	SD2	SD3	SD4	SD5	SD6	IMW1	ITB	IMW2
Key Resources	KIS Care2U	+	+	//	//	//	+	+	DNM	//
	MGP	DNM	DNM	DNM	DNM	DNM	+	+	DNM	+
	Poh's	DNM	DNM	DNM	DNM	DNM	DNM	//	DNM	DNM
	Specialized GP (kaderarts)	DNM	DNM	DNM	DNM	DNM	DNM	+	+	++
	Management	DNM	//	-	DNM	+	DNM	+	+	+
	Board of directors	DNM	+	//	DNM	+	DNM	+	+	+
	Personnel / staff	DNM	+	-	DNM	//	DNM	+	+	+
	Flexpool	DNM	DNM	DNM	DNM	DNM	DNM	+	DNM	+
	Subcontracters	DNM	DNM	DNM	DNM	DNM	DNM	+	DNM	+
	VIP Live	DNM	DNM	DNM	DNM	DNM	DNM	+	DNM	+

Figure 10.3 Key resources findings element from compiled data matrix..

Resources can be split up in technological resources and human resources. For BeRoEmD, 2 main technological resources are found; *KetenInformatieSysteem (KIS)* Care2U, *MijnGezondheidsPlatform (MGP)* portal and VIP Live. Especially the Care2U is a crucial resource for BeRoEmD, yet at the same time is a finding under discussion. The care group relies heavily on the KIS software package for all daily practice as it is the tool for communication, information, coordination, and declaration. However, the tool is very costly. So costly it exceeds ICT budgets. Therefore, alternatives are being monitored and discussed in some of the data sources. In 2018, a re-evaluation is at hand. MGP is a tool still under development aimed at closer involving patients in their own care. VIP Live is used in the financial process for declarations. The human resources can be split into a couple of groups. *Kaderartsen* – specialised general practitioners – are an important resource as they are the link between medical and organizational staff. Furthermore, a discussion arose during the first interview whether the *PraktijkOndersteunerHuisarts (POH)* – general practice-based nurse specialist – can be considered a resource of the care group, or not. These POH's are under employment of the GPs, but are closely managed by the care group, as it carries out the chronic care programs set out by BeRoEmD on site. The rest of human resources are comprised out of the board of directors and other staffing personnel.

For the business element key resources, each of the findings indicate internal consistency for the overall element. However, two findings indicate inconsistency within themselves. First, the KIS Care2U is heavily relied upon by BeRoEmD, yet is too costly and may have to be replaced by an alternative in the future. The care group is already planning to revaluate this resource though. Second, POH's are not employed by BeRoEmD, but are vital to the processes of the care group. This results in an ambiguous attitude towards this group. Overall for the element, the findings are internal consistent,

The resources suit and support the activities the care group intends to conduct and the use of the resources is appropriate towards the care groups' values. However, some external consistencies are brought to the attention. First, the technological resource Care2U. This system is heavily relied on for most of the

care groups activities, but causes hefty expenses. Therefore it is uncertain if the care group can and will continue usage in the future. Second, the activities element already indicated that the staffing personnel resource might need expansion in order to be able to reach full potential.

Key partners

"Parties the organization regards to as partners. For instance, suppliers, joint ventures, or other complementary organizations"

Business Model Element	Findings	Data source								
		SD1	SD2	SD3	SD4	SD5	SD6	IMW1	ITB	IMW2
Key Partners	Certificate holders	+	+	+	DNM	+	+	//	//	+
	General Practitioners	+	+	+	DNM	+	+	+	//	+
	Health insurers (CZ & VGZ)	DNM	+	+	DNM	+	+	+	+	+
	Other chainpartners	DNM	+	+	DNM	+	+	+	+	+
	Other care groups	DNM	DNM	+	+	+	+	+	+	+
	Care2U	DNM	+	DNM	DNM	DNM	+	+	DNM	+
	MGP	DNM	DNM	DNM	DNM	DNM	+	+	DNM	+
	Municipalities	DNM	DNM	+	DNM	DNM	DNM	+	+	+
	Regional associations	DNM	DNM	+	DNM	DNM	+	+	+	+
	National associations	DNM	DNM	+	DNM	DNM	+	+	+	+
	Secondary care	DNM	DNM	+	DNM	DNM	DNM	+	DNM	+
	GGZ (haspel)	DNM	DNM	+	DNM	DNM	DNM	+	DNM	+
	GGD	DNM	DNM	+	DNM	DNM	DNM	+	DNM	+
	Education	DNM	DNM	DNM	DNM	DNM	DNM	DNM	DNM	+
	POH	DNM	DNM	DNM	DNM	DNM	+	//	DNM	DNM

Figure 10.4 findings key partners element from compiled data matrix.

A multitude of (possible) partners have been found for BeRoEmD. Some of these partners are given a higher priority than others. BeRoEmD identifies several parties as important partners with a high priority. The primary partner is the group of *certificaathouders* or certificate holders. Certificate holders are parties that have bought themselves into the corporation of BeRoEmD. This list of certificate holders consists mainly of general practitioners and a few other chain partners, like apothecary association Concordant. Notable is the particular dual role these certificate holders assume. On the one hand they are, on paper, owner of BeRoEmD. On the other, they carry out the provision of care distributed by BeRoEmD. A second partner are general practitioners themselves. Most GPs BeRoEmD works with, are certificate holders, but not all of them. Furthermore, BeRoEmD considers the health insurance companies as a partner. BeRoEmD negotiates care contracts with VGZ and CZ yearly. Other insurers have the option to comply with one of these two contracts. For mental care, *GGZ* is the biggest partner that can be identified. Lastly, BeRoEmD works together and coordinates with some of the other care groups in the region. The medium priority partners consist of municipal government in the region that BeRoEmD covers care for, other chain partners that are sometimes contracted to provide care (i.e. physicians, dieticians and pedicurists), some of the more regional associations with regard to health care (most notable: Kring, the regional association of general practitioners), and InEen, the national association of integrated care. Some partners can be identified as

relevant to BeRoEmD, but with low priority. These parties being the national association of general practitioners, the Ministry of Health, Welfare and Sport, and possibly other associations.

With regard to internal consistency, again the POH are object of discussion. The POH's support GPs in a variety of areas. During the interviews, a discussion concerning this topic arose. POH's are a vital part of the integrated care BeRoEmD provides and coordinates. They are the practitioners that incorporate BeRoEmD's policies in practice. However, POH's are generally employed by either the GPs or the GGZ. Thereby making them employees of the higher level partner, rather than a partner themselves. Would they be identified as a partner on their own, they would be ranked as high priority partners, considering they are vital to carrying out policy.

The findings for *partners* is considered externally consistent with the preceding elements. The partners mentioned are in line with the *values* and *activities* BeRoEmD propagates. It should be noted that POH is both mentioned in *resources* and *partners*. On both occasions, this party does not fit the element to the word. Discussion arose on both occasions.

Competitors

"Parties the organization regards to as possible rival or threat to the organization"

Business Model Element	Findings	Data source								
		SD1	SD2	SD3	SD4	SD5	SD6	IMW1	ITB	IMW2
Competitors	Health centres	DNM	+	DNM	DNM	DNM	DNM	+	DNM	DNM
	Other care groups	DNM	+	DNM	+	+	DNM	+	DNM	DNM
	Other health care organizations	DNM	+	DNM	+	DNM	DNM	+	DNM	DNM
	Unaffiliated general practitioner	DNM	+	DNM	DNM	DNM	DNM	DNM	DNM	DNM
	Ziekenhuizen	DNM	+	DNM	DNM	DNM	DNM	+	DNM	+
	Substitues	DNM	+	DNM	DNM	DNM	DNM	+	DNM	DNM
	New Entrants	DNM	+	DNM	DNM	DNM	DNM	+	DNM	DNM

Figure 10.5: Findings competitors element from compiled data matrix.

The care group identifies a few (potential) competitors. The organizational concept of care groups are established mediating organization for the organization and coordination of chronic care as in the Netherlands. However, there is some competition in the field. *Gezondheidscentra's*, – health care centers, most commonly an association of GPs –, other care groups in the region, and possible alternative care organizations are considered direct competitors in some cases or care programs. Hospitals, a form of secondary care, can sometimes overlap with primary chronic care, but are not considered a threat. Of course some new substitutes or entrants arise every now and again, however these do not seem to be in direct competition with the care group.

No inconsistencies were found within the element *competitors*, therefore the element is assessed as internally consistent. The same logic applies for the external consistency of this element; the findings do not conflict with findings in the other elements discussed so far.

External

"1. Developments: Regards to developments outside of the organizations environment that can be relevant to the organization. (e.g. governance or new laws that relate to the organization).

2. Threats: Possible threats to the organization that should be monitored that are not directly linked to competitors"

Business Model Element	Findings	Data source								
		SD1	SD2	SD3	SD4	SD5	SD6	IMW1	ITB	IMW2
External	Laws and regulations	DNM	DNM	+	DNM	DNM	DNM	+	+	+
	Economical prospects	DNM	DNM	+	DNM	DNM	DNM	+	+	+
	Labor market issues	DNM	DNM	+	DNM	DNM	DNM	++	DNM	++
	Technology (ICT)	DNM	DNM	+	DNM	DNM	DNM	++	DNM	+
	E-Health	DNM	DNM	+	DNM	DNM	DNM	+	DNM	DNM
	VAT liable	DNM	DNM	DNM	DNM	DNM	DNM	+	+	+
	Persoonsgegevens (AVG)	DNM	DNM	DNM	DNM	DNM	DNM	++	++	++
	Culture in the health care sector	DNM	DNM	DNM	DNM	DNM	DNM	+	++	+

Figure 10.6: Findings external element from compiled data matrix.

The element *external* was assessed by BeRoEmD with the help of a PESTL and 5-forces model. This led to identifying the above findings as relevant developments in the external environment of the care group. First, it is subjective to law and governing from national and regional government. The health care section is a dynamic environment with changes every year. These changes often affect the care group. For instance, during contract negotiations with health insurers. Another important law impacting the care group is the *Algemene verordening gegevensbescherming (AVG)* or General Data Protection Regulation (GDPR) in English. This enactment intends to strengthen and extend patients privacy rights, but increases the responsibilities for organizations like the care group at the same time. Also, economical progress in the country and the labor market are relevant factors to account for. Although economics are on the rise, the labor market seems to be tightening. A problem for both the care group and its partners. Also, technological advancements, mainly in the ICT section are highly relevant for the care group considering the costs for ICT are roughly a third of the entire yearly budget. E-health is a viable development of the last years. A substitute developed by Philips that allows patients to be more involved with their own care program. Furthermore, since 2016 the care group is obligated by law to pay taxes because it is labelled a socially cultural institution by the Dutch tax authorities instead of a health care organization. A contradictory decision considered other authorities label the care group as a health institution with the corresponding laws and obligations applied. Lastly, the culture in the primary health care sector is to be considered an environmental factor to be taken into account. Many of the GPs tend to be very conservative towards change. That attitude can cause delays and/or complications for the care group's strategy.

Internally, the findings on the *external* element are very diverse. This isn't surprising, considering the environment is build up by a variety of factors (PESTLE). However, this makes it hard to assess internal consistency. None of the values are truly at odds with each other. Nor do they match / strengthen each other. Some have overlap or are an extent of law and regulations, like the privacy enactment.

With regard to external consistency, some of the findings are or could be in conflict with findings in other elements of the business model. Law and regulation developments are to be followed and are not always in favor of the strategic goals set by BeRoEmD. Nor is the reigning culture among GPs in the Netherlands. It is hard for the care group to convince a practitioner of the added value adopting the care programs or to convince them to change their opinions. Often, small steps have to be taken in order to not spook the GP. In sum, it can be argued that these external developments are challenges the care group will have to face and conquer in order to survive and be viable.

Measurement

”Aimed at measuring performances, what is the norm, current value and possible gap between these. A depiction of what is measured and with the help of what means are used to present an overview of these measurements”

Business Model Element	Findings	Data source								
		SD1	SD2	SD3	SD4	SD5	SD6	IMW1	ITB	IMW2
Measurement	Care2U offers management and control information	DNM	+	+	DNM	DNM	+	+	DNM	++*
	Management based on information			+	DNM	DNM	+	DNM	DNM	+
	ICT systems have to connect	+	+	+	DNM	DNM	+	+	DNM	+
	Benchmarking regional and national	DNM	DNM	++	DNM	DNM	DNM	DNM	DNM	+
	Quantitate tasks and activities of (management) care group	+	+	//	DNM	DNM	+	DNM	DNM	+
	MGP eases consults by offering measurement options	DNM	DNM	DNM	DNM	DNM	++	DNM	DNM	+
	KPI's indicates performances care group	DNM	+	+	DNM	DNM	DNM	DNM	DNM	+
	Periodic assessment interviews	+	+	DNM	DNM	DNM	DNM	DNM	DNM	+
	Recording data / reports is important	DNM	+	+	DNM	DNM	+	DNM	DNM	//

Figure 10.7: Findings measurement element from compiled data matrix.

For the element *measurement*, the KIS system Care2U is a very important resource. This system enables the care group to extract information that can be measured and used to set out strategic goals. However, the system only does so for the care group and connected GPs, BeRoEmD’s main partners. Other partners can only use some parts of the system. With the current capabilities of Care2U, the KIS can’t be used to measure information from those other partners. Therefore, these ICT systems should be improved for better inter-connectivity among all of the care group’s partners. This will also enlarge benchmarking possibilities. Besides Care2U, BeRoEmD also uses MGP as an ICT system to deliver measurable information. The information is bundled into Key Performance Indicators, that the care group uses to assess performance of the care group, but also performance of their partners from micro to macro level. So it is possible to draft KPI’s for a single practitioner, a group of practitioners (i.e. a certain region), or for a specific care program (i.e. diabetes, asthma, etc.). Lastly, the care group values that information is captured and reported on. Something that, according to the second interview with the new director is desirable but not done

consequently in recent years. In some occasions, it is unclear how and where gathered information is retained within the organization. This topic is further discussed during the *learning* element.

The findings on the element *measurement* show internal consistency in its desires, yet lack complete consistency due to the incapability's of the ICT systems in place. Measurement is made possible for the performance of GPs, yet not for other chain partners. Or at least not to the same extent. This is a problem the care group should address.

With regard to external consistency, the findings show signs of inconsistency due to the analytical restrictions that are imposed by the ICT resources. Care2U and MGP restrict the care group of fully measuring information for all involved care providers. The impact of this restriction is something that could be assessed by the care group in the future. Furthermore, the unclear ways of data retention conflict with some of the *values* and *key activities* that BeRoEmD that propagates. The other findings are considered externally consistent with the earlier discussed elements.

Customers

"Segments: Who are your customers? And can they be divided into groups?

Relations: What kind of relationship do you want / have with your customers, how do you culture / maintain this?"

Business Model Element	Findings	Data source								
		SD1	SD2	SD3	SD4	SD5	SD6	IMW1	ITB	IMW2
Customers	Issue who is the customer for Beroemd	DNM	+	+	DNM	DNM	+	+	+	+
	Customer = patient / civilian	DNM	//	//	DNM	DNM	//	//	+	//
	Customer = general practioner or other care provider	DNM	//	//	DNM	DNM	+	+	+	++
	Customer = Healthcare insurer	DNM	DNM	DNM	DNM	DNM	DNM	//	+	//
	Customer = municipalities	DNM	DNM	DNM	DNM	DNM	DNM	DNM	+	//
	Segmentation of customers	DNM	//	//	DNM	DNM	//	//	+	+
	increase patient self-management and self-care	DNM	DNM	+	DNM	DNM	+	+	+	+

Figure 10.8: Findings customers element from compiled data matrix.

The findings for the element *customers* are the most controversial. All data points towards ambiguity on whom the actual customer of BeRoEmD is or should be. A lot of the information given by the care group creates the impression that the patient or citizen is considered the customer, like the goal to increase patient self-management. However, all treatment is provided via the care group's partners, resulting in the lack of a direct treatment relationship with the patient for BeRoEmD. There is no direct care relationship between the care group and patients. The care group's focus lies with enabling partners to provide the best possible chronic care to its patients. SD3, IMW1 and ITB indicate a mismatch in the process of chain care, which should be customer orientated. Versus the actual care product/providence, which is product-oriented through standardization. Therefore, the question who is the customer of BeRoEmD results in ambiguous answers. The former director states the care group should identify 4 customer segments; patients, GPs, health

insurers, municipalities. The new director partially agrees with this view, however states that this is not the current propagated vision of BeRoEmD, but rather a future possibility.

Internally, findings on the *customer* element conflict with each other heavily. There is no clear cut answer whom the customer of BeRoEmD is. The initial answer that patients are the primary customer of BeRoEmD might not even be correct, because no direct care relation between the care group and patient can be found. In the end, consensus can be found in a possible segmentation of customers for the future. Yet, currently there is no clear answer to be found in the strategy by BeRoEmD.

The internal inconsistency in this element causes external consistency with several of the aforementioned elements as well. Having ambiguity in whomever is your customer, hinders in-depth strategizing. A direct inconsistency can be pinpointed with a the *value* of providing high-quality care to patients. Because it has become apparent that BeRoEmD itself does not provide that care. BeRoEmD is, in essence, the coordinator and enabler of the ones that actually do provide said care.

Channels

"*Communication:* all modes of communication within the organization itself, but also all communication that is outbound. Also pertain the how and why a message is communicated

Information: All modes of information streams for the organization, both inbound and outbound. What information systems are being used?"

Business Model Element	Findings	Data source								
		SD1	SD2	SD3	SD4	SD5	SD6	IMW1	ITB	IMW2
Channels	General communication via: website, newsletters, folders, posters, mailings	+	DNM	DNM	DNM	DNM	+	+	DNM	+
	Professional communication via (lunch) meetings, e-mail, phone	+	DNM	DNM	DNM	DNM	+	+	DNM	+
	Care2U as communication tool	+	DNM	+	DNM	DNM	+	+	DNM	+
	MGP as communication tool	+	DNM		DNM	DNM	+	+	DNM	+
	VIP Live system for declarations	DNM	DNM	DNM	DNM	DNM	DNM	+	DNM	+
	Promote ICT systems for better communication	+	DNM	+	DNM	DNM	+	+	DNM	+

Figure 10.9: Findings channels element from compiled data matrix.

The findings for *Channels* show us that BeRoEmD employs various modes of communicative channels. General communication is done via the website, newsletters, mailings, posters and flyers for a more informal mode of communication. Formal communication is done via e-mail, lunch or regular meetings and telephone. Furthermore, BeRoEmD uses the ICT resources as ways of communication. The Care2U software allows for communication between the care group and GPs and enables GPs to communicate among themselves. For other chain partners, fewer functions are available. MGP allows communication between the care provider and the patient. Another ICT resource that is mentioned is VIP Live. This system is used for financial communication purposes. BeRoEmD thereby relies on ICT for a considerable portion of

its communication. It is also stated in several sources that BeRoEmD should manage and further these systems for better, more fluent and more complete ways of communication. For instance, other chain partners are heavily restricted when it comes to their usage of ICT resources compared to the GPs.

The findings for this element are considered internally consistent. The modes of communication complement each other and information is shared and communicated via these modes.

With regard to external consistency, the findings for *channels* show no inconsistencies with the above discussed findings on preceding elements. Therefore, the findings are considered externally consistent as well.

Learning

"Relates to how learning is incorporated within the organization and how this knowledge is attained, shared, and retained"

Business Model Element	Findings	Data source								
		SD1	SD2	SD3	SD4	SD5	SD6	IMW1	ITB	IMW2
Learning	Knowledge sharing must be done online; via the website or other means	+	DNM	DNM	DNM	DNM	DNM	+	DNM	//
	Organized schooling	+	DNM	DNM	DNM	DNM	+	++	DNM	+
	Discuss and deploy feedback	+	DNM	DNM	DNM	DNM	DNM	+	DNM	+
	Setting up goals together	+	DNM	DNM	DNM	DNM		+	DNM	+
	Record minutes of meetings and save / share these minutes	+	DNM	DNM	DNM	DNM	DNM	+	DNM	+
	Strengthen knowledge sharing between care provider and patient	DNM	DNM	DNM	DNM	DNM	++	DNM	DNM	+
	Schooling of own staff stems from need. This can be (partially) financed under certain conditions	DNM	DNM	DNM	DNM	DNM	DNM	+	DNM	+
	Care providers must keep up with knowledge (per care program)	DNM	DNM	DNM	DNM	DNM	DNM	+	DNM	+
	Schooling is demand driven from the field	DNM	DNM	DNM	DNM	DNM	DNM	//	DNM	+
	Schooling is driven by recommendations from doctors	DNM	DNM	DNM	DNM	DNM	DNM	+	DNM	+
	Schooling is driven from from information / figures	DNM	DNM	DNM	DNM	DNM	DNM	+	DNM	+
	Uncertainty where knowledge is stored	+	DNM	DNM	DNM	DNM	DNM	+	DNM	+
	More involvement from universities and high schools in learning opportunities	DNM	DNM	DNM	DNM	DNM	DNM	+	DNM	+

Figure 10.10: Findings learning element from compiled data matrix.

The findings on *learning* are thinly spread throughout the data sources. Several sources have no data recorded on the element of learning, others show just one or a few findings. The most common learning findings are organized schooling of care providers, the sharing of knowledge between patient and care provider and the goal of settings goals together. Learning can be driven from various instigators; the field, personnel, the *kaderarts (*doctor specialized in a certain field of expertise), information derived from reports

or the KIS, or for financial reasons. The care group values that its doctors keep up with developments in the field. In the interviews the director of BeRoEmD states that she wishes to cooperate more with universities and scholars in the future. These interviews also uncovered that currently there is no clear protocol for knowledge retention and distribution. The care group aims to store and share knowledge via its website or 'other means', yet on multiple occasions it proves unclear where, how, or even if, the knowledge is documented, stored and shared.

The *learning* findings indicate no internal inconsistencies. Learning can be done in several ways and be driven from various instigators. The care group has to decide which learning opportunities are worth acting upon. Noteworthy is that there is no clear protocol for decision making in this area.

Externally, the learning element uses resources, activities and partners to enable, instigate, stimulate and foster learning opportunities. The inconsistency in this process is retaining acquired knowledge. The interview data indicates no protocols are present for knowledge retention, potentially resulting loss of knowledge in the future and lack of knowledge dispersion.

Financial

"*Revenue structure:* All financial aspects related to the revenues created by the organization.
Cost Structure: All financial aspects related to costs being made by the organization"

Business Model Element	Findings	Data source								
		SD1	SD2	SD3	SD4	SD5	SD6	IMW1	ITB	IMW2
Financial	Current overhead costs are too high for the size of care group	+	DNM	DNM	DNM	DNM	DNM	DNM	DNM	//
	Search for alternatives for ICT cost savings	+	DNM	DNM	DNM	DNM	DNM	DNM	DNM	+
	Multidisciplinary collaboration can be cost-reducing	+	DNM	DNM	DNM	DNM	DNM	DNM	+	+
	Care2U is used for financial management	DNM	+	DNM	DNM	DNM	DNM	DNM	DNM	+
	Non-profit organization	DNM	DNM	DNM	DNM	DNM	DNM	DNM	DNM	+
	Division between care and overhead costs national guideline = 80/20	DNM	DNM	DNM	DNM	DNM	DNM	DNM	DNM	+
	Health insurers are the main source of income	DNM	+	DNM	DNM	DNM	DNM	DNM	+	+
	Main costs formed by the payment of healthcare provided by partners. These costs have crystallized over the years	DNM	+	DNM	DNM	DNM	+	DNM	+	+
	Other costs in organizing training, meetings, ICT and other overheads	DNM	+	DNM	DNM	DNM	+	DNM	DNM	+
	Overhead costs exceed the guideline at Beroemd	DNM	DNM	DNM	DNM	DNM	DNM	DNM	DNM	+
	Since 2016 the care group is taxed by the tax authorities	DNM	DNM	DNM	DNM	DNM	DNM	DNM	+	+

Figure 10.11: Findings financial element from compiled data matrix.

Findings on the *financial* element show the care group is a non-profit organization with health insurers as the primary source of benefits for the care group. There are no other benefits as of 2018. Costs can be split into

care related costs and overhead costs. For which the care group aims to achieve a 80 / 20 division ratio respectively. This ratio is imposed by the health insurers. The data makes clear this ratio is put under a lot a stress due to the IT costs. In the budget for 2017-2018, IT costs are roughly 20% of total costs for the care group. The director states that currently IT is considered overhead as a whole, whilst a large sum of IT-costs are actually relatable to the care provision activities. Other overhead costs are schooling, meetings and personnel related. Striving towards a more multi-disciplinary care system could reduce costs overall according to SD1, the current director and former director. Another cost related issue are the tax regulations surrounding care groups since 2016. Under these new tax legislations, care groups are obliged to pay taxes because they are considered socially cultural institutes. A decision that contradicts all other legislation demarking a care group as health care institute. Having to pay taxes puts extra strain on the already tight budget. Therefore, BeRoEmD plans to re-evaluate its IT resources in the near future. The current resources are heavily relied upon, but maybe cheaper alternatives are available that satisfy the demands of the care group.

The findings on the *financial* element show internal consistency. They point out that all income is derived from the health insurers, mainly VGZ and CZ. Costs are distributed between direct health care related and overhead costs. Whereas overhead costs can be split into ICT, personnel, schooling and various. Most findings also point out that the budget of the care group is stressed by the (growing) overhead costs. Multiple data sources also indicate that the 80/20 guideline, set by the health insurers, limits the care groups abilities and possibly hinders other strategic goals.

Externally, findings on the financial element indicate extensive inconsistencies with other elements. The main issue is related to costs allocation. The 80/20 ratio of health care versus overhead costs distribution stresses the budgeting and abilities of the care group. ICT costs alone swallow up the majority of the overhead budget. The care group argues that ICT costs should be split between indirect care related costs and overhead costs, instead of solely overhead, because a lot of ICT is used in or in support of the actual health care process. Due to the high costs of ICT, these resources are under constant pressure of re-evaluation. For this reason, the care group is planning to research alternative options for KIS Care2U in 2018. The financial stress on the resources element trickles down to other elements of BeRoEmD's strategy, because the care group is highly dependent on those *resources*. The care group uses Care2U for its *activities*, *measurement*, *learning*, and as a *channel* of communication. Finally impeding the core values of BeRoEmD's strategy as well.

Chapter 5 Conclusion part 1: evaluating formal correctness for BeRoEmD's strategy

Strategic research questions:

- *What does existing literature say about formal correctness of strategy?*
- *What is BeRoEmD's strategy?*
- *To what extent is the strategy of BeRoEmD formally correct?*

§5.1 Introduction

This chapter concludes part 1 of this research. The goal of Part 1 was to evaluate the formal correctness of BeRoEmD's strategy. Formal correctness can be evaluated by ways of assessing completeness and consistency for a strategy. Therefore, previous chapters have constructed a conceptual framework and used this to gather and analyse data. This chapter concludes the evaluation of BeRoEmD's strategy based on an assessment of completeness and internal & external consistency of the organization's business model with the help of table ?? on the next page.

§5.2 Conclusions

Completeness

The conceptual business model presented in chapter 2 consisted of 11 elements. All of the elements have been found present in the strategy of BeRoEmD. It should be noted that some elements were more prominently present than others. For instance, the *value* element was most represented by being present in nearly all data sources. The *learning* and *financial* elements were least represented. Both were discussed in only a few sources and in those sources data on the topics was scarce. Thus, although the model is complete, some elements have been given a more prominent role than others in the strategy for BeRoEmD. After presenting table 10, the most important issues with completeness are discussed.

Consistency

With regard to consistency, some noteworthy findings have come forward. First, several topics are spread over multiple elements. Examples are the plurality of roles GPs are given, the issue of what POHs are to the care group and the interwovenness of the KIS system Care2U throughout all of BeRoEmD's operations. Second, several inconsistencies have been found. Some are internal, some are external. Remarkable is that internal inconsistencies tend to lead to problems with the external consistency for that element as well.

Overview

Table 11 presents the concluding assessment for each of the business model elements for completeness, internal consistency and external consistency. At face value, something can be either consistent, or inconsistent. However, the degree of implication has to be taken into consideration as well. Not each inconsistencies weight as heavily as the other. Therefore, we differentiate in inconsistencies that have no direct negative implications for the strategy of BeRoEmD and inconsistencies that do have direct negative implications for the strategy of BeRoEmD. Elements that lack completeness and/or are considered negatively inconsistent are flagged in the table and will be discussed in further detail below.

Business Model Element	**Completeness**	**Internal consistency**	**External consistency**
Value(s)	Complete Data distributed proportionately	Consistent -Slight shift in emphasis over time: more focus on multi-disciplinary aspects	Inconsistent, no direct impact -Some values are hard to obtain with current financial constraints, accompanying resources and attitude of main partners (GPs)
Key activities	Complete Data distributed proportionately	Consistent -Employment activity: size of staffing personnel might be insufficient to support all activity	Consistent -Size staffing personnel might impair other elements
Key resources	Complete Data distributed disproportionately: little data in SDs, rich data in interviews	Consistent -Care2U is under discussion, might be replaced by alternative in the future - Ambiguity about POH	Inconsistent, direct impact - Resources suit the other elements - ICT resources are under stress / evaluation due to financial impact. - Size staffing personnel impairs activities
Key partners	Complete Data distributed predominantly in SD3, SD6 and interviews	Inconsistent, slight direct impact -Discussion role POHs; partner themselves or subordinate of higher level partner?	Inconsistent, slight direct impact -Plurality of roles GPs, POHs -Difference in gravity between GPs and other chain partners
Competitors	Complete Data predominantly gathered via 2 sources (SD2, IMW1), other sources no data	Consistent -No conflicts in data sources	Consistent -Some competitors are also considered potential partners
External	Complete Data distributed predominantly in SD3 and interviews. Some SDs no data at all.	Consistent Data is very diverse due to PESTLE factors, but no real inconsistencies	Inconsistent, no direct impact -Law & regulation changes not in favour of BeRoEmD's strategy -Reigning culture Dutch GPs

			impedes change of the sector
Measurement	Somewhat complete Scarce amount of data on this element.	Inconsistent, no direct impact -Lack consistency in practice: measurement is not the same for all factors.	Inconsistent, direct impact -Measurement inabilities due to incapabilities of ICT resources -Direct negative effect on activities, learning and indirect effect on values.
Customers	Somewhat complete Data is somewhat dispersed & under discussed	Inconsistent, heavy direct impact Large ambiguity on whomever is the customer for BeRoEmD.	Inconsistent, slight direct impact The internal inconsistency leads to external inconsistencies, because there is no consensus.
Channels	Complete Data distributed reasonably proportionate	Consistent -Modes and channels of communication suit each other and its respective purposes. -Care2U's applicability could be enlarged to strengthen this element.	Consistent -Channels suit the other strategic elements. Some could be deployed more or better to strengthen overall strategy
Learning	Somewhat complete Scarce data that provides a divergence of findings	Inconsistent, no direct impact -Findings show no real inconsistencies, yet no strong protocols or guidelines either. -Lack of knowledge retention protocols	Inconsistent, no direct impact The learning elements does not empower other elements to full potential due to the lack of knowledge retention / dispersion
Financial	Complete Data distributed disproportionately in collection, but data is clear for BeRoEmD.	Consistent Data shows consistent findings and the same problems are pointed out in various data sources.	Inconsistent, heavy direct impact The financial element puts a strain on most of the other strategic elements. Mainly due to budget allocation (80/20) rule imposed by insurers.

Table 11: Final evaluation of BeRoEmD's strategy: completeness, internal & external consistency

Red flags

- **Financial:** The financial element is the biggest strain on the strategy. The limited budget and imposed allocation of 80% care related costs versus 20% overhead related costs impair multiple other business model elements. The 20% overhead budget is almost entirely swallowed up by IT costs alone. BeRoEmD pleads to redistribute IT costs, because part of the IT is directly relatable to the health care process. However, as of yet, health insurers do not comply with this preposition. Resulting in BeRoEmD exceeding the overhead costs allocation guidelines. Management is considering cutting IT

costs by switching to alternative cost-saving resources. More on this in the *resources* element. Not only the overhead budget is tight for BeRoEmD, care related costs stipulated in detail for each care program or action leave little margins for care providers. This limited financial latitude results external inconsistencies with other elements of BeRoEmD's strategy. As already mentioned, resources are under distress. But also the key activities and values for BeRoEmD are impaired by this element.

- **Customers:** Currently, BeRoEmD has no clear vision on whom its customer is, or customers are. Some sources indicate that the citizen/patient is the direct customer, whilst most evidence indicates no direct care relationship between BeRoEmD and the patient. BeRoEmD enables other care providers to cater chronic care to these patients instead. Thereby making those parties the customers of BeRoEmD. Moreover, it can be argued that the customer element has to be segmented and customized to each of the parties. This internal inconsistency also negatively affects the external consistency of the customer element, because it inhabits the care group to adapt other elements as long as there is no clear defining of customers.

Orange Flags

- **Measurement:** BeRoEmD mainly measures performances via IT resource Care2U. The system is well-suited towards working with the GPs, but lacks the same applicability for other chain partners such as dieticians, pedicures, etc. Making measuring performances of those other partners a difficult task. This external inconsistency caused by the resource directly affects the elements key partners and key activities, but also impedes the learning element.
- **Resources:** At first glance, the resources at hand seem to suit the strategy well. However, the tech-related resources of BeRoEmD are under stress due to budget allocation and financial resources as a whole. BeRoEmD is heavily dependent on these resources however. BeRoEmD uses Care2U as primary communication, measurement, declaration and information system. Care2U will be re-evaluated in 2018 and alternatives are sought to cut costs. Meanwhile, the system has its limitations as well in the applicability discrepancy between GPs and other chain partners. Finally, the amount human resources are limited according to several sources. A slight increase in personnel could help the care group strengthen the resources and thereby assure performance on other elements as well.

Yellow Flags

- **Learning**: Although the learning element has been indicated by several data sources, the protocols or guidelines for knowledge acquirement, distribution and retention are unclear. Due to the lack of these protocols, knowledge is poorly managed. This leads to external inconsistencies towards other elements. Other elements would benefit and improve more if the learning element was employed more.

- **Key partners:** The findings on the partners element indicate a few noteworthy inconsistencies. First off, the difference of gravity that is made between partners. GPs are given much more priority and resources than other care providing partners. Part of this difference is explicable, considering GPs provide the majority of the required chronic care. However, GPs themselves and in some ways the care group tend to downplay the role of other chain partners. Accompanied by lack of involvement and capabilities that follow. Other chain partners are given less schooling and resources are less suited towards working with the remaining chain partners. Second, POHs are a topic under discussion. Are these people a partner for BeRoEmD? Technically the POH is an employee of a GP, practically the POH is closely involved in the activities of the care group. A clear position on this matter misses, leading to ambiguity in how this group of people should be managed. Third, GPs play a plurality of roles in the strategy for BeRoEmD. They are a partner, a resource, an owner and sometimes even a competitor. BeRoEmD seems to manage this plurality pretty well at the moment, but should be wary of the situation in the future. Especially when considering future developments that cause conflict in this plurality of roles.
- **External:** Law and governing in the health care sector is under constant development. Each year, regulation changes on several aspects impacting the care group. BeRoEmD has to cope with these changes. Some of the recent heavy impact developments are the tax obligations, liability issues and the General Data Protection Regulation regarding privacy. These developments all impact the care group's strategic elements in specific ways. Taxes put strain on finances. Liability standards increase administrative work pressure and possibly finances. The GDPR impacts the activities and resources element. Another pressing external issue is the culture of GPs. Based on the acquired data, GPs are described as hesitant to change and are less likely to make compromises in order to strive forward. Especially when compared to other chain partners.
- **Values:** The values of BeRoEmD have been constant for the majority of time since the care group was founded. Some shift in emphasis on the values can be noticed. Most specifically, the wish to be a multi-disciplinary care group has become stronger in recent years. The data on values show completeness and internal consistency. The external consistency is a culmination of the consistency from all other elements. Inconsistencies from (i.e.) the key resource element influence how well the care group is able to attain the value it strives for. The external inconsistency of Care2U capabilities towards other chain partners, hinders the value to enable the highest quality care by all care providers.

Part 2 Network Relations

The goal of the second part of this research is to diagnose the network of BeRoEmd and, subsequently, the activities in that network. To attain this goal, this research needs a conceptual framework that enables a diagnosis of a network. This diagnosing framework must enable the research to assess whether the network's activities are in line with the strategic goals that were set in the previous part of this research. Chapter 6 will be used to construct that conceptual framework. After constructing a framework, chapter 7 details the methods for this part of my research. The methods section details the research design, operationalization and ways of data collection that are suited for the goals of this diagnosis. Chapter 8 is used to present the findings of data collection and corresponding analyses performing a diagnosis of the network for BeRoEmD. Chapter 9 draws the intermediate conclusions for the network diagnosing part of this research, finalizing this part of the research. A final 10th chapter is used to present the reader with final conclusions, implications and discussion of this research.

Chapter 6: Conceptual underpinnings: Diagnosing the network

§6.1 Introduction

In order to diagnose the network for BeRoEmD, the goal of this conceptual section is to support a diagnosis by constructing a conceptual framework that is able to perform a diagnosis of networks in relation to the strategic goals. To realize and possibly adapt those goals, each network performs certain activities. Therefore, a diagnostic tool should be able to first map and then analyse the goals, actors, and activities of a network. To construct this tool, this chapter is structured as follows.

First, a network diagnosis must be able to assess what activities are required to realize and adapt the goals of that network. Section 6.2 of this chapter explains to the reader the Viable System Model by Beer (1985, 1995). This model provides our research with the conceptual underpinnings that explicate what activities should be present in a network to realize viability, resulting in a normative set of activities that should be executed by the network.

Second, these activities have to be actually executed by certain the actors or parties within the network. Therefore, we need a way of mapping the execution and the distribution of activities within the network. Section 6.3 constructs a step-by-step approach towards analysing activities for a network. We draw upon a recently constructed framework by Nieuwkamp & Achterbergh (2017). The authors' framework operationalizes Beer's functions to a degree of functionality. This introduces the comparison between normative activities and the factual execution by the network. Building upon this notion, we construct a tool that is able to map the values, parties and activities of a network. This should then be followed by a diagnosis of that network by comparing norms and facts. Additionally, a diagnosis could point out any deficiencies of the network. Deficiencies can be found in the form of omissions, duplications or fragmentations.

Lastly, section 6.4 presents the reader with a conceptual model. This model or framework depicts the underpinnings and roadmap for diagnosing a network for this thesis.

§6.2 Beer: Normative activities a network must perform

The goal of this part of the research is to diagnose the network for BeRoEmD. In order to do so, I will first explain to the reader that the highest goal of every system is meaningful survival and how this relates to diagnosing a network. Beer (1985, 1995) provides us with normative set of five activities that are required for a network to realize and adapt its strategic goals with the viable systems model. This model will therefore be used to create a normative set of activities by which a network can be diagnosed.

Meaningful survival can be defined as *"Maintaining a separate and meaningful existence by selecting and realizing goals to contribute to the creation of societal conditions enabling human beings to develop and realize their humanity because this is considered to be the meaningful thing to do."* (Achterbergh & Vriens, 2010, p12). To achieve meaningful survival, system theorists developed functional and specific design principles trying to explain how a systems' infrastructure should be designed. The specific principles are more detailed and give the design for specific pieces of that system's infrastructure. They set up the rules and heuristics for specific parts of the organization (Achterberg & Vriens, 2010). Thereby the specific principles make sure that the functional design principles work correctly.

Beer (1985) extends these functional design principles with his *Viable Systems Model (VSM).* The VSM specifies the essential functions and relations between these functions a systems needs in order to be viable. The VSM is a prescriptive framework that can help evaluate the viability of an system's network.

Beer (1985) based his works on the classical cybernetics stream. According to Wiener (1948), considered the founder of cybernetics, cybernetics can be defined as *'the science of control and communication, in the animal and the machine'* (Wiener, as quoted in Beer, 1985, p. ix). Beer combines Wiener's 'control' and 'communication' into 'regulation'. Regulation can be considered as the capacity to effectively organize. This, together with cybernetics being considered a science, leads to Beer's translation of cybernetics: *"The science of effective organization"*(Beer, 1985, p. ix).

Beer then procedes to formulate the Viable System Model (VSM), as a way of designing such a system that is capable to deal with complexity. This model states that the functions a system needs – and that are sufficient – to lead a separate survival should enable the organization to realise and adapt its goals (Achterbergh & Vriens, 2010). In total, Beer (1995) prescribes 5 functions that are a required for the viability of a system. These 5 functions can be further divided in 2 sets of activities. The first set of activities enables *realisation* of the systems goals. The second set of activities enables *adaptation* of the systems goals. Both sets are detailled below, notice the *control* activity's dual role, occuring in both sets of activities.

Realisation of goals

1. *Primary activities:* The collection of primary activities are the core actitivies a system realizes its products and services. They are the system's *raison d'être* (Espejo *et al*. 1996, p110, as cited in Achterbergh & Vriens, 2010). Beer also explains that each primary activity is a viable system with its own sub-sets of primary activities, referring to the recursive nature of the model.
2. *Coordination:* This function coordinates the primary activites interdepencies and ensures they can co-exist within the viable system. A system's primary actitivies may share resources like materials, machines or human resources. The coordination function is designed to align the interdepencies that arise because of this. For instance, when a machine is used by 2 of the primary activities, planning how the machine's usage is distributed can be considered a task for coordination.
3. *Control:* The control function makes sure that each of the primary activities serves the goals of the viable system as a whole. Each of the primary activities pursue its own goals, which are not nescessserily coherent with the viable systems' strategy. Control translates the goals of the viable system to goals for each of the primary activities. Moreover, control also checks the coordination function to avoid or solve issues that impair the systems strategy. Beer (1995) states that the control function is *inside* and *now*. Control is aware of all that is ongoing in the system and makes sure the system functions properly. Is does so by doing the fulfilling the following three tasks:
    a. *Command & report:* Control sets the goals for the primary activities in alignment with the goals from the viable system. It gathers reports on performance and how well the goals are met
    b. *Bargaining:* Control negotiates how the system distributes its shared resources over each of the primary activities.
    c. *Audit:* Control periodically audits the primary activities and employees by checking 'on-site'. Gathering first-hand information is important, because reports do not always portray situations to their full extent.

Adaptation of goals

4. *Intelligence:* To be viable, a system has to be able to adapt to its environment. Therefore, the intelligence function monitors the environment and is constanly scanning for new developments or trends that could benefit the system. Intelligence is focussed *outside* and *then* (Beer, 1994); it drafts plans to innovate the viable system based on the observed developments from the environment. The intelligece function then enters a dialogue with control to adapt new ideas within the organization.
3. *Control:* Control has to assess whether the proposed ideas by intelligence are feasible and should be implemented.

5. *Policy:* To guide the discussion between control and intelligence, Beer developped the fifth and final function policy. *'To develop plans both relevant "outside and then" and feasible "inside and now", intelligence and control should discuss them in-depth'* (Achterberg & Vriens, 2010, p. 203). The policy function facilitates, coordinates and sets the rules for the discussion between these functions. It makes sure the results are in line with the identity and strategy of the viable system. It also keeps the balance between the functions; dominance by the intelligence function promotes *innovatism.* Whereas a dominant control function leads to *conservatism.*

Relations and nature of the model

The first group focusses on the *realisation* of goals and checks if the system is performing well. This group consists of primary activities, coordination and control. The second group consists of control, information and policy. The latter group focusses on *adaptation* of goals by checking if the system has the right goals. The control function is present in both groups. In the realisation group, control manages the synergy and cohesion of the primary actitvities and their coordination. In the adaption group, control manages adaptation of the system's mission and goals by reviewing initiatives for innovation (Achterbergh & Vriens, 2010).

With the help of this model, organizations have three approaches to combat complexity; 1) setting goals, 2) attenuation & amplification, and 3) recursion (Achterbergh & Vriens, 2010). In particular, the notion of recursion is interesting. Recursion states that every system is part of a system itself and that system can also be divided in subsystems again. That way, complex systems can be unraveled in understandable subsystems via recursion, taking away complexity. Applying recursion allows you to study a 'system' of a single employee, a unit or taskforce, a department, an oranization, a network of organizations, or even bigger systems. This concept of recursion fits well with the goals of this research. The goal of this chapter is to construct a conceptual model that enables diagnosing the network for BeRoEmD and the concept of recursion allows for analyzing systems on various levels. Thus recursion allows us to study the network for BeRoEmD

Moreover, the VSM is considered a prescriptive and functional model. It prescribes *what* functions are essential for viability and that they should be present in the system, but it does not stipulate *how* they should be present. This prescriptive and functional nature, makes the VSM very well-suited to diagnose or evaluate the network (system) an organization is part of. Using the 5 functions from Beer suits the goal of this research. Now, with the knowledge of what functions should normatively be present and executed by the system, I have to consider the factual execution and distribution of activities among actors within the network, which could be entirely different. Most practicians will have never heard of Beer nor his VSM. Therefore, activities are not categorized by these functions. This is something Beer does not cover. Luckily, the authors Nieuwkamp and Achterbergh (2017) have recently posted a framework directed to diagnosing

the quality of work and quality of care that could help construct the conceptual model for this thesis. These authors used the VSM model by Beer to construct a tool that enables the user to assess whether the network's activities realize the systems goals by first defining the normative activities for a network followed by comparing them to the actual activity execution and distribution. The next section touches upon parts of the framework by Nieuwkamp and Achterbergh that are relevant for this research, followed by constructing this thesis' conceptual diagnostic tool.

§6.3 Constructing a diagnostic tool: The 3-step approach

The goal of this section is to construct a tool that enables this research to first map and then diagnose the network for BeRoEmD. The previous section detailed the 5 functions a network should execute in order to realize the goals and be able to adapt these goals within the network. These 5 functions (primary activities, coordination, control, information and policy) are prescriptive and function. The VSM model does not detail how they should be executed nor distributed within the network. The goal of this section is to extend these normative functions into a practical tool that enables us to diagnose to diagnose the network for BeRoEmD. It does so by first introducing the recently published framework of Nieuwkamp and Achterbergh (2017), which also aims to diagnose networks. Then I will detail why and how certain aspects of the role module are helpful in our goal to diagnose the network for BeRoEmD. Lastly, this section constructs a step-by-step approach for diagnosing a network.

Nieuwkamp & Achterbergh

Nieuwkamp en Achterbergh developed a tool to: *"assess whether a network performs the activities that are required to realize or to adapts the values of the network. Moreover, the tool can detect gaps in, duplication and fragmentation of the activities in the network that can be of influence to the intended quality of care and quality of work"* (Nieuwkamp & Achterbergh, 2017). Their tool is based on the *viable system model* by Beer (Beer, 1985; Beer 1995; Achterbergh & Vriens, 2010) and the '*capabilities approach'* by Nussbaum and Sen (Nussbaum & Sen, 1993; Sen, 1999; Sen, 2005; Nussbaum, 2011). By combining the VSM and the capabilities approach, the authors created a framework consisting of a *value module* and a *role module*.

For this research, the role module gives insights on how to investigate roles performed in the network, which strokes very well with the goal to diagnose the network and its distribution of activities. This role module links a network's activities to the VSM functions and considers how the distribution of these functions influence the network's realized goals and values. In the case of Nieuwkamp and Achterbergh, the authors focus on what degree of quality of work and quality of care the network realizes. This focus can be

broadened to the entire core values of a network, making the role module a functional adaptation of Beer's VSM model.

Furthermore, the authors indicate that diagnosing the network using the role module could unveil issues regarding the distribution of activities in the network. These issues can be divided in *omissions, duplication,* and/or *fragmentation* of activities in the network (Nieuwkamp & Achterbergh, 2017). omissions indicate an activity should be present in the network according to the norms, however it is not executed. Imagine a patient is supposed to have blood samples taken regularly. All of the involved parties each think some other party executes this activity, resulting in none of them executing this task. Having duplicates means that the same activity or activities are executed multiple times. Either by the same party, or multiple partners. In this case, multiple care takes take a blood sample from the patient, whilst one would suffice. Fragmentation relates to what extent the primary activities of all parties in the network are linked to the products/services of the network. A high amount of involved parties require more coordination and control activities to regulate the complexity created. Also, the more parties are involved in the primary activities of the client, the more product or service is fragmented in the eyes of the client. In the case of blood samples case, the client has to deal with a multitude of parties to receive the health care he or she requires. For instance, the blood has to be taken at the POH, which sends it to the laboratory and the patients has to contact the GP for the results

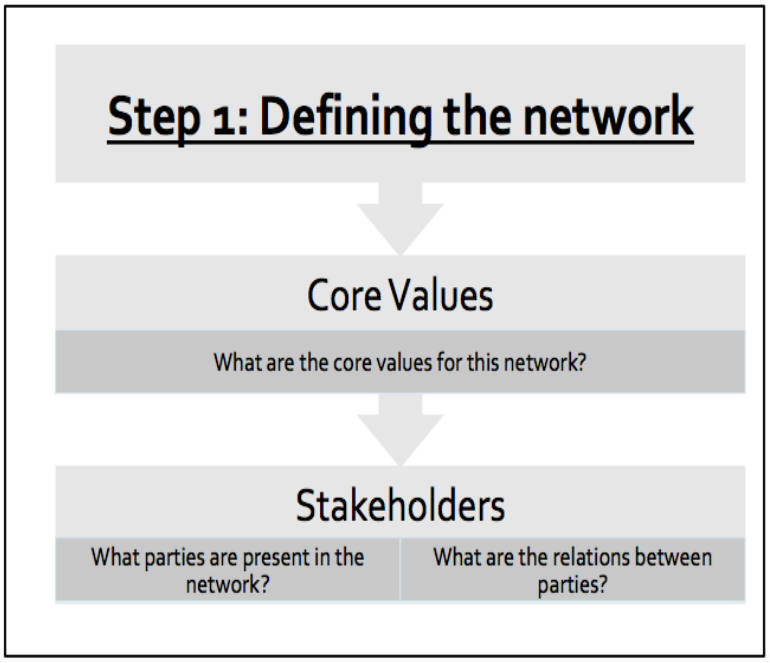
In sum, the role module employs the VSM-functions as activities executed by and distributed among the network's parties and diagnoses for possible issues that could impair realization or adaptation of the core goals. The role module is well suited to serve as a basis for designing our three-step approach towards diagnosing a network.

Diagnosing a network via a 3-step approach

The goal of this chapter is to enable this research to diagnose the network for BeRoEmD. Diagnosing a network, as we have learned in the previous sections entails not only defining the core values of that network, but also who are responsible for attaining those values and by what activities. To meet the goal of enabling a diagnosis of that network for BeRoEmD, I have broken into three steps:

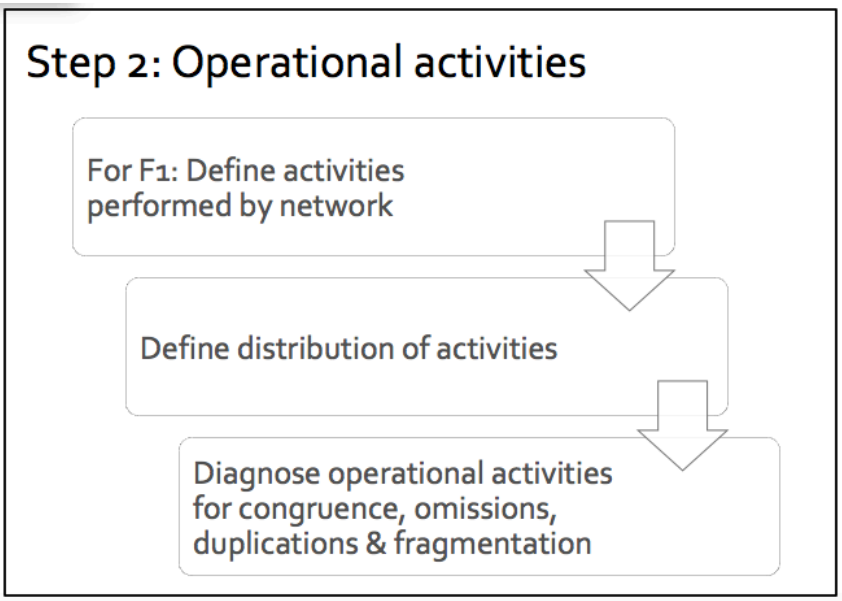
Step 1: Defining the network

First, the network itself has to be defined by establishing what the core goal(s) this network wishes to realise and possibly adapt. The core goals are the reason of existence of this network and what should drive all activities undertaken by the network. Secondly, we have to map what parties are present and involved in the network. Parties can also be named actors, as they act within the network. This step thus deals with the question what values the network wants to realize for which stakeholders and with the help of what products, services and resources.

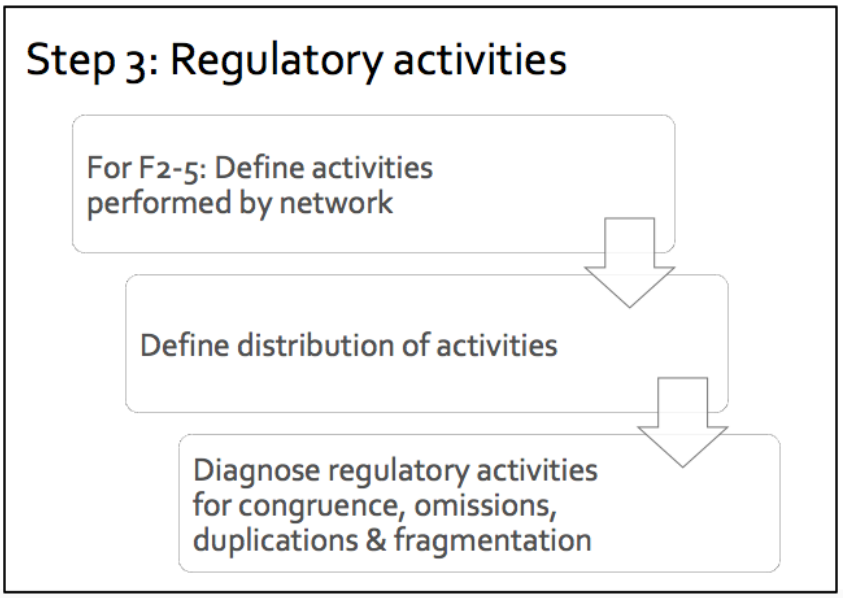


Step 2: Operational activities

To realize the values determined in step 1, a network must choose and perform a set of operational activities. That's why the second step in this approach deals with the operational activities of the network. These executing activities are employed to attain by actors within the network to realize the core goal that has been established in step 1. As we learned earlier, the operational activities can be considered the primary activities by the VSM model. Therefore, we can define these primary activities as the normative activities that *should* be present in the network to realize that core goal. Subsequently, we have to investigate which primary activities are performed in the network and by whom. The first part of this investigation maps the activities; the second part maps the distribution of those activities. After we have mapped the activities, we can start diagnosis. To diagnose, we must first assess whether the primary activities are congruent with the core goal of the network. Second, we check the distribution of activities for omissions, duplications and/or fragmentation. Analysing for these issues might unveil issues regarding the distribution of activities. These issues can then be reported so they can be solved.



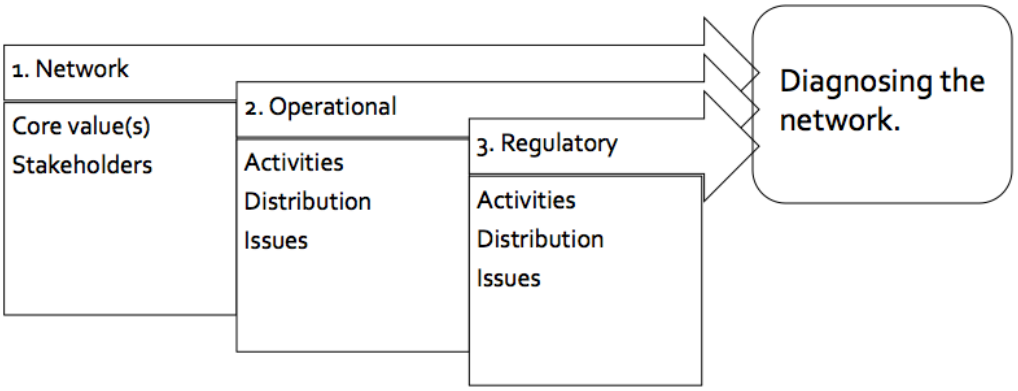
Step 3: Regulatory activities



In addition, a network needs a selection of regulatory activities that support and control the primary activities so that they are able to realise the desired goals. This third step revolves around mapping and diagnosing these regulatory activities for a network. The VSM prescribes that the functions of coordination, control, information and policy *should* be present within the network. Again, we have to investigate which regulatory activities are performed in the network and by whom. The first part of this investigation maps the activities; the second part maps the distribution of those activities. After we have mapped the regulatory activities by function, we can start diagnosis. To diagnose, we must first assess whether the regulatory activities are congruent with the core goal of the network. Second, we check the distribution of activities for omissions, duplications and/or fragmentation. Analysing for these issues might unveil issues regarding the distribution of activities. These issues can then be reported so they can be solved.

Conceptual model

The goal of this chapter was to enable a diagnosis of BeRoEmD's network and that networks performance by activities. This chapter has served as conceptual underpinnings of the tool to be constructed. After detailing how we can define activities within a network and how we can diagnose with the help of aspects from the role module, we present the three-step approach towards diagnosing a network. Each step ends with a partial diagnosis for that network. Combining the results of all steps forms a complete diagnosis. Per step, we have shown a quick view of the process. For a full overview of the diagnosing process, we hereby present a full conceptual model.



Chapter 7 Methods

§7.1 Introduction

The goal of this methodological chapter is to further elaborate on the methods for part 2. Since chapter 3, methods part 1, laid the groundwork for most of the methodological aspects of qualitative research, this chapter will make use of the explanations already given there. Changes and additions to methods will detailed in this chapter. This chapter is structured as follows: The first paragraph will account for the research design of Part 2 that enables diagnosing BeRoEmD's network. Secondly, a paragraph is devoted to the operationalization and data collection methods.. The final paragraph builds upon establishing and ensuring the assessment criteria for qualitative research similar to that of part 1.

§7.2 Research Design

The second part of this research has to be designed towards diagnosing the network of BeRoEmD and that networks performance. In order to do so, a conceptual framework has been constructed to enable an analysis that network. The goal for this operational part of the network diagnosis is twofold.

First, I want to capture the network of BeRoEmD as is. This means I have to analyse the network according to the conceptual framework as drafted in chapter 6 with the help of the value and role modules. Using those modules, I set norms for the network and analyse the actual facts empirically before assessing gaps between these two. This should results in an overview of the network as is and how it should be according to the norms, resulting in a diagnosis of possible hiatuses, duplications and fragmentations that should be addressed.

Second, we have the intervention goal of creating awareness and willingness from the stakeholders in the network towards change. *"the primary objective in strategic decision making is frequently not to find a robust policy, but rather to encourage team learning, to foster consensus and to create commitment to the resulting decision, in particular when divergent opinions are involved"* (Vennix, Akkermans, & Rouwette, 1996). The strategic evaluation of part 1 acknowledged the care group has multiple strategic hindrances relating with the network that impair realizing all of the care group's goals to its fullest potential. This part of the research should be designed to aid the care group to create awareness and willingness among stakeholders to achieve momentum for BeRoEmD.

To meet both the network analysis goal and the intervention goal, this part of the research is designed as a case study. To recapitulate, a case study is a research strategy in which the researcher tries to gain a profound insight into the issue under investigation in a confined time and space. Characterised by a small number of research units, intensive data generation, a selectively chosen sample, and open observation on site. In consultation with BeRoEmD, a participative stakeholder method was chosen in the form of

organizing a workshop meeting with members of the care group and deputies from the general practitioners and other care providers (e.g. apothecaries, dietists, physicians) to capture the care providing component of BeRoEmD's network. To complement this data, interviews will be held with deputies from the health insurers to incorporate their view on the network. By engaging the stakeholders within the network and actively encouraging them to think alongside BeRoEmD, this research not only collects a broader amount of data, but also strengthens the care group's momentum for change.

§7.3 Research Methods

This section contains the detailed explanation of methods used during this part of the research. First, a section is devoted to operationalising the conceptual framework constructed in chapter 6. Second, this part of the research's ways of data collection as discussed. This section will explain what methods of collection were applied and why they are congruent towards the goal of this research design. Third, data analysis is detailed. This section will explicate the plans for analysing the collected data once it has been gathered

§7.3.1 Operationalisation of conceptual framework

In order to analyse the network of BeRoEmD and that network's performance, the conceptual framework constructed in chapter 6 has to be operationalised. The conceptual framework proposes a network analysis based on assessing norm values and factual values for a network's values and roles. Where the role module can be split into primary activities (function 1) and regulatory / supporting activities (functions 2-5). This section operationalizes what is understood under *network, operational activities, regulatory activities, norm values, factual values* to underpin data collection methods that follow in the section hereafter.

Network & Value of the network

In this research the network is defined as the system in which BeRoEmD and her partners strive towards creating value for the client and itself by selecting and realizing congruent goals. This system is hereafter named care network BeRoEmD. This research wishes to establish which actors (parties) are present or surround that network and what core values the network has selected.

Operational activities

Operational activities are the network's executing activities as defined by the VSM's primary activities function from Beer (1995). Primary activities are the key activities the network executes in order to realize the values which the network intends produce.

Regulatory activities

Regulatory activities are the supporting activities that the network undertakes in order to be able to execute the primary activities and are subdivided in the functions 2-5 from the VSM (beer, 1995): coordination, control, information, policy.

Norm values & Factual values

Values are, in the case of this research, an outcome of how activities are performed. A distinction can be made between norm value and factual value. Norm value indicated how things *should be*, whereas factual value indicates how things *are*. The premise of this research is to be able to indicate a gap between the norm and factual value whenever this is present. These gaps can be a hiatus, duplication or fragmentation of activity.

§7.3.2 Data collection

For the network analysis a workshop was held as the primary data collection method. A workshop is a participative stakeholder meeting that serves both goals of this part of the research; 1) collect the required data to diagnose the network of BeRoEmD, 2) create awareness and willingness among stakeholders towards BeRoEmD's strategic goals. In addition to this workshop, two interviews were held with the health insurance companies, because they did not participate in the workshop. One interview was held with a deputy from CZ, and one interview with a deputy from VGZ. In preparation of these interviews, the researcher has received the procurement policy statements from both CZ and VGZ for perusal. In consultation with BeRoEmD, the health insurers were intentionally questioned via separate interviews. It wasn't deemed productive to organize a meeting wherein both the health insurance parties and care providing parties were present, because of the overall differences between those parties.

Workshop

Design

A workshop is a participative method that allows the participants to engage in discussion with one another under guidance by a facilitator. The researcher will assume the role of facilitator in order to guide the participants through the process. The workshop is designed to bring together the parties involved in the care network of BeRoEmD. For that reason, deputies from BeRoEmD, general practitioners and the other chain partners have been invited to participate. To enrich the input from all participants, *brainstorming* principles of *nominal group technique* (NGT)are used to activate participants beforehand. "*Brainstorming ensures a*

more rich discussion and is expected to counter a number of tendencies humans could have. Tendencies that halts creativity, focusing on negative aspects, self-discouragement, timidity and others" (Osborn, 1957; p227). A participant is more likely to come up with input when he or she is asked individually beforehand. Moreover, principles from group model building (GMB) are employed to facilitate this workshop. "*Group Model Building uses a combination of systems dynamics and facilitation, it uses the methodological framework of system dynamics but also uses the participative approach used in facilitation*." (Rouwette & Alberto Franco, 2015; p60). GMB enables the researcher to tackle complex problems with multiple stakeholders, making its principles and methods suited for the purpose of this research. This technique is most used to build models, however, it can also be employed towards the purpose of analyzing the network for BeRoEmD, where we strive to set norms for both the value and the role module, followed by assessing factual values and roles. GMB prescribes the researcher to assume a facilitating role in which he or she enables participants to bring forth ideas and opinions on the matter that is discussed, identifying variables and problems along the way. In this case, variables are answers to norms and factual values, whereas problems can be interpreted as the hiatuses, duplications and fragmentation of the network. *"Participation will increase quality of the outcome and change on implementation"* (Rouwette & Alberto Franco, 2015; p62). Summing up both goals of this network analysis; acquire rich data on the network plus helping BeRoEmD in gaining support for its strategic goals.

Protocol

The workshop has been organized in association with BeRoEmD's director. For ensuring richness of data for this research, participation of each network party was desired. Therefore, 2 general practitioners, a deputy for the remaining chain partners, BeRoEmD's quality manager and the director herself were invited to join the workshop. All participants were sent an e-mail to detailing the purpose and planning of the workshop. After confirmation, participants were sent a second e-mail disclosing additional information, the agenda and a set of questions and statements about the network. The set of questions and statements serves to activate participants and to actively engage each participant towards the workshop. The workshop will be held may 17th of 2018 in the office of one of the participating general practitioners. During the workshop, the researcher will assume the role of facilitator. Facilitating the participants through the network analysis by encouraging their input and discussions, but also maintaining balance and serve as timekeeper. For a full overview of the workshop's invitation, additional participant information, agenda, and a workbook of the workshop's results, This research refers the reader to Appendix 6.

Interviews

Design

The interviews serve as addition data collection to acquire input from the health insurers. It was deemed more appropriate to do a separate inquiry, than to invite them to the workshop as well. This because the health insurers and care providers operate on totally opposite planes. By interviewing them separately, it is possible to ask them for their input and create a more complete picture of the network for BeRoEmD. The procurement policy documents from respectively CZ and VGZ were used to gain insights in considerations and point of view on chronic care policy and served as background information for the researchers interview questionnaire.

Protocol

The interviews will be held via telephone, at a time and date suitable for the respondents. The respondents will receive an e-mail beforehand from the researcher detailing what they can expect from the interview. This e-mail contains explanation of the purpose for organizing this interview, a brief summary of what is researched and is concluded with a set of questions and statements to activate the respondents line of thought. It is preferable that the telephone interview is be recorded. Therefore, the researcher will indicate this preference via e-mail and ask permission to record the conversation at the start of the interview. The interview itself will be semi-structured. This means that the researcher has devised a questionnaire for the respondent, but the flow of the interview is determined during the interview itself. After conducting the interview, the respondent will be informed what the researcher intends to do with the acquired data. A transcription will be drafted and sent to the respondent for approval before usage in the network analysis. For a full overview of the interview questionnaire This research refers the reader to appendix 6. For the transcripts, This research refers the reader to the transcript book.

§7.3.3 Data analysis

The goal of data analysis is to present the findings and analysis in an orderly fashion. Therefore, data will be analysed with the help of the 3-step approach as designed in the conceptual model. This entails first analysing by defining the network of BeRoEmD by its core values and stakeholders. Second analysing the operational activities for that network. Third, analysing the regulatory activities for BeRoEmD's network.

All of the collected data will be used as input for the analysis chapter. The transcripts of the workshop and interviews will be leading data entries, supported by the researchers impressions gathered during data collection. A full overview of data sources will be given in the next section. With the help of these data sources, the network for BeRoEmD will be analysed in three steps. Starting with defining the core values for the network and what parties are present in this network. A second section analyses the operational, primary, activities the network executes in order to realise the values found in the former section. A third and final section analyses the regulatory activities needed to support the operational

activities. The goal is to be able to draw the network and formulate matrices for both the operational activities and regulatory activities.

§7.4 Data-sources

For this part, the network of BeRoEmD is the object under investigation. This stretches beyond the borders of the organization of BeRoEmD. Paragraph 7.2 detailed the data collection methods. This resulted in three data sources of data. First, for this research I have consulted with the director of the care group. In consultation, we decided to organize a workshop for all of the care providing organizations in the network. To complement the data gathered from this workshop with input from the financial organizations in the network, two additional interviews were held with the health insurers. These interviews were supported by the insurers procurement policies. This results in the following data-sources:

N	Data source	Type	Date	Duration	Abbr.
1	Director BeRoEmD	Personal interaction	16-04-2018	120	PMW
2	VGZ representative	Interview	09-05-2018	35	IMA
3	CZ representative	Interview	14-05-2018	35	IKS
4	1. Director BeRoEmD 2. Medical director BeRoEmd & GP 3. General practitioner 4. Apothecary and representative for paramedic partners 5. Quality manager BeRoEmD	Interactive workshop	17-05-2018	130	WNA
5	CZ procurement policy 2019	Strategic document	01-05-2018	-	-
6	VGZ procurement policy 2019	Strategic document	01-05-2018	-	-

Table 12: list of data sources part 2: Diagnosis of the network for BeRoEmD.

§7.5 Assessment criteria qualitative research

The measures set to uphold the criteria for qualitative research will be identical to those set in the methods section of part 1. A quick recap for the reader: This implies upholding both the positivist criteria (validity, reliability, generalizability & objectivity) and the naturalist criteria (credibility, transferability, dependability & confirmability) as described in table ?? on page ?? of this research.

In addition to the measures set there, this part of the research involves organizing a stakeholder workshop. To ensure this also satisfies the qualitative criteria, the following measures are taken. Beforehand, the workshop is grounded in a conceptual framework based on theory described in chapter 6. Also, all communication, additional information and documentation are saved and attached to this research in appendix 5 & 6. The workshop itself will be recorded and a workbook will be made afterwards summarizing the process and results of the workshop to aid the network analysis. This workbook will be shared with all participants. Participants are asked to review correctness and completeness of this workbook. Any comments will be taken seriously. Moreover, the researcher assumes the role of facilitator. A role in which he intends to uphold his objectivity, to prevent any personal biases entering the research data.

Chapter 8 Findings and analyses

§8.1 Introduction

The goal of this chapter is to diagnose the network for BeRoEmD. A diagnosis should be made for what is considered to be the network by BeRoEmD and her partners and what the core values are this network strives to achieve. Subsequent to this are the operational activities with which the network aims to realize the aforementioned core values. Followed by the regulatory activities that are needed to support and regulate these operational activities. First, a section details and reviews the data collection process. Hereafter, the network analysis for BeRoEmD is split into three sections that follow the conceptual framework as constructed in chapter 6. The first analysis section is aimed at defining the network, its core values and present parties within the network. The second section analyses the operational activities with the help of Beer's first function (F1: primary activities). The third section is devoted to analysing the regulatory activities (F2-5: coordination, control, information, policy). Both activity sections first presents the findings from data collection and then analyses these findings by diagnosing for omissions, duplications and / or fragmentation.

§8.2 Data collection process review

This section will be used to inform the reader on the process of data collection and to critically reflect on that process. The primary source of data for this network analyses is the workshop held with 5 actors from the network. Before this workshop, two separate interviews were conducted with the primary health insurers that are part of the network, VGZ and CZ respectively, in order to include their view on the network. I will detail the process in chronological order in the next paragraphs.

With the help of the director of BeRoEmD, both health insurance parties agreed to participate in this research. Representatives for both VGZ and CZ were sent a document detailing some background information about the research and research goal (Appendix 5). This document also contained a series of 8 questions and 8 statements. The respondents were asked to study this document before the interview would take place. The goal of the series of questions and statements was to activate the respondent's line of thought regarding the network. The researcher also received a procurement policy document from VGZ and CZ. Both interviews were conducted following the same questionnaire (minor adaptions related to dealing with 2 separate entities) that was constructed based on the conceptual framework supplemented with respective procurement policies. These questionnaires have been added to this research in appendix 6. Both interviews were conducted via telephone and permission was asked (and granted) to record the conversation. Both interviews lasted roughly 35 minutes in which the entire questionnaire was discussed and the respondent

was given room to elaborate. Transcripts have been drafted and respondents were asked permission before usage in this analysis.

The second method of data collection was in the form of organizing a workshop with stakeholders from within the network. The goal of this workshop was twofold; First it served the purpose of gathering data for this research, second the workshop served the purpose of bringing stakeholders within the network together and activate them to think about the future of the network. Whereas the first goal serves the goals of this research, the latter goals are mainly practical. Part 1 of this research, where a strategical assessment was conducted showed care group BeRoEmD would benefit from having its partners more actively involved. This could provide the care group with ammunition to bring about desired change.

For this workshop, it would have been ideal to have at least one emissary from each care providing party active in the network. Unfortunately, this wasn't deemed feasible. The course of the workshop would be more beneficial at a participant count ranging somewhere between 4 and 8 people. Therefore, in conclusion we decided to invite 2 GP's and an emissary representing the other chain partners, supplemented with the care group's quality manager and managing director. Participation from these people was arranged via the managing director. All participants received an e-mail detailing the whereabouts, time constraint and further practical details for this workshop 3 weeks in advance. This e-mail also contained additional information regarding the goal of this research, background information and a set of 8 questions and 8 statements to activate their line of thought. Participants were asked to read this document in advance and prepare their answers as well. A few days prior to the workshop, one of the participating GP's cancelled. To solve this, the medical director of care group BeRoEmD, whom is also a GP, was invited to substitute for her in the workshop.

The workshop was held during lunch break from 12.00 to 14.00 at the office of Marcel Rombeek. The workshop was divided into 4 parts; first a general introduction of the research followed by explaining some of the theory used (mainly Beer's 5 functions). Second, the participants were asked to define the network in terms of core values and actors within the network. Third, participants were asked to define operational activities of the network and how these were distributed. Fourth, and finally, the participants were asked about the regulatory activities within the network and their distribution. A remark should be made concerning recursion. During the workshop, the recursive nature of analyzing systems sometimes got in the way of productivity. Each party could be identified as its own system, and they have their own primary activities, sometimes that intertwined for the respondents leading to answers that were harder to interpret. The workshop was concluded with a summary and information of what would be done with the data. After the workshop, the researcher has drafted a workbook for all participants. This workbook served as report on what was discussed and what was achieved during the workshop (Appendix 8).

§8.3 Findings and analyses

This section presents the findings from the data collection process in conjunction with analysing the network for BeRoEmD. Data from all sources has been gathered and will be used to support this analysis. For a full overview of the collected data, This research refers the reader to Appendix 5, 6, 7 and to the transcript book.

The findings and analyses sections are built in accordance to the 3-step approach: The first section details the defining of the network, dealing with the question what are the core values of this network and what parties are part of the network. The second section details the operational activities found for this network and the distribution of these activities. The third section details the regulatory activities found within the network and their distribution. For all sections, I will first present the findings gathered from the workshop supplemented with data from the interviews where possible. If any conflicts or ambiguity arises between either of these data sources, this will be detailed.

§8.3.1 Defining the network's core values & actors

This section provides the findings and subsequent analysis for the first step of the 3-step approach: defining a network by its core values and stakeholders. First the core values are discussed, followed by the actors within the network. After presenting all findings, diagnosis is discussed.

Core values of the network

After identifying which parties are present in the care network BeRoEmD and in what capacity, core values of this network were under investigation. The current mission for the care group BeRoEmD, as taken from care group website, reads as follows:

> *"De leden van zorggroep BeRoEmD willen kwalitatief goede, doelmatige en nabije eerstelijnszorg voor chronische ziekten leveren aan de bevolking binnen het huidige en toekomstige werkgebied."*

During the workshop, using NGT brainstorm techniques, all participants were asked to write down the values they considered core values for the network. After several minutes we compared notes. All participants agreed that providing care to the patient was the core activity for the network. This care should meet the following core values:

- *Quality*
- *Continuity*
- *Close by*
- *Low threshold*
- *Accessible*

- *Integrated*
- *Efficient*
- *Affordable*

Combining all of the core values, the workshop resulted in the following statement:

> *"Het zorgnetwerk BeRoEmD moet geïntegreerde zorg leveren die tegelijkertijd van voldoende kwaliteit is, laagdrempelig, toegankelijk, efficiënt, terwijl deze continu en betaalbaar is"*

The health insurers supplemented these goals with:

- *Effective*
- *Able to meet contract conditions*

Actors in the network

After defining the core values of care network BeRoEmD, all respondents were asked what actors or parties they considered part of the network we were about the analyze. Table ?? on the next page summarizes the final list of actors within the network. First off, we had to differentiate between care group BeRoEmD as an organization and the care network BeRoEmD, the network we were analyzing. In which the care group is an actor within the care network. Next to the care group, the following parties have been identified as actors in the care network BeRoEmD.

First, we can identify a group of parties acting in a care providing facility. We can identify a direct care relation between the following parties and patients. 12 General practitioners are currently affiliated. Other chain partners fall under the category paramedics. Paramedics is the collective term for, among others, dieticians, physical therapists, podotherapists, occupational therapists, psychologists, and radiologists. Apothecaries are also present within the network, a group that is also unified via the apothecary association. Moreover, GPs use diagnostic centres to test patients for various illnesses. Next are the *kaderartsen,* GPs with a specialization in a certain area of expertise. These specialized Gps practice medicine, but also set the frames for relevant schooling opportunities. Lastly, the Jeroen Bosch Hospital is the regional hospital providing secondary care.

The second group of actors actors are on the financial side of the care network, but are also in contact with civilians, because they want to insure themselves. This group is formed by the health insurance companies CZ and VGZ. These 2 insurers are leading in the region for BeRoEmD. Other health insurers are obligated to follow the contracts signed with one off the above in the case a patient is insured elsewhere.

A third group was created, in which parties were identified to be in the network in some form, but not in a direct relation or active role. This group consists of other care groups in the region, most notably

Chronos. In some occasions resources are shared or schooling is coordinated together, but they remain a separate entity. Home care organizations (e.g. Vivent) are affiliated with the network when needed, but are not actively involved in the network's activities. Furthermore, local government in the form of municipalities fall in this group. Just as other unaffiliated GPs and other associations like InEen and LHV. These parties sometimes interact with the network, but are not actively *in* the network.

Last, but not least, we identify the patient / civilian as an active member of the care network. After all, without patients this network would lose all of its purpose. Patients are considered client of the care providing parties and clients of the health insurers, making them the client for the majority of parties in this network.

Actively present	**Passively present**
Care group BeRoEmD	Hospital Jeroen Bosch
General practitioners (affiliated)	Other care groups, in particular Chronos
Praktijkondersteuners (POH)	Home care (Vivent)
Paramedics*	Municipality
Apothecaries	Other, unaffiliated, GP's
Diagnostic centers	Other associations (e.g. Ineen, LHV)
GP with specialization (Dutch: Kaderarts)	
Health insurers: CZ & VGZ	
Patients / civilians	

Table 13: list of parties that can be identified as present in the care network BeRoEmD, divided between actively present and passively present.

Conclusions

All parties have given input on what they consider core values for care network BeRoEmD. This has led to several lists of core values and several statements concerning the core values. An effort to combine all of the above leads to the following core value statement for the care network BeRoEmD:

> *"The care network BeRoEmD should provide integrated and qualitative chronic care that is close by, accessible, with a low threshold, effective and efficient, whilst maintaining affordable and able to meet contract conditions for both the patient and its members within the current and future working area"*

Furthermore, we can identify certain groups of stakeholders and identify their relation in and with the network. We have all the care providing parties (GP, paramedics, apothecaries, etc.), health insurers (CZ & VGZ) with care group BeRoEmD in between as the three biggest groups identifiable. Some other stakeholders are present in the network; POH's and specialized GPs are given their own place. Lastly, several parties interact with the level on in a passive way; only on some occasions and no direct active involvement. This leads to the following sketch of the network.

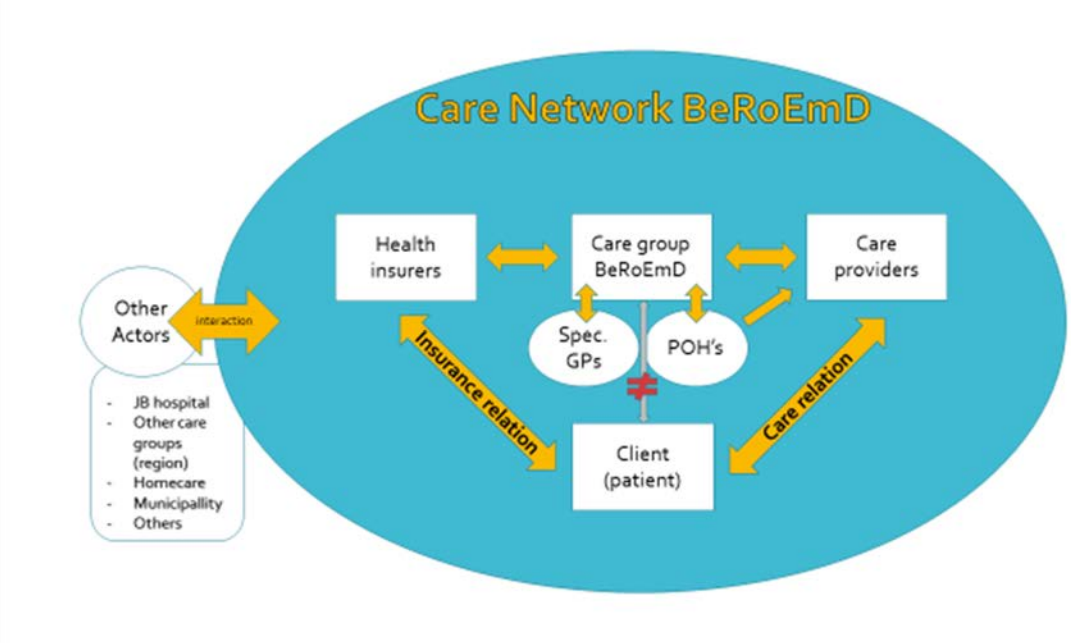


Figure 11: graphical representation of the care network BeRoEmD.

The yellow arrows indicate relations between different actors of the network. 2 distinct direct relations can be found with the client. First, health insurance companies have an *insurance relationship*. Customers pay the health insurer in order to receive care as contracted. The second direct relationship can be found between the care providers and client. This is defined as the *care relation.* The client receives care specific to his or her illness from one or more of the care providers present within the care network. Noteworthy is that care group BeRoEmD does not have a direct relationship with the client. This lack of relationship was already hinted at in the strategic part 1 of this research and is now confirmed. The care group itself does not have a customer relationship with patients, but should rather view the health insurers and care providers as its customers. Moreover, the care group can be considered the mediator for this network. This means most interactions are with or through care group BeRoEmD. The care group has interaction with all members of the network and most of the indirect parties that can be linked to the network.

§8.2.2 Operational activities

This next section is devoted to presenting and analysing the findings for the second step of the 3-step approach; operational activities for the care network BeRoEmD. First all findings are discussed, followed by a diagnosis of the operational activities.

Findings and distribution for operational activities

With regard to the question *" what is the primary operational activity for care network BeRoEmD"* , all respondent answered unanimously. The primary activity of the care network is *to provide care*. To gain deeper understanding of this activity, respondents were asked what they understood by providing care. In the case of care group BeRoEmD, care can be considered chronic care. Chronic care can be broken down into several segments: Diabetes, COPD/asthma, CVRM, GGZ, elderly care and a category for others. The first three segments have been established since the early years of the care group. GGZ and elderly care are a trend noticeable recent years. Furthermore, it is possible that patients are part of one segment, or multiple segments if that patient suffers more than one chronic illness.

To further narrow down the providence of care and how activities are distributed proved to be a difficult task as processes within and between these segments are highly diverse and case specific. What could be defined was the general path a patient walks in the chronic care. 99% Of all patients that enter the care network via a GP. A GP is responsible for diagnosing the patient, after which he draws up a treatment plan. In some cases, other chain partners are involved at this point. For instance, some patients diagnosed with diabetes are sent to the dietician to evaluate his or her food intake and lifestyle. In other cases, an occupational therapists or pedicure might be involved depending on the patient's ailments. After executing treatment, treatment and results have to be analysed for desired effects. If the outcome is positive, treatment is continued. If the outcome is negative, the treatment plan has to be altered or a new plan entirely has to be drafted. Finally, the process should evaluated. Evaluation benefits both patient and care provider.

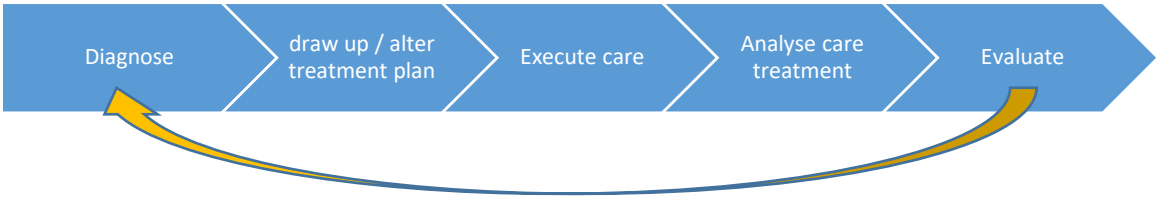


Figure 10: General overview of primary activities of the care network BeRoEmD.

Diagnosis

F1: Primary activities		Actors within the network												
		1. BeRoEmD	2. Patients	3. Health Insurers	4. GPs	5. POHs	5. Paramedics	6. Apothecaries	7. Diagnostics	8. Specialized GP	9. JB Hospital	10. Home care	11. Municipallity	12. Other*
1	Diagnose patient				X					X				
2	Create treatment plan		X		X					X				
3	Execution of care				X		X			X	X	X		
4	Analyse care				X	X	X			X				
5	Evaluate		X		X	X	X			X				
6	Supporting care activities					X	X	X	X	X	X	X	X	X
7	Hold meetings / schooling	X												
8	Negotiate & contract	X		X										

Table 14: Primary activities and distribution care network BeRoEmD

The operational activities are the primary activities by which the network strives to realize this core value statement. For the care network of BeRoEmD, the main operational activities are considered the actual providence to clients. This can be segmented into 6 streams based on the illness of the patient: diabetes, COPD/asthma, CVD, GGZ, elderly care, other. It is possible that clients are member of multiple segments, due to multimorbidity. The primary activities directed at providing care are entirely distributed among the care providers of the network. The biggest task load lies with the GPs, followed by paramedics. The apothecaries indicate that this professional group could decrease the workload of GPs if given a more extensive mandate to prescribe medicine to patients. The representative for apothecaries argues that the knowledge is already present within the apothecaries to diagnose a lot more patients and directly provide them with the correct medicine, instead of these patients having to see their GP first. It is difficult to analyze this primary activity in detail any further, due to limited data. The diversity of illnesses, possible treatment options and care providers lead to believing that depth on the care providing activities was too big of a topic to discuss in the workshop.

Besides providing care, two more primary activities have been identified. The first activity is that of holding and attending meetings / schoolings. To ensure quality of service and product, everyone in the network has to keep up with developments in the environment. This means that the actors have to keep developing themselves as well. The care group is responsible for holding these meetings, whereas the other partners are responsible for attending them. These meetings can be of various natures. Schooling for example, but also networking, acquainting, evaluating can be considered productive meetings. The second additional primary activity is the negating and contracting of care agreements. This is a activity between health insurers and the care group. Having two prominent insurers in the region puts extra stress on the

workload of the care group, because they have to do everything in twofold, with parties that can differ in opinion on important topics.

Conclusion

The primary activities for care network BeRoEmD imply a few chances for disturbances. First of all, the risk of omissions, duplications and fragmentations are present in the treatment op patients when multiple care providers are connected to the same patient. Fortunately, coordination and policy seem to have reduced this risk significantly. Another issue directed at the primary activities is related to omissions of analyzing and evaluating treatment. Policy is made to ensure both activities are executed. However, due to heavy workloads from the care providers, this is still open to omissions as this is one of the first things that might be postponed. A final direct occurrence of duplication can be found in the negotiating and contracting activity, because care group BeRoEmD deals with not 1 but 2 prominent health insurers in this region. Each insurer has their own procurement policy, provides different payments and has unique demands. This results in double the work for care group BeRoEmD, considering they have to organize double the meetings, do the negotiations with both parties and perform the calculations for budgeting twice. Both health insurers have indicated that they realize this extra workload for the management of the care group, yet changing the situation is no real option.

§8.2.3 Regulatory activities

Finally, this section presents and analyses the findings for the third step of the 3-step approach: regulatory activities for the care network BeRoEmD. The regulatory activities are captured with the VSM-functions 2 through 5; coordination, control, information and policy. This section will first discuss findings and diagnosis per function, starting with coordination, and ends with a conclusion for the regulatory activities as a whole.

Coordination findings

The responsibility for and executing of coordinating activities within the care network are primarily tasked to care group BeRoEmD. The network requires a lot of ICT support in order to coordinate and communicate properly. The care group is tasked with facilitating the required ICT. Moreover, the care group is responsible for the division of tasks / labor for all of the care providing partners. Also, the care group has to connect all its partners to each other and bring them in contact with one another. The care group distributes important information and news updates concerning the relevant parties. Lastly, the care group organizes meetings and schooling for partners in the network to keep everyone up-to-date and informed. For this last item, the specialized GPs are often involved, because they have set out the guidelines for this schooling opportunity. POHs might be involved to, to help plan and coordinate. In some cases, other chain partners are involved, because the schooling initiative came from them, but this is only on a rare occasion.

Diagnosis

F2: Coordination		Actors within the network												
		1. BeRoEmD	2. Patients	3. Health Insurers	4. GPs	5. POHs	5. Paramedics	6. Apothecaries	7. Diagnostics	8. Specialized GP	9. JB Hospital	10. Home care	11. Municipallity	12. Other*
1	Facilitate ICT services	X												
2	Division of tasks	X												
3	Connect partners	X												
4	Distribute information	X												
5	Organize meeting / school	X				X				X				
6	Redirect patients				X	X	X				X	X		

Table 15: Coordinating activities and distribution care network BeRoEmD

Coordination activities in the care network BeRoEmD are highly distributed towards care group BeRoEMD. It is responsible for nearly all activities that were defined during data the workshop and interviews. In some occasions, this responsibility for execution is shared with a second party from the network. The activity of organizing meetings and schooling, for instance, is shared with specialized GPs because they are the ones

responsible for reporting schooling opportunities (see information function) and should therefore be involved in the coordination task as well.

Redirecting patients is a coordinating activity performed by the care providers of the care network. This activity can sometimes lead to issues regarding omissions or duplications for the providers if multiple care providers are involved in their treatment. An example is given during the interview whereas it was unclear who was responsible for contacting a patient after the GP decided a patient needed additional treatment from a paramedic. Moreover, this activity can lead to fragmentation in the eyes of the patient. The care providers and care group BeRoEmD can counter perceived fragmentation by effectively coordinating task division and keeping to protocols.

Control findings

The control activities span from measuring performance, assessing performance, evaluating performance and, if deemed necessary, adjusting activities. Measuring and assessing activities are mainly performed by care group BeRoEmD. The evaluation and adjustments that follow from evaluation is a joint operation by the care group and involved chain partners. The health insurers play a role in controlling activities as well. They evaluate performance and compare this to the negotiated contract agreements. These activities all focus on are we doing the things we do well? Besides activities, the control function also evaluates whether the activities are good in the first place. This activity is taken up by evaluating protocols and activities together. Care group BeRoEmD, again, plays a crucial role in this activity as it has the best overview of the entire network. However, both the health insurers and the care providing partners have indicated that this is partly their responsibility as well during the interviews and workshop. It can be said that all of the network partners are responsible for controlling, yet care group BeRoEmD is the actor that has to coordinate and facilitate this control.

Diagnosis

F3: Control		**Actors within the network**												
		1. BeRoEmD	2. Patients	3. Health Insurers	4. GPs	5. POHs	5. Paramedics	6. Apothecaries	7. Diagnostics	8. Specialized GP	9. JB Hospital	10. Home care	11. Municipallity	12. Other*
1	Measure performance	X				X								
2	Assess performance	X				X								
3	Evaluate performance	X		x	x	x	x	x						
4	Adjust activities	X												
5	Evaluate protocols	X		x	x	x	x	x						

6	Negotiate with information	X												

Table 16: Control activities and distribution care network BeRoEmD

The control activities for care network BeRoEmD are again highly distributed to care group BeRoEmD. BeRoEmD is involved in all controlling activities that have been identified during data collection. That indicates that the care group also performs both elements of control; *inside* and *now* controlling the performance of activities for the network and *outside* and *then* controlling the fit of activities and goals for the network. With regard to evaluating performance and evaluating protocols, other parties are involved as well. For evaluating performance of the network, the health insurers have a controlling role, because they do not want to overpay for care nor do they want bad quality of care. The care providers on the other hand primarily want to maintain high quality of care whilst also maintaining quality of work. In the end, it is the care group that does most of the evaluation activity, after which it reports outcomes to the network. With those outcomes, decisions are made regarding continuation, adjustments, or termination of other activities.

Possible issues detected in the controlling activities are connected to the passive attitude most other parties have with their control responsibilities. They are reliant on the care group to perform the control function, whereas they themselves could pick up more of this responsibility and take matters into their own hands in some cases. After all, it is better to prevent than to cure.

Information findings

The activity of scanning the environment for new opportunities and trends that could be adopted by the network is a joint effort by care group BeRoEmD and the specialized GPs. Most law and regulations developments impacting the care network are monitored and handled by the care group, whilst specialized GPs monitor and handle care related developments. In some occasions, a regular GP, paramedic or other chain partner introduces an opportunity from the field. Other developments are mostly divided by theme as to which partner coordinates this information. Most care providers have expressed that they want to be involved in this process, yet the same care providers also acknowledge that they should take up a more active role in this themselves as well. These statements seem to contradict themselves. However, both can be present at the same time. After all, cooperation needs both sides. This means that care providers should take their responsibility and try to be more active in scanning the environment plus actively inquire about current topics. On the other hand, the care group could involve the care providers a bit more in their process of scanning the environment and developing innovations. For instance, some schooling opportunities could benefit more partners than have been invited to previous meetings. The care group could have asked whether the other partners deemed attendance beneficial.

Diagnosis

F4: Information		Actors within the network												
		1. BeRoEmD	2. Patients	3. Health Insurers	4. GPs	5. POHs	5. Paramedics	6. Apothecaries	7. Diagnostics	8. Specialized GP	9. JB Hospital	10. Home care	11. Municipallity	12. Other*
1	Identify trends	X			x	x				X				
2	Draft innovation plans	X								X				
3	Negotiate with control	X								X				

Table 17: Information activities and distribution care network BeRoEmD

In care network BeRoEmD, information is a shared activity between care group BeRoEmD and the specialized GPs, with an occasional execution by regular GPs or POHs. The care group mainly scans the environment for law & regulation, financial, privacy, and overall developments. Whereas the specialized GPs scan the medical environment for developments within their own care specialization. As mentioned, in some occasions a GP or POH inputs a development open for innovation from the work field.

No impacting issues have been found within the data concerning omissions, duplications or fragmentation. However, the researcher is under the impression that tighter coordination of the information activities might lead to a more streamlined process.

Policy findings

The policy function is primarily executed by care group BeRoEmD. The care group is responsible for drafting contracts and protocols that are vital to the performance of the care network's primary activities. It is, however, desirable that the care group consults with the other parties in the process of setting policy. Health insurers have requirements that need to be met and care providers have to be able to meet these requirements. Moreover, participants of the workshop indicate that the network should not be flooded with policy. They value enough freedom to perform their activities their own way within certain preconditions. This way, professional autonomy is guaranteed whilst the network meets the core values as defined in the first section of this analysis.

Diagnosis

F5: Policy	Actors within the network												
	1. BeRoEmD	2. Patients	3. Health Insurers	4. GPs	5. POHs	5. Paramedics	6. Apothecaries	7. Diagnostics	8. Specialized GP	9. JB Hospital	10. Home care	11. Municipallity	12. Other*

1	Set care protocols	X		X										
2	Set communication protocols	X												
3	Distribute protocols	X												
4	Uphold protocols	X												

Table 18: Policy activities and distribution care network BeRoEmD

Within the care network BeRoEmD, it is mainly care group BeRoEmD that is responsible for making policy for the rest of the network. This policy, however, is driven from a higher level in a lot of instances. Law and government oppose a lot of policy to which the network is subjected. The care group is the executing party for transforming this opposed policy to network policy as a whole. Moreover, the health insurers are subject to plenty policy themselves, which they in turn oppose on care group BeRoEmD in the negotiating and contracting activities. When contracted, the care group has to distribute this policy to the care providing parties.

There is a small risk of duplications for the policy function considering law and regulation is often updated and both the care group and health insurers might investigate their options without conferring with the others. The opposite might occur as well, leading to omission, where all parties are under the impression that someone else is responsible for drafting policy on that issue. There are no fragmentations found for policy.

Conclusions regulatory activities

The regulatory activities have been diagnosed using the VSM functions by Beer. For each of these functions findings indicate an important role for care group BeRoEmD. The care group performs a pivotal role in the coordination, control, information and policy activities from care network BeRoEmD. This is a shift compared to the operational activities, whereas most responsibility was distributed to the care providing partners. For each of the regulatory activities, care group BeRoEmD is appointed to take the lead. This is a role the care group itself is aware of and propagates. During the workshop, other partners were aware of this distribution as well, yet seemed not to consider the importance of these functions for the performance of the network. Creating the awareness of the gravity these functions have within the network was part of the practical goal of this research and we seem to have succeeded in doing so.

Diagnosing for omissions, duplications and fragmentations led to the following results. The care group performs most of the regulatory activities. The majority of coordinating activities are performed by the care group, with the exception of redirecting patients. The latter activity is performed solely by care providing partners. Because of this distribution, chance of duplications and fragmentations is low. Omissions could occur in the case of miscommunication or lack of communication between the care group and other partners. For all controlling activities the care group is the leading partner, but evaluation is

expected from the other partners as well. Data shows chance for omission and fragmentation, but no real cases could be found during the workshop or interviews. The information function is a collaboration between the care group and specialists in the field. The specialists are responsible for detecting opportunities related to care, the care group is responsible for all other developments as well as follow-up activities. Chances for duplication and omission is present, considering both parties might assume the other takes up responsibility. Finally, the policy activities are, again, distributed heavily towards care group BeRoEmD. A note should be placed at the responsibility of other chain partners to check and uphold policy made by the care group. This is where chances of omissions reside for this activity. Omissions could occur when the care group overlooks certain issues or topics.

Chapter 9 Conclusions part 2: Diagnosing BeRoEmD's network

Network research questions:

- *What does existing literature say about networks and network performances?*
- *What is the network for BeRoEmD and how does that network perform?*
- *To what extent does the network of BeRoEmD perform as desired?*

§9.1 Introduction

This chapter concludes part 2 of this research. The goal of Part 2 was to diagnose the network that care group BeRoEmD is part of; the care network. The previous chapters have constructed and employed a conceptual framework to fulfil the goal of diagnosing the care network we call BeRoEmD. Diagnosing the network was done in three phases with the 3-step diagnosis model. First, the network was defined by determining the core values for the network and, subsequently, identifying the actors within the network. The second phase consisted of mapping the operational activities with which the network intends to realise the previously determined core values and the distribution of the primary activities within the network, and ended with diagnosing for possible disturbances. Third, the regulatory activities that support and manage the operational activities have been mapped for the network alongside their distribution within the network and also diagnosed for possible disturbances. In accordance to the goal of diagnosing the network for BeRoEmD, this chapter will draw up the conclusions for this part of the research.

§9.2 Conclusions

§9.2.1 The Network

Combining all of the findings on core values for the care network BeRoEmD has led to the following aggregated core value statement for the care network BeRoEmD:

> *"The care network BeRoEmD should provide integrated and qualitative chronic care that is close by, accessible, with a low threshold, effective and efficient, whilst maintaining affordable and able to meet contract conditions for both the patient and its members within the current and future working area"*

Moreover, by organizing a workshop with care group BeRoEmD and several care providers, supplemented by interviews held with both health insurance companies an overview of all stakeholders for the network and how relevant relations can be made. A graphical representation of the care network for BeRoEmD was shown in figure 11.

§9.2.2 Operational activities

The dominant primary activity for the care network BeRoEmD is to actually provide care to the chronically diseased patients within the region. The process of this activity entails: diagnosing, drawing up a treatment plan, executing care, analyzing care and success of treatment, evaluate treatment. Furthermore, this activity is segmented into 6 streams, based on the clinical picture of each chronic illness. The distribution of care providing activities are subjected to what care is required for the disease and where in the region the patient enters the network. As one of the core values is to provide close by and accessible care, a patient is assigned to the nearest care provider. A second and third primary activity is identified for the network as a whole. Holding meetings / schooling and the negotiating and contracting activity. The first activity is a primary activity for care group BeRoEmD, as it is responsible for organizing these kinds of meetings. The second primary activity is distributed among the care group and the health insurers CV and VGZ.

§9.3.3 Regulatory activities

The regulatory functions are those of coordination, control, information and policy. These activities serve to manage the primary activities in ways that we are able to realize the core goals. Moreover, these functions serve to keep the core goals and methods are still in line with the desirable outcomes. In the care network of BeRoEmD, the data shows that regulatory activities are distributed predominantly to care group BeRoEmD.

The care group is in the center of the regulatory activity. For coordination, the care group facilitates the ICT-resources the network uses for communication, documentation, declaration and much more. The control activity is a responsibility for all actors in the network, but again should be coordinated by care group BeRoEmD. The information activity is a joint operation between the care group and specialized GPs,

where sometimes proposals for innovation come via other partners from the field. Lastly, the activity of policy making and maintaining is a shared function between care group BeRoEmD and the health insurers. The contracts signed between these two parties set the boundaries for healthcare policy. Furthermore, the care providing partners indicate they desire to enjoy a high degree of professional autonomy within these borders as long as results are made.

In summation, the regulatory activities for care network BeRoEmD are heavily distributed to care group BeRoEmD. However, the care group should involve the other parties whenever this is relevant in regulating activities. For example, the planning and creation of schooling is done in conjunction with specialized GPs. Moreover, the care providing parties would appreciate it if they were more actively involved in policymaking.

Chapter 10 Conclusion, discussion and limitations

§10.1 Introduction

This is the final and concluding chapter of this thesis. The goal of this chapter is to conclude this thesis by informing the reader by presenting conclusions, reflective discussion and limitations of this research. Therefore, this chapter first quickly summarizes the research thus far and repeat the goal and research question formulated in the introduction of this research. The following section is devoted to answering this research question in order to draw conclusions for this research. After concluding, a section is devoted towards discussing the research. This section contains a reflection on theory, methods and process. A fourth section discusses the limitations of this research and possible recommendations are given.

§10.2 Summary

This thesis investigated the strategy and network relations for BeRoEmD. BeRoEmD is a care group in the region of ‘s Hertogenbosch. Care groups have taken a prominent role in coordinating and mediating within the chronic health care sector. A sector that deserves more attention, considering over a third of the Dutch population suffers from at least one chronic disease as of 2014, and even 65 per cent among just the elderly. Traditional health care organization is not well suited to facilitate this chronic care and therefore, a new approach was taken with the help of care groups. Now, ten years after introducing these organizational constructs, BeRoEmD requested an assessment of its strategy and the network relations. This has led to the following research goal for this thesis:

Research goal: “T*o contribute to the practical challenges of care group BeRoEmD by gaining insights in the formal correctness of care group’s strategy and the network situation of the care group.*”

To arrive at these insights and attain the research goal, this thesis is structured in two parts. The first part is directed towards a formal evaluation of BeRoEmD’s strategy and the second part aims to diagnose the network BeRoEmD is part of. Each part is underpinned with a conceptual chapter constructed by extensive study of relevant literature. To formally evaluate the strategy for BeRoEmD, this research used several business models available in literature and combined these to the conceptual business model as presented in figure 9. This business model was used to evaluate the completeness and consistency of BeRoEmD’s strategy. To diagnose the network for BeRoEmD, Beer’s viable systems model was used to define activities of the network and their distribution among actors within that network. Research methods for both parts of this research are comparable. The strategic evaluation made use of document study supplemented with a

series of interviews with the management of BeRoEmD. The network is diagnosed by conducting interviews with the health insurance parties and by organizing an interactive stakeholder meeting with the health providing parties. The interviews and meeting are also underpinned with a set of documents available beforehand. This leads to presenting the results for each part individually in the respective findings chapters. The following section connects the results of both parts to answer this thesis head research question.

§10.3 Conclusion to research question

Head research question:
"What is the strategy and network for care group BeRoEmD, to what extent is that strategy correct and robust, and how well does that network perform?"

Strategic correctness evaluation

The formal correctness of BeRoEmD's strategy product is evaluated by assessing the completeness and consistency of the strategic data found. A strategy product can be broken down in to a set of business model elements. In total, 11 elements were taken into this research's strategic evaluation that are tested on completeness, internal consistency and external consistency. After assessing each element individually, the formal correctness of strategy for BeRoEmD can be evaluated.

All of the 11 business model elements are present within the strategy by BeRoEmd and therefore the strategy is deemed complete. However, it is noteworthy that some elements are more prominently present than others, considering the richness and distribution of data. In comparison, the strategic elements of learning, measurement and finance were far less detailed within BeRoEmD's strategy than value, activities, resources and partners.

The evaluation of consistency resulted in several noteworthy findings with a couple of inconsistencies that certainly impact BeRoEmD's strategy and the ability to achieve the strategic goals. The red flags due to inconsistency were found in the financial and customer elements. Financially, the care group is hindered by the allocation of financial resources as imposed by the health insurers. Mainly considering the huge impact ICT-related costs have on the budget for BeRoEmD. Due to tight budgets, other elements such as resources, measurement and learning are put under stress. This inconsistency thus affects the majority of the strategic capabilities in kind of a ripple effect. These findings are in line with earlier research conducted by Busetto et al (2015) that indicate economic, political and IT-related hindrances were encountered most frequently as strategic barriers for care groups in the Netherlands. Unfortunately, budgeting is not something BeRoEmD itself can easily change, considering its relationship with health insurers and current regulation. The care group has to make do with the current budget. Careful consideration of what is most important is deemed a necessity. The second red flag found in BeRoEmD's strategy revolves around whom the care group considers to be its actual customer. The data proves to be ambiguous on this topic. Part of the data

presented patients as customer. However most of the later data and interviews points out that BeRoEmD does not actually have a direct relationship with the patient. Rather, BeRoEmD enables the care providers to serve the patient. Thus the customers for BeRoEmD are the care providing parties, such as general practitioners and other paramedics. BeRoEmd should arrive at an unambiguous answer to this question to strengthen her strategy and subsequent activities efforts.

In conclusion, the strategy as found for BeRoEmD is evaluated as formally correct by this research. However, a number of important points for consideration or improvement have been brought to the attention. BeRoEmD should focus on solving the inconsistencies that were encountered within its strategy in order to strengthen that strategy. This will benefit the care group's activities and subsequently the overall performance of chronic health care for this region.

Network diagnosis

The network for BeRoEmD was diagnosed through a series phases. Starting by defining the network, followed by analyzing that networks operational activities and that networks regulatory activities and the distribution of all activities within and among the defined network. This diagnosis is grounded by Beer's (1985) viable systems model supplemented with the recently developed diagnosing framework by Nieuwkamp and Achterbergh (2017).

Defining the network results in a graphical representation of the network exposing what parties are part of the network and how they relate within the network. We call this network *care network BeRoEmD.* A distinction has to be made from between care group BeRoEmD, which is an organization within this care network. Moreover, this phase results in the following core value statement for the network: *"The care network BeRoEmD should provide integrated and qualitative chronic care that is close by, accessible, with a low threshold, effective and efficient, whilst maintaining affordable and able to meet contract conditions for both the patient and its members within the current and future working area"*.

Following the core value statement for the network, this research diagnoses the operational activities with which the network intends to fulfill the core values. The operational activities are considered the first function of the viable systems model: primary functions. The main primary functions of care network BeRoEmD consist of all the care providing activities towards the patient. Providing chronic care can be segmented by illness, resulting in six segments: diabetes, COPD/asthma, CVD, GGZ, elderly care, other. It is possible for a patient to be part of more than one segment when he or she suffers from multiple chronic diseases. This is called multimorbidity. The distribution of care providing activities resides completely among the caretaking parties. The majority of patients enter the network via a general practitioner and other caretakers are involved in accordance to the treatment plan. All patients must be insured to receive treatment, however this is regulated by law in the Netherlands and therefore not considered a primary activity for the network, but rather a passive duty for health insurers to check this. Diagnosing the care

network primary activities also confirmed the relationship, or lack thereof, between care group BeRoEmD and the patient. There is no direct relationship between these two, patients only interacts with health insurers and care providers. Implying the care group should not consider patients as its customer, but rather establish the health insurers and care providers as its customers and devise its strategy accordingly.

Two more primary activities are established within the care network; holding meetings / schooling plus the negotiation and contracting of chronic care. Meetings and schooling are required to keep everyone in the network up to date on the latest developments and knowledge. Holding these meetings is a responsibility for care group BeRoEmd, whereas attendance is a responsibility for care providers and in some cases health insurers. Lastly, the negation and contracting of care programs is a activity between care group BeRoEmD and the health insurers. In this region, two health insurers are prominent; CZ and VGZ. In most regions of the Netherlands, only one insurer is prominent and the other insurers have a follow policy. Having two prominent health insurers results in double the work for care group BeRoEmD, as the care group now has to negotiate and contract with two separate parties instead of one. This leads to more meetings, paperwork and workload for personnel of the care group.

The regulatory activities are constituted by the remaining functions of the viable system model: coordination, control, information and policy. All findings endorse the pivotal role care group BeRoEmD has in all of these activities. The care group is the so-called ‘spider in the web’ that facilitates and brings together all parties within the network. The care group is responsible for the division of work, facilitating and management of ICT-resources, setting and upholding quality standards, detecting opportunities for schooling and actually organizing schooling and many more regulatory activities. The prior strategic evaluation indicated that the care group is aware of this role, yet suffered from a lack of acknowledgement from other parties within the network, mainly from general practitioners. During the workshop, this topic was discussed. This resulted in awareness from general practitioners that they should be more open towards the care group’s input and initiatives. On the flipside, care providers would like to be more involved in the process of setting policy themselves. This is a two-way street. On the one hand, the care group should strive to include the other parties in the process of policy-making. On the other, the other parties should put effort into actively informing with the care group.

Overall, the distribution of activities is clear among parties within the network. Operational activities are to be executed by care providing parties, with the exemption of holding meetings plus the negotiation and contracting of care programs. The latter activity is between health insurers and the care group. The regulatory activities are mainly a responsibility for the care group, yet the other parties should be actively involved in many cases by the care group. In return, the other parties should take effort to be involved themselves. The care group should be given the mandate to execute the regulatory activities. This is done by the care providers in general, but practice points out that the care group is still undermined in some cases.

§10.4 Implications

This section will first discuss the theoretical implications of this research, followed by discussing the managerial implications.

Theoretical implications

In this section, this research elaborates on the theoretical implications of this research. A total of four implications come forth from this thesis.

1. This research has studied the plethora of business models that are available within strategy theory. After studying the multitude of models available, this research compared and analyzed the similarities, differences alongside strengths and weaknesses of each model as can be found in appendix 2. This has led to an adaptation of the business model canvas (Osterwalder & Pigneur, 2010) that is supplemented with characteristics from the other available theories. This model was further adapted towards analyzing strategy within the health care sector with the help of the Chronic Care Model (Wagner, et al., 2001). However, the elements taken from the CCM are only for the researchers information. The model, as is, can be used to analyze strategy products in the future in various sectors due to its broadness and overall use.
2. Results from the strategic phase of this research are congruent with earlier research conducted on care groups for the chronic health care sector in the Netherlands (Busetto, Luijkx, Huizing, & Vrijhoef, 2015). Earlier research showed that the strategic aspects of learning, measurement and community were less prominently or not present at care groups. This proved to be true to some extent in the case of care group BeRoEmD, yet aspects of all aspects were present. Moreover, the barriers addressed by Busetto et al (2015). proved to be present at this care group as well. A finding that adds to the base of knowledge we have on the topic of care groups in the chronic care.
3. The network analyses phase of this research made use of a recent article that proposes a framework that aids researchers in analyzing the network's quality of work and quality of care. This framework was, albeit adapted, put to the test empirically. The notions introduced by the authors that draw upon Beer's (1985) viable system model proved to be highly user friendly for the researcher. However, the framework was not used to its fullest potential, due to not being able to compare norms versus factual values. A shortcoming discussed earlier in the limitations section.

Managerial implications

As this research was conducted in association with care group BeRoEmD, managerial implications are predominantly directed towards this care group. This section first presents two managerial implications directed at care group BeRoEmD in particular, followed by a general managerial implication.

1. The strategic evaluation showed that the care groups strategy to be complete. As mentioned in the section above, data showed findings on all eleven business model elements. However, a couple of elements recorded far less data than others. Now that the care group is aware of this, they can strive to further complete and strengthen its strategy. Furthermore, certain inconsistencies were found in the strategy that might impact the organization negatively in the future if not addressed. Awareness of these inconsistencies is the first step towards solving them, if possible.
2. The network analysis has mapped the network care group BeRoEmD is a part of, together with her partners. This joint effort was organized to help the care group gain momentum towards its strategic goals. The practical goal of organizing an interactive stakeholder meeting was to make the care providing partners realize the distribution of activities within the network. This research argues this goal was met, considering some of the statements during and after the workshop. The workshop created the awareness that the care group is the organization needed for regulatory activities, whereas the care providers should focus on the primary activities. One end cannot function properly without the other, implying the partners need each other to let the network function as intended and meet the core values that were set.
3. The findings in both the strategic part of this research, as well as the network part of this research were conducted at a single care group, with a unique set of characteristics and parameters. However, findings from the network part can generalized to similar situations for other care groups in the Netherlands. A care group is ‘the spider in the web’ that coordinates and controls for its affiliated partners. Although this might not come as a surprise, the care providing parties tend to forget or ignore this notion. Therefore this notion holds value for other care groups that want to ascertain its added value within its respective network as well.

§10.5 Discussion

The conclusions of this thesis have been presented and discussed in the previous paragraph. This section is devoted to reflecting on the process and research itself to draw lessons from the trajectory and to place a critical note. This discussion is divided in three parts. The first section reflects on theory, theory usage and implications. The second section reflects on the research’s methods and application. The third section is an ethical reflection on the course and actions that were taken during this research. After reflecting, the next paragraph discusses the limitations of this research.

§10.5.1 Reflection on theory

To construct a conceptual framework for both parts of this research, extensive literature studies have been conducted. This section reflects on the process and development of theory usage that grounded this thesis and constructed the conceptual frameworks. First the strategic business model framework is discussed, followed by the network framework.

Within business literature, an abundance of theory exist on strategy, strategizing and strategic management. At first, this was somewhat confusing and intimidating. Mapping what part of strategy this research wanted to analyze helped sift through the plethora of available material to focus on theory directed at evaluating strategy formally and product orientated (see figure 1 on evaluating strategy). The next hurdle was encountered in business model theory. Again a multitude of business model tools and theory are made available to the researcher. To come to the final conceptual model, the approach of assessing the most relevant options was chosen. Taking the useful elements from each of these models enabled this research to construct a conceptual model for this research that fully captured a strategic product and enabled a formal evaluation of said product. Moreover, this model was visually strong, meaning it was easily explainable to the respondents. During data collection and analyses of collected data, the model proved to be useful and adequate to capturing the formal strategy product for BeRoEmD. The elements formed the basic line of questioning during interviews, discussing each element and possible overlap with other elements with the respondents.

The network analysis was predominantly underpinned by Beer's (1985, 1995) viable system model theory supplemented with notions from a recent article from Nieuwkamp and Achterberg (2017). This provided the researcher with a focused and effective scope on theory to construct a conceptual framework to use. At first, a broader introduction of the subject was drafted. However, after a peer review and careful consideration, this research came to the conclusion that excessive information would only confuse the reader from what was necessary. However, reading the additional literature was useful for the researchers own understanding and ability to explain the remaining concepts concisely to the reader.

§10.5.1 Reflection on methods

Considering this research is conducted in association with practise, care group BeRoEmD, implying multiple stakeholders and parties involved. Therefore, this research aimed to apply the principles of engaged Scholarship. Engaged scholarship can be defined as *"a participative form of research for obtaining the different perspectives of key stakeholders (researchers, users, clients, sponsors, and practitioners) in studying complex problems"* (van de Ven, 2007). Taking an engaged scholarship approach aids in jointly producing knowledge that can both advance the scientific enterprise as well as enlighten practitioners. This

implies that if a researcher engages with stakeholders in order to gain insights about problems, the knowledge attained during research is more likely to find its resonance in practice compared to when researchers take a passive approach towards practise. To attain an engaged scholarship attitude, This research tried to engage stakeholders as actively as possible throughout the course of this research. However, a critical note must be placed in this process. In the early phases of this research, communication has been under par due to personal issues of the researcher. Only wanting to report to the researcher's supervisor and BeRoEmD when the researcher was satisfied with my progress, resulting in long periods of silence in communication. Having trouble of translating thoughts onto paper, because of wanting the text to be perfect in the first go. In hindsight, this was not the appropriate conduct. After realizing these errors, the researcher committed to update my stakeholders on a regular basis, even if there was nothing significant to report. Staying in touch was more important and progressive towards research goals.

For data collection, a qualitative approach was chosen to attain depth and richness of data and subsequent findings. In the first part, a case study method with document analysis and semi-structured interviews was used to collect data. The second part was very similar to this, with an additional interactive stakeholder meeting. This meeting was favourable towards the practice goal of this thesis. It served a dual purpose. First of, it served as a means of data collection for this research. The second goal might have been even more important for BeRoEmD. By organizing a meeting with stakeholders from within the network, we wanted to create awareness among the other parties of the added value care group BeRoEmD provides to the network. The care providers ofter overlook the importance of BeRoEmD in order for the network to perform well. It proved to be difficult to organize this meeting, as respondents already had very busy schedules, resulting in some delay of the research. In the end, this research considers the workshop was worth the wait and resulted in at least serving the second goal of this data collection method. However, due to the busy schedules, this workshop had a time frame of two hours with five participants. This was a little brief to collect all data desired. Further implications of this method for data collection will be discussed in the limitations section.

§10.5.1 Ethical reflection

After reflecting on theoretical and methodological decisions, a final reflection is made towards the ethics of this research. Doing something, because it is best for a research, does not have to be considered best with regards to ethics. For example, torturing a captive might be the best method to extract information from him. However, this is not considered a humane thing to do and is therefore not considered ethical.

For the relevancy and applicability of this research, the choice was made to conduct several interviews, face to face and via telephone. Moreover, a workshop meeting was organized with various stakeholders from within the network. All contact was kept appropriate, organized and permissions were

asked from respondents whenever deemed necessary to record conversations. After each interview and the workshop, a transcript was drafted from these recordings. These drafts were then checked with the respondent(s) before they were incorporated into the research. This ensured that statements could not be taken out of the context for respondents.

Moreover, contact with both supervisor and liaison from care group BeRoEmD (managing director was kept professional. A small remark should be made with regard to keeping both of them updated during the earlier phase of this research, as was mentioned in the methodological section. After becoming aware of this error, apologies to all parties and increased effort into improving timely communications were made. Personally, I think I have succeeded in this for the later part of my research.

Lastly, this research is conducted solely by the researcher. Information was gathered through various data sources and databases made available and no plagiarism was committed to his knowledge. All relevant information is referenced by APA norms and a full list of references is included at the end of this research.

§10.6 Limitations

This research and the conclusions as presented earlier in this chapter have some limitations. This section presents four limitations the researcher acknowledges:

1) This research was conducted with care group BeRoEmD. Therefore, applicability is limited to this care group specifically. Each care group in the Netherlands has its own strategy, network and other parameters that could influence outcomes of this research. For example, BeRoEmD deals with two prominent health insurers in its region, whereas most other care groups only deal with 1 health insurer. Another factor is the care groups size. BeRoEmD is one of the smaller care groups in the Netherlands. Size, demographical factors and many more factors can influence the strategic and network related outcomes. Therefore, the conclusions of this thesis are limited to care group BeRoEmD. Some findings might be transferrable to other cases, but researchers should be wary of differences in parameters that most certainly impact outcomes.
2) In conjunction to the first limitation, the theoretical frameworks and methods are considered applicable to other cases in which a researcher wishes to evaluate an organization's (care group) strategy or diagnose a network. The foundation of both conceptual models is built from existing business literature within strategy and system theory. The conceptual business model was supplemented with concepts from the chronic care model, however if a researcher wishes to assess formal product correctness for another type of organization, these influences are easily left out. Therefore, both conceptual models are applicable / transferable to other cases.

3) Data collection for the second part of this thesis was not ideal for the richness and quality of data. The interactive stakeholder meeting was considered most effective in realizing both goals of the data collection phase. This method served its purpose of providing BeRoEmD with ammunition to display its added value to the network very well. However, in the case of collecting rich data, this method came short. The initial goal of organizing the workshop was to be able to analyze the network and network activities on the level of norm value and factual value. However, considering this meeting only spanned a two hour time frame with five participants, this goal was not met. This workshop was able to define the network and to address all activities within the network along with distribution of these activities. However, the workshop only touched upon the activities very briefly. It was impossible to define norm values and compare these with factual values within the time constraint. For data richness and depth of subsequent findings, it would have been beneficial to have a larger window of data collection. For example, organizing a series of workshops, allowing for a more in depth discussion per topic.
4) Another limitation of chosen data collection methods is connected to the interviews. Because knowledge can be considered intangible and user specific, interviewees have their own way of expressing their thoughts and composing answers. The strategic evaluation is predominantly based on interviews with one respondent, the managing director for BeRoEmD. Efforts to triangulate sources were taken by also interviewing the former director and analyzing strategic documents. However, the interviews were semi-structured and relied on protocols to combat this bias of data. BeRoEmD's managing director was the main data source, considering she is the director of this care group and most likely possesses the most knowledge with regard to the care group's strategy.

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Appendices

Appendix 1: Supporting data from earlier research

Overview of barriers and facilitators by Busetto, Luijkx, Huizing, & Vrijhoef, 2015

Table 3 Overview of barriers and facilitators to the implementation of integrated care per IM level

IM level	Barriers	Facilitators
Innovation	• Disease-specific care management • Insufficient integration between the various patient databases	• Performance monitoring via the care chain information system
Individual professional	• Decreased earnings • Too many innovations • Resistance by GPs	• Increased earnings • GP support
Patient	• Patients' insufficient medical and policy-making expertise	• Increased focus on self-management
Social context	• Resistance by GP assistants due to perceived competition	• Innovators in primary and secondary care • Tradition of transmural cooperation
Organisational context	• Lack of qualified PNs • Too much care provided by PNs	• Care group management and support • PNs and DNSs acting as integrators
Economic and political context	• The negative role of some health insurers • Yearly changes in insurance policies • The funding system incentivising the provision of care exactly as described in the care protocols	• Financial incentives for care innovations • Health insurer cooperation • Financial pressure in the health sector • Financial incentives for guideline adherence

Appendix 2: Analysis of Business Model elements

A total of 39 elements were gathered. However, some elements appeared in several models or seemed to overlap with other elements within the compiled list. Therefore, all elements received a verbatim label (e.g. all elements directed at value were named Value; Value structure → Value). This resulted in a list of 15 unique elements in the first iteration. Some of these unique items still seemed to overlap or did not fit accordingly to the goal of this thesis, requiring a second iteration of relabeling the business model elements. The following actions were undertaken:

- The *transactive environment* is considered to have a customer side and partner/supplier side. Resulting in this item being split and reassigned to *Customer* and *Partners* label respectively.
- The labels *Revenues* and *Costs* closely correlate to the label *Financial*, as the latter can be considered a summation of the former.
- *Processes* and *Activities* are merged to one label.
- *Distribution, Measurement* and *Learning* are considered relevant elements to the business model evaluation even though they are only represented once in the complete set.
- *Quantitative* elements are left out of the final concept, because they do not match the goal of formal evaluation.

The second iteration of labelling resulted in a list of 12 elements from which a business model should constitute according to this thesis. The figures depicted below illustrate the process of labelling.

Categorization of Business Model elements						
Original compiled list of elements		Labeling	First iteration		Second iteration	
Author / model	Elements named	Identified Elements	Unique values	Frequency	Unique Elements	Represents # of variables
George & Bock	Resource Structure	Resources	Value	5	Value	5
	Transactive Structure	Transactional	Partners	5	Partners	5
	Value Structure	Value	Resources	4	Financial	5
Zott, Amit & Massa	Value Proposition	Value	Transactional	1	Resources	4
	Revenue model	Revenue	Revenue	3	Customers	4
	Network of relationships	Partners	Costs	1	Competitors	3
Christensen: Driving forces	Customer value Proposition	Value	Competitors	3	Processes	3
	Profit formula	Revenue	Financial	1	quantitative	3
	Key resources	Resources	Processes	2	External	3
	Key processes	Processes	Activities	1	Distribution channels	1
Porter: 6 Forces	Competition in industry	Competitors	Learning	1	Measurement	1
	Potential of new entrants	Competitors	Measurement	1	Learning	1
	Power of suppliers	Partners	External	3		
	Power of customers	Customers	Customers	4		
	Threat of substitutes	Competitors	Distribution channel	1		
	Complementary products	Partners	quantitative	3		
Balanced Scorecard	Critical success factors	Value				
	Financial perspective	Financial				
	Customer perspective	Customers				
	Internal processes perspective	Processes				
	Learnings & growth perspective	Learning				
	Critical measures	Measurement				
Stakeholder mapping	Power of stakeholders	External				
	Interest of stakeholders	External				
	Internal stakeholders	Resources				
	Connected stakeholders	Partners				
	External stakeholders	External				
Business Model Canvas	Key partners	Partners				
	Key activities	Activities				
	Key resources	Resources				
	Value Proposition	Value				
	Revenue flows	Revenue				
	Customer Relationships	Customers				
	Distribution channels	Distribution				
	Cost structure	Costs				
	Customer Segments	Customers				
Causal Looping and stocks & flows model	Feedback loops	quantitative				
	Causal relations	quantitative				
	Group model building	quantitative				
# of values	39	39	15	39	12	38

Figure 9: Iterative process of labelling elements of the business model

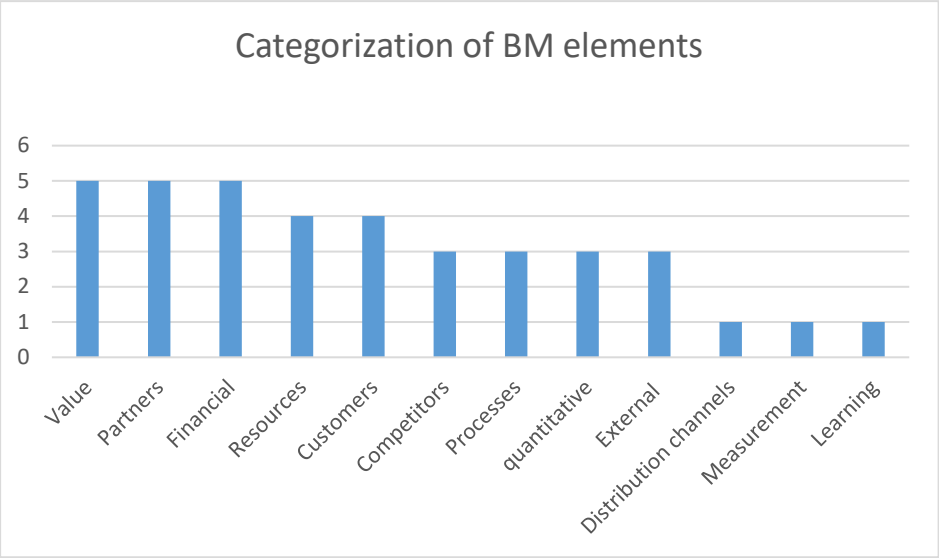
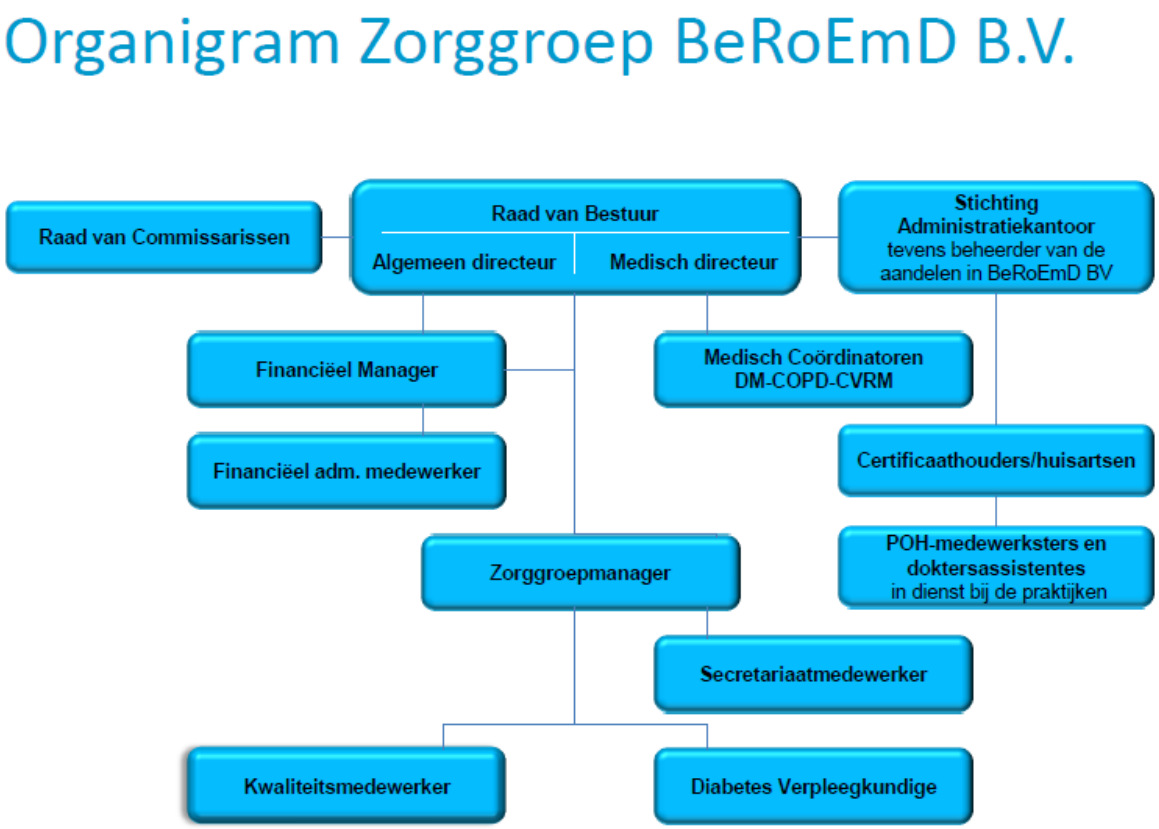


Figure 10: Final list of business model elements and the frequency they represent from the original compiled list.

The final 12 elements are selected to constitute this thesis' business model concept to formally evaluate the strategic product of BeRoEmD. Several original models discussed featured some of the final elements. For each of the models, a summation of how many elements made the final cut can be made by reviewing how many elements made the final set of business model elements compared to how many elements this particular model suggested (e.g. 3 out of 5 elements from a model

were taken results in a 3/5 score). All of the elements from the compiled definition (4/4), key components (3/3), and Driving forces (4/4) were included in the final list of elements. However each of these business models were considered too narrow on their own. Porter's 6 forces model (4/6), the Balanced scorecard (4/6), and the Stakeholder model (3/5) were each represented fairly high in the ending set of elements. However, all three of these models did not seem to capture the entirety of the goal for this thesis. Each model centered around its own point of view, resulting in strong focus towards some of the elements, yet neglecting others. The Business Model Canvas (8/9) was also highly represented in the final set of business model elements. Finally, the quantitative causal looping and formal models did not make the final cut. These models do not match the goal of charting and evaluating the formal strategy product of BeRoEmD. In fact, they would overshoot this goal.

Appendix 3: Supporting data research methods



Appendix 4: Full overview of strategy data collected

Strategy Collection Raw Data Matrix

Data source	Data on values
SD1	Zorggroep moet de HA helpen kwaliteit van de zorg te leveren Zorggroep moet autonomie HA helpen te behouden Zorggroep moet bestaansrecht behouden Transparantie in organisatie en werkzaamheden bestuur Meer zorgprogramma's aanbieden met behoud van chronische zorg voor HA multidisciplinaire zorggroep worden
SD2	BeRoEMD in 2009 zijn de missie, visie en doelstellingen in zijn geheel vermeld: De leden van zorggroep BeRoEmD willen kwalitatief goede, doelmatige en nabije eerstelijnszorg voor chronische aandoeningen leveren aan de bevolking binnen het huidige en toekomstige werkgebied. Het doel is om een proactieve waarborg te bieden dat alle noodzakelijke zorg zo veel en zo lang mogelijk in de eigen woonomgeving wordt aangeboden, met herkenbare begeleiding. Indien de tweede lijn zich terugtrekt uit het werkgebied zal de zorggroep zich inspannen om door substitutie toch een adequaat aanbod te realiseren. Opsporing, monitoring, screening, interventie en behandeling kunnen door de multidisciplinaire inzet van de professionals in de zorggroep onder verantwoordelijkheid van de eigen huisarts plaatsvinden. Naast een goede service zal dit ook een effectieve en efficiënte zorgverlening in de eerste lijn betekenen. De juiste bejegening van patiënten is een kernwaarde. De zorgvraag van de patiënt staat hierbij altijd centraal. Samengevat: • Er wordt kwalitatief goede zorg geleverd volgens de richtlijnen van de betrokken professionals, die bereikbaar en herkenbaar zijn als behandelaar voor de patiënt. • Efficiëntere organisatie van de aan te bieden zorg. • Volledige transparantie in de wijze van werken, de kosten en de resultaten van de inspanningen. • De Zorggroep wil graag dat patiënten zich bij ons veilig en gehoord voelen als klant en in elke fase van de behandeling De huidige beschreven missie, visie en doelstellingen van BeRoEmD lijken nog steeds aardig aan te sluiten bij de transities in zorg en maatschappij. Desalniettemin zou het toetsen en herformuleren tijdens een missie/visie traject van meerwaarde zijn voor zorggroep BeRoEmD.
SD3	In 2009 opgestelde missie, visie en doelstellingen van Zorggroep Beroemd wordt in zijn geheel vermeld. Zie SD2 Doorontwikkeling Multidisciplinaire zorg Door de wijzigingen in de zorg in Nederland zullen er naar verwachting meer taken naar de zorggroep komen in de komende jaren. De zorggroep is nadrukkelijk uit op samenwerking met partners, maar zal de verantwoordelijkheden die noodzakelijk door haar gedragen moeten worden ook op zich nemen mits er voldoende middelen aanwezig zijn om de verwachtingen waar te maken. Schaalgrootte van de zorggroep is suboptimaal om een uitbreiding van het takenpakket te kunnen realiseren
SD4	Herhaling missie, visie, doelen statement: De leden van zorggroep BeRoEmD willen kwalitatief goede, doelmatige en nabije eerstelijnszorg voor chronische ziekten leveren aan de bevolking binnen het huidige en toekomstige werkgebied. Het doel is om een proactieve waarborg te bieden dat alle noodzakelijke zorg zo veel en zo lang mogelijk in de eigen woonomgeving wordt aangeboden, met herkenbare begeleiding. Indien de tweede lijn zich terugtrekt uit het werkgebied zal de zorggroep zich inspannen om door

	substitutie toch een adequaat aanbod te realiseren. Opsporing, monitoring, screening, interventie en behandeling kunnen door de multidisciplinaire inzet van de professionals in de zorggroep onder verantwoordelijkheid van de eigen huisarts plaatsvinden. Naast een goede service zal dit ook een effectieve en efficiënte zorgverlening in de eerste lijn betekenen. De juiste bejegening van patiënten is een kernwaarde. De zorgvraag van de patiënt staat hierbij altijd centraal Uitbreiding van brede rol voor de zorggroep realiseren
SD5	Zelfstandig doorgaan van de zorggroep betekent: - Organiseren GGZ - Organiseren Ouderenzorg - Wijkverpleging - Samenwerking GHC's (mede gezien aanstaande O&I financiering per 1-1-2018) - Dienstverlening voor huisartsen (bijv. Flexpool, werkgeverschap, centrale inkoop)
SD6	Het **vergroten van zelfmanagement** bij patiënten van BeRoEmD, de burgers in ons werkgebied. In 2016 heeft Zorggroep BeRoEmD zich dan ook nadrukkelijk uitgesproken voor het actief stimuleren van de inzet van ondersteunde zelfzorg door Samen met onze medewerkers en patiënten een boost geven aan de implementatie van persoonsgerichte zorg. Zorggroep BeRoEmD wil de aanpak van eigen regie en zelfmanagement nadrukkelijk praktisch vormgeven. Doelstelling: binnen twee jaar alle praktijken de scholing m.b.t. persoonsgerichte zorg te hebben laten volgen. Daarnaast dienen alle praktijken binnen deze termijn kennis te hebben gemaakt met de in het project omschreven overige tools, en deze bij behoefte in kunnen zetten.
IMW1	de eerste echte **multidisciplinaire zorggroep worden** (omwille waarborging bestaansrecht): Om daarnaartoe te ontwikkelen. Daar ben ik het wel mee eens, maar daar moet ik wel mijn huisartsen voor mee krijgen. Die zijn bang voor machtsverlies, wat op papier misschien zo is. Maar in de praktijk is het ook werkdruk verlagend. .. Er moet een gevoel gaan komen dat dat echt van meerwaarde is. Dat de andere disciplines vanuit hun context en belang meedenken over hoe we het samen in de regio kunnen doen. Zolang dat er niet is, gaan ze hun stemrecht niet inleveren **Professionele autonomie**. **toegankelijkheid bieden en de continuïteit** van de zorg waarborgen in ons werkgebied. aansluiten op trends en ontwikkelingen
ITB	wil je echt die multidisciplinaire zorggroep gaan worden? Want dat betekent ook dat je meer gaat samenwerken. Taakverschuiving, je gaat veel meer gebruikmaken van elkaars expertise en kunde en beschikbaarheid in plaats van dat je het zelf moet oplossen de **professionele autonomie** van de huisarts, van de dokters in zijn algemeenheid in de gezondheidszorg, wordt weer teruggebracht tot het begrip waar het thuishoort. Medische inhoudelijk. Daar ben je professioneel autonoom Wij pretenderen als zorggroepen dat wij die veranderingsslag een rol kunnen spelen, zowel op strategisch niveau, tactisch niveau en operationeel niveau. Per regio is dat verschillend. De aggregatiesnelheid ligt verschillend, oftewel fasemanagement komt voor. Dat is waarschijnlijk ook noodzakelijk, want je kunt niet alles tegelijk. Zorggroep heeft buffer rol tussen huisartsen en zorgverzekeraar Er moet meer netwerkorganisatorisch nagedacht worden dan technocratisch
IMW2	Wat wel echt typisch BeRoEmD is, vanaf het begin af aan, is dat we wel vooruitstrevend zijn in nieuwe ontwikkelingen. Zoals die persoonsgerichte zorg

Data source	Data on key activities
SD1	Nascholing verzorgen, werkgeverschap verzorgen voor POH somatiek Meer zorgprogramma's aanbieden Betere samenwerking intern en extern; Overhead ook inzetten voor andere partijen/ zorggroepen het inrichten van multidisciplinaire werkgroepen voor bepaalde chronische zorgprogramma's. Evt. later in bestuur opnemen? Onderzoeken en nadere uitwerking hiervan is nodig om dit goed te kunnen beoordelen
SD2	Overzicht van 3 zorgovereenkomsten om te onderhandelen, sluiten en uitvoeren: 1) Zorginkoopovereenkomst (zorgverzekeraar □□ huisarts). 2) Verzekeringsovereenkomst (zorgverzekeraar □□ patiënt) 3) Geneeskundige behandelovereenkomst (patiënt □□ huisarts) Toetsen of de inhoud van de zorginkoopovereenkomst in lijn met de WGBO tijdens contractbesprekingen met zorgverzekeraar. Aanvullende activiteiten: Zorgprogramma's aanpakken & aanbieden Eerstelijns zorgaanbieder Aantrekken financiers Werkgever zijn Ondersteuning primaire processen De huidige schaalgrootte van de zorggroep is suboptimaal om een uitbreiding van het takenpakket (brede rol) gedegen te kunnen uitvoeren en de innovaties ten gevolge van alle ontwikkelingen incrementeel te implementeren Het proces van ketenzorg is klantgericht maar het zorgproduct is door standaardisatie, per definitie, productgericht Naast de reguliere, gecontracteerde ketenzorgprogramma's is de zorggroep bij veel regionale activiteiten betrokken. Steeds vaker wordt de samenwerking gezocht met andere zorgorganisaties in de regio. In deze samenwerkingen heeft BeRoEmD steeds de kartrekkers rol op zich genomen en is de stuwende, sturende kracht bij de totstandkoming van vele ontwikkelingen in de regio. De zorggroep is sterk in procesmanagement. Proces van ketenzorg is klantgericht, maar het zorgproduct is standaardisatie en dus per definitie productgericht. Processen worden ondersteund door KIS Care2U De zorggroep is sterk in procesmanagement Sterk actief in innovatie & portfolio management
SD3	Zorggroep is actief in verschillende markten 1) zorgmarkt: profileren als eerstelijnszorgaanbieder naar patient en verwijzers; 2) Zorginkoopmarkt: onderhandelen met verzekeraars over te leveren zorg (prijs, volume, kwaliteit) ; 3) Kapitaalmarkt: aantrekken van financiers 4) Arbeidsmarkt: werkgeverschap
SD4	Uitbreiding, oftewel brede rol zorggroep:

	- Organiseren GGZ biedt aanzienlijk volumevoordeel - Organiseren Ouderenzorg biedt volumevoordeel. - Wijkverpleging - Samenwerking GHC's (mede gezien aanstaande O&I financiering per 1-1-2018) - Dienstverlening voor huisartsen (bijv. Flexpool, werkgeverschap, centrale inkoop) N.B. Uitbreiding van activiteiten betekent niet automatisch alles zelf doen en organiseren. Dit kan ook uitbesteed worden.
SD5	Beroemd moet zich inzetten in: - Organiseren GGZ - Organiseren Ouderenzorg - Wijkverpleging - Samenwerking GHC's (mede gezien aanstaande O&I financiering per 1-1-2018) - Dienstverlening voor huisartsen (bijv. Flexpool, werkgeverschap, centrale inkoop)
SD6	Zorggroep BeRoEmD wil de aanpak van eigen regie en zelfmanagement nadrukkelijk praktisch vormgeven door middel van: Goed voorlichten van betrokken zorgverleners Heldere communicatie Vergroten draagvlak belang van eigen regie voor de patient In eerste instantie een koplopersgroep van praktijken uit de zorggroep scholing m.b.t. persoonsgerichte zorg te hebben laten volgen. Daarnaast dienen alle praktijken kennis te hebben gemaakt met de in het project omschreven overige tools, en deze bij behoefte in kunnen zetten. In samenwerking met onze Keten Informatie Systeem (KIS) leverancier Care2U en het digitale patiënten portaal Mijn GezondheidsPlatform (MGP) heeft de zorggroep het sinds vorig jaar voor patiënten mogelijk gemaakt om digitaal hun consulten voor te bereiden, meetwaarden voorafgaand aan hun consult in te voeren en zelf aan de slag te gaan met hun Individueel Zorgplan. Tevens kunnen patiënten in MGP digitaal gecoachte worden op hun leefstijl
IMW1	-Sparren met STAK: 1x per jaar evaluatiegesprekken met alle ketenpartners -Onderhandelen met zorgverzekeraars -Coördinatie van zorg voor ketenpartners (hoofdzakelijk huisartsen) -De Zorggroep is vooral betrokken bij de eerste 2 onderhandelingen zoals ze genoemd zijn in SD2. De geneeskundige overeenkomst (behandelovereenkomst) is er een tussen huisarts en patiënt, die moet de huisarts wel hebben, anders kunnen ze niet samenwerken met de zorggroep. -informatie voorziening naar alle partners + patient
ITB	De buffer tussen huisartsen en zorgverzekeraars Onderhandelen met zorgverzekeraars Coordinatie van zorgverlening Huisartsen neuzen dezelfde kant op krijgen.
IMW2	Onderhandelen met zorgverzekeraars Coördinatie zorg KIS sturingsinformatie en spiegelinformatie in de gaten houden Strategische lijnen uitzetten Scholing en bijeenkomsten verzorgen Poortwachtersfunctie van de huisarts waarborgen. Deze komt soms in gevaar door waarnemers die de populatie niet goed kennen of bang zijn om een medische misser te maken. Hier scholing/gedegen opvang in aanbieden. Pilot persoonsgerichte zorg mbv MGP in 3 koploperpraktijken

Data source	Data on Key Partners
SD1	Actieve inbreng/ houding van alle certificaathouders is van belang. Dit kan worden vormgegeven door (al dan niet verplichte) deelname aan werkgroepen
SD2	alle betrokkenen (zorgverleners en stakeholders) twee dominante zorgverzekeraars in de regio (VGZ en CZ) Ketenpartners: podotherapeuten Care2U
SD3	Zorgverzekeraars: 2 dominante partijen, namelijk VGZ & CZ Certificaathouders STAK Landelijke huisartsen Vereniging (LHV) InEen landelijke organisatie ketenzorg Landelijke vereniging geoorganiseerde eerstelijn (LVG) Zorgverzekeraars Nederland (ZN) De Minister van Volksgezondheid, Welzijn en Sport (VWS) Vereniging Huisartsenposten Nederland (VHN) Naast de reguliere, gecontracteerde ketenzorgprogramma's is de zorggroep bij veel regionale activiteiten betrokken. Steeds vaker wordt de samenwerking gezocht met andere zorgorganisaties in de regio. In deze samenwerkingen heeft BeRoEmD steeds de kartrekkers rol op zich genomen en is de stuwende, sturende kracht bij de totstandkoming van vele ontwikkelingen in de regio. De zorggroep is sterk in procesmanagement. Macht zorgverzekeraars wordt gezien als een bedreiging
SD4	Eventueel samenwerken met andere zorggroepen Chronos, RCH, DOH, JBZ
SD5	Ketenpartners Zorgverzekeraars Eventuele samenwerking andere zorggroepen in de regio (Chronos, RCH, DOH)
SD6	Leveranciers (Care2U) & MGP Ketenpartners Vilans Huisartsen Praktijkondersteuners <u>Relatie met externe organisaties</u> ZO! helpt bij het tot stand komen van het plan van aanpak en speelt een rol in de bemiddeling met de zorgverzekeraar. (consultant) Care2U is de betrokken ICT leverancier. Overigens zijn betrokken de ketenpartners van de zorggroep, CZ en VGZ, patiëntenorganisaties. Effectief en gestructureerd werken aan het versterken van persoonsgerichte zorg vraagt gecoördineerde inzet van bestuur en directie, huisartsen en praktijkondersteuners. Commitment van de zorgverzekeraar. Ketenpartners
IMW1	Huisartsen: certificaathouders van de BV. "huisartsen zijn aandeelhouder/certificaathouder en tegelijkertijd ook een van de zorgverleners, dus onderaannemers" Voor de huisarts hebben we een soort van vangnet georganiseerd. Voor die andere ketenpartners niet, dat

	is eigenlijk niet eerlijk anderzijds als je kijkt naar ketenzorg, de huisarts en POH doen 80 a 90% van alle zorg die er vanuit het ketenzorg programma geleverd moet worden aan de patiënt Overige ketenpartners andere zorggroepen: samen (na)scholing & regionale thema's pakken de samenwerking. partijen als een deel van de GGZ (met name Haspel, detacheren POH GGZ's). → Discussie POH = wel of = geen partner. Conclusie: POH's zijn in dienst van een van de partners (c.q. de huisarts of GGZ) van Beroemd. Daarom niet direct zelf partner, maar wel een zeer belangrijke spil. STAK: stichting administratie kantoor, beheert certificaten van de BV in handen van Huisartsen en andere ketenpartners zoals Concordant. Geeft Certificaathouders een soort advies, zwaarwegend adviesrecht rondom wel of niet dingen gaan doen feitelijk gezien geen recht om beleid en dergelijke te maken, maar we zien ze echt als sparringpartner & de verbindende factor richting de rest van de achterban Concordant: coöperatie van Apothekers tweedelijns. Ziekenhuis en verpleeg/verzorginstellingen "Daar kunnen we meer structuur in gaan brengen en eea faciliteren" Cooperatie Beroemd: Dat is niet de zorggroep, maar meer de huisartsengroep rondom de dienstenstructuur/verdeling. Deels overlap met zorggroep, deels ook niet mbt huisartsen. eigenlijk heeft Coöperatie Beroemd que functie niks te maken met de zorggroep Gemeenten: Dat is wel een partij waar we meer mee samen moeten gaan doen denk ik. Ik heb het gevoel dat alles wat er gaande is, dat we een aantal problemen hebben waar we allebei tegenaan lopen, waar we elkaar door samenwerking echt kunnen helpen. maar dat we dat nu nog niet doen, omdat we eigenlijk nog zo met onze eigen brandjes blussen bezig zijn en met schaarse middelen die er zijn dingen te doen. Terwijl ik denk dat we volgens mij beter samen kunnen werken Zorgverzekeraars: CZ & VGZ als hoofdpartners met elk aparte onderhandeling. Voor andere zorgverzekeraars geldt landelijk volgbeleid in Nederland Het is een soort noodzakelijke samenwerking. Als wij geen contact hebben met de zorgverzekeraar. Als die niet wilt inkopen wat wij aanbieden, dan houdt het op in principe. Die hebben geld gedreven argumenten en vervolgens maken ze daar toch beleid op. Maar wij zitten vanuit de inhoud en kwaliteit van de zorg. Dat botst. Met andere financiers doen we niets (terugverwijzend naar SD3) De Kring: regionale kamers van de LHV. Die vinden zichzelf, die bedelen zichzelf een vrij belangrijke rol toe. Maar die zitten toch bij vrij veel overlegstoelen. EN dat vind ik helemaal niet erg he, maar ik zeg wel: Jullie zijn huisarts, eerstelijns. Zorggroep is eerstelijns en ook meer dan alleen huisarts. Die andere ketenpartner disciplines, die zijn helaas minder goed georganiseerd. Overige ketenpartners die minder goed georganiseerd zijn: diëtist, de fysiotherapeuten, podotherapeuten, pedicures, Vanuit MW zelf intentie om overige ketenpartners meer te betrekken bij de zorggroep (mits zij zich beter organiseren). Ligt gevoelig bij huisartsen. Hogescholen / universiteiten: Avans programma aansluiting op POH / huisartsassistent
ITB	De huisarts momenteel wordt gezien als zowel klant als baas, financier als middel. Zorgverzekeraar: grotendeels verantwoordelijk voor de financiering. We krijgen te maken ook met de domeinen. Oftewel, we komen weer met ons gezicht naar de samenleving te staan, naar gemeentes toe Dietisten Gemeenten ligt meer ruimte voor samenwerking LHV (Landelijke BeroepsVereniging van Huisartsen) Andere zorggroepen Regionale instanties
IMW2	Huisartsen, andere ketenpartners, gemeentes, ziekenhuizen, ggd, ggz, andere zorggroepen, Onderwijs. Samen met onderwijs kijken naar de toekomst voor E-health, netwerk & organisatorisch inrichten En ik denk dat er heel veel complexe vraagstukken op regionaal niveau liggen die we prima met andere zorggroepen en met de gemeente en het ziekenhuis kunnen en moeten gaan oppakken

Data source	Data on resources
SD1	Streven naar eenzelfde KIS voor zorggroepen in de hele regio inclusief Haspel. Voorkeur Care2U
SD2	Organigram en functiehuis beroemd worden hier al bijlage gegeven. Kijkend naar het organigram van zorggroep BeRoEmD (zie bijlage 1) is de organisatiestructuur te typeren als Functioneel. Het BeRoEmD functiehuis (zie bijlage 2) beschrijft per functie de algemene doelstelling, kernactiviteiten, kerntaken, functie-eisen, competenties, aantal FTE en indien van toepassing bijbehorende FWG. Binnen BeRoEmD is de gebruikelijke Governance structuur herkenbaar Functiehuis Zorggroep BeRoEmD 2015 Bestaande uit de functies: 1. Algemeen Directeur (AD) 2. Medisch Directeur (MD) 3. Medisch Coördinator (MC) 4. Zorggroepmanager (ZGM) 5. Kwaliteitsfunctionaris (KF) 6. Informatiemanager (IM) (nog) niet aanwezig wel wenselijk 7. Financieel Manager (FM) 8. Financieel administratief medewerker (FAM) 9. Office manager (OM) De omvang van de huidige interne organisatie maakt de zorggroep kwetsbaar; het weg-/uitvallen een functionaris vormt een serieus risico voor de continuïteit van de organisatie. Daarbij is de slagkracht bij de huidige schaalgrootte onvoldoende om gedegen te kunnen blijven anticiperen op alle verschuivingen en transities. Processen worden ondersteund door KIS Care2U. Het ict systeem moet voldoen aan de doelstelling “kostenbesparende ondersteuning op gebied van zorg, logistieke, facilitaire en administratieve processen. Regionaal worden de mogelijkheden van een ict platform verkend met alle belanghebbende stakeholders.
SD3	De omvang van de huidige interne organisatie maakt de zorggroep kwetsbaar; het weg-/uitvallen een functionaris vormt een serieus risico voor de continuïteit van de organisatie. Daarbij is de slagkracht bij de huidige schaalgrootte onvoldoende om gedegen te kunnen blijven anticiperen op alle verschuivingen en transities Klein, pro-actief aanspreekbaar team als verbindende schakel (lean&mean) Schaarste arbeidsmarkt kan tot problemen leiden Subtoptimale & kwetsbare zorginfrastructuur door huidige ICT
SD4	Heroriëntatie KIS: Care2U versus Vital Health (VH).
SD5	Personeel KIS: Care2U eventueel heroverwegen Vital Health ivm kosten
SD6	Patiëntenportaal KIS care2U
IMW1	Is de POH een Resource van Beroemd ? Ja /nee? die zijn wel heel belangrijk. Want als de POH's afhaken, dan hebben we als zorggroep meer een probleem, dan als de huisartsen dat bijvoorbeeld doen eigenlijk. Want eigenlijk voert de POH grotendeels ons beleid uit in geprotocolleerd, gestandaardiseerd uit in de praktijk. De huisarts is nog wel eindverantwoordelijk en moet zijn personeel hier op aanspreken. Of die wel de

	dingen uitvoert die in het contract staan Flexpool aan mensen (POH en doktersassistentes) die in staat zijn nieuwe POH's snel in te werken in geval van ziekte, zwangerschap of andere redenen voor langdurige afwezigheid. Alle onderaannemers: huisartsen en andere ketenpartners +personeel van deze partners. HR: Raad van bestuur, stak, directie, raad van toezicht, stafmedewerkers (back-office) KIS (care2U): : communicatie, sturingsinformatie, declaratie, spiegelinformatie. Er is alleen de koppeling tussen de XISSEN, eigenlijk alle andere systemen die er verder nog zijn van andere ketenpartners, waardoor deze nog vaak met dubbele administratie zitten. → Drukt flink op de overheadkosten. "een ICT-tool die dus met verschillende doelen, zowel op ketenniveau als declaratie en sturingsinformatie wel van belang" heroverweging welke is wel een optie. GezondheidsPortaal, dat is een patiëntenplatform
ITB1	Noemt verschillende functies op binnen bestuur, management en back-office van de zorggroep.
IMW2	Kaderartsen zijn belangrijk voor connectie met de praktijk. Zij zetten grotendeels lijnen uit voor scholing etc. KIS en HIS zijn belangrijke resources. Wel een Re-evaluatie mbt hoge overheadkosten op ICT door deze systemen. de ICT, Care2U, terwijl dat echt ten dienste staat van primair de ondersteuning van het zorgproces, coordinatie en organisatie binnen die praktijk. →mogelijk VIP Calculus als alternatief. = goedkoper, maar kan minder momenteel + wachtrij. MGP: MijnGezondheidsPlatform = patientenportaal voor persoonsgerichte zorg. Patiënt en behandelaar kunnen hier doelen invoeren, vragenlijsten, consult voorbereiden. Koppelt met Care2U.

Data source	**Data on competitors**
SD1	
SD2	<u>Direct concurrenten:</u> Gezondheidscentra Andere zorggroepen Huisartsen of andere disciplines (onderlinge rivaliteit) Zorgorganisaties, zoals Praktijksteun en Haspel, die huisartsen ondersteunen/ontzorgen bij facetten als POH-GGZ-zorgverlening en ontwikkelingen <u>Potentiele bedreigingen</u> Substituten: E-Health, (Tele-)diagnostiek, Apps, thuisarts.nl, Wijkverpleegkundige, GGD (preventie), ARBOcuratieve centra, ROS Nieuwe Toetreders: Commerciële partijen (Siemens/Philips Medical, farmaceuten, Google/Apple). Oranje klinieken, Ziekenhuizen (1,5 lijnscentra), GGZ instellingen (basis GGZ Er is sprake van toenemende concurrentie, waarbij het vraagstuk concurreren of samenwerken speelt.
SD3	
SD4	Chronos, RCH, DOH, JBZ
SD5	Chronos, RCH, DOH
SD6	
IMW1	Andere zorggroepen in de regio zijn mogelijk concurrent. Philips heeft met VitalHealth, een ander KIS systeem.
ITB	
IMW2	

Data source	Data on external
SD1	
SD2	
SD3	Deze omgeving is de afgelopen jaren alles behalve rustig geweest, en de vele transities waar de eerstelijnszorg direct en indirect mee te maken heeft/krijgt, brengen kritische onzekerheden maar ook kansen met zich mee Political - Lidmaatschap EU - Beleidsagenda VWS (ten gunste van eerstelijn) - Krachtenveld en lobby - Politieke stabiliteit Economic - algemene economische vooruitzichten en stijgende zorguitgaven volgens het CPB - VWS begroting, met groei in budgettair kader huisartsenzorg en multidisciplinaire zorg - Risicovereveningsstelsel (afbouw ex post compensatie) Social - Solidariteit (houdbaarheid van het huidige systeem) - Arbeidsmarkt (schaarste) - Demografische factoren - Pluriforme samenleving - Verwachting en positie patiënt/burger Technological - Snelheid van technologische ontwikkelingen - ICT als belangrijk onderdeel van de zorginfrastructuur op regionaal- en lokaalniveau. - eHealth mogelijkheden en voordelen bij gebruikers (zorgverleners en patiënten/burgers) zijn beperkt bekend, en vraagt om procesinnovatie (barrière). Legal - Wetgeving en transities Opportunities 2015 1. Beleidsagenda VWS biedt een gunstige positie voor de eerstelijn. 2. Als enige onderdelen in de VWS begroting, additionele groei in budgettair kader huisartsenzorg en multidisciplinaire zorg. 3. Transitievraagstukken, zoals verschuiving onderdelen uit WLZ en Zvw naar bijv. Jeugdwet onder verantwoordelijkheid gemeente, biedt nieuwe mogelijkheden tot duurzaam partnership. 4. Toekomstramingen 2016 voorspellen voor het adherentiegebied BeRoEmD geen significante afwijkingen t.o.v. ontwikkelingen op nationaalniveau. 5. Gidsfunctie en verbinden i.v.m. complexer wordend zorgsysteem. 6. Wijkverpleegkundige als verbindende schakel tussen medisch en sociaal domein. 7. Sterkere positie van de patiënt/burger (gelijkwaardige gesprekspartner), en bewustwording. Threats 1. Onzekerheid over consistentie overheidsbeleid en beleid van gemeenten. 2. Onzekerheid herstel en aantrekken economie. 3. Dreigend tekort aan zorgverleners van diverse competentieniveaus (continuïteit van zorg). 4. Suboptimale en kwetsbare zorginfrastructuur door huidige ICT (on)mogelijkheden. 5. Macht van de zorgverzekeraars. 6. Individueel belang van zorgverleners prevaleert boven collectief. 7. Transitievraagstukken vragen om regiodenken (gemeenschappelijke agenda). Partijen die elkaar nog niet kennen en elkaars taal niet spreken, moeten met elkaar gaan samenwerken. SWOT:

	Informatievoorzieningen / koppeling CARE2U met andere HIS/XIS/KIS zorgproduct dat door standaardisatie productgericht is. Kwetsbare infrastructuur Macht zorgverzekeraars Subtoptimale & kwetsbare zorginfrastructuur door huidige ICT Schaarste arbeidsmarkt
SD4	
SD5	
SD6	
IMW1	-Landelijk: ministeries: zetten kaders uit -het arbeidsmarktprobleem. Huisartsen arbeidmarkt is een probleem, maar goeie praktijkondersteuners wordt ook een steeds groter probleem → E-Health mogelijke oplossing? -Zorggroep btw plichtig volgens belastingsdienst, terwijl het door andere wetten als zorginstantie wordt erkend. - Regelgeving rondom bescherming persoonsgegevens grote impact op de zorggroep en zorgsector in algemeen.
ITB	nu toe klassiek in de gezondheidszorg in Nederland was, dat de meerderheid eigenlijk geremd wordt door de minderheid die niet wil En dat je dus zult zien dat er plekken zullen zijn waar de voorwaartse ontwikkeling wel gebeurt, omdat ze daar aan toe zijn, omdat er mensen zijn, omdat er keuzes gemaakt worden. En er zullen plekken zijn, die blijven achter…. de wet van behoudende krachten is gigantisch. Dat heeft met angst te maken, met eigenlijk de constantheid van verandering wordt ontkent. Medische profs zijn heel erg gehecht aan zoals het was was het goed zoals het is moet het blijven. Regelgeving rondom aansprakelijkheid en belastingen bemoeilijkt functioneren van de zorggroep. we zijn een sociaal culturele instelling sinds 1 januari 2016. De belastingautoriteiten zien ons dus als een sociaal culturele instelling Rol van technologie in de toekomst
IMW2	Regelgeving AVG: algemene verordening gegevensbescherming, wat eisen gaat stellen aan zorggroep en praktijken Technologie: Vooral ICT vraagstukken. ICT drukt zwaar op de begrotingen van zorggroepen. Verschillende wegen/oplossingen. Dit is meer een landelijk vraagstuk. Politiek / financieel: nieuwe O&I financiering: org en infrastructuur ondersteuningskosten worden straks anders herverdeeld. Verdeling eerstelijns en tweedelijns stemt niet goed op elkaar af. enerzijds willen ze heel erg de substitutie van tweedelijns naar de eerstelijns toe. Vervolgens heb je macrobudgetair VWS afspraken gemaakt dat er maximaal zoveel uitgegeven mag worden in de eerstelijnszorg

Data source	Data on measurement
SD1	Huisarts autonomie geven door eigen manier om resultaten aan te leveren Waardeerbaar maken van taken en werkzaamheden van bestuur; Feedback verzorgen en bespreken op praktijkniveau, maar niet blind staren op cijfers; gezamenlijk doelen opstellen
SD2	Er wordt periodiek met alle medewerkers een functionerings- en beoordelingsgesprek gevoerd. Daar wordt ook verslag van gedaan. Care2U biedt sturingsinformatie (output) op zorggroep- en praktijkniveau. Vanaf Q4 2015 vormt dit systeem ook voor het financiële proces de basis. Het functioneren van het systeem én de input vormen de kritische succesfactoren voor een gezonde bedrijfsvoering. Beiden zijn nog niet geoptimaliseerd
SD3	Processen worden ondersteund door KIS Care2U. Het ict systeem moet voldoen aan de doelstelling "kostenbesparende ondersteuning op gebied van zorg, logistieke, facilitaire en administratieve processen Voor ontsluiting met andere systemen (HIS) is nodig, echter verloopt niet op alle fronten even soepel. Care2U bied sturingsinformatie op zorggroep & praktijk niveau. Het functioneren van het systeem (CARE2U) én de input vormen de kritische succesfactoren voor een gezonde bedrijfsvoering. Beiden zijn nog niet geoptimaliseerd. De resultaten van de geleverde zorg worden verbeterd door goede vastlegging van gegevens en deskundige bewerking daarvan met terugkoppeling naar patiënt en zorgproces. De zorggroep behoort tot de top in de landelijke ketenzorg benchmark op prestaties.
SD4	
SD5	
SD6	In samenwerking met onze Keten Informatie Systeem (KIS) leverancier Care2U en het digitale patiënten portaal Mijn GezondheidsPlatform (MGP) heeft de zorggroep het sinds vorig jaar voor patiënten mogelijk gemaakt om digitaal hun consulten voor te bereiden, meetwaarden voorafgaand aan hun consult in te voeren en zelf aan de slag te gaan met hun Individueel Zorgplan. Tevens kunnen patiënten in MGP digitaal gecoachte worden op hun leefstijl
IMW1	
ITB	
IMW2	-Keteninformatie systeem als voornaamste bron voor measurement: Care2U Datamanagement mbt spiegel&sturings informatie wordt veel gebruikt via Care2U Automatische koppeling met HIS als bronbestand. Moet wel gecodeerd worden. → Benchmarking: Care2U kan op basis van rapportagefunctie die er in zit, kun je een hele hoop indicatoren laten berekenen hoe we er voor staan; uitkomsten, procesindicatoren. Dat kan je zien per praktijk hoe je het doet, op huisartsniveau, als praktijk met meerdere huisartsen bij elkaar en vervolgens ook nog op clusters, maar ook ten opzichte van de rest van de zorggroep -Stimuluren dat praktijken zelf ook met deze informatie gaan werken: We vinden het dusdanig belangrijk dat praktijken hier beleid op gaan maken. Wat past bij hun praktijk, organisatie en kwaliteitsbeleid meten gebeurd zowel op zorggroep niveau als op praktijk niveau. Care2U is alleen ingericht dat huisartspraktijken dit kunnen. Helaas bestaat de functie niet voor andere ketenpartners. Hier is wel vraag naar, want ook voor hen is verantwoording net zo belangrijk.

Data source	Data on customer
SD1	
SD2	Vraagstuk: Wie beschouwt de organisatie als haar klanten (huisartsen en/of patiënten/burgers)? Welke associaties wil BeRoEmD bij haar klanten creeëren? aangezien de zorggroep geen directe behandelrelatie met de patiënt heeft
SD3	ontstaan vraag: wie beschouwt Beroemd als haar klanten? Zijn dat de patiënten en/of de huisartsen? De Zorggroep wil graag dat patiënten zich bij ons veilig en gehoord voelen als klant en in elke fase van de behandeling De zorggroep heeft geen directe behandelrelatie met de patiënt Mismatch bij klantgerichtheid (proces van ketenzorg) & zorgproduct dat door standaardisatie productgericht is.
SD4	
SD5	
SD6	Doelstellingen allemaal gericht op zelfmanagement en zelfzorg van patiënt. Niet duidelijk of patiënt in deze ook klant is, of niet. Ook duidelijk naar voren dat de zorggroep de zorgverlener in staat moet stellen goede zorg te leveren.
IMW1	Eigenlijk zijn het de Huisartsen die de zorggroep bediend. “de klant is de certificaathouder” Dus dan zijn de huisartsen mijn klant, maar goed dan zou ik denken de certificaathouders. Dat zijn in ons geval bijna alleen maar huisartsen. Maar dan moeten we, vind ik, wel op een aantal dingen dat mooie verhaal over patiënt centraal stellen er uit halen, want die is mijn klant dan helemaal niet. De huisarts is mijn klant. Dus dan zet ik de huisarts centraal Hoewel het wel langs elkaar heen loopt in mijn hoofd en mijn gevoel. De ene keer de een is en dan de ander. Geeft misschien ook wel een beetje weer wat dan het complexe ervan
ITB	“de klant bestaat niet” Er is niet één klant aan te wijzen voor Beroemd. Afhankelijk van gemaakte keuzes ziet Theo 4 klant segmenten: Patiënt: We zijn een organisatie die ge-ent is op een keuze voor systeemdenken. Dat is eigenlijk het gezondheidsdenken, wat achter de chronische zorg heeft gezeten. En daar staat de patiënt centraal. In de praktijk is gebleken dat de zorggroep zich vooral richting de communicatie op de uitvoerende in de keten. En daarmee komt automatisch het perspectief van de klant anders te liggen. Wij zijn een middelgerichte organisatie die productgericht werkt. Terwijl die eigenlijk consumentgericht georiënteerd zou moeten zijn. Dat betekent dat daarmee ook de klantprofielen gaan veranderen. En het zou kunnen dat de komende jaren de klant wel degelijk de burger gaat worden Huisarts: Huidige situatie: Onze klant in de technische zin zijn, dat zijn de artsen. Dat is nou eenmaal een probleem, want die zijn zowel klant als baas. Die zijn zowel financier als middel. 80% van de tijd gaat zitten in de huisarts Zorgverzekeraar: Financiering wordt indirect door de zorgverzekeraar geregeld. En daar heb je dus weer een volgende probleem, want die is eigenlijk ook klant want die koopt bij ons de dienstverlening in. Gemeente: Dus ook de gemeente wordt een klant. Het is eigenlijk al een klant.
IMW2	Huisartsen en andere ketenpartners Zorgverzekeraars betalen voor zorgprogramma’s

Data source	Data on Channels
SD1	Verbeteren van communicatie: Website actiever gebruiken, dynamische agenda, maandelijkse nieuwsbrief van bestuur, lunchbijeenkomsten organiseren Streven naar eenzelfde KIS voor zorggroepen in de regio (incl Haspel) Patiëntenportaal aanleggen en benutten Betere communicatie creëren. Communiceren naar patiënten toe d.m.v. posters of folders
SD2	
SD3	Informatievoorzieningen / koppeling CARE2U met andere HIS/XIS/KIS Suboptimale en kwetsbare zorginfrastructuur door huidige ICT (on)mogelijkheden.
SD4	
SD5	
SD6	Het houden van bijeenkomsten voor scholing / kennisdeling Inzet van het patiëntenportaal Mijn Gezondheids Platform: In samenwerking met onze Keten Informatie Systeem (KIS) leverancier Care2U en het digitale patiënten portaal Mijn GezondheidsPlatform (MGP) heeft de zorggroep het sinds vorig jaar voor patiënten mogelijk gemaakt om digitaal hun consulten voor te bereiden, meetwaarden voorafgaand aan hun consult in te voeren en zelf aan de slag te gaan met hun Individueel Zorgplan. Tevens kunnen patiënten in MGP digitaal gecoachte worden op hun leefstijl
IMW1	-Keteninformatie systeem CARE2U: communicatie, sturingsinformatie, declaratie, spiegelinformatie -Patiëntenplatform MijnGezondheidsPortaal (MGP): kanaal om de patient meer te betrekken bij zijn/haar zorg. - VIP Live: systeem voor declaraties - Communicatie voorloopt vooral via: de nieuwsbrief, website, e-mails inderdaad, bijeenkomsten, trainingen, scholingen. Webinars is recentelijk nieuwe ontwikkeling. - Website Beroemd bedient zowel patiënt als zorgverlener: "We hebben een deel voor patiënten erop staan, dat is vooral over achtergrond en aandoeningen en dergelijke. En een deel voor de zorgpartners" →
ITB	
IMW2	Bijeenkomsten (formeel en informeel) Scholingsdagen Care2u voor communicatie, sturingsinformatie, declaratie, spiegelinformatie ledenvergaderingen , netwerkbijeenkomsten MGP: MijnGezondheidsPlatform = patientenportaal voor persoonsgerichte zorg. Patiënt en behandelaar kunnen hier doelen invoeren, vragenlijsten, consult voorbereiden. Koppelt met Care2U. →Vereist integratie in consultvoering, levert voordelen op: een manier om de patiënt te activeren en tegelijktijdig het consult efficiënter ,sneller en gerichter te maken

Data source	Data on learning
SD1	Kennisdeling moet via de website, bijvoorbeeld van bezochte bijeenkomsten Nascholing organiseren met andere zorggroepen het organiseren van nascholingen en het verzorgen en bespreken van feedbackgegevens Feedback verzorgen en bespreken op praktijkniveau, maar niet blind staren op cijfers; gezamenlijk doelen opstellen Werkgroepen organiseren Uitwisselen opgedane kennis tijdens bezochte scholingen Notulen bestuur, directie, commissies op website zetten
SD2	
SD3	
SD4	
SD5	
SD6	Het houden van bijeenkomsten voor scholing / kennisdeling Kennisdeling tussen hulpverlener en patiënt sturen: *De hulpverleners binnen de zorggroep realiseren en respecteren deze autonomie en dragen kennis/voorlichting en vaardigheden aan, zodat de patiënt adequate coping strategieën kan inzetten.*
IMW1	opleidingen voor praktijkondersteuners waar we mee aan het kijken zijn voor Avans Hogeschool ook van goh kunnen jullie dan zo'n module ontwikkelen die aansluit op het werkveld. - Documentatie, Kennisbank, de cloudomgeving, nascholing -Nascholing: wel één van de belangrijke dingen die wij aanbieden aan onze zorgverleners. Dat zijn de scholingen en in overleg met de kaderartsen eigenlijk, kwaliteitsmedewerker en kaderartsen bepalen eigenlijk per jaar, wordt er vastgesteld, op basis van landelijke ontwikkelingen maar ook als we dingen zien, of er dingen achterblijven. - Praktijken steeds meer stimuleren om zelf met hun spiegelinformatie aan de slag te gaan en van die informatie te leren
ITB	
IMW2	Scholing / uitbreiden / behouden van kennis -Eigen personeel: behoefte wordt bepaald in persoonlijke en evaluatie gesprekken. Indien behoefte aan scholing/cursus wordt gekeken naar inrichten hiervan. Dit wordt deels of volledig gefinancierd onder afspraken. → onduidelijkheid formele proces hiervan. -Zorgverleners: Als zorggroep hebben we insteek om te zorgen dat de zorgverleners bijblijven in kennis. Dat is dan vooral vaak per zorgprogramma wordt er gekeken naar veranderingen in zorgstandaarden of afspraken met partners die belangrijk zijn en toegelicht moeten worden. Dat is meer het faciliteren van deskundigheidsbevordering van ons richting vooral de huisartsen en POH. Afhankelijk van het onderwerp kijken we ook of dat voor andere ketenpartners interessant is → Scholing is deels vraag gestuurd vanuit het veld, deels op basis van kaderarts aanbevelingen, deels op basis van sturingsinformatie uit systeem. Andere ketenpartners: We gaan niet specifiek voor bijvoorbeeld diëtistes een aparte scholing doen, maar als wij een onderwerp hebben waarbij enigszins een of meerdere andere disciplines uit de keten relevant zijn, dan nodigen we ze altijd uit Opslag van kennis is onduidelijk of en waar dat momenteel gebeurd.

Data source	Data on Financial
SD1	Organisatie zorggroep niet te groot, maar groot genoeg om overhead effectief te maken Overhead zoals huidig, is te duur. Focus op alternatieven/multidisciplinaire samenwerking?
SD2	om te komen tot een lager overheadtarief heeft BeRoEmD eind 2013, tijdens een strategiesessie met de certificaathouders, diverse toekomstscenario's verkend. Dit heeft geresulteerd in het nog lopende traject waarin de mogelijkheden tot structurele samenwerking, en mogelijk toekomstige fusie, met een andere zorggroep (van even grote omvang) op diverse dossiers wordt verkend Ieder kwartaal komen directie, STAK bestuur, Raad van commissarissen, financieel- en zorggroepmanager van BeRoEMD bijeen om o.a. zowel de financiële (kwartaal)cijfers als managementrapportage te bespreken. Eenmaal per jaar legt het bestuur financiële en inhoudelijke verantwoording af richting financiers en certificaathouders. Verantwoording aan de patiënt en maatschappij is (nog) niet expliciet geregeld binnen de huidige governance structuur. Of dit überhaupt geregeld moet zijn valt te bediscussiëren, aangezien de zorggroep geen directe behandelrelatie met de patiënt heeft Care2U vormt dit systeem ook voor het financiële proces de basis. De financiële positie van zorggroep BeRoEmD wordt geanalyseerd door een drietal ratio's te bepalen: liquiditeit, solvabiliteit en rentabiliteit. Ratio´s 2013 2014 Conclusie Liquiditeit 1,07 1,08 voldoende Solvabiliteit 7,7% 9,3% risico Rentabiliteit 102 30 voldoende
SD3	Als enige zorggroep heeft Beroemd onderdelen in de VWS begroting, additionele groei in budgettair kader huisartsenzorg en multidisciplinaire zorg.
SD4	
SD5	
SD6	Organiseren van bijeenkomsten en zorgprogramma's uitrollen
IMW1	
ITB	financiering van de behoefte voor een groot gedeelte niet door de klant, maar indirect door de zorgverzekeraar wordt geregeld. BTW plichtig omdat sinds 1 jan 2016 de zorggroep wordt beschouwd als sociaal culturele instelling IPV zorginstelling
IMW2	De zorggroep mag geen winst maken Opbrengsten Zorgverzekeraar belangrijkste bron van inkomsten: een afspraak met de zorgverzekeraar dat we een bepaald budget krijgen voor mensen die in een chronisch zorgprogramma zitten. Een deel daarvan is zorgkosten, geoormerkt voor uitgaven aan zorg. En een deel is overhead. In principe ligt deze verhouding op 80/20. Verhouding bij Beroemd: 72/28 indien ict overhead is. Zorggroepen komen in de knel door deze gestelde verhouding (zie ict). Zorg: Een paar jaar geleden werkten we nog met minutenschema's. Zoveel minuten heb je voor een diabeet en zoveel diabeten hebben we. Prevalentiecijfers en googelen. Nu is het wel redelijk uitgekristalliseerd Voorheen werkte de zorggroep met prestatiebeloningen van de verzekeraars als de KPI bepaalde percentages haalde, dat is sinds 2017 afgeschaft. Nog steeds wel de bedoeling dat ze gehaald worden, maar geen financiële gevolgen meer.

	Kosten: Zorgkosten: betaling aan huisartsen per patiënt. Huisarts krijgt per kwartaal betaalt voor patiënten onder zijn behandeling. Andere zorgverleners krijgen op basis van declaratie. Hier is een pot met geld voor. Fin manager houdt dit per kwartaal in de gaten. Overhead: Lonen personeel & kaderartsen, ICT, scholing, bijeenkomsten, ontwikkelingsprojecten, lidmaatschapsgelden, kantoorkosten, MGP patiëntplatform Mogelijke financiële beloning voor praktijken die zelf met KIS spiegelinformatie aan de slag gaan vanaf 2019 Overhead: Voor kleine zorggroep meer druk op de overheadkosten ivm personeel etc. ICT zware stempel op overhead. Stijging lonen via CAO wordt geen rekening mee gehouden door Zorgverzekeraars. Discussie ICT van Care2U = zorgkosten of = overhead kosten Wij zeggen, dat is geen overhead, dat zijn indirecte zorgkosten. Want die zijn A betaald aan Care2U per diabetespatient in het programma. Drukt momenteel de begroting van Beroemd met 20% (1 ton) Andere financiers zijn er wel, maar wordt niets mee gedaan. Hooguit af en toe gemeentes met subsidie. Financiële gezondheid zorggroep momenteel nog gezond. Wel steeds krapper vanwege bezuinigingen die niet eerlijk zijn. Geld weggehaald uit eerstelijns, terwijl eerstelijns wel functie-uitbreiding vanuit de tweedelijns heeft gekregen.

NOTES

Discussion points from IMW1:

- POH

Die hebben een hele zware centrale rol binnen die zorgprogramma's.

En een aantal POH's zitten bijvoorbeeld ook weer in onze werkgroepen. Die hebben we per zorgprogramma, omdat we een bepaald beleid willen toetsen aan diegenen die het uitvoeren. Er zit altijd een huisarts, praktijkondersteuner en kaderarts afhankelijk van het onderwerp wat op tafel komt nog iemand anders uit de keten ingevlogen. Dus daar zijn ze eigenlijk key partner in, in die zin. Ik zie wat dubbele petten

- Wie is nou eigenlijk de klant

Huisarts partner, klant, resource? De vraag ontstaat wie nou werkelijk de klant van Beroemd is. Zijn dat daadwerkelijk de burgers/patiënten? OF is het eigenlijk de Huisarts (ketenpartner), welke door beroemd in staat moet worden gesteld om die burger te helpen?

- Netwerk:

positie van, inhoud van, bewustzijn van netwerk wordt meermaals genoemd in de interviews en heeft zeer duidelijk met de strategie te maken. De positionering en in gang zetting van strategy is nauw gelinkt aan dit netwerk. Daarom dit meer gravity geven in thesis.

- Strategische issue: bestuur van de zorggroep zijn geen dokters. De huisartsen nemen daardoor weinig aan van de zorggroep. Bemoeilijking functioneren van de zorggroep.

- Er is binnen de strategie van de Zorggroep een duidelijke voorkeur op de huisarts merkbaar in alle strategische documenten en interviews.

- De zorggroep presteert momenteel boven het landelijk gemiddelde

- Revaluatie ICT kosten gebruik Care2U en alternatieven op komst.

Appendix 5: Workshop material

Uitnodiging workshop *Netwerkanalyse*

Om de strategie van de zorggroep en haar leden scherp te stellen en om alle neuzen meer dezelfde kant op te krijgen, organiseren wij binnenkort een workshop waarin we een netwerk analyse gaan maken. Het doel is te komen tot een 'gedeeld inzicht' van het zorgnetwerk. Gedeeld omdat de verschillende visies worden uitgewisseld, worden verduidelijkt (concretiseren) en worden samengesmeed tot een gedeelde visie op het zorgnetwerk.

Dit doen we met behulp van de *participatieve stakeholder engagement* methode. Deze methode is zeer geschikt voor het analyseren van complexe en snel veranderende omgevingen en onzekere toekomsten voor organisaties en het aandragen van oplossingsrichtingen. In deze methode worden de stakeholders sterk betrokken bij het onderzoek. Dit doen we in samenwerking met - en onder leiding van - Roy van Amsterdam, student Bedrijfskunde. Roy schrijft zijn masterscriptie over de strategie en het netwerk van de zorggroep BeRoEmD. Hij heeft tijdens deze workshop de rol van facilitator van het onderzoeksproces

Wat te verwachten: een 2 uur durende workshop waarbij we samen aan de slag gaan om het netwerk van de zorggroep in kaart te brengen. Daarbij kijken we naar welke waarden we als netwerk willen realiseren en hoe we dit doen. Welke activiteiten zijn er nodig voor optimale prestaties voor ons allen? Lukt dat momenteel? Of zijn er dingen die we beter kunnen doen? Etc. Vooraf leggen wij de deelnemers (4-6 personen) een aantal vragen / stellingen voor, die ongeveer een kwartier van je tijd kosten.

Wij streven er naar om in de bijeenkomst een afvaardiging te hebben vanuit de zorggroep, huisartsen en ketenpartners.

Rekening houdend met diverse voorkeuren, stel ik voor om de workshop te plannen op **donderdag 17 mei 12.00 – 14.00 uur. Locatie: praktijk van Marcel (Vincent van Goghlaan 1B, Rosmalen).** N.B. lunch bijeenkomst STAK-Directie zou hiermee komen te vervallen.

Schikt jou dit? Ik hoop van harte je te mogen verwelkomen bij deze workshop, zodat onze ketenpartners ook vertegenwoordigd en betrokken zijn.

Alvast bedankt voor je reactie.

Additional information sent to participants beforehand

Hartelijk dank voor uw deelname aan de netwerk analyse workshop. Dit document dient om u wat meer informatie te verschaffen voor de aankomende workshop. Hiervoor is een agenda opgesteld met tijdsindicatie per onderdeel. Vervolgens geef ik u wat achtergrond informatie waarop de netwerk analyse is gebaseerd, zodat u een beeld krijgt van wat we tijdens de workshop zullen doen. Tot slot staan onderaan een aantal vragen / stellingen om u alvast even aan het denken te zetten.

Zoals eerder aangegeven zullen wij op 17 mei een workshop bijeenkomst houden met als doel het creëren van een gedeeld inzicht van het zorgnetwerk van BeRoEmD, haar partners en leden. Dit gaan we doen door middel van een *participatieve stakeholder* methode. Hiermee wordt bedoeld dat de stakeholders, de deelnemers, actief deelnemen aan de workshop en samen het netwerk in kaart brengen. Om deze workshop in goede banen te leiden zal ik jullie faciliteren door vragen te stellen, aantekeningen te maken

en jullie de kans geven met elkaar in gesprek te gaan. Door de verschillende achtergronden van de deelnemers, leidt dit hopelijk tot een productief en interessant resultaat!

Aangezien de bijeenkomst plaats zal vinden onder lunchtijd, zullen wij een lunch verzorgen. Deze kan tijdens de workshop worden genuttigd.

Agenda

De agenda voor de workshop ziet er als volgt uit:

Agenda netwerk analyse workshop BeRoEmD			**17-05-2018**
Deel	**Activiteit**	**Duur (min)**	**Tijd**
1	**Welkom**	5	12.00-12.05
2	**Introductie**	5	12.05-12.10
3	**Definiëring & inkadering** We definiëren wat we onder het netwerk verstaan en kaderen dit in met de waardes die het netwerk de klant, maar ook onszelf, moet opleveren.	30	12.10-12.40
4	**Primaire (uitvoerende) activiteiten** We bepalen wat de primaire activiteiten zijn die het netwerk uit moet voeren om. Daarbovenop kijken we wie of welke partijen deze activiteiten daadwerkelijk uit (horen te) voeren.	30	12.40-13.10
5	**Korte pauze**	5	13.10-13.15
6	**Regulerende activiteiten** We bepalen welke regulerende activiteiten in het netwerk plaats moeten vinden om de primaire activiteiten te ondersteunen + wie of welke partijen deze activiteiten daadwerkelijk uit (horen te) voeren.	30	13.15-13-45
7	**Afsluiting** We ronden de activiteiten af, vatten deze samen en komen tot een gezamenlijke conclusie	15	13.45-14.00

Achtergrond informatie over netwerken

Een succesvol netwerk is in staat om te overleven binnen een snel veranderende en complexe omgeving. Om dit te kunnen, heeft het netwerk volgens systeem theorie 5 functies nodig:

1. **Primaire activiteiten**: De uitvoerende taken die het bestaansrecht van het netwerk opleveren. Deze taken vervullen de waardes die je met het netwerk wenst waar te maken.
2. **Coördinatie:** Om de verschillende uitvoerende taken goed te laten functioneren is er coördinatie nodig.
3. **Controle:** de controle functie zorgt voor de cohesie van het netwerk. Dat wil zeggen dat er gecontroleerd wordt of we dingen goed doen én of de dingen die we doen daadwerkelijk goed zijn.
4. **Intelligentie:** Om mee te gaan met veranderingen moeten we soms vernieuwen. De functie intelligentie scant te omgeving op trends en ontwikkelingen die het netwerk kunnen versterken. Het creëert voorstellen om deze vernieuwingen toe te passen
5. **Beleid:** Beleid zet te richtlijnen uit. Het beheert discussie tussen vernieuwen en behouden van de activiteiten.

De primaire activiteiten kunnen worden gezien als uitvoerende activiteiten, welke worden aangevuld door de resterende regelende activiteiten. Met behulp van deze activiteiten zullen wij tijdens de workshop een netwerk analyse maken. Bij deze analyse houden we rekening met de norm: hoe willen we eigenlijk dat het netwerk functioneert? Deze vergelijken we met de werkelijkheid: hoe functioneert het netwerk daadwerkelijk? Door dit voor zowel de uitvoerende als de regelende taken te beoordelen hoe we het doen en wie het doen, creëren we een gedeeld inzicht van het netwerk. Waarbij het ook duidelijk wordt welke delen sterk functioneren, of juist onze aandacht vereisen omdat ze wat minder functioneren.

Vragen / stellingen vooraf

Om u alvast een beetje aan het denken te zetten, willen we u vragen om alvast na te denken over de volgende vragen en stellingen. Probeer op elk punt een kort (geschreven) antwoord te geven.

Vragen:

1. Wat is, volgens u, het zorgnetwerk BeRoEmD?
2. Uit welke partijen bestaat het netwerk?
3. Wat is, of wat zijn, de belangrijkste waarde(n) die het netwerk dient te realiseren?
4. Hoe realiseert het netwerk deze waarden?
5. Welke primaire activiteiten zijn nodig binnen het netwerk?
6. Welke ondersteunende / regelende activiteiten dienen daarom aanwezig te zijn?
7. In welke capaciteit moeten deze activiteiten ingericht worden binnen het netwerk?

Stellingen:

1. Het zorgnetwerk, zoals het nu is, functioneert prima
2. Het zorgnetwerk, zoals het nu is, kan op bepaalde punten nog zeker verbeterd worden
3. Het is voor mij duidelijk welke activiteiten ik uit moet voeren binnen het netwerk
4. Ik word voldoende ondersteun door andere partijen in het netwerk om mijn werkzaamheden ten volle uit te voeren

5. De communicatie binnen het netwerk verloopt soepel
6. De samenwerking binnen het netwerk verloopt soepel
7. Er sluipt wel eens een foutje in de service richting de patiënt ten gevolge van het netwerk

Powerpoint presentation workshop

Workshop
Netwerk Analyse
BeRoEmD 17-05-2018

1. Welkom
2. Agenda
3. Achtergrond
4. Het Netwerk
5. Uitvoerende activiteiten
6. Pauze
7. Regelende activiteiten
8. Afronding

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6	**Korte pauze**	5	13.10-13.15
7	**Reguierende activiteiten** We bepalen welke regulerende activiteiten in het netwerk plaats moeten vinden om de primaire activiteiten te ondersteunen + wie of welke partijen deze activiteiten daadwerkelijk uit (horen te) voeren.	30	13.15-13.45
8	**Afsluiting** We ronden de activiteiten af, vatten deze samen en komen tot een gezamenlijke conclusie.	15	13.45-14.00

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- Korte introductie van het onderzoek tot dusver
- Doel van deze workshop
- 5 functies van een gezond netwerk
  - Primaire activiteiten
  - Coördinatie
  - Controle
  - Informatie
  - Beleid
- Netwerken analyseren
  - Het netwerk inkaderen
  - Bepalen welke waarde(n) het netwerk wil realiseren
  - Identificeren uitvoerende (primaire) activiteiten die daarbij horen
  - Regelende & ondersteunende activiteiten aangeven

1. Welkom
2. Agenda
3. Achtergrond
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6. Pauze
7. Regelende activiteiten
8. Afronding

- Wat is "het zorgnetwerk" BeRoEmD?

1. Welkom
2. Agenda
3. Achtergrond
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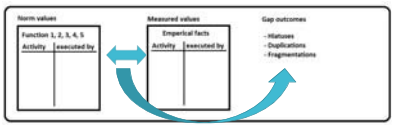
5. Uitvoerende activiteiten
6. Pauze
7. Regelende activiteiten
8. Afronding

- Wat zijn de primaire activiteiten van het zorgnetwerk BeRoEmD?
- Welke dingen moeten echt gebeuren om de waarde van ons netwerk te realiseren?
- Functie 1: Primary activities



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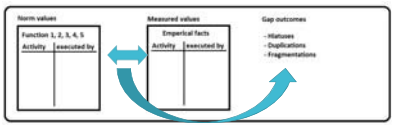
7. Regelende activiteiten
8. Afronding

- Wat zijn de ondersteunende en regelende activiteiten van het zorgnetwerk BeRoEmD?
- Welke regelende taken en ondersteunende functies zijn er nodig om de primaire activiteiten vlekkeloos te laten verlopen?
- Functies 2-5: coördinatie, controle, informatie, beleid



1. Welkom
2. Agenda
3. Achtergrond
4. Het Netwerk
5. Uitvoerende activiteiten
6. Pauze
7. Regelende activiteiten
8. Afronding

- **Wrap-up**
- Korte samenvatting
- Conclusie van vandaag
- Vervolg van het onderzoek

Appendix 6: Interview questionnaires health insurers

Interview Mark Able

Bedankt voor je tijd. Ik zou dit interview graag willen opnemen, voor de kwaliteit van het onderzoek. Vind je dat goed? Voor deze netwerk analyse beperk ik mij tot het zorgnetwerk waar BeRoEmD zich in bevindt. Dat zien we met name in de zorgverzekeraars, beroemd zelf en de uitvoerende partijen zoals de huisartsen, diëtisten, en andere therapeuten. Ik wil graag de norm vergelijken met de feiten. Misschien kunnen we eerst samen de globale vragen en stellingen doornemen die ik vooraf had gestuurd? Waarna ik nog een paar verdiepende vragen voor je heb.

Vragen:

8. Wat is, volgens u, het zorgnetwerk BeRoEmD?
9. Uit welke partijen bestaat het netwerk?
10. Wat is, of wat zijn, de belangrijkste waarde(n) die het netwerk dient te realiseren?
11. Hoe realiseert het netwerk deze waarden?
12. Welke primaire activiteiten zijn nodig binnen het netwerk?
13. Welke ondersteunende / regelende activiteiten dienen daarom aanwezig te zijn?
14. In welke capaciteit moeten deze activiteiten ingericht worden binnen het netwerk?

Stellingen:

8. Het zorgnetwerk, zoals het nu is, functioneert prima
9. Het zorgnetwerk, zoals het nu is, kan op bepaalde punten nog zeker verbeterd worden
10. Het is voor mij duidelijk welke activiteiten ik (mijn partij) uit moet voeren binnen het netwerk
11. Ik word voldoende ondersteun door andere partijen in het netwerk om mijn werkzaamheden ten volle uit te voeren
12. De communicatie binnen het netwerk verloopt soepel
13. De samenwerking binnen het netwerk verloopt soepel
14. Er sluipt wel eens een foutje in de service richting de patiënt ten gevolge van het netwerk

Aanvullende vragen:

Ik wil graag nog iets dieper ingaan op jullie interactie met BeRoEmD. Vandaar dat ik je ook graag wil vragen om kritisch over dit netwerk na te denken. Jullie zijn net weer begonnen met het inkoopbeleid voor 2020 als ik het goed begrepen heb uit jullie inkoopbeleid document.

-Kun je misschien specifiek de relatie tussen VGZ en Beroemd aanduiden?

-Wat is jouw rol hierin?

-Zijn er bepaalde protocollen opgesteld? Over hoe zaken geregeld zouden moeten worden?

-Worden deze protocollen altijd nageleefd?

Gaat het soms anders?

Moet het soms anders?

Welke invloed hebben de werkdruk- en personeels-problematiek op het functioneren van het netwerk?

Jullie hebben in jullie zorgbeleid nu combinatieketens opgenomen, wat betekent dat als patiënten lijden aan meerdere chronische ziekten, ze daar in kunnen vallen, in plaats van deel te nemen aan 2 losse ketens. Dit zou je kunnen opvatten als klantsegmentatie en nieuwe ontwikkeling, hoe is deze tot stand gekomen?

Uit de hierop voorafgaande strategische analyse kwam naar voren dat de financiën een beperkende factor zijn voor de zorggroep. Dit kwam met name door de verdeling tussen directe zorgkosten en overhead kosten, waarbij alle ICT op 1 hoop onder overhead wordt geplaatst. De zorggroep geeft aan dat dit anders zou moeten zijn. Wat is jouw visie hier op? Jullie noemen al het verminderen van de differentiatie tussen zorggroepen.

Zelfmanagement van de patiënt is een term die ik steeds vaker ben tegen gekomen. Ook in jullie inkoopbeleid. Welke implicaties levert dit op voor het netwerk?

Tot slot, zijn er volgens jou nog zaken over het zorgnetwerk (BeRoEmD) die ik moet meenemen in mijn netwerk analyse?

Interview Karen Schram (CZ)

Bedankt voor je tijd. Ik zou dit interview graag willen opnemen, voor de kwaliteit van het onderzoek. Vind je dat goed? Voor deze netwerk analyse beperk ik mij tot het zorgnetwerk waar BeRoEmD zich in bevindt. Dat zien we met name in de zorgverzekeraars, beroemd zelf en de uitvoerende partijen zoals de huisartsen, diëtisten, en andere therapeuten. Ik wil graag de norm vergelijken met de feiten. Misschien kunnen we eerst samen de globale vragen en stellingen doornemen die ik vooraf had gestuurd? Waarna ik nog een paar verdiepende vragen voor je heb.

Vragen:

1. Wat is, volgens u, het zorgnetwerk BeRoEmD?
2. Uit welke partijen bestaat het netwerk?
3. Wat is, of wat zijn, de belangrijkste waarde(n) die het netwerk dient te realiseren?
4. Hoe realiseert het netwerk deze waarden?
5. Welke primaire activiteiten zijn nodig binnen het netwerk?
6. Welke ondersteunende / regelende activiteiten dienen daarom aanwezig te zijn?
7. In welke capaciteit moeten deze activiteiten ingericht worden binnen het netwerk?

Stellingen:

1. Het zorgnetwerk, zoals het nu is, functioneert prima
2. Het zorgnetwerk, zoals het nu is, kan op bepaalde punten nog zeker verbeterd worden
3. Het is voor mij duidelijk welke activiteiten ik (mijn partij) uit moet voeren binnen het netwerk
4. Ik word voldoende ondersteun door andere partijen in het netwerk om mijn werkzaamheden ten volle uit te voeren
5. De communicatie binnen het netwerk verloopt soepel
6. De samenwerking binnen het netwerk verloopt soepel
7. Er sluipt wel eens een foutje in de service richting de patiënt ten gevolge van het netwerk

Aanvullende vragen:

Ik wil graag nog iets dieper ingaan op jullie interactie met BeRoEmD. Vandaar dat ik je ook graag wil vragen om kritisch over dit netwerk na te denken. Jullie zijn net weer

begonnen met het inkoopbeleid voor 2020 als ik het goed begrepen heb uit jullie inkoopbeleid document.

-Kun je misschien specifiek de relatie tussen CZ en Beroemd aanduiden?

-Wat is jouw rol hierin?

Jullie zijn samen met VGZ preferente verzekeraar in de regio voor Beroemd.

- Wat zijn de verschillen tussen jullie en VGZ in de aanpak?
- Zijn er ook overeenkomsten?
- Wat heeft het hebben van 2 verzekeraars voor impact op jullie beleidsvoering?
- En hoe denk je dat dit voor Beroemd is?

Jullie inkoopbeleid noemt de verkrapping van de arbeidscapaciteit in de eerste lijn, terwijl er meer beroep op deze sector wordt gedaan. Welke invloed hebben de werkdruk- en personeels-problematiek op het functioneren van het netwerk?

Jullie noemen ondersteuning voor ICT-systemen zelf ook in het inkoopbeleid. Uit de hierop voorafgaande strategische analyse kwam naar voren dat de financiën een beperkende factor zijn voor de zorggroep. Dit kwam met name door de verdeling tussen directe zorgkosten en overhead kosten, waarbij alle ICT op 1 hoop onder overhead wordt geplaatst. De zorggroep geeft aan dat dit anders zou moeten zijn. Wat is jouw visie hier op? Jullie noemen al het verminderen van de differentiatie tussen zorggroepen.

Jullie zorginkoop beleid is er op gericht om initiatieven verder te ontwikkelen en ondersteunen. Kun je hier voorbeelden van noemen in het geval van Beroemd?

Zelfmanagement van de patiënt is een term die ik steeds vaker ben tegen gekomen. Ook in jullie inkoopbeleid. Welke implicaties levert dit op voor het netwerk?

Tot slot, zijn er volgens jou nog zaken over het zorgnetwerk (BeRoEmD) die ik moet meenemen in mijn netwerk analyse?

Appendix 7: Workbook from Workshop 17-05-2018

Werkboek Workshop
Netwerk Analyse Beroemd

Rapportage van de workshop netwerk analyse

Donderdag 17 mei (12.00u – 14.00u)

Vincent van Goghlaan 1B, Rosmalen

Roy van Amsterdam

Roy.van.amsterdam@gmail.com

Tel. 06 10 32 46 42

Voorwoord

Deze rapportage van de workshop nodigt u uit om te reflecteren op de workshop. Bovendien dient dit rapport als opslag van de tijdens de workshop vergaarde kennis. De uitkomsten van de workshop zijn hierin gerapporteerd en Ik heb geprobeerd transparantie over de totstandkoming van deze uitkomsten te bevorderen. Ik wil u met deze rapportage uitnodigen verder na te denken over het netwerk waar u deel van uitmaakt. Dit op het gebied van de verhoudingen in het netwerk evenals de activiteiten in en door het netwerk.

Met vriendelijke groet,
Roy van Amsterdam

Inhoud

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INHOUD **FOUT! BLADWIJZER NIET GEDEFINIEERD.**

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Introductie

De workshop Netwerk analyseren heeft plaatsgevonden op donderdag 17 mei van 12.00 uur tot en met 14.00 uur. Dit was op de Vincent van Goghlaan 1B, Rosmalen, waar de huisartsenpraktijk van Marcel Rombeek gevestigd is. De volgende deelnemers hebben deelgenomen aan de workshop in de volgende hoedanigheid.

Aanwezig:

- Monique Weisse, directeur Zorggroep BeRoEmD
- Diedelinde van Riel, kwaliteitsmanager Zorggroep BeRoEmD
- Han Ferree, medisch directeur Zorggroep BeRoEmD, tevens aangesloten huisarts
- Marcel Rombeek, huisarts
- Jan Andeweg, apotheker en afgevaardigde van de resterende ketenpartners

Afwezig:

- Irene van Ditzhuijsen, huisarts.

Roy van Amsterdam, master student Bedrijfskunde (Organisatie Ontwerp & Ontwikkeling) aan de Radboud Universiteit heeft deze workshop gefaciliteerd met hulp van Rosalie Adolfs.

Aanleiding

Deze workshop is onderdeel van een strategisch onderzoek dat Roy van Amsterdam tezamen met BeRoEmD uitvoert voor het behalen van zijn master thesis. Dit onderzoek heeft eerst de strategie van BeRoEmD geanalyseerd op formele correctheid in de vorm van compleetheid plus interne & externe consistentie. Als vervolg hierop wordt bekeken naar hoe een organisatie of netwerk levensvatbaarheid, of bij voorkeur een nuttig voortbestaan kan garanderen. Deze workshop dient om het zorgnetwerk BeRoEmD in kaart te brengen en analyse mogelijk te maken. Tijdens deze workshop zal het netwerk geanalyseerd worden in 3 stappen:

1. Wat is het zorgnetwerk BeRoEmD? En welke waarde(n) streeft dit netwerk na?
2. Welke primaire (uitvoerende) activiteiten moet het netwerk uitvoeren om deze waarde(n) te realiseren?
3. Welke secundaire (regelende & ondersteunende) activiteiten heeft het netwerk nodig om de primaire activiteiten naar behoren te laten functioneren?

Processueel verloop workshop

We zijn de workshop begonnen met een korte introductie en samenvatting van het onderzoek dat ik verricht bij Zorggroep BeRoEmD. Hierbij is toegelicht dat voorafgaand aan deze netwerk analyse, we in samenwerking hebben gekeken naar de formele correctheid van de strategie voor Zorggroep BeRoEmD. Uit deze strategische analyse kwam naar voren dat Zorggroep BeRoEmD gebaat zou zijn met een overzicht van het netwerk en hoe dit netwerk in elkaar zit. Tevens was de wens aanwezig om dit te doen met deelnemers uit dat netwerk, zodat we de partners van Zorggroep BeRoEmD actief betrekken.

Vervolgens hebben we kort herhaald wat kan worden verstaan onder het *Viable Systems Model* van Beer (1985) en de 5 functies die hij voorschrijft om een systeem levensvatbaar te houden. Een systeem kan worden vertaald naar een organisatie of netwerk. Deze functies zijn onderverdeeld in de uitvoerende functies (primaire activiteiten) en regulerende functies (coördinatie, controle, informatie & beleid). Al deze functies moeten aanwezig en ingevuld zijn in een systeem om sterk te functioneren.

Hierna zijn we de werkelijke workshop gestart door het systeem te definiëren. Hierbij heb ik jullie middels NGT brainstormtechnieken gevraagd om allemaal 5 partijen die lid zijn van het netwerk te bedenken en voor jezelf op te schrijven. Nadat jullie voor jezelf hier over nagedacht hadden, hebben we gezamenlijk een lijst opgesteld met partijen die, volgens jullie, lid zijn van het netwerk. Aansluitend hierop heb ik jullie gevraagd naar de belangrijkste waarden die het netwerk op moet leveren voor zowel de klant als de deelnemende partijen zelf. Het was hier van belang om aan te duiden dat voor de zorgverleners de patiënt aslant wordt gezien, terwijl voor de organisatie BeRoEmD juist de zorgverleners als klant kunnen worden aangewezen. Nadat we de belangrijkste waarden hadden geformuleerd, hebben we hier 1 lopende zin van gemaakt.

Aansluitend op de inkadering van het netwerk, zijn we gaan kijken wat de primaire, ofwel uitvoerende, activiteiten zijn van dit netwerk. Hier bleek enige verwarring te ontstaan over hoe we uitvoerend van regulerend onderscheiden. Evenals de vraag welke pet sommige van onze deelnemers op moesten zetten, op welk aggregatielevel zij moesten denken over primaire activiteiten. Uiteindelijk hebben we dit opgelost door aan te geven dat we kijken naar de activiteiten van het netwerk als geheel, in plaats van de

partijen als losse identiteiten te zien. Hierdoor ontstond consensus over dat de daadwerkelijke zorg leveren de primaire activiteit van het netwerk is.

Aanvullend op de primaire activiteiten, was duidelijk dat er behoorlijk veel regulerende activiteiten nodig zijn in het zorgnetwerk BeRoEmD. Daarom hebben we hier wat langer over gediscussieerd en heb ik iedereen de kans gegeven om zijn of haar input te geven op alle 4 de regulerende functies.

Tot slot hebben we het geheel samengevat in een overzicht van het netwerk en de activiteiten van het netwerk waarin een ieder zich kon vinden.

Inhoudelijk verloop workshop

Zoals in de vorige paragraaf processueel is samengevat, hebben we de workshop in 3 onderwerpen verdeeld; 1) het netwerk, 2) de primaire activiteiten en 3) de regulerende activiteiten. Daarom worden hieronder de onderwerpen ook in die volgorde inhoudelijk gepresenteerd.

1. Netwerk

Bij het definiëren van het netwerk hebben we eerst een overzicht gemaakt van alle partijen die volgens de deelnemers in het zorgnetwerk BeRoEmD aanwezig zijn. Hieruit kwam naar voren dat de volgende partijen deel uit maken van het zorgnetwerk:

Partijen direct in het netwerk	**Partijen in de periferie van het netwerk**
Zorggroep BeRoEmD	Ziekenhuis Jeroen Bosch
Huisartsen	Andere zorggroepen, met name Chronos
Praktijkondersteuners	Vivent
Paramedici, verzamelnaam o.a. voor: Diëtisten, podotherapeuten, ergotherapeuten, psycholoog, radioloog fysiotherapeut	Thuiszorg
Apothekers	Gemeente
Diagnostisch centrum	Overige, niet aangesloten, huisartsen in de regio
Kaderartsen	Andere verenigingen zoals: Ineen, Apothekersgroep, LHV
Zorgverzekeraars: CZ & VGZ	
Patiënt / burger	

Vervolgens hebben we gekeken naar wat de belangrijkste waarden zijn die het netwerk op moet leveren met betrekking tot het leveren van zorg. Hier kwam uit naar voren dat de volgende waarden als essentieel worden beschouwt:

Waarden
Kwaliteit*
Continuïteit
Bereikbaarheid / dichtbij
Laagdrempeligheid
Toegankelijkheid
Geïntegreerd**
Efficiënt
Betaalbaar

*Over de waarde kwaliteit ontstond enige discussie omtrent wat we hieronder moeten verstaan. Is dit de 'ervaren kwaliteit' van de klant, of is dit 'meetbare kwaliteit' van de zorgstandaarden. Uiteindelijk hebben we besloten dat het eigenlijk om beiden gaat, zolang de klant hier maar het meest gebaat bij is.

**Geïntegreerd kan worden begrepen als goed op elkaar aansluitend.

➔ **Hoofddoel:** *Het zorgnetwerk BeRoEmD streeft er naar om geïntegreerde zorg te leveren van voldoende kwaliteit en continuïteit welke evenwel laagdrempelig, toegankelijk en bereikbaar is voor de burger en tegelijkertijd ook efficiënt en betaalbaar blijft.*

2. Primaire activiteiten

Primair moet het netwerk de zorg leveren aan burgers in de regio van het zorgnetwerk. Deze zorg moet voldoen aan de doelstelling zoals deze hierboven gedefinieerd is. De verlening van zorg wordt met name uitgevoerd door de huisartsen, paramedici, apothekers en diagnostische centra. Verder kunnen we de zorg segmenteren in ketens gerelateerd aan het ziektebeeld. Dit leidt tot de volgende ketens:

Diabetes
COPD / astma
CVD
GGZ*
Ouderenzorg*
Overig chronisch**

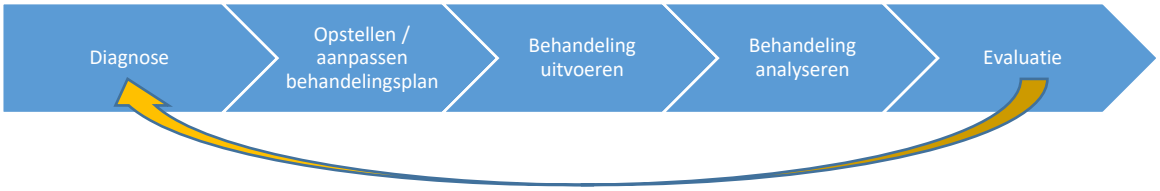
* De ketens diabetes, COPD en CVRM zijn bestaande en verankerde ketens binnen de chronische zorg, zoals deze nu in Nederland geleverd wordt. De ketens GGZ & ouderenzorg zijn in ontwikkeling en breiden de laatste jaren uit. Het ziet er naar uit dat deze, net als de reeds bestaande ketens, een vaste plaats in de chronische zorg zullen innemen.

**Onder overige chronisch kan alle chronische zorg worden verstaan die niet in een van de daarboven genoemde ketens valt in te delen.

Het is mogelijk dat een patiënt in één keten ingedeeld wordt, maar het is ook mogelijk dat een patiënt in een combinatie van ketens valt in te delen als gevolg van multimorbiditeit.

Voor het begrip van de facilitator heb ik gevraagd naar de logische stappen binnen het verlenen van deze zorg. Hieruit werd duidelijk dat het tot in detail uitschrijven van

deze primaire activiteiten niet mogelijk / haalbaar is, zeker niet binnen de hiervoor gestelde tijd van de workshop. Wat we wel vast kunnen stellen is dat de meerderheid van de patiënten het netwerk binnenkomt via de huisarts. De huisarts heeft daarmee de poortwachtersfunctie en zal een diagnose stellen, waarna een behandelingsplan wordt opgezet. Indien nodig met andere partners uit het netwerk.



3. Regulerende activiteiten

De regulerende activiteiten zijn ondersteunend aan de primaire activiteiten (uitvoeren van zorgverlening). Waar de uitvoerende rol voornamelijk ligt bij de huisartsen, paramedici en apothekers, ligt de verantwoordelijkheid voor de regulerende activiteiten hoofdzakelijk bij Zorggroep BeRoEmD. Aangevuld door de POH's, de kaderartsen en wellicht deels bij de zorgverzekeraars.

3.1 Coördinatie

Zorggroep BeRoEmD krijgt met name een faciliterende rol aangeschreven in de coördinatie van de zorg. Zij verzorgt onder andere de ICT-ondersteuning in de vorm van KIS, HIS & declaratieproces. Daarnaast is de zorggroep verantwoordelijk voor aansturing, scholing, taakverdeling van de uitvoerende partijen. De zorggroep zorgt voor het samenbrengen van partijen en kennis. Daarnaast vervullen de POH's ook een groot deel van de coördinatie.

3.2 Controle

De controle activiteiten liggen ten dele bij alle ketenpartners zelf, maar moet worden gecoördineerd door Zorggroep BeRoEmD. Daarnaast is het de zorggroep die het grotere plaatje in de gaten houdt. Zij controleert voor heel de regio (alle aangesloten partners) of er wordt voldaan aan de afspraken. Is dit niet het geval, is het ook de taak aan de zorggroep om hier melding van te maken en waar nodig mee te denken over oplossingen.

Er zijn periode evaluatie momenten, in de vorm van ledenvergaderingen. De deelnemers geven echter aan dat deze niet bijzonder goed worden bezocht. Redenen hiervoor kunnen worden

gezocht in de communicatie hiervan, tijdgebrek vanuit de kant van de partners en ‘het gaat goed dus ik bemoei me er niet mee’ wordt als mentaliteit aangegeven.

3.3 Informatie

De activiteit van het actief in de gaten houden van trends en ontwikkelingen voor het netwerk gebeurt grotendeels via de kaderartsen in samenwerking met Zorggroep BeRoEmD. Daarnaast gebeurt het ook wel eens dat huisartsen of paramedici iets aandragen waar zij tegenaan zijn gelopen. Wanneer veranderingen vanuit wet- & regelgeving komen, is het meestal de zorggroep die dit uitzoekt voor alle partners. Andere trends en ontwikkelingen worden voornamelijk verdeeld op thema voor wie dit uitzoekt. Daarnaast vinden de deelnemers het belangrijk om alle partijen in het netwerk actief te betrekken op dit gebied. Het zou, voor het netwerk, positief zijn als partijen enerzijds wat meer bereidheid en welwillendheid tonen omtrent verandering / vernieuwing. Anderzijds kan de zorggroep hier een actievere rol in aannemen om partijen sterker te betrekken bij ontwikkelingen die spelen.

3.4 Beleid

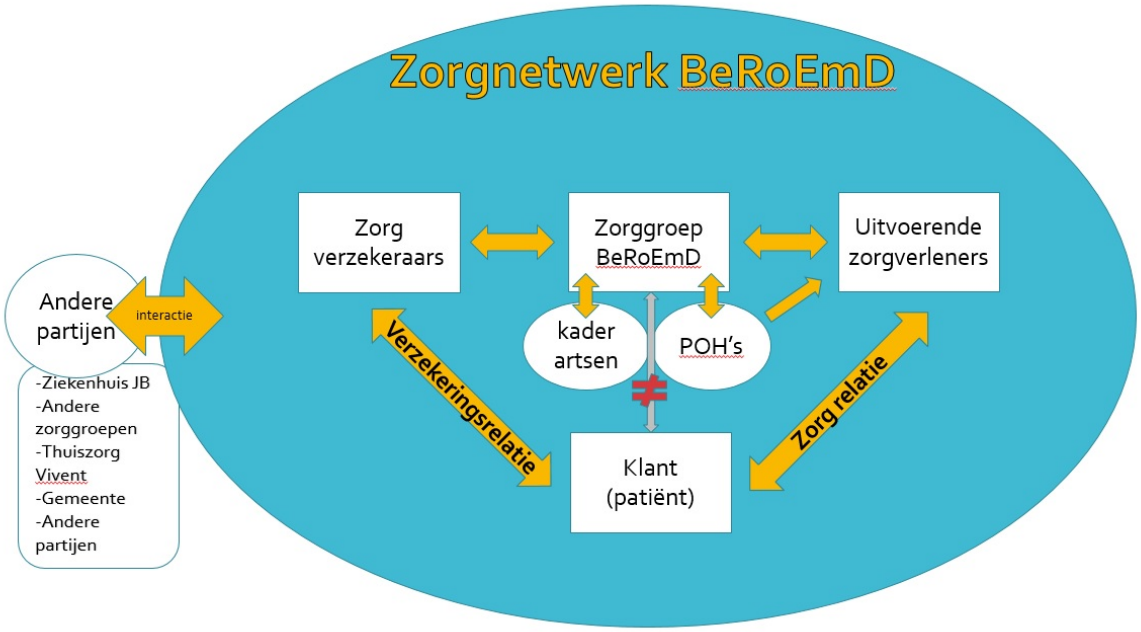
De functie beleid ligt hoofdzakelijk bij Zorggroep BeRoEmD. Zij is verantwoordelijk voor het opstellen van contracten en / of protocollen die noodzakelijk zijn voor het juist functioneren van de andere activiteiten. Voor het maken van dit beleid is het wel weer gewild en verstandig om andere partijen te raadplegen. Tevens zal de zorgverzekeraar ook eisen hebben. Wel geven de deelnemers aan dat het netwerk niet overspoeld moet worden met regeltjes en eisen, omdat dit geen toegevoegde waarde biedt. Er moet genoeg vrijheid zijn om zaken zelf in te vullen en op te lossen binnen bepaalde randvoorwaarden. Op die manier blijft de professionele autonomie gewaarborgd, maar voldoet het netwerk als geheel wel aan de standaarden die gezet worden, welke af te leiden zijn vanuit het hoofddoel.

Conclusie

Deze 2 uur durende workshop heeft opgeleverd dat we gezamenlijk het zorgnetwerk BeRoEmD in kaart hebben weten te brengen. Hierbij hebben we de *core values* van het netwerk gedefinieerd. Met behulp van deze waarden kan de volgende hoofddoelstelling voor het netwerk worden opgesteld:

"Het zorgnetwerk BeRoEmD streeft er naar om geïntegreerde zorg te leveren van voldoende kwaliteit en continuïteit welke evenwel laagdrempelig, toegankelijk en bereikbaar is voor de burger en tegelijkertijd ook efficiënt en betaalbaar blijft."

Daar op aanvullend hebben we geïdentificeerd welke partijen er allemaal deel uit maken van het zorgnetwerk BeRoEmD. Hierbij hebben we een onderscheid gemaakt tussen partijen die zich direct en actief in het netwerk bevinden en partijen die zich in de periferie van het netwerk bevinden. Dit levert de volgende schets van het netwerk op:



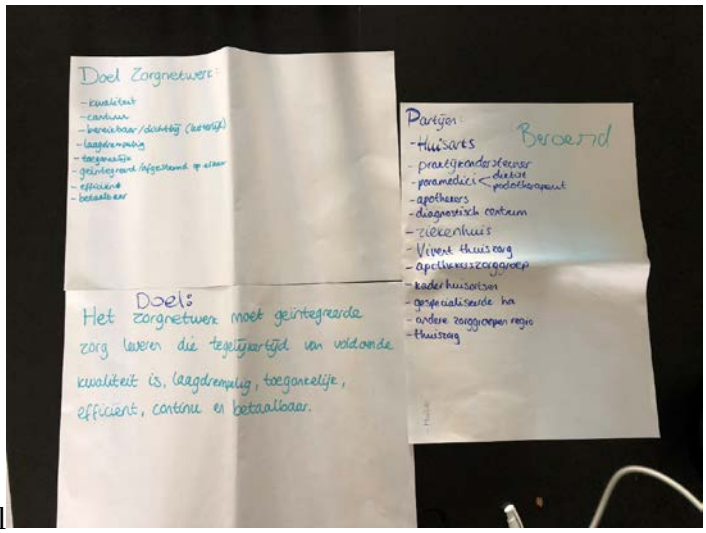
Toelichting op deze schets:

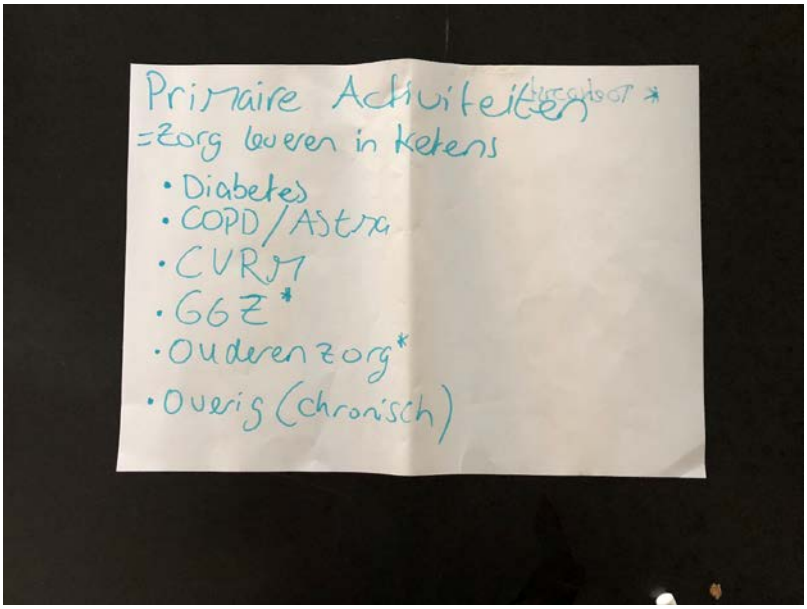
- De zorgverzekeraars gaan met de patiënten een verzekeringsrelatie aan
- De zorgverleners gaan met de patiënten een zorgrelatie aan.
- Zorggroep BeRoEmD heeft geen direct contact met de patiënt, dit verloopt via 1 van de 2 andere kanalen.
- Zorggroep BeRoEmD heeft wel relaties met de zorgverzekeraars, uitvoerende zorgverleners, kaderartsen en POH's.
- Andere partijen interacteren met het netwerk, of partijen uit het netwerk waar nodig.
-

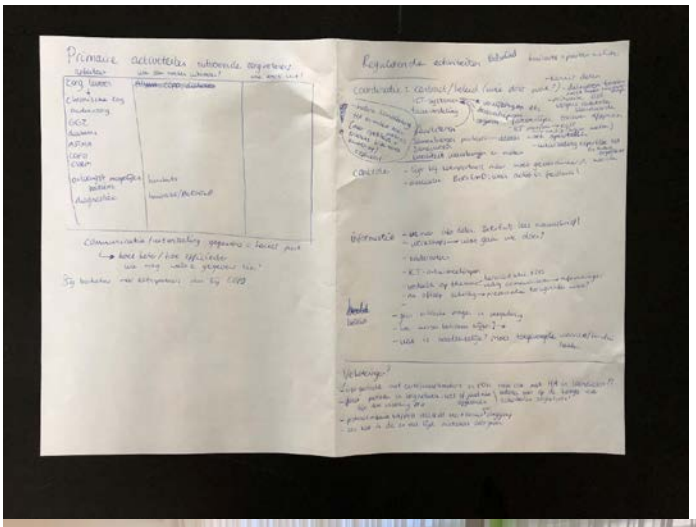
Hier op voortbouwend hebben we gekeken naar welke uitvoerende activiteiten vereist / aanwezig zijn in het netwerk om het eerder opgestelde hoofddoel van het netwerk te behalen. Hierbij zijn we tot de conclusie gekomen dat het leveren van zorg, gesegmenteerd in ketens, kan worden aangemerkt als primaire activiteiten. Deze activiteiten worden hoofdzakelijk uitgevoegd door de zorgverleners van het netwerk (c.q. huisartsen, paramedici, apothekers en diagnostische centra).

De regulerende activiteiten ondersteunen het netwerk en de uitvoerende activiteiten door coördinatie, controle, informatie en beleid toe te voegen aan het netwerk. Op die manier bieden deze functies structuur en zorgen ze voor het juist functioneren van de primaire activiteiten. We zien dat deze taken hoofdzakelijk bij Zorggroep BeRoEmD liggen. Hierbij is het wel van belang dat de zorggroep nauw samenwerkt met de andere partijen en deze, waar nodig, betrekt bij deze activiteiten.

Met elkaar zijn we tot de conclusie gekomen dat de uitvoering van primaire activiteiten bij de zorgverleners moet liggen, waarbij de zorg verlenende partijen zo goed mogelijk worden ondersteund door (hoofdzakelijk) Zorggroep BeRoEmD via regulerende activiteiten. De uitvoering van de zorg aan patiënt moet voldoen aan de hoofd doelstelling zoals deze vandaag is geformuleerd. Hierover dragen we gezamenlijke zorg met alle partijen in het netwerk. Dit bereiken we door samen te werken, elkaar aan te vullen en de dialoog met elkaar aan te blijven gaan.

Fotomateriaal 





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