

THE ADDED VALUE OF FM FOR DUTCH IC

A MULTIPLE-CASE STUDY



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ABBREVIATIONS

CH	- Current hospital: hospital that is not practicing IC
FM	- FM
FME	- Facility Management Expert
GP	- General Practitioner
IC	- Integrated Care
ICC	- IC Centre: care centre that is practicing IC
ICE	- Integrated Care Expert
IH	- Integrated Hospital: hospital that is practicing IC
IT	- Information Technology
PR	- Patients representative
vs	- Versus

ABSTRACT

Background

Worldwide healthcare systems insist a patient centred, integrated, approach, which improves clinical outcomes, quality of life, patient satisfaction, effectiveness, and efficiency. In the Netherlands, Integrated care (IC) centres arise, but literature does not attend Facility Managements (FM) role. This research addresses FM value needs for IC.

Methods

In this multiple case study research, data is collected by using semi-structured interviews, an expert meeting and secondary data (triangulation). Sampling is purposive and non-probability based. The response rate of semi-structured interviews was higher than the response rate of the expert meeting (4 out of 5 vs 3 out of 10).

All four cases separately represented either a first or second line organization, from either an integrated or not integrated perspective. Semi-structured interviews, using an interview guide, are conducted with a medical specialist and a general manager per case.

An expert meeting with an IC expert, FM expert and patient representative is organized and nine non-academic secondary documents written in the last four years are analysed, to determine consistencies and differences with case study data.

Results

In the Netherlands, IC considers shifting low complex second line care to first line, improving quality and service and reducing costs (triple aim). FM needs and FM added value are indefinite, especially within cases without IC. IC needs little accommodation adjustments. Specifically, FM needs to support self-management, prevention, and communication. Added value of FM for IC is increase customer satisfaction, support image and improve productivity.

Conclusion

FM can add value to IC through a demand-driven organizational strategy that increases satisfaction, creating a customer friendly environment, and excellent digital infrastructure that supports image and improves productivity, reinforcing IC's triple aim.

FOREWORD

In front of you, you find my thesis about the added value of FM for IC. This thesis reports my study in the field of FM, commissioned by the University of Greenwich. Except where stated otherwise, content is based on my work only.

All my life I have been passionate about people's health. My second obsession is organizing; I am always busy planning, managing, and coordinating events. Nursing did not seemed to fit me well, however, coordinating circumstances to enable nurses to do their job properly, suited me better.

During my master FM, I explored management of the built environment on a higher level by learning about management principles, supporting services and building management. In search for an interesting topic to write my master thesis about, I turned to Stefan Lechner, my former bachelor tutor. He brought my fascination for healthcare to light, when he inspired me to do research on the Dutch development of integrated care.

This thesis is written for everyone interested in the development of IC in the Netherlands, but especially for facility managers that currently face a changing healthcare environment. I hope this thesis inspires them to tackle challenges in a pro-active way, so that they become successful and thereby promoters of the field of FM.

I want to thank Stefan Lechner for his contributions and support during the process of research and writing a proper thesis. I am grateful for all the supporting conversations with my tutor, Jan van den Hogen. I want to thank Adrienn Eros for her classes on research methods. I want to thank all research respondents that participated in semi-structured interviews and the expert meeting.

Although conducted research provided me a lot of knowledge and writing the thesis was a great learning experience, there is a world ahead of me with unresolved questions. I hope that in the future I get a chance to discover more in my attempt to support people's health.

Coline van de Belt,

September 2015

1. INTRODUCTION

Due to a rapid aging population, the rise of chronic diseases and multi-morbidity, the growing demands and expectations of people and the need for more efficient healthcare processes, all over the world healthcare systems change, to a new, integrated, healthcare system (World Health Organization, 2015). Integrated care (IC) programs are proposed to be the answer, aiming for better and cost-effective healthcare by centralizing and focusing on people, fighting fragmentation and improving collaboration between different parties involved (WHO Department of Health System Governance and Service Delivery, 2008; Kodner and Spreeuwenberg, 2002). These far-reaching healthcare developments could affect management of hospitals, healthcare centres or facilities. The main objective of FM organizations is the development and provision of services to support primary activities that satisfy customer needs and expectations, thereby ensuring its own economic survival (Johnston et al., 2012, derived from Coenen and von Felten, 2014). FM should not only focus on operational level and day-to-day management, but also on tactical and strategic level, as it proved to be successful in supporting corporate business objectives and thereby adding value to the corporate organization (Jensen, et al., 2012). Ulaga and Chacour (2001) and O'Cass and Ngo (2011) claim that today's business markets in particular focus on pursuing to deliver superior value to its' customers, and consider questions on what value is and how it is created, being one of the most important issues for business managers and academia. In 2011, Prevosth and van der Voordt conducted research on the added values of FM for Dutch hospitals, because of the need for knowledge on this topic for organizations to establish, improve or secure their competitive position. Based on a facility and real estate management literature research they established a list defining and explaining the eleven added values of FM. During their multiple-case studies, interviewing eight facility managers of different hospitals in the Netherlands, they discovered that Dutch hospitals emphasize increased satisfaction, increased productivity, and cost reduction as most important added values of FM (Prevosth and van der Voordt, 2011). Although the healthcare sector is developing rapidly and FM faces change related challenges, no similar research on added value of FM has been conducted since. Nevertheless, it is important to know how to manage this new (integrated) healthcare situation, because "the ability to predict and manage change is probably the single most important quality a facilities manager needs" (Smith, 1995: 11). This research aims to discover how FM can add value to Dutch IC. Jensen, et al. (2012) stress the importance of interface between FM services provided and value by stakeholders perceived, when managing value. They conclude a paradigm shift within the field of FM from an input-output mindset, to a more input-throughput-output focus, thereby acknowledging the importance of stakeholders' involvement (Jensen, et al., 2012). By asking healthcare employees to define IC and its' added value, discussing the value adding role FM can play, and discussing similar topic with experts, this research aims to draw a picture on FM value needs in an IC situation.

2. LITERATURE REVIEW

This chapter discusses the current Dutch healthcare system, the international definition of integrated care (IC) and an international example of implemented IC. Additionally, the concept of added value of Facility Management (FM) is reviewed. Although little literature is available on IC, this literature research inquired nineteen sources of information, being refereed journals and books, on the issues of IC, FM services, and the added value of FM, published preferably in the last five years, but at least published in the last ten years. Finally, this chapter addresses the conceptual research framework and research questions.

2.1 ADDED VALUE OF FACILITY MANAGEMENT

“FM is the integration of processes within organizations to maintain and develop the agreed services which support and improve the effectiveness of its primary activities” (NEN, 2006: 5). A FM organization is responsible for managing the built environment and its’ impact on the workplace and people. It focuses on planning and coordinating supportive services to improve the success of organizations’ primary processes (NEN 2748; derived from Prevosth, 2011). Hospitals in particular expect the FM organization to be a professional and independent organization that supports the primary process, unburdens general management, and facilitates patients from the moment they enter the building until the moment they leave the building (Prevosth, 2011). FM focuses on the external and internal built environment, IT infrastructure, security and reception, cleaning, catering and laundry services. Asset Management (AM), Corporate Real Estate Management (CREM) and FM are areas of interest that overlap (Prevosth and van der Voordt, 2011) and in some situations, organizations effectively combine both work fields in one organization (Groen and Ruepert, 2010). In this thesis, AM, CREM and FM are stipulated combined and denoted as FM.

FM’s area of activity configures input-throughput-output processes, where input are resources and activities, throughput are processes, and output are services and products (Jensen, 2010). FM input are facilities, real estate, technology, activities, manpower, and know-how (Jensen, 2010). Jensen (2010) explains throughput as management processes. He defined space, services, basic products, additional offerings, development, and relations as FM organizations’ output. FM services are characterized by their intangibility, customer integration, heterogeneity, and perishability. Customer integration refers to understanding choice, experience and evaluation of services by customers (Coenen and von Felten, 2014). When a service or product, which is a proposed value offering, is consumed, value shows (Vargo and Lusch, 2008). In other words, value is the residue of sacrifices made and value perceived in a market exchange (Jensen, 2010), being not something that is delivered, but something that is experienced (Coenen and von Felten, 2014). Jensen, et al. (2012) claim that when considering value, roles and perceptions are of great relevance because customers are heterogeneous and therefore perceived value differs within similar offerings. Assessing value is not a rational process, but is influenced by individual emotions, beliefs, expectations, and context. Additionally, value is relative to competition because perceived value is based on additional advantages that are expected or experienced, compared to competitive offerings in case of substitutability (NEN, 2006; Jensen, et al., 2012).

FM proved to be a value adding resource to corporate business by improving productivity, profitability, sustainability and competitive advances (Jensen, et al., 2012). Prevosth and van der Voordt (2011) stress the added value of FM in terms of satisfaction, costs, productivity, reliability, adaptability, and culture. The field of FM often refers to value as money, by lowering costs or increasing revenue for the corporate organization. The paradigm is: the lower the price, the higher the value (Coenen, et al., 2012). However, Cook (1997, derived from Jensen et al., 2012) claims that price is just an expression of value and that value is more than financial considerations only. Coenen, et al. (2012) claim that FM's bias on value might be a result of deficient understanding on FM added value, that is actually more concerned with quality and customer service than it is with lowering costs. The added value of FM is the extent to which real estate, supporting services and resources, help the organization in realizing business objectives (Prevosth and van der Voordt, 2011). According to business alignment principles, the purpose and scope of the FM organization for meeting stakeholder's expectations and adding value need to be similar to corporate strategic aims for FM to support corporate business (van der Velden, 2011).

Jensen (2010) developed the FM value map: a conceptual framework based on before mentioned input-process-output fundamentals that identifies and demonstrates elements for value creation of FM, as a tool to develop strategies and configure tactical implementations. Jensen et al., (2012) emphasize importance of the FM value map as a starting point for other FM value concepts, and not as an end in itself. Critics argue that the FM value map does not consider the distinction between operational, tactical, and strategic levels of FM, it does not take corporate strategy as a starting point and it is not a practical model (Jensen, 2012). Coenen et al. (2013) add that the FM-value map only focuses on the 'supply-side' of value, missing the value perception perspective. They stress the importance of the demand management perspective, because all users have different backgrounds and needs and therefore perceive value differently. As an answer to this, Coenen, et al. (2013) developed the FM value network, emphasizing the meaning and perception of value of FM stakeholders. The FM value network explains FM as an open system of relationships, by attending its' stakeholders. It reflects the service-oriented and stakeholder perspective, which is important because of the trade-off characteristic of services (benefits vs. sacrifices), the impact of roles and perceptions (different customers perceive different value within similar offering), and the importance of competition (better value leads to a stronger competitive position) (Ulaga and Chacour, 2001). The FM value network takes a more holistic standpoint instead of a financial (shareholder) perspective only, and gives priority to stakeholders' (subjective) value perceptions created through a network of relations (Coenen, et al., 2013). Vargo and Lusch (2008), point out that co-creation of consumers involved affects the experienced value of FM output, because value is created when the consumer is using the product or service. Therefore, customers should not be treated as if they are a target, but need to be involved in the entire value and service chain so that they become co-producer (Vargo and Lusch, 2008). Coenen, et al. (2012) agrees that multiple stakeholders, those who benefit from the value and those who sacrifice, influence FM value perception of a service or product, emphasizing the importance of co-creation in managing value by involving and collaborating with stakeholders (Coenen, et al., 2012). In contradiction to the belief that consumers passively receive the value that is supplied by the organization, the co-creation paradigm focuses on cooperatively value creation by customer and supplier or through the

customers' processes only (Coenen, et al., 2013). O'Cass and Ngo (2011: 652) agree by saying that "co-creation value rests on the premise of firm- customer working together to create a consumption experience". In fact, Coenen, et al. (2013) claim that co-creation of services, by effective communication and integration of resources, builds strong relationships in FM, leading to a more holistic conceptual framework in which the network of relationships of all stakeholders involved creates perceived value. Coenen, et al. (2013), insist that all facility managers adopt this new way of thinking, to manage value successfully.

To help organizations manage value, van der Voordt and van der Zwart (2011) attempted to develop a list of FM added values. Building on highly appreciated work of several CREM researchers, they defined reduce costs, improve flexibility, improve financial position, support image, increase productivity, increase innovation, increase user satisfaction, controlling risk and improve culture as the nine added values of real estate and building services. Prevosth and van der Voordt (2011) reviewed these nine added values using FM and CREM literature, and decided to add sustainability and healing environment to this list. According to them, the eleven added values of FM for healthcare organizations are: increase productivity, reduce costs, control risk, improve building value, improve flexibility, support culture, support image, support innovation, increase satisfaction, improve sustainability and support healing environment (Prevosth and van der Voordt, 2011). Prevosth and van der Voordt (2011) explain that productivity could be improved by using housing, services and resources as a tool for efficiency and effectivity, for example by smart location choices, short distances between cooperating functions, ergonomic responsible furniture and excellent functioning IT. Costs could be reduced by saving on investment costs and operating costs of real estate and other facilities. Establishing tight square feet standards, focusing on rules reducing energy-use, implementing flexible working stations, more efficient use of rooms and efficient purchasing are examples of cost reducing actions. Controlling risks focusses on preventing undesired situations in terms of safety, health, and finances, for example by involving security, mapping risks, managing in house emergency services, working condition consultants, and insurances. Improve building value considers managing the future value of the building, by planned maintenance and renovation of the accommodation, and considers everything regarding the financial value of the accommodation. Flexibility can be improved by managing the organization in a way that adjustments are easy to implement, in terms of space and construction work, by for example using flexible walls, in terms of the organization by implementing flexible working hours, and in legal terms by smart contracting. Support culture is about adding value to the organizational culture, for example by making use of a particular lay-out and interior design to support a culture change, stimulating positive behaviour of people by facilitating a neat and clean environment, or by supporting fusion of cultures after a merger. Support image regards FM's contribution to branding and a positive image, for example by facilitating an attractive design of buildings and other facilities, or by the quality of service and customer-friendly employees. Innovation can be supported by strengthening creativity and innovation, for example by interior design and support of interaction between employees. Increased satisfaction is about ensuring highly satisfied customers- and employees, for example by being hospitable, realizing a functional, pleasant, and comfortable environment and a pleasant and healthy indoor climate, and by providing high quality facilities. Sustainability improvement aims to not harm the environment, for instance by conscious purchasing, managing lower energy-use and

eco-friendly material use. Support healing environment concerns creating an environment that contributes to cure of patients. The use of colour, how patients are handled, and the quality of food are important themes considering healing environment. By practicing healing environment elements, other added values such as satisfaction, image and productivity are supported as well.

Prevosth and van der Voordt (2011) presented their list of these eleven added values to eight facility managers of Dutch hospitals. At that time, they found increasing satisfaction as the most important added value of FM. Second most important added values were improving productivity and decreasing costs. Sustainability or improving building value are not ranked in any facility managers' top three. Prevosth (2011) explains her findings as follows. Internal and external contextual factors influence ranking of added values. For example, when an incident has occurred recently, controlling risks is probably very important, or when the hospital strategically focuses on cost reduction, cost reduction could also be an important issue for a facility manager. Additionally, Prevost (2011) found that improving productivity and reducing costs both relate to efficiency. Moreover, all hospitals claimed to focus on productivity, target reducing costs and controlling risks as an ongoing process, and did not prioritize building value as important added value. Flexibility is a value most hospitals claim to manage, however most FM organizations are not as flexible as desired. Hospitality is an important item for hospitals and relates to supporting image. Especially university hospitals highlight innovation as important added value. Every hospital affirms satisfaction as important value adding concept, although there is an area of tension between high satisfaction and increased costs.

2.2 DUTCH HEALTHCARE SYSTEM

Currently, the Dutch healthcare system distinguishes four categories, also referred to as echelons, being zero, first, second and third line. Van der Burgt, et al. (2006) explain the Dutch healthcare system as follows. Every 'line' represents a different function. Zero line healthcare is directly accessible for everyone and is focused on providing care instead of cure, providing prevention care to people without a medical issue. First line healthcare providers are also directly accessible, but are professionals with a medical degree who can be approached in case of medical issues that can't be answered by zero line healthcare providers. General Practitioners (GP's), paramedics, dentists, nurse practitioners, pharmacists and midwives are first line healthcare providers, providing healthcare at the patients' home or at a healthcare organization where there is no possibility to stay. Patients can only address second line healthcare with a reference from a first line healthcare provider. Second line healthcare providers are specialists within a certain healthcare segment that for example work in a public hospital or a private healthcare organization. To access third line healthcare, a referral from first or second line healthcare is needed. Third line healthcare is specialized academic top clinical healthcare, which is provided in academic health centres (university hospitals).

2.3 INTEGRATED CARE

This paragraph firstly explains the international development of IC, then considers different ways to practice IC, and finally provides an example of IC practices.

Antunes and Moreira (2011) systematically reviewed 24 articles on IC published between 2002 and 2008, focusing on IC developments of sixteen European countries (UK, Germany, Finland, Sweden,

Austria, Spain, Netherlands, Ireland, Portugal, Denmark, France, Greece, Italy, Norway, Poland, and Switzerland) and concluded that all countries face similar healthcare challenges. An ageing population, development of healthcare, increasing amount of chronic illnesses, an hospital-based healthcare system, inadequate supply of society care services, deficiency of cooperation and partnership between healthcare providers with different professions, fragmentation of healthcare systems and rurality, are developments that cause healthcare systems to change (Antunes and Moreira, 2011). Nolte and McKee (2008) add that new medical solutions allow people with fatal diseases to survive and the increased numbers of people dealing with chronic diseases are a major challenge for healthcare organizations in Europe. Without the integrated approach at various levels, performances of all healthcare aspects will not only be too expensive, but will also suffer (Kodner and Spreeuwenberg, 2002). Worldwide, organizations are moving towards value-based care delivery models (Teperi et al., 2009). Based on their systematic literature review, Antunes and Moreira (2011) concluded that IC is about breaking down barriers, and defined IC as a restructured healthcare system that improves relations between care institutions or is based on a partnership between healthcare professionals, organizations, and providers. IC improves clinical outcomes, quality of life, patient satisfaction, effectiveness, and efficiency or reduces costs (Kodner and Spreeuwenberg, 2002; Evans and Baker, 2012). IC aims to provide continuity of patient care, in which communication between health team members, health institutions, and the society plays a central role. IC is “the integration of activities between disciplines, professions, departments, and organizations which is about tackling professional and organizational quality simultaneously through integrating professional and organizational best practices” (Antunes and Moreira, 2011: 130). However this definition seems clear, Kodner and Spreeuwenberg (2002) stress that the meaning and practical implementation of IC differs between countries. IC is ‘shared care’ in the UK, ‘trans mural care’ (integrating ‘lines’) in the Netherlands, and ‘managed care’ in the US and for some other countries it means ‘comprehensive care’ or ‘disease management’. Because practical implementation differs between countries (Antunes and Moreira, 2011; Kodner and Spreeuwenberg, 2002), directly application of foreign best practices to Dutch IC seems challenging. Leichenring (2004) however, claims that Finland’s former healthcare system equals Dutch current healthcare system, in particular considering the echeloned structure. Nowadays, in Finland, IC is already self-evident, linking and coordinating primary care (which equals Dutch first line healthcare) and secondary care and social services (which equals Dutch second line healthcare), organizing especially long-term care around specific medical conditions of patients (Leichenring, 2004). Leichenring (2004) claims that Finnish literature “refers to IC as seamless service chains, an operating model in which social welfare and healthcare services are integrated into a flexible entity which will satisfy the client’s needs regardless of which operating unit provides or implements the services” (Ranta, 2001: 274, 275 as cited in: Leichenring, 2004). Teperi et al., (2009) argue that Finnish IC maximizes the added value of healthcare provided, which concept they define as ‘the cycle of care’. According to Teperi, et al. (2009), Finland’s care delivery is value-based, organized around the medical condition of the patient, integrating the set of specialties and activities needed to address a medical condition. Care integrates across both specialties and time, aiming for multidisciplinary teams that work together, to minimize the act of passing on control between different specialists and maximizing coordination. Some providers are co-located in dedicated facilities that are called integrated practice units (IPU’s), where specialties and services are provided to anticipate, treat co-occurrences and complications on one

specific medical condition (cycle of care). For maximum added value of integration, IPU's work together with primary care practices (PCP's), so that from the very first entrance of a patient, coordination of healthcare services are fluent (Teperi et al., 2009). Teperi, et al. (2009) concludes that patient involvement is one of the key value adding propositions of IC in Finland. The patient becomes part of the healthcare providing team, him being co-producer of health and healthcare together with the healthcare employee. This happens for example by involving the patient in drug regimes, scheduling of appointments and lifestyle modifications (Teperi et al., 2009). Also, Teperi et al., (2009) claim that value is added because of the rise of specialist practices, increasing the healthcare providers experience on one or little specific medical issues, scale, and learning at the medical condition level. Although Teperi et al. (2009) argue there is no globally accepted measurement tool for measuring effectiveness of IC, they believe it to be successful in Finland. Nevertheless, the lack of electronic support that is accessible for all healthcare providers throughout the process, such as structured administration systems and systems that collect, analyse and report results, slow down value creation. Moreover, they claim that health plans or funding agencies need to focus on contributing value, instead of acting as passive players (Teperi et al., 2009). Teperi, et al. (2009) also claim that the primary goal is to add value for patients, and improving health outcomes is the only way to control costs and increase value. Care needs to be organized around the medical conditions, considering the full cycle of care, and restitution needs to be aligned with value and reward innovation. Care needs to be restructured, but on the same time competition based on value needs to occur for patients interests (Teperi et al., 2009).

2.4 CONCEPTUAL FRAMEWORK AND RESEARCH OBJECTIVES

The literature study led to a conceptual framework containing the constructs (1) added value of FM, in particular for healthcare organizations, and (2) IC from international and Dutch context (figure 1). The green round in the centre of the framework represents the main concept research needs to investigate; FM value needs for IC.

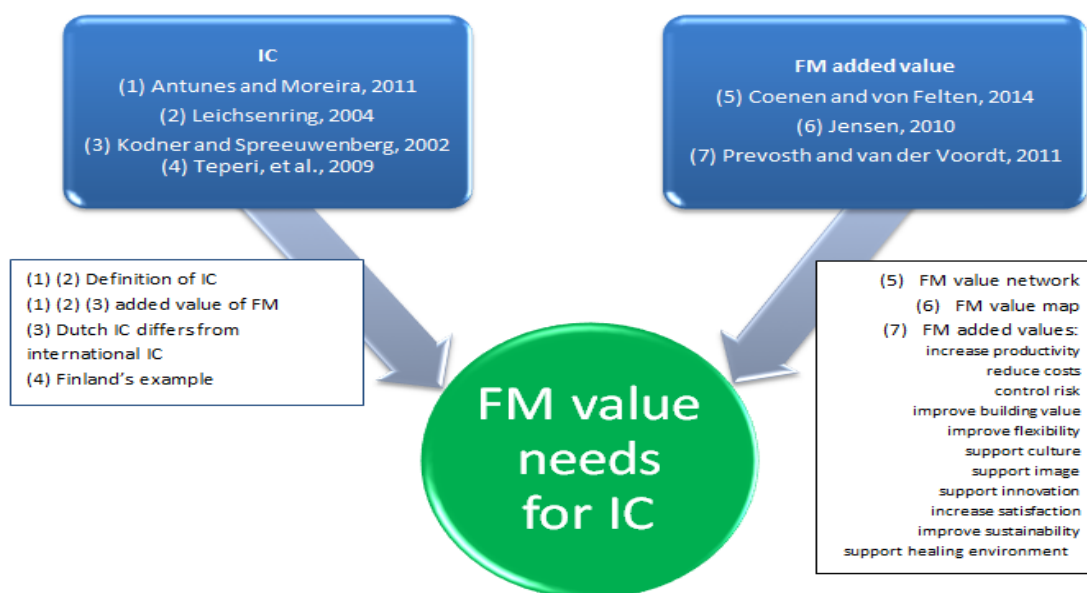


Figure 1. Conceptual framework

Because no constructs on FM value needs for IC are known, this research attempts to develop a theory on the added value of FM for IC, by determining which FM added values healthcare employees find important for supporting IC, using literature on IC by Antunes and Moreira (2011), Leischenring (2004), Kodner and Spreeuwenberg (2002) and Teperi, et al. (2009), literature on added value of FM by Coenen and von Felten (2014), Jensen (2010) and Prevost and van der Voordt (2011) and by conducting empirical research. Main objective of research is to discover and build a theory focused on how FM can add value to Dutch IC. This line of thought led to the following main research question:

<i>How can FM add value to Dutch IC?</i>

The main research question incorporates the two main concepts, FM and Dutch IC. Sub questions consider the content and interrelation of those two main research concepts and are focal points of research to enable the researcher to answer the main question. Sub questions are: *What is the definition of Dutch IC? What is the added value of IC? What are FM needs for practicing IC? What is the added value of FM for IC? What factors influence importance ranking of value adding propositions?* The following chapter describes research methods that are used to answer these research questions.

3. METHODOLOGY

The chapter methodology explains in what way research will be conducted. Firstly, type and design of research is described. Secondly, this chapter outlines data collection techniques, operationalisation, sampling and analysing techniques.

3.1 TYPE OF RESEARCH

This research addresses FM value needs of healthcare employees in an IC situation. Dutch IC is a new topic in Dutch literature. This research contains a qualitative approach, using a multiple-case study design. Because it is possible that perceptions and preferences per situation differ, and a rich understanding of the context and processes enacted is to be established, the multiple-case study design fits (Saunders, et al., 2009).

Inspiration for research is the work of Prevosth and van der Voordt (2011) on the added value of FM for Dutch hospitals. During their research, they developed and tested a list of eleven added values of FM focusing only on second line healthcare organizations, by interviewing one facility manager per case. This research tries to discover FM needs for IC by interviewing two employees per case. Interviews enable the researcher to ask questions and to assess the phenomena, in this case the added value of FM, in a new light to seek insights (Saunders, Lewis and Thornhill, 2009).

3.2 RESEARCH DESIGN

Because IC involves first and second line healthcare organizations, four cases with different backgrounds are appointed. An embedded approach, considering two units of analyses per case, being two persons with different specialisms, will create a representative picture of the organizational perspective on IC and FM's added value. The specific research design of the multiple-cases study is further explained in the following paragraph.

3.3 DATA COLLECTION TECHNIQUES

To ensure data tells what is assumed to tell, different data collection techniques are used, which Saunders, et al. (200) refers to as triangulation. In this research, three different types of data are used to answer sub questions, which secondary data, semi-structured interviews and an expert meeting and will be specifically explained in the following sub-paragraphs. Triangulation enables the researcher to compare empirical data with secondary data to find consistencies and to explain why negative cases occur, so that valid and well-grounded conclusions can be developed (Saunders, et al., 2009).

SEMI-STRUCTURED INTERVIEWS

In the Netherlands, there are 1426 first line healthcare organizations and 380 second line healthcare centres (Ministerie van Volksgezondheid, Welzijn en Sport, 2014). According to stichting Nivel (2015) there are 516 GP facilities, 30 GP centres with 24-hour service, 468 first line psychologists, 93 physiotherapist facilities, 61 Cesar and Mensendieck therapy centres, 73 dietetic practices, and 185 pharmaceutical chemists. The Netherlands is facilitated in second line healthcare provision by 84 hospitals of which 8 are academic. There are 131 Dutch hospital locations, meaning that the 76

general hospitals together have 44 sub-locations. Additionally, they manage 112 external policlinics which are freestanding facilities that are part of a hospital organization. Moreover, there are 119 specialized centres, for specific pathologies, from which 21 have external policlinics (Nederlandse Vereniging van Ziekenhuizen, 2015; Zelfstandige Klinieken Nederland, 2015). In total, this means there are 380 second line healthcare centres located in the Netherlands. Due to limited time and resources, it was not feasible to research the whole population, which insisted the need for a sample. Since GP's represent the large group of the total of first line healthcare organizations, and GP's are at the heart of current Dutch healthcare structure due to their coordinating and referring role, research focuses on this group when considering first line healthcare. Hospitals represent the greatest group considering second line healthcare, which is why this research samples this population.

Dutch IC is not common and well defined, insisting possible different opinions and viewpoints. Thus, to represent the population four cases with all different perspectives on integrated care were needed; one first line healthcare organization not practicing IC, one first line healthcare organization practicing integrated care, one second line healthcare organization not practicing and one second line health care organization practicing IC. Interviews are organizational focused; therefore, multiple units of analyses per case will be used. For this reason, it was not feasible and practical to do random sampling. By non-probability, purposive sampling, organizations were contacted that would probably provide valuable information. Through the network of Health Space Design, four cases were assigned, and by reference checking of healthcare articles, one other suitable organization was found and contacted. The five organizations were by e-mail inquired to cooperate in research. All five organizations were willing to cooperate, but one organization was not available at the time interviews needed to be done. Hence, this organization was not appointed. The response rate was 80%.

The four cases involved in this research represent the population in the context of the development of Dutch IC, each representing a group of organizations working from another perspective. All participating organizations were asked to arrange interviews with two employees; a manager, managing director, project manager or coordinator and a medical specialist or GP.

Case one is a first line healthcare organization that is not practicing IC, which is within this research referred to as GP. GP allowed only interviewing the general manager, referred to as manager GP, because a bachelor FM student recently conducted similar research. GP gave access to the research' findings of this bachelor FM-student who focused her explorative single-case study on IC and facility needs within GP, by having interviews with eight employees to establish rich pictures (Sinnema, 2015). This research documentation is taken into consideration in paragraph 4.1. Case two is a first line healthcare organization providing IC, in this study referred to as ICC. ICC agreed on interviewing a central manager, referred to as manager ICC, and a GP, referred to as GP ICC. Case three is a second line healthcare centre not providing IC, named HC. HC allowed interviewing a central manager, referred to as manager CH. Moreover, they put forth a project coordinator part-time working for the hospital targeting IC, and part-time working as a GP, which in this thesis is referred to as policy maker CH. The fourth case represents a hospital organization that is practicing IC, referred to as IH. IH allowed to interview a dermatologist involved in IC, referred to as specialist IH, and the directing manager of the cooperation exploiting IC that is representing the GP's and hospital,

referred to as coordinator IH. An overview of the research design and abbreviations that refer to the cases and participants, is provided in figure 2.

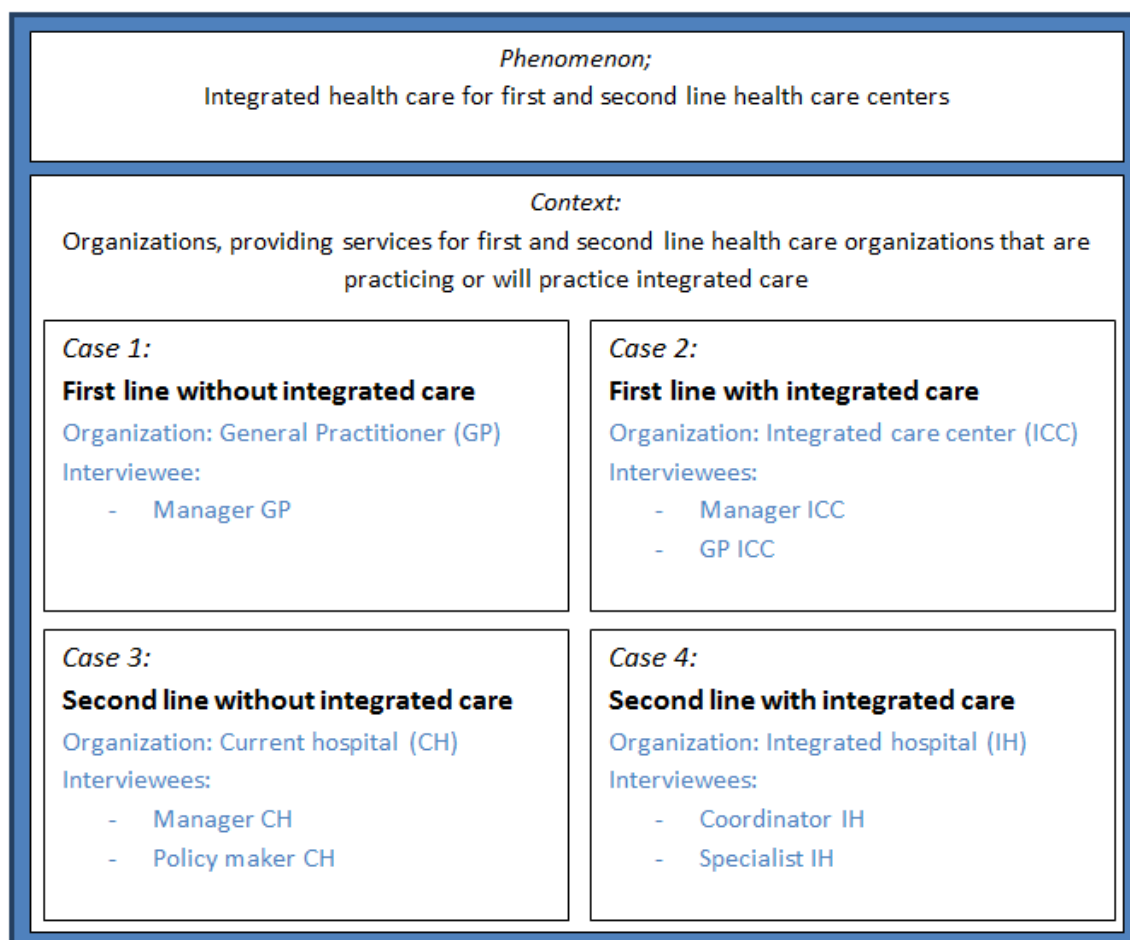


Figure 2. Multiple-case study unravelled

Berg (2009) advises to use interview guides, representing important themes and questions, while conducting one-to-one, non-standardized, semi-structured interviews to increase validity. The list of eleven added values of FM by Prevosth and van der Voordt (2011) is used as validated scale and direct input for interviews. Using an interview guide for every interview, as showed in appendix 2 in English and appendix 3 in Dutch, ensures the researcher that data collection is similar for all circumstances and therefore increases reliability of data collected. To ensure that questions are interpreted in the right way, important definitions and a list of explanations are added to the interviews. The interview guide is structured in a way that per category the interviewer first asks participants for their opinion, and then explains the definition derived from literature, so that participants will not be biased. The interview will be pre tested, and adjusted where needed. Interviews will be audio recorded and processed in verbatim transcripts¹. In addition, notes on nonverbal communication, interruptions and external factors, for example location and other remarks will be described in similar document.

¹ Transcripts are confidential and added to this document, after appendices.

As preparation for the interviews, all participants will receive an introducing e-mail, with a small introduction and an agenda of the interview, to inform them about the content of the interview and expectations of input.

EXPERT MEETING

An expert meeting, in literature also referred to as focus group is an interactive discussion between at least two participants next to the interviewer (Saunders, et al., 2009). An expert meeting could be of great relevance, assuming that experts have great knowledge and experience considering the research topic, which makes this kind of peer debriefing of great value for validity of research (Saunders, et al., 2009).

Saunders, et al. (2009) claim that the more complex the subject is, the smaller the number of interviewees will be. This research topic is very complex, and the interviewer is not very experienced, which made the researcher decide to invite three experts. Due to the fact that this research is about IC and FM, it seemed relevant to invite an IC expert (ICE) and a FM expert (FME). Including a representative of healthcare consumers (RPE) working for an organization established by the government to support Dutch inhabitants and patients, to provide information on end users' needs, seemed beneficial as well, although the multiple-case study does not focus on healthcare customers. The fact that literature argues the importance of customer integration and participation, concerning healthcare developments as well as FM developments, ensures usefulness.

Purposive, non-probability based, sampling is used to contact experts. During a session of living lab Health Space Design, an ICE proposed to cooperate in research. The project manager of Health Space Design, a FM lecturer and researcher involved in healthcare projects, was also eager to collaborate. Contact information of a representative of patients for IC programs, a GP involved in IC projects, a specialist involved in IC, and three IC project coordinators was found in secondary data documentary and used to approach experts for cooperation. Three experts agreed on participating in the expert meeting, indicating a response rate of 37,5%. Expert one, referred to as ICE (ICE), works at a hospital organization, and has experience in designing and implementing IC. Expert two, referred to as FME (FME), is researcher and lecturer FM. Expert three, referred to as patients representative (PR), works for an organization representing inhabitants perspective on healthcare issues. All participants are academic educated.

MULTIPLE-SOURCE SECONDARY DATA

By searching for all kind of public information sources, for example documents, news articles, and reports, helpful evaluation material can be gathered (Taylor-Powell and Renner, 2003). Although sufficient literature on international IC and added value of FM can be obtained, no academic literature on Dutch IC development and implementations is available. Therefore, governmental documents, health insurance and healthcare organizations' policies, and newspaper articles are used as secondary data source to collect national focused data on IC. In this thesis, sources of secondary data used are two healthcare government reports (Raad voor de Volksgezondheid en Zorg, 2011) (Kabinet-Rutte-Asscher, 2012), an article from a Dutch newspaper (De Volkskrant, 2014), an invitation for offering IC initiatives discussing what Dutch IC is about that is written by an insurance

company (De Friesland zorgverzekeraar, 2014) and a report of a national bank (Dantuma, 2015). Moreover, secondary data is derived from a book about social responsibilities for companies focused on a changing healthcare structure in Groningen, the Netherlands, written by two lecturers in high education that are interested and involved in several research projects concerning the development of IC (Stijnenbosch and Wolf, 2014). In addition, a medical magazine issuing IC (Fiolet et al., 2013), a not published paper of a GP and project leader of IC (Cator, 2015), and a not published bachelor thesis on physical changes needed when introducing the IC concept (Sinnema, 2015)² are used. All documents used are written during the last four years.

3.4 ANALYSING TECHNIQUES

According to Taylor-Powell and Renner (2003), there is not one best way to analyse data; it requires a systematic approach, creativity, and discipline. However, they advise to first get to know data, and then focus the analysis, categorize information, identify patterns and connections within and between categories, and eventually interpret by bringing it all together (Taylor-Powell and Renner, 2003). The following paragraphs presents the analysing steps taken per data collection method.

SEMI-STRUCTURED INTERVIEWS

Every interview will be audio recorded. Additionally, notes on the environment, atmosphere and behaviour of interviewee will be made. Audio recordings will be processed in a verbatim transcript and coded using the following five steps, based on before described advice of Taylor-Powell and Renner (2003):

- *Step 1:* summarizing interviews and context. This step enhanced the researcher to reduce collected data to the minimum extent, so that key themes emerge and position of interviewee gets clear. After interviews, a summary with interpretations of key issues will be made, and send to every participant.
- *Step 2:* concluding answers on interview questions. By combining data per questions of all participants, consistencies and differences become clear (Taylor-Powell and Renner, 2003).
- *Step 3:* not predefined find words that are mentioned often, to be able to identify emerging themes (pattern search) (Taylor-Powell and Renner, 2003).
- *Step 4:* find often mentioned predefined words, based on literature, to be able to see whether expected words occur, and in which interview they occur more than in others. Predefined words are derived from the two definitions of IC mentioned in the interviews (showed in appendix 1) and the list of added values of Prevosth and van der Voordt (Prevosth and van der Voordt, 2011).
- *Step 5:* In vivo coding. Coding interviews by framing interpretations of 'every day live' terms and sentences, metaphors, analogies and examples, and key-words-in-context to determine key elements and issues. Data will be reduced to the minimum data needed; key elements remain. This coding is particularly useful because it considers context (Saunders, et al., 2009).

Counting not predefined and predefined, which step two and three insist, to create an overview on frequent mentioned words, is a form of quantification of qualitative data. Saunders, et al. (2009)

² Not published documents can be obtained by contacting the researcher

claim that quantification of qualitative data is useful to a certain extent, being a useful supplement as long as it is not reduced to such a simplified form that it is neglecting nature and value of data.

Due to the fact that results of analysing step two and five will probably overlap, reinforce, or supplement each other, these results will be combined in one overview of key issues and perspectives per interview, reduced to ten to fifteen statements. These results will be individually compared to each other, to find consistencies and differences. Results of analysing steps two, three, four and five will be separately inter-case compared to discover salient features on differences or compliances, to produce an organizational view. Because within the GP case only one interview is allowed, inter-case comparison is not possible. The inter-case analysing structure for steps one, three and four is showed in figure 3. Furthermore, a cross case analysis on step one, three and four will be undertaken to compare results of integrated cases and not integrated cases Findings will be combined based on perspective, resulting in an overview of findings considering integrated and not integrated situations. Subsequently, IC findings and not IC findings will be cross-analysed as well. This structure is showed in figure 4.

	GP	ICC	CH	IH
GP	Manager GP			
ICC		Manager ICC versus GP ICC		
CH			Manager CH versus Policy maker CH	
IH				Coordinator IH versus Specialist IH

Figure 3. Inter-case analysing

	Integrated perspective
Not integrated perspective	ICC vs IH versus GP vs CH

Figure 4. Cross case and perspective analysis

EXPERT MEETING

Before the expert meeting will take place, participants will receive an agenda as showed in appendix 7, explaining the structure of the meeting. On the agenda, the fourth item will only mention that some statements from interviews will be discussed, without explaining which. By doing this, experts will not be able to think about these statements before the expert meeting started, avoiding bias. Experts will be asked to define IC and the added value of FM before the meeting will start, to avoid cross-expert influencing.

The expert meeting needs to be audio recorded and coded in accordance to step five of interview analyses. By doing this, the researcher is able to determine key issues, words and definitions. Results

originated from the expert meeting can be used to compare with secondary data and interview results.

MULTIPLE-SOURCE SECONDARY DATA

Secondary data will be used to collect data on Dutch IC, due to shortfall of literature on this field of interest. Using secondary data could decrease internal validity, because data is pulled from its' original context. Therefore, secondary data need to be handled with precautions, ensuring contextual information is taken into account (Saunders, et al., 2009). Most conspicuous and conclusive theory will be analysed by thoroughly reading and summarizing documents. No specific coding technique will be used for analysis.

4. RESULTS

The first paragraph of this chapter describes data derived from analysing interviews. The second paragraph shows data analysed from the expert meeting. Analysing secondary data resulted in several findings that are displayed paragraph three of this chapter. Paragraph one and two first consider the analysing technique used, before describing results. All paragraphs are structured according to the order of sub-questions, meaning that first the definition of IC is addressed, then the added value of IC, hereafter FM needs for IC are mentioned, then FM added values and finally factors that influence FM added value propositions for IC.

4.1 SEMI-STRUCTURED INTERVIEWS

Interviews are analysed using five steps. By carrying on step one summaries of interviews are produced, step two interview questions are answered, step three often mentioned not predefined words are counted, step four predefined words are counted, and step five in vivo coding is produced.

Step one of analysing is used to get familiar with participants view on IC from their organizational context. Summaries of the interview as showed in appendix 6 are executed and send to participants, enabling them to confirm correctness of interpretations, which they all did.

Analysing results of step three and four combined and ranked most mentioned not predefined words per case, providing case specific information as showed in table 5, appendix 5. All cases mostly mentioned healthcare organizations, referring to the GP, the hospital, or the society care centre, during their interview. Cases ICC, CH, and IC often mentioned the word 'hospital', and the GP case brought up 'society centre' repeatedly. The term IC frequently appeared within the GP and ICC cases, both first line healthcare organizations. The word 'home' is incorporated in the top five of case CH and IC, both second line healthcare organizations. Ranking most mentioned predefined words per interview, as displayed in table 6, appendix 5, shows that the word cooperation is mentioned most frequently. Secondly, costs are often mentioned. Knowledge sharing, decentralization, centralization, and substitution are not remarked.

Combining analysing steps two and five revealed that respondents consistently defined IC as the interface between first and second line healthcare, shifting low complex second line care to first line healthcare providers. They add that only in case of acute or specialist care, patients need to be referred to second line. Accordingly, the GP needs to deliver and coordinate patient care, because he knows his patients best, has time, and delivers equal or better quality of care, but whenever necessary, first line healthcare providers ask and receive support from second line specialists. Manager CH implies that self-management and participation will play an important role in IC. He also stresses an important role for IT. Coordinator IH thinks that managers of healthcare organizations should not act from their own perspective but take responsibility for the Dutch society. Manager ICC defines IC as is the right care on the right place, arguing that IC keeps improper tasks away from the more expensive second line. Manager GP believes that IC is fatal to the right of hospitals existence. Manager GP claims that IC is a temporary term, because what is now defined as substituted care will become first line care. Manager CH and GP ICC emphasize the use of protocols, guides, and agreements between healthcare providers for developing IC. Manager CH claims that hospitals need

to distinguish themselves from others to ensure business value. Manager ICC and CH emphasize centralization of diagnostic equipment as an opportunity for hospitals to generate income and for the society to save costs because not all organizations need to purchase equipment separately, risking not optimal use.

Step one and two led to an overview of participants top three of FM added values as displayed in table 3, appendix 5. Four out of seven participants ranked increasing customer satisfaction as the most important FM added value for IC. Second most often emphasized added values are improve flexibility, support healing environment and reduce costs. Increase sustainability and productivity were included in the top three of two participants. Supporting innovation, culture and image, and controlling risks were listed once, and improving building value was never mentioned as one of the three most important added values of FM by any interview participant. The inter-case analysis, as displayed in table 1, appendix 5, shows that prioritized FM added values for IC differ between the two participants interviewed per case. Nevertheless, within ICC the participants ranked similar first and second most important added values. Both participants of the CH case emphasize reduce costs and flexibility as important FM added values. Within IH only increasing satisfaction corresponds inter-case. The cross-case analysis, displayed in table 2, 3 and 4 in appendix 5, shows that manager GP and manager CH, both representing organizations without IC, stress a difference between added values for current, not integrated, situation and added values for future, integrated, situation. Policy maker CH argues no difference in FM added values concerning organizations with and without IC, claiming that in the IC context “a GP remains a GP and a hospital remains a hospital”. However, policy maker CH stresses a difference between added values for IC organizations from first line perspective and second line perspective. Yet, the added values that policy maker CH stresses for first line IC organizations, differ from the top three of FM added values within the GP case. Manager HC and GP ICC distinguishes patient involvement as an important factor healthcare changes, such as IC.

All respondents argue IC is beneficial for all parties involved. They think centralizing diagnostic equipment and specialized care ensures reducing costs. Accordingly, IC projects need to be advantageous in terms of quality, service, and costs, for all parties involved, which are patients, government (representing the Dutch society), insurance companies and healthcare providers (first and second line). Respondents agree that IC is patient centred care, organized around patients’ needs, beneficial for patients because it provides care close to home that is free of charge. IC is beneficial for government and insurance companies because of it improves convenience and efficiency. Additionally, participants claim that through the development of IC, GPs receive the role of patients’ care coordinator, assisted by second line specialists when necessary, and the second line specialist benefits because of he is enabled to specialize by focusing on complicated and challenging cases. All participants are consistent in insisting a neutral location for integrated care, not provided from GP’s office and neither a hospital location.

Specialist IH believes that IC is about doing a lot, with little equipment. Manager CH agrees that in the context of IC, GP’s probably would not do interventions, but could do low risk operations in the future. Manager ICC thinks that because of the central coordinating and organizing GP’s role, he will practice interventions. Manager GP claims that the organization he works for focuses on growth, and

that when implementing IC, he expects the organization to grow more.

Manager ICC states that when specialists consult GP's for IC purposes, a 'filter function' will evolve, meaning that specialists decide or help GP's decide, which care should stay in first line and which should be transferred to second line. Rising partnerships between healthcare providers have the additional benefit that they support new initiatives, solutions, and approaches that from singular perspective alone would not arise, according to manager ICC.

All interview respondents argue FM as secondary priority, little interesting, according to manager GP, operationally focused and, as mentioned by GP ICC, re-active instead of pro-actively involved. Manager CH claims that care and FM are two worlds apart. Coordinator IH argues that IC managers managing IC is small business. On the contrary, manager ICC claims FM is an important profession that in particular can add value through building performances and hospitality. GP ICC urges the need to feel supported by proper, clear and logical FM. GP ICC and coordinator IH argue that FM can add value when it is organized well. Coordinator IH stresses that value perception differs between people, making it challenging to satisfy customers. FM could add value by supporting customer friendly, welcoming, domestic and a 'not-hospitalish' atmosphere according to manager ICC, GP ICC, manager CH, and coordinator IH. Coordinator IH argues it is easier to start something new on a new location, then on an old location because of culture and mindset. Policy maker CH insists on not to think in bricks and buildings but focus on a network of relations and processes.

This paragraph stresses that participants are consistent in defining IC, arguing it is good care, on the right place for lowest possible costs, tailored on patients' needs, beneficial for all parties involved. They find it challenging to define FM needs and rank FM added value, however, they argue that increasing customer satisfaction is FM's most important added value.

4.2 EXPERT MEETING

The expert meeting with an ICE, FM and PR, took place on the 20th of August at knowledge centre Noordruimte, Hanze University of Applied Sciences Groningen. After the ICE, FME and PR introduced themselves, they were asked to define IC and practical implementation of IC. Hereafter, they were invited to distinguish services and products needed in an IC situation. Finally, experts shared their pre-prepared top three of FM added values, based on the list of eleven added values of FM by Prevosth and van der Voordt (2011). After expert input was gathered, the interview changed to a more discussion focused meeting, where experts were asked to discuss statements derived from the interview, as displayed in appendix 8, which incited valuable data. In vivo coding of the expert meeting, led to the following results.

All experts agree that IC aims for affordable healthcare for everyone, partially by eliminating unnecessary care provision. The definition as mentioned in the interview guide seems correct from their perspective. Experts add that patients need to be referred to specialized care when necessary but where possible should also return to the lowest possible scale. The ICE emphasizes that the substitution of care that IC emphasizes, encourages a paradigm shift, for which healthcare providers need to be ready, because they need to collaborate with other healthcare providers and step out of their own shadow to make themselves dispensable in the long-term interest of IC. In particular, ICE

stresses, a mindset change is needed for hospitals that in the not-integrated situation do too much; in the IC situation, hospitals will start doing what they are supposed to do. ICE claims that 70% of healthcare consumers could stay in first line healthcare. In addition, the ICE emphasizes that most people can be treated or helped without the need of any equipment. Exclusively for some patient groups an ECG and ultrasound device is needed, which can be purchased low priced, the PR and ICE explain. The ICE claims that ideally specialist diagnostic devices and material are centrally located and usable without specialist interference. The PR and ICE agree that Dutch inhabitants benefit from IC because it is good care, close by, free of charge, and available when needed.

The ICE argues the central role of the GP in IC, focusing on prevention to keep clients healthy and coordinating all necessary care processes for his client, consulting second line specialists for identification and observation when necessary. Increasing self-management by involving patients in healthcare processes and focusing on prevention, supports timely interventions, according to the RP. The ICE claims that in the future hospital organizations will downsize. According to the IC and PR for patients it does not matter from where healthcare is provided and how it is called and whether or not it is a temporary term. According to the FME, it should also not matter from what location IC is provided. The IC and PR experts argue that a neutral location is not necessary. ICE argues that patients' illnesses and regional needs are bases for structuring IC: the market determines an IC centres' focus. The ICE and PR stress the importance of people's participation in all healthcare processes and in particular in decision-making. They claim that participation of inhabitants is vital in designing projects to enhance the feeling that the centre is theirs and to enable the organization to respond to customer needs.

When organizations decide to turn a current healthcare organization into an IC organization, the PR claims the organization need to be aware of the importance of strategic positioning; introducing something new on a different location, is clear, however, something new on a location that is already known in a certain context, is not clear and forces the client to think differently.

When discussing location and accommodation for IC, experts debate whether a physical environment is essential. The ICE discusses that digital consulting works perfectly in some cases, but in other cases, a doctor needs to see, feel, or smell, for diagnosis. All participants agreed that e-health and online interaction between specialist and GP gain importance, thereby emphasizing a crucial role of IT.

Experts think that as a result of the development of IC, FM needs in terms of services and products will change. However, FME thinks that for most organizations, FM is daily routine and for that reason not very interesting to healthcare organizations and employees. However, the FME claims that GP's practices need to deal with fast developing e-health applications, and ICE argues that hospitals will need to downgrade. Additionally, all experts agree that an IC centre needs to look differently than current healthcare organizations. According to them, the physical IC environment needs to look nice and trendy, provoke curiosity, and, according to the ICE, on top of that should support a good working atmosphere to generate traffic. Traffic in an IC centre is needed to generate income, but the meeting-place also works preventative as a result of people talking with each other and monitor one another without direct interfaces of medical specialists, the ICE claims.

According to the IC and PR expert, FM can create value by exceeding expectations, making the

difference, for example by providing high quality of services, and being hospitable, in which employees could play a large role. However, the ICE stressed, culture is not something that is changed by rebuilding or designing a centre; that is about energy and behaviour. According to the ICE, flexibility is an important FM added value for handling changing customer demands. All participants agreed that customer satisfaction is most important added value of FM, and needs to be FM's focus, however it consider experiences; everybody appreciates and feels differently, which makes it hard to define and establish what makes people satisfied. Additionally, the PR stressed that satisfaction is often something that is top-bottom imposed, lacking intrinsic motivation of the FM organization. According to the IC and PR expert, increasing and ensuring future building value in terms of money is of minor importance; increasing value for inhabitants, referrer, and government is more relevant. Creating a healing environment is something FM can add value to as well, according to the PR expert. The ICE stresses importance of innovation support by FM.

Respondents agreed that list of FM values described by Prevosth and van der Voordt may be complete, but is written from a single perspective. The IC and PR miss people's perspective, which challenged them in establishing a top three. The FM specialist emphasized that all added values on the list seemed to be correct, which made it hard for him to rank most important added values. The ICE and PR claimed that the two separately defined added values culture and image, can better be combined as added value considering the creation of an environment that looks good and welcoming to customers. All participants agree that, when developing a model, it needs to be tested, supplemented, and improved to arrive at its' essence. They claim that this can only be done by working together, with different people from different perspectives. They all consider that the eleven added values model needs to be redrafted and retested for it to become a valuable tool.

This paragraph shows that experts emphasize a paradigm shift, explaining the mindset shift from hospital and supply focused healthcare to demand focused healthcare that is centralized around the patient who participates in healthcare processes, where the GP coordinates his patients' care and hospitals downsize. Experts stress the importance of patient focused FM added values.

4.3 SECONDARY DATA

This paragraphs gives an overview of findings derived from secondary data documentary. This overview is produced by collecting data, emphasizing main issues and combining and comparing data.

Stijnenbosch and Wolf (2014) argue that increasing healthcare demands insist a structural change in the Dutch healthcare context. Dutch government constructed a policy targeting three priorities, being a fundament for a solid first line and integrated focused healthcare structure in the Netherlands (Kabinet-Rutte-Asscher, 2012). First priority aims improvement of healthcare quality, by measuring quality, decreasing variation within and between healthcare organizations, and stop delivering unnecessary medical interventions. Second priority is to reduce costs, by controlling volume of care, reducing overtreatment, and overcapacity, and fight misuse of care. The third priority concerns supporting cooperation and establishing partnerships between healthcare providers. Additionally, government steers on concentrating expensive, complex, and acute care and deconcentrating less complex care by providing healthcare close to inhabitants (Kabinet-Rutte-

Asscher, 2012). Hence, agreements between the government, healthcare insurance companies, and healthcare providing organizations, target substitution of second line care to first line, improving the delivery of care for chronically ill in the first line (Kabinet-Rutte-Asscher, 2012) and discouraging unnecessary referrals (Dantuma, 2015; Kabinet-Rutte-Asscher, 2012). As a result, different lines within current Dutch healthcare system will fade (Raad voor de Volksgezondheid en Zorg, 2011). What evolves is one and a half line healthcare (in Dutch 'anderhalvelijnszorg'), in international literature referred to as 'IC', overarching all domains and systems within current Dutch healthcare structure (De Volkskrant, 2014). Insurance company VGZ points out that IC is not only about implementing a new system or structure, but insists a change of behaviour of insurance companies, healthcare providers, and inhabitants (Fiolet et al., 2013). Stijnenbosch and Wolf (2014) consider a paradigm shift emphasizing patient focused care in which the patient plays an active role. They claim that healthcare needs to be organized demand-driven instead of supply-driven. The priority axis of Dutch care will shift from second line healthcare to first line healthcare, self-management and prevention, to ensure a reduced need for medical care and long-term care (Dantuma, 2015; Kabinet-Rutte-Asscher, 2012). IC aims to provide all necessary care in a way that centralizes people, without taking into account different disciplines or systems (De Volkskrant, 2014) by partnerships, cooperation and collaboration between first and second line healthcare (Raad voor de Volksgezondheid en Zorg, 2011), insisting a shift of low complex care provision from hospitals to IC centres (De Friesland zorgverzekeraar, 2014). Substitution of low complex second line healthcare tasks to first line, will result in knowledge transfers, declination of tariffs for similar performances, consistent or improved healthcare quality (De Friesland zorgverzekeraar, 2014), and satisfied customers (Fiolet et al., 2013). Integrated care realizes high quality of care, on the right place, for the lowest possible costs (Cator, 2015; Fiolet et al., 2013). IC emphasizes self-management (Stijnenbosch and Wolf, 2014) by which patients will be self-coordinating and carry responsibility to certain means (Fiolet et al., 2013). In addition, GP's will play a central role for IC as connecting factor between healthcare providers and the patient (Dantuma, 2015). A GP is able to provide customized high quality care because he knows his patient bests and is easy accessible, is aware of patients' context and medical care processes, and patients have the feeling that the GP is involved in a network of caretakers with close communication lines (Cator, 2015; Fiolet et al., 2013). In addition, GP's coordinating role will be saving costs, since a GP organization has low overhead costs, GP's salary is lower than specialists' salary, and the collaboration between GP and specialist enables most patients to stay in first line (Fiolet et al., 2013). Due to further specialization and delegation between practices, GP's will less focus on patientcare and increasingly concentrate on coordinating prevention, care provision, treatment plans and collaboration between different healthcare organizations outside their own practice (Dantuma, 2015).

Cator (2015) distinguishes four possible types or concepts for practicing IC, based on executed IC projects in the Netherlands. The first type he determines as healthcare substitution, where patients are referred backwards, from second line to first line for treatment and follow up. The second type insists that a GP refers a patient to a specialized GP that considers diagnosis and treatment and advises to continue first line healthcare or refers to second line when necessary. Third form of IC is similar to the second option, but consulting is done by second line care specialists instead of specialized GP's. In the fourth IC model the GP is able to contact second line healthcare providers for

advice and support, by using digital consulting. Cator (2015) stresses that a combination of types is possible, when preferred. The Orde van Medisch Specialisten (2012) stresses the bottom up strategy concerning restructuring Dutch healthcare, in which local initiatives of healthcare organizations decide how to practically implement IC.

Dantuma (2015) argues that successful IC requires a well-functioning financial structure, well-educated primary care assistant practitioners, and IT innovations to strengthen network organizations and support self-management. In addition, the development of IC influences accommodation and location needs (Stijnenbosch and Wolf, 2014). When first line healthcare providers expand their healthcare services by doing low complex interventions, that are in the not-integrated situation practiced by specialists (Orde van Medisch Specialisten, 2012), these first line healthcare organizations will face significant growth (Dantuma, 2015). This development could support the rise of hundreds of IC centres all through the Netherlands (Orde van Medisch Specialisten, 2012). However, Dantuma (2015) proposes to redesign current first line healthcare accommodations to IC centres. De Friesland (2014) insists IC provision from an independent IC centre that is attached neither to a first line healthcare organization nor to a second line healthcare organization. Stijnenbosch and Wolf (2014) argue that IC can be provided either from a second line healthcare organization that diminishes their supplied services, or from a first line healthcare organization that expands and upgrades their services. They add that specialized second line healthcare will concentrate within a few locations.

Sinnema (2015) argues that healthcare employees find it hard to relate a changing healthcare structure with facility management issues. Nevertheless, she determined that within the first line healthcare case she conducted research, only some small low-cost and low-risk adjustments for interior design and facilities were needed to implement IC, for example creating one waiting area instead of several isolated waiting areas, by having one reception desk serving all disciplines and creating a shared space where employees can meet.

Despite all benefits of IC, the development of IC also carries certain risks (Orde van Medisch Specialisten, 2012). The Orde van Medisch specialisten (2012) claim that, initially, the gatekeeping role of the GP could end up being under great pressure. Secondly, it is possible that the specialist working in an IC setting does not have the facilities needed, which means that the patient needs to go to the hospital as well (Orde van Medisch Specialisten, 2012). Cator (2015) describes that in the context of first line healthcare providers, there are too many simultaneously organized projects which makes this group tired of changing processes, that first line is a heterogeneous grouped profession, differing from one-man practices to society centres with more than ten disciplines, and financial insecurity concerning short term subsidized projects are three major disturbing factors. Second line healthcare interferences are worries about decreasing revenue and the anxiety to pass on care to first line organizations (Cator, 2015; Fiolet et al., 2013). Impotence of health insurance companies and the opaque hospital financing are not supporting the development of IC as well, Cator (2015) argues.

Hence, this paragraph on secondary data analysis points out that IC evolved because of structural

changes of healthcare demands, increasing the need for a healthcare structure focused on improving quality, reducing costs and increasing service. IC emphasizes decentralization of low complex care in which GP's will play an essential role, centralization of high complex and acute care and an increasing focus on prevention and self-management. There is no consensus on location or accommodation from where and by whom IC needs to be provided. However, it is clear that to support IC, adjusting the building is not essential, however, IT support is.

5. DISCUSSION

Results of different data analysis and literature reviewed are debated in the first paragraph of this chapter, where literature review is compared with empirical data to find consistencies and differences, and show contributions of research. The second paragraph displays management implications. The third paragraph considers limitations of research, validity and reliability. Finally, paragraphs four shows recommendations for further research.

5.1 DISCUSSION OF RESULTS

The structure of this paragraph is based on sub research questions' order. First, it focuses on the definition of Dutch IC. Secondly, it emphasizes its' added value. Hereafter, the focus is on FM needs for practicing IC. The fourth part of this paragraph addresses the added value of FM for IC and the fifth part is about factors influencing importance ranking of value adding propositions.

There is great consensus between what is found in literature and data derived from interviews and secondary documents on IC's definition. Antunes and Moreira (2011) argue that IC is about breaking down barriers to provide patient centred care, integrating care from different healthcare providers and supporting communication between health team members, health institutions and the society. This research defines Dutch IC as the decentralization of relatively simple healthcare tasks and centralization of complex and acute care, insisting a shift of low complex healthcare tasks from second line to first line, based on regional patient needs. This research emphasizes that Dutch IC is in fact, as Leichsenring (2004) claimed, transmural care. Antunes and Moreira (2011), stress the importance of the patient centred perspective and the increasing role of society. This study agrees on Coenen, et al. (2012) and Vargo and Lusch (2008) that customer integration and involving Dutch inhabitants in IC projects and their personal healthcare processes, allowing them to participate in healthcare, ensures they become co-producer and support value creation. This research claims a demand driven focused, patient centred care system in the Netherlands that emphasizes preventative care, participation, and self-management, to create a healing environment outside the walls of healthcare organizations.

Dutch IC is beneficial for all parties involved considering the triple aim, that insists on increasing quality, improving service and reducing costs. Empirical data points out that Dutch inhabitants benefit because care is provided nearby and free of charge. Additionally, governmental and insurance institutions benefit from IC because its convenience and efficiency. The GP becomes patients' coordinator of all care provided, self-practicing as much care as possible, using specialist consultation if necessary, which enables the GP to stay involved in his patients wellbeing. Second line specialists benefit of chances to specialize and focus on complicated and challenging cases, enabling them to do what they have learned.

Although Stijnenbosch and Wolf (2014) argue changing facility- and real estate needs for IC, employees and experts did not propose major changes needed in terms of the accommodation and other FM services or products, besides the need for an ECG and ultrasound device, some supplementary operation tools and, according to the CH case and the IC and PR experts, IT support. The fact that all data sources and literature claim IC can be practiced in several ways could cause

inconsistency on FM needs. Nevertheless, respondents of this research agree with findings of Sinnema (2015) that no or only little building adjustments are needed. Research respondents urge increasing self-management and communication between healthcare organizations, and between healthcare organization and patient. They claim that FM should focus on the digital support for healthcare providers and people at home.

Interesting is that Prevosth and van der Voordt (2011) concluded that hospital organizations needed FM to facilitate the patient inside the healthcare accommodation. The focus on prevention, e-consulting and self-management within IC however insists that FM support will not stop when the patient has left the building insisting a large environment for FM to support.

Strategic alignment principles urge FM to add value to IC by attending its' triple aim, focusing on increasing quality, reducing costs and increasing service. The PR and ICE propose FM to add value when working demand-driven like IC. To enable participants to rank their top three of most important added values of FM, the list of Prevosth and van der Voordt (2011) is used. Participating experts of this research argue that the added values defined on this list are correct, however explanations consider organizational perspective only, reflecting the criticism of Coenen et al. (2013) on the FM value map of Jensen (2010) which ignored meaning and perception of value of FM stakeholders. This lack of multiple perspectives on added value, challenged this study's experts in creating their top three. The fact that interview respondents from not integrated cases within this research see FM as secondary interest could explain their trouble with prioritizing FM added values. The organizational managers of both hospitals and the IC-centre found it easier to rank FM added values, indicating that they probably realize FM's importance. Nevertheless, participants of semi-structured interviews and experts agreed that increasing customer satisfaction is FM's most important added value, which corresponds the main finding of Prevosth and van der Voordt (2011). Combining empirical data of this research with literature on the two constructs, in particular theory of Prevosth and van der Voordt (2011) and Teperi (2009), and in addition the theory of Coenen, et al. (2013), this research finds that FM can increase satisfaction by providing services that support improving productivity and supporting culture and image. Productivity can be improved by effectively managing locations, targeting traffic inside IC locations, and providing excellent functioning IT. Besides, this study argues that FM could add value by designing a building that is customer friendly and welcoming and having hospitable employees, in order to stimulate positive behaviour in society towards prevention, e-health, and self-management, which is in regard to the list of Prevosth and van der Voordt (2011) a combination of the values culture and image support, however merely pursuant to culture support. Experts and interview participants also insisted flexibility support and healing environment as added values.

The fact that five out of seven interviewed specialists see FM as small business that is little interesting, could have possibly influenced their prioritization of FM added values. This intangibility of FM services is possibly a reason why no overviews of FM values for healthcare are found during literature study, other than the list of eleven added values by Prevosth and van der Voordt (2011).

This paragraph discusses key issues derived from comparing and contrasting literature with empirical

data on Dutch IC. Customer satisfaction, which is number one added value of FM for IC, can be achieved by a customer-centred approach, targeting IC's triple aim. Additionally, improving productivity and supporting culture are important FM added values for IC.

5.2 MANAGEMENT IMPLICATIONS

Like the research of Prevosth and van der Voordt (2011) this research insists FM to focus on increasing satisfaction, supported by increasing productivity and supporting culture. Based on business alignment principles, this research advises to focus all FM strategies on the triple aim that IC desires. Additionally, this research argues that when facility organizations are challenged by IC developments, they need to assure their strategy is based on the specific customer needs and demands in that certain case. Because there are different ways to implement and practice IC, and FM needs differ between organizations, it is nearly impossible to directly apply one organizations' best practices to another organization. This research advises FM organizations to approach their IC situation as it is unique, deserving a thorough research to find out which support is needed in the specific situation concerned, which will cost time and effort but will improve FM added value.

IC does not necessarily insist on new accommodations and redesigned buildings. This research agrees on the conclusion of Sinnema (2015) that not many building adjustments and service supply changes are needed to support IC. IC however, insists a paradigm shift, substituting healthcare tasks from second to first line, and emphasizing prevention and self-management. Facility managers need to be aware that according this research, IC does not stop when a patient leaves the healthcare accommodation, as it may have been before (Prevosth and van der Voordt, 2011). Therefore, FM organizations should focus on supporting the network of relations, ensuring digital communication, and managing pre-conditions for self-management and prevention issues, to add value. The expectation is that healthcare facilities, especially hospitals, will decrease in size and self-management and prevention increases importance, which insists FM to support the digital infrastructure and provide hardware needed to support care from other places than the healthcare centre.

5.3 LIMITATIONS

Although this research is conducted carefully and enough data is gathered to be able to answer the main research question, some limitations were inevitable due to little time and resources available. Limitations considered are displayed in the following sub-paragraphs, which first focuses on construct validity, then discusses internal validity, hereafter explains external validity and finally considers reliability of research.

CONSTRUCT VALIDITY

Construct validity focuses on the question if measurement applications measure what they need to measure (Saunders, et al., 2009). Construct validity explains in what way the two main constructs of this research, being IC and added value, are measured. First factor influencing construct validity, is the use of literature on IC and added value of FM, that were basis for the interview guide. The definition of IC used in interviews is derived from Antunes and Moreira (2011), who systematically reviewed international integrated care using 24 academic sources describing IC in sixteen European

countries, which ensures a valid theory. Added value of FM is measured using the theory of Prevosth and van der Voordt (2011), who developed a list of FM added values, building on three academic articles on added value of CREM, testing the list by interviewing facility managers of eight Dutch hospitals, and afterwards conducting an expert meeting to discuss findings. However based on academic literature and published in different magazines, research of Prevosth and van der Voordt (2011) is not replicated or academically tested. Nevertheless, no other validated list of added values was found on this specific topic, insisting the researcher to use this list or no list of added values. In the latter case, the researcher would have needed to produce a list of added values based on a systematic literature review, which was not feasible to do within the three months' time this research is conducted.

To ensure that through semi-structured interviews data particularly needed for research was collected, the structure of the interview guide is based on the different research sub questions, thereby increasing construct validity. The agenda of the expert meeting is based on the interview guide as well, ensuring that during semi-structured interviews and expert meeting similar issues are discussed to ensure data collected on research' key constructs is aligned.

Since the main research objective is to find out how FM could add value to IC, it is useful that those who will practice IC, the healthcare employees, were asked what FM services and values they needed. However, healthcare employees were not all able to determine the added value of FM, let alone prioritize three main added values derived from the list of Prevosth and van der Voordt (2011). This possible treat is resolved by questioning the added value of IC as well, since healthcare employees would most probably be better aware of IC's benefits. Lechner (2013) explains that construct validity is also about relating one construct to another in a way that certain findings can support others. This research argues that, in accordance to business alignment principles, added value of IC is closely related to the added value of FM, which enabled the researcher to extract added value of FM from the added values of IC determined by respondents.

INTERNAL VALIDITY

Internal validity is concerned with the ability of the research methodology to measure what it needs to measure (Saunders, et al., 2009). To ensure internal validity, the research sample must represent the research population. In this research, the population consists of integrated and not integrated first and second line healthcare centres, which are represented by the four cases, each representing one out of four possible perspectives.

Internal validity also concentrates on whether the interview questions represent the reality of what is measured, ensuring the right conclusions will be made. The use of multiple data sources, being secondary data, interviews, and an expert meeting, ensured the researcher to discover confirmations and disconfirmations, which increased internal validity. In particular, the use of similar key subjects and questions during the semi-structured interview and the expert meeting, enhanced the researcher to compare and reveal consistencies and differences.

The methodology of research is strictly applied. All five analysing steps were interrelated and ensured the researcher to analyse in a structured way. In particular, in vivo coding of verbatim

transcripts, despite extensive reduction of data, revealed appropriate data considering its' context. However, during two out of seven interviews, one out of 20 questions was missed. In the first case, the interviewer was able to retrieve the needed information from the interview. In the second case, the interviewer was not able to retrieve the data required from the interview, and send the interview participant concerned an e-mail to answer this particular question, to ascertain all issues on the interview guide were argued for all cases. The fact that the interviewer forgot to mention one issue during two interviews, was not consistent, however, the chance this mistake influenced internal validity is little, because the deviation was minor and eventually, all needed information was gathered.

To ensure key issues, as discussed in the semi-structured interviews, are interpreted correctly, a summary of the interview is sent to all participants. All interview participants agreed on the summary received. Two out of seven participants requested the transcript as well, on which they made some adjustments for publication purposes. However, the two participants agreed that as input for this research, the original transcripts could be used. This member validation method, ensuring agreement of participants, increased internal validity.

A peer debriefing technique was used during the expert meeting. Seven distinctive statements, showed in appendix 8, derived from interviews are discussed during the expert meeting, to explore importance and correctness of these statements through the eyes of experts. Their expertise is used to distinguish key importance's from insignificant issues, to ensure well founded conclusions.

EXTERNAL VALIDITY

External validity concerns to what extent research outcomes can be generalised (Saunders, et al., 2009). Due to the fact that every case within this research represents another integrated care perspectives, analysing would not lead to increased generalisation possibilities. However, the advantage of differing cases is that all perspectives are represented, which enables the researcher to find consistencies and shared values. Dutch IC is a relatively new concept of which there is not one clear definition. Considering the fact that case one and case three did not practice IC at the moment they were interviewed, could mean they were not having a clear vision on IC and its implications. However, during interviews this did not show. Besides, the fact that per case two participants are involved, and case one is supported by data derived from former research, reinforces internal validity per case and therefore increases the possibility to generalise.

Despite the fact that there is little literature available on the specific topics of this study, the discussion of results compares empirical data with literature on added value by Coenen, et al. (2013) and Vargo and Lusch (2008), and literature on IC with Leischenring (2004), Antunes and Moreira (2011) and Stijnenbosch and Wolf (2014). Findings on the added value of FM within this research, although focused on integrated care, are compared with research outcomes of Prevosth and van der Voordt (2011) on FM added value for hospitals.

The four cases cooperating in the semi-structured interviews and the three experts participating in the meeting were sampled non-probability based. Although the sampling was representative for the population, four cases do not represent more than 1700 healthcare organizations, and three experts

can not represent all experts in the field of interest. The consequence of the chosen sampling method and size is that results of research are less generalizable.

RELIABILITY

This paragraph considers reliability of methodology. Saunders, et al. (2009: 326) claim that “reliability is concerned with whether alternative researchers would reveal similar information.” Sampling is non-probability based which makes it less obvious that alternative researchers would approach similar persons for cooperation in research. However, the research sample represents the research population, involving participants from each perspective, ensuring all important issues that could possibly differ cross-case, would show.

Interviewees’ bias could have emerged during semi-structured interviews, because for any reason, respondents could have given desirable answers to protect their organization. However, the fact that respondents were given the opportunity to stay anonymous, transcripts and names were promised not to publish, and additionally, added value propositions are not sensitive or confidential issues, decreases interviewees’ bias. Additionally, participants of semi-structured interviews were per issue first asked to explain their definitions, before the interviewer explained the definition derived from literature. Furthermore, experts received the agenda of the expert meeting as showed in appendix 7, without a display of statements to be discussed, to avoid them to, intentionally or non-intentionally, use these statement as basis for their own input. During the expert meeting, the researcher needed to motivate experts in discussing several issues to a certain extent. Additionally, the ICE dominated the discussion, therefore, the researcher sought to reduce her contributions carefully, to bring in the contributions of the other two experts, as Saunders (2009) advised, to increase reliability of results.

The interview guide used for semi-structured interviews is pre-tested on a hospital manager involved in integrated care issues, met during a network session of Health Space Design. Pre-testing led to some adjustments in the interview guide, considering the order of questions; nonetheless, no textual adjustments were needed. All interviews and the expert meeting were audio recorded and processed in verbatim transcripts. Every ehm, pause, and interruption is transcribed and checked twice. However, typos could occur. Additional notes ensured contextual issues for analysis, and a case study database ascertained no data disappeared. This enabled the researcher to code data properly, to gain reliable results.

Some interview data is quantified by counting predefined and not predefined often mentioned words. However, this data showed the main themes within IC, the word count led to data reduction to a certain simplified form over passing context, which made this data was not useful for discussion and conclusion.

5.4 FURTHER RESEARCH

Experts argued that the explanations on the list of Prevosth and van der Voordt (2011) are based on organizational perspective only, not taking into account end-users’ perspective. This study investigates employees needs and expectations of FM services and its’ added value, because they are direct user of FM services and dependent on FM supply for providing IC. However, additional research could consider end-user perspective, to discover consistencies and differences, which could

lead to additional value adding propositions.

Due to the fact that this qualitative research is little generalizable, it is interesting to conduct similar research with other respondents, or a qualitative follow up research on healthcare employees and healthcare consumers, to conceivably support research outcomes and improve reliability. Besides, this research is conducted with the aim to discover FM added values, without taking into account specific financial regulations set by the government, medical concerns, and specific healthcare organizational objectives, for example increasing profit to decrease deaths by diseases or the amount of multi morbidly people. Considering these specific factors could lead to additional insights.

IC insists a paradigm shift in healthcare, but also in FM, towards customer centred, demand-driven strategies. For this reason, conducting similar research on facility managers would be interesting to determine their perspective on added values, to gain insight on consistencies and inconsistencies between the 'supply' and 'demand' side of FM. Outcomes could also be compared with findings of Prevosth and van der Voordt (2011), which could clarify differences between not-integrated and integrated perspective.

Although during this research, a thorough literature search is conducted, no literature on Dutch IC is found. A systematic review, targeting all literature on Dutch IC, for example in the way that Antunes and Moreira (2011) did on IC from international perspective, could probably lead to more data, that can be compared with empirical data of this research to build a strong construct.

This research proposes FM able to support IC to achieve its' triple aim objectives, by strategically focusing on customer satisfaction, improve productivity and support culture. However, some managers of facilities could desire a practical guide for implementing value adding strategies and tactics, proposing steps and actions to take to achieve added value. Other research could attempt to produce a certain guide to help facility managers.

Additionally, the ICE insisted on the important role of FM employees when providing value. It would be interesting to research to what extent FM's employees influence the FM added value for IC. If there is a relation, FM can actively steer on employees' ability to support value adding.

Integrated care in Finland seems equal to Dutch integrated care. Using the article of Teperi, et al. (2009) led to valuable information on IC practices and defaults. A more intensive literature study or a case study including Finland's' perspective, could be supportive to Dutch implementation of integrated care, because in Finland is more experienced in practicing IC and probably has figures and facts to its' disposal from which Dutch organizations can learn.

6. CONCLUSION

The Dutch government reacted on the increasing and changing healthcare consumption in the Netherlands by prioritizing improving healthcare quality, reducing costs, and supporting partnerships between healthcare providers, which led to a national discussion on IC. IC is the decentralization of relatively simple healthcare tasks and centralization of complex and acute care, insisting a shift of low complex healthcare tasks from second line to first line, and an increasing focus on prevention and self-management. IC emphasizes the right care, on the right place for the lowest possible costs.

IC is beneficial for patients because it ensures high quality of care, provided close to home and free of charge. Insurance companies and the government profit from IC because it is efficient and effective. Second line healthcare organizations are encouraged to develop a stronger profile, by specializing on high complex healthcare, by which they can distinguish themselves from others. GP's benefit from IC as they become their patients' care coordinator through all healthcare processes. In IC, first line healthcare providers and second line care providers will join forces for the purpose the whole society. The triple aim of IC is to improve quality and service and reduce costs.

Integrated care is not necessarily about building and construction issues, because little building adjustments are needed to provide IC from current care organizations. FM needs to support a solid and safe digital infrastructure, support communication and e-consulting between health care providers and between health care providers and their patient, and provide applications to support peoples' self-management.

The added value of FM is explained as the extent to which real estate, supporting services, and resources, help the organization in realizing business objectives. According to business alignment principles, FM should pursue the triple aim to add value to IC. By increasing customer satisfaction through a demand-driven approach, involving the customer to enhance co-creation of value, improving productivity, in particularly by effective IT support, and supporting culture by creating a friendly, welcoming, and domestic environment to generate traffic and stimulate prevention and self-management, FM can add value.

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APPENDICES

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APPENDIX 1: PREDEFINED WORDS FOR CODING STEP THREE

<i>Anderhalvelijnszorg volgens definitie 1:</i>	<i>IC definition 1</i>
Samenwerking	Cooperation
Kennisdeling	Knowledge sharing
Decentralisatie	Decentralization
Centralisatie	Centralization
<i>Anderhalvelijnszorg volgens definitie 2:</i>	<i>IC definition 2</i>
Verschuiving	Substitution
Ziekenhuis	Hospital
Gezondheidscentr (um/a)	Communicate care centre
Huisarts	GP
Specialist	Specialist
<i>Toegevoegde waarde FM Prevosth, vd V.</i>	<i>FM added values</i>
Productiviteit (verhogen)	Productivity
Kosten (verlagen)	Costs
Risico's (beheersen)	Risks
Waardestijg (ing)	Appreciation (value)
Flexibel / flexibiliteit (verhogen)	Flexibility
Cultuur (ondersteunen)	Culture
Imago (ondersteunen)	Image
Innovatie (f) (stimuleren)	Innovation
Tevredenheid (verhogen)	Satisfaction
Duurzaam (heid)	Sustainability
Healing environment	Healing environment

Introduction (5. Min)

- First of all, thank you for your cooperation.
- *Introduction*
 - My name is Coline van de Belt, student of the master FREM.
- *Introducing research:*
 - I am studying the added value of FM for Dutch IHC for my master thesis.
- *Research results*
 - Results of this interview will be compared with other cases. Through discussion and conclusion, an overview of FM value needs of healthcare employees will be developed. This could be useful for healthcare organizations, to structure the FM organization
 - My thesis needs to be handed in on the 11th of September. Would you like to receive a copy by e-mail?
 - Yes; towards which address can I send it?
- *Agreements*
 - The conversation will not take more than an hour of your time, as appointed.
 - I would like to stress that during this conversation, you have the right to stay anonymous, not to answer a certain question and to stop the interview when wished.
 - Recording the interview will lead to verbatim transcripts, which will enhance better analysis. Do you agree with recording the interview?
 - Of every interview, I will make a summary containing key information and interpretations. I would like you to check this summary, before I start analysing. Do you agree on this?
- *Interview structure*
 - This interview will start some questions about your organization and responsibilities. Hereafter, it will address your view on Dutch IC, the added value of Dutch IC, healthcare FM and the possible added value of FM for IC.
- Do you have any questions so far?
- Do I have your permission to start?

Research questions (30 – 45 min.)

Participants' organization

1. The organization you work for is (..)
2. What kind of healthcare services are provided?
3. What is your responsibility in this organization?

IC

4. Are you familiar with 'IC'?
5. Can you explain to me, what IC means?
6. In what way do you think IC is different than not IC provision?
7. From where (location) do you think IC can best be provided?

Explaining the definition of IC

According to literature, integrated care is care focused on decentralising low complex issues and centralising high complex and acute care. IC aims for partnership and knowledge sharing between first and second line healthcare providers.

8. Do you agree on this definition? Why do or don't you? Any additions?

In general, IC focuses on shifting certain hospital tasks to a GP or society centre. This would mean that the volume of hospital tasks would reduce.

9. Do you agree on this description? Why do or don't you? Any additions?

Vindt u deze algemene beschrijving juist? Waarom wel/ niet, evt. Aanvullingen?

Added value

'added value'. Is an often discussed concept in literature. By added value, we mean the increase in value, as a result of an intervention. In the context of this research, added value is the extent to which value is added to achieving organizational objectives.

10. What is the added value of IC for your organization, in your opinion?
 - Why and for whom?
11. Is your organization able to provide IC from the accommodation it is currently using?
 - Yes, why?
 - No, why not? What is missing? What is needed moreover?
12. Is your organization able to provide integrated care considering currently provided services and facilities?
 - Yes, why?

- No, why not? What is missing? What is needed moreover?

FM

FM is the integration of processes within organizations to maintain and develop the agreed services which support and improve the effectiveness of its primary activities. A FM department or organization is responsible for managing the built environment and its' impact on the workplace and people. It focusses on planning and coordinating supportive services to improve the success of organizational primary processes. FM focusses on the external and internal built environment, security and reception, IT, cleaning, catering and laundry services.

13. Could you describe the FM organization of the organization you work for?

14. Could you define the role of FM within your organization?

- Strategic, tactical or operational?

15. What is the added value of FM for your organization?

16. Could you explain in what way you think FM could support achieving IC goals?

- Hand over the document with eleven added values of FM

The added value of FM is researched before. The following eleven added values are provided by Prevosth and van der Voordt (2011). I would like you to read it carefully.

	Increase productivity – using housing, services and resources as a tool for efficiency and effectivity. For example by smart location choices, short distances between cooperating functions, ergonomic responsible furniture and excellent functioning IT
	Reduce costs – saving on investment costs and operating costs of real estate and other facilities. For example by establishing tight square feet standards, focusing on rules reducing energy-use, implementing flexible working stations, more efficient use of rooms and efficient purchasing.
	Control risks – preventing undesired situation concerning safety, health and financial risks. For example by security, mapping risks, in house emergency services, working condition consultants and insurances.
	Improve building value – managing the future value of the building. For example by planned maintenance and renovation of the housing, everything that has to do with the financial value of the accommodation.
	Improve flexibility – organize in a way that adjustments are easy to implement. In terms of space and construction work, by for example using flexible walls, and in terms of the organization by implementing flexible working hours, in legal terms by smart contracting.
	Support culture – adding value to the organizational culture. For example by using of a particular lay-out and interior design to support a culture change and stimulating people in positive behavior, by facilitating a neat and clean environment, or by supporting cultures fusion after a merger
	Support image – contributing to organizations branding and a positive image. For example by facilitating an attractive design of buildings and other facilities, or by the quality of service and customer-friendly employees.
	Support innovation – strengthening creativity and innovation. For example by interior design and facilitating interaction between employees.
	Increase satisfaction – ensuring a high customer- and employee satisfaction. For example by hospitality, realizing an functional, pleasant and comfortable environment and a pleasant and healthy indoor climate and by providing high quality facilities.
	Improve sustainability – damaging the environment as less as possible. For example by conscious purchasing, managing lower energy-use and eco-friendly material use.
	Healing environment – Creating an environment that contributes to cure of patients. For example by use of color, how patients are handled and the quality of food. By practicing healing environment elements, other added values such as satisfaction, image an productivity are supported as well.

17. Could you use the following eleven added values to make a top three of added values of FM for your organization?

- Why did you choose (..) as one, two and three on your list?
- Why did you use this ranking order?

Finishing up

We are arriving at the end of the interview.

18. Do you have any additional information that could be helpful for research?

19. Do you have any questions?

I want to thank you for your time. Within two days I will send you the summary of this conversation. Do you want to read this, and reply my e-mail with agreement or disagreement within three days?

APPENDIX 3. INTERVIEW GUIDE NEDERLANDS

Introductie (5. Min)

- Bedank voor acceptatie en vrijmaken tijd.
- *Voorstellen;*
 - Mijn naam is Coline van de Belt, ik ben student FREM.
- *Het onderzoek introduceren:*
 - Ik doe onderzoek naar de toegevoegde waarde van FM voor anderhalvelijnszorg.
- *Uitleg over het resultaat van onderzoek:*
 - Ons gesprek zal worden geanalyseerd, en uitkomsten van u en andere deelnemers worden gebruikt in de discussie en conclusie van mijn thesis. Dit zal leiden tot een overzicht van de toegevoegde waarde van FM voor anderhalvelijnszorg. Deze informatie is bruikbaar voor organisatorische doeleinden in de wereld van FM (evt ook per mail)
 - Op 11 september zal ik mijn thesis inleveren. Zou u een kopie van de thesis via de email willen ontvangen?
- *Uitleggen spelregels*
 - Gesprek duurt max. 1 uur.
 - Benadrukken anonimiteit indien gewenst. Weigeren van antwoorden of beeindigen van het gesprek ten allen tijde, zonder motivatie.
 - Wanneer u akkoord gaat met het opnemen van dit gesprek, kan de middels opname gesprek omgezet worden naar tekst (transcriptie). Dit bevordert de betrouwbaarheid van de onderzoeksuitkomsten.
 - Graag stuur ik een overzicht van de meest belangrijke onderdelen het transcript binnen drie werkdagen na dit interview ter controle naar u op, zodat u binnen drie werkdagen uw reactie kunt geven op de juistheid van het geheel, voordat het verwerkt wordt in mijn onderzoek. Gaat u hiermee akkoord?
- *Uitleggen interviewstructuur*
 - Dit interview start met een aantal vragen over uw achtergrond en de organisatie waarvoor u werkzaam bent. Daarna zal uw visie op anderhalvelijnszorg en haar toegevoegde waarde in uw ogen, en de toegevoegde waarde van FM ter discussie gesteld worden.
- Heeft u tot zover vragen?
- Zullen we van start gaan?

Interview vragen (30 – 45 min.)

Organisatie van de deelnemer

1. U werkt voor (..)
2. Wat voor zorg biedt uw organisatie op dit moment?
3. Wat is uw functie binnen de organisatie?

Anderhalvelijnszorg

4. Bent u bekend met anderhalvelijnszorg? JA / NEE
5. Kunt u mij uitleggen, wat anderhalvelijnszorg voor u betekent?
6. Op wat voor manier verschilt anderhalvelijnszorg van de traditionele eerste of tweedelijnszorg die jullie organisatie voorheen/nu aanbood/aanbiedt?
7. Vanaf waar denkt u dat anderhalvelijnszorg het best aangeboden kan worden?

Definitie anderhalvelijnszorg uitleggen

Volgens literatuur kan anderhalvelijnszorg uitgelegd worden als zorg, gericht op decentralisatie van relatief simpele zorgtaken en centralisatie van complexe en acute zorg. Het doel van anderhalvelijnszorg is samenwerking en kennisdeling tussen eerste en tweedelijnszorg aanbieders.

8. Vindt u deze definitie volwaardig? Waarom wel/niet, evt. Aanvullingen?

In het algemeen wordt anderhalvelijnszorg gezien als een verschuiving van bepaalde ziekenhuiszorgtaken naar de huisarts of gezondheidscentra. Dit zou een beperking van ziekenhuistaken betekenen.

9. Vindt u deze algemene beschrijving juist? Waarom wel/ niet, evt. Aanvullingen?

Toegevoegde waarde

In literatuur wordt veel gesproken over het concept 'toegevoegde waarde'. Hiermee wordt de waardevermeerdering bedoeld, die plaatsvindt na bewerking of handeling. In deze context bedoel ik met toegevoegde waarde; de mate waarin bijgedragen wordt aan het realiseren van organisatiedoelen.

10. Wat denkt u dat de toegevoegde waarde(n) van anderhalvelijnszorg is of zijn voor uw organisatie?
 - Waarom en voor wie?
11. Kan uw organisatie anderhalvelijnszorg aanbieden vanuit het huidige gebouw waarin de

organisatie gevestigd is? JA / NEE

- Ja, waarom?
- Nee, waarom niet? Wat mist? Wat is nog meer nodig?

12. Kan uw organisatie anderhalvelijnszorg aanbieden met de huidige staat van diensten en ondersteuning? JA / NEE

- Ja, waarom?
- Nee, waarom niet? Wat mist? Wat is nog meer nodig?

FM

FM is de integratie van processen binnen een organisatie, om overeengekomen diensten te ontwikkelen en in stand te houden, gericht op de ondersteuning en bevordering van de effectiviteit van het primaire proces.

FM is dus een algemene managementfunctie, verantwoordelijk voor de gebouwde omgeving. Het vakgebied richt zich op planning en coördinatie van ondersteunende processen, ter bevordering van het succes van het primaire proces van de organisatie. Facilitaire voorzieningen zijn huisvesting, diensten en middelen, informatie- en communicatie technologie (ICT), externe voorzieningen en FM (administratie). De afdeling richt zich dus onder andere op het gebouw en zijn inrichting, de beveiliging en receptie, schoonmaak, restauratieve diensten en textielvoorziening.

13. Kunt u de Facilitaire organisatie binnen uw organisatie beschrijven?

14. Kunt u de rol van FM definiëren in uw organisatie?

- Strategisch, tactisch of operationeel?

15. Wat is de toegevoegde waarde van FM binnen uw organisatie?

16. Kunt u uitleggen hoe u denkt dat FM kan bijdragen aan doelstellingen van anderhalvelijnszorg?

In het verleden is al vaker onderzoek gedaan naar de eventuele toegevoegde waarden van FM in zorgomgevingen. De volgende elf toegevoegde waarden zijn daaruit voortgekomen.

	Productiviteit verhogen – De huisvesting, diensten en middelen als middel inzetten voor efficiënter en effectiever werken. Bijvoorbeeld door een slimme locatiekeuze, korte looplijnen tussen functies die veel met elkaar samenwerken, ergonomisch verantwoord meubilair en probleemloos functionerende ICT.
	Kosten verlagen – Het besparen op investeringskosten en exploitatiekosten van vastgoed en andere faciliteiten. Bijvoorbeeld door een scherpe m ² normering, maatregelen ter beperking van het energieverbruik, invoering van flexibele werkplekken, efficiënter gebruik van ruimtes en efficiënte inkoop.
	Risico's beheersen – Het voorkomen van ongewenste situaties met betrekking tot veiligheid, gezondheid en financiële risico's. Bijvoorbeeld door beveiliging, risico inventarisatie, bedrijfshulpverlening, arbo en verzekeringen.
	Waardestijging – Het sturen op de toekomstwaarde van het gebouw. Bijvoorbeeld door planmatig onderhoud en renovatie van het vastgoed, kortom alles wat met de financiële waarde van het vastgoed te maken heeft.
	Flexibiliteit vergroten – De organisatie zodanig inrichten dat er gemakkelijk aanpassingen mogelijk zijn. Ruimtelijk-bouwkundig door bijvoorbeeld flexibele systeemwanden, organisatorisch door bijvoorbeeld flexibele werktijden toe te passen, juridisch door slimme contracten af te sluiten.
	Cultuur ondersteunen – Een bijdrage leveren aan de organisatiecultuur. Bijvoorbeeld doormiddel van layout en inrichting een cultuurverandering ondersteunen, mensen stimuleren tot positief gedrag, door een nette en verzorgde omgeving, of door verschillende culturen te laten versmelten na een fusie.
	Imago ondersteunen – Het bijdragen aan de branding van de organisatie en een positief imago. Bijvoorbeeld door een aantrekkelijk ontwerp van het gebouw en andere faciliteiten, de kwaliteit van dienstverlening of klantvriendelijk personeel.
	Innovatie stimuleren – Het bevorderen van creativiteit en innovatie. Bijvoorbeeld door de inrichting van ruimtes en het faciliteren van interactie tussen medewerkers.
	Tevredenheid verhogen – Zorgen voor een hoge klant- en medewerkerstevredenheid. Bijvoorbeeld door gastvrijheid, het realiseren van een functionele, plezierige en comfortabele omgeving, een prettig en gezond binnenklimaat en het bieden van kwalitatief hoogwaardige faciliteiten.
	Duurzaamheid – Zo min mogelijk schade toebrengen aan het milieu. Bijvoorbeeld door bewust inkopen, sturen op lager energieverbruik en milieuvriendelijk materiaalgebruik.
	Healing environment – Het creëren van een omgeving die bijdraagt aan de genezing van patiënten. Bijvoorbeeld door kleurgebruik, bejegening, en kwaliteit van voedsel. Door het toepassen van elementen uit het healing environment principe, wordt ook bijgedragen aan andere toegevoegde waarden zoals tevredenheid, imago en productiviteit.

17. Kunt u middels deze elf toegevoegde waarden een top drie van toegevoegde warden van FM binnen uw organisatie maken?

- Waarom 1, 2 en 3?
- Waarom in deze volgorde?

Afsluiting (5 – 10 min.)

We naderen het einde van dit interview.

18. Heeft u misschien nog aanvullende informatieve of opmerkingen aangaande het onderwerp, die van belang zouden kunnen zijn voor het onderzoek?

19. Heeft u nog vragen aan mij?

20. Ik wil u bedanken voor uw tijd. Binnen 2 werkdagen zou ik u graag het transcript per e-mail toesturen. Zou u deze willen doorlezen en een bevestiging of eventuele wijziging per e-mail binnen 3 werkdagen terug willen zenden?

APPENDIX 4: ANSWERS ON INTERVIEW QUESTIONS PER PARTICIPANT

Inter view ee		1: Definitie anderhalvelijnszorg
<i>JD</i>		Anderhalvelijnszorg is een 'tussenterm' voor de ontwikkeling van substitutie van tweedelijnsstaken naar de eerstelijns.
<i>IM</i>		Zorg die normaliter in de tweedelijns opgepakt wordt, maar nu in de eerstelijns, waarbij de huisarts regie houdt en expertise en ondersteuning laat invliegen waar nodig; zo blijft patiënt in de eerstelijns.
<i>MB</i>		samenwerking tussen de eerste en tweede lijn, huisarts in de lead en gebruik maakt van tweedelijns expertise. Anderhalvelijnszorg moet voldoen aan vier voorwaarden; het win-vier model (een rolmodel om te begrijpen of de ideeën passen binnen economische wetten)
<i>RC</i>		Anderhalvelijnszorg is het geheel van bindende werkafspraken tussen de eerste en de tweedelijns met als doel om op de juiste plek en tegen de laatste kosten kwalitatief goede zorg te leveren. Dus: goede zorg, dicht bij de patiënt, kwalitatief goed, betere service voor de patiënt
<i>RS</i>		Verplaatsing van tweedelijnszorg naar de eerstelijns. Eerstelijnszorg waar het kan; tweedelijnszorg waar het moet.
<i>HM</i>		Het gebied waar in kennis en expertise van de tweedelijns zo dicht mogelijk naar die eerstelijns toegeschoven wordt
<i>CU</i>		specialistische zorg, niet in het ziekenhuis en niet in de huisartspraktijk geboden, maar daar tussen in. Anderhalvelijnszorg heeft ook een filterfunctie; wat hoort wél en wat níet in de tweedelijns.
Inter view ee		2: Praktische invulling anderhalvelijnszorg

<i>JD</i>		Gezondheidscentrum waar je kleine ingreep zou kunnen gaan doen, of ingrepen waar het risico nihil is en die je ook facilitair kunt ondersteunen en dan drie dat zou dan een ziekenhuisachtige setting,
<i>IM</i>		Huisarts wordt (bij voorkeur) opgeleid om meer te doen, schakelt expertise in waar nodig, of specialist komt in de anderhalvelijn de verrichting doen onder regie van de huisarts.
<i>MB</i>		Een specialist zoals POH, PA of specialist verpleegkundige, doet laag complexe zorg. Als het buiten protocollen, gebruikelijke referentiekaders treedt, moet het overlegd worden met collega specialist.
<i>RC</i>		Onder gezamenlijk regie; samenwerkingsprotocol, en meest waarschijnlijk vanuit het budget vanuit de eerste lijn. Aangeboden zorg afhankelijk van de vraag; omgevingsfactoren zijn bepalend.
<i>RS</i>		Faciliteren van de eerstelijns, zorg dichtbij de patient organiseren in samenwerking met de eerstelijns de zorg, weten waar je elkaar kunt vinden, dus: teleconsulten; ICT gebruiken bijv. door; telemonitoring, ECG's uitlezen, inloggen en onderzoek analyseren; de specialist adviseert de verwijzer. Zo houd je patient uit medische circuit, maak je wel gebruik van medische kennis en kunde, faciliteer je ten gunste van de patient, zorgkosten en consumptie dalen.
<i>HM</i>		Er zijn meerdere opties; niet 1 optie is voor alle regio's geschikt. Drietal opties: 1 = digitale ondersteuning vanuit het ziekenhuis aan de huisarts (regiehouder) 2 = carrousel; waar specialist bij huisarts komt en zij samen met patient in gesprek gaan. 3 = stadspoli' effect; neutraal terrein waar specialist meedenkt en meekijkt bij 'twijfel casussen' huisarts; geen fysieke handelingen.
<i>CU</i>		huisarts is en blijft hoofdbehandelaar, roept consultatie in bij medisch specialist.
Inter view ee		3: Locatie anderhalvelijnszorg
<i>JD</i>		In een gezondheidscentrum. Adherentiegebied (volume) moet groot zijn, voordat een centrum als Sunenz werkt; doelmatig vanwege grote volume (55 huisartsen). Volume maakt dat je kunt bundelen; specialist komt voor meerdere huisartsen, zodat hij tijd doelmatig kan invullen.

<i>IM</i>		In het anderhalvelijnszorgcentrum Sunenz.
<i>MB</i>		Vindt niet plaats in de huisartspraktijk, niet in het ziekenhuis, maar extern, zoals in Limburg bij het meekijkconsult (Maastricht, ZIO)
<i>RC</i>		Buiten de muren van het ziekenhuis. Niet in een nieuw (gezondheids)centrum, maar bij de (uitgebreide) praktijk van de huisarts. Niet denken in stenen maar in diensten. ICT speelt een belangrijke rol.
<i>RS</i>		E-mail: buiten de muren van het ziekenhuis. Sommige zorg (bijv MRI) kan in het ziekenhuis blijven, maar in ieder geval betaald uit eerstelijns budget.
<i>HM</i>		verschillende invulling mogelijk, afhankelijk van situatie en regio; bij de huisarts bleek in Maastricht niet succesvol, dus is gekozen voor neutraal terrein
<i>CU</i>		onafhankelijke locatie, waar geen huisartsenpraktijk zit, maar de specialist uit het ziekenhuis gewone spreekuren gaat draaien.
<i>Inter view ee</i>		4: Reactie op definitie 1 : zorg, gericht op decentralisatie van relatief simpele zorgtaken en centralisatie van complexe en acute zorg. Het doel van anderhalvelijnszorg is samenwerking en kennisdeling tussen eerste en tweedelijnszorg aanbieders
<i>JD</i>	Eens	Samenwerking tussen huisarts en specialist is er wel (huidige situatie). Het doel is kosten besparen > daar is de hele ontwikkeling op gebaseerd. Hogere doel is best mogelijke patientenzorg.
<i>IM</i>	Eens	Dit is het verhaal van Felix van der Wissel
<i>MB</i>	Oneens	Centralisatie van complexe en acute zorg hoort niet in de definitie van anderhalvelijnszorg
<i>RC</i>	Oneens	Samenwerking en kennisdeling is niet het doel van anderhalvelijnszorg, maar een middel. Doel is betaalbare kwalitatief goede zorg.
<i>RS</i>	Eens	Niet onnodig naar het ziekehuis en toegankelijke zorg is het doel. Uiteindelijk wordt het doel; zo goed mogelijk self management, waarbij de patient de regie heeft en alleen naar het ziekenhuis gaat waar nodig.
<i>HM</i>	Eens	[no comment]
<i>CU</i>		[not asked]

Inter view ee		5: Reactie op definitie 2 anderhalvelijnszorg: een verschuiving van bepaalde ziekenhuiszorgtaken naar de huisarts of gezondheidscentra
<i>JD</i>	Eens	[no comment]
<i>IM</i>	Oneens	Substitutie; ja, maar beperking van ziekenhuiszorgtaken; absoluut niet. Het is het weghalen van oneigenlijke taken uit het ziekehuis.
<i>MB</i>	Eens	[no comment]
<i>RC</i>	Eens	Substitutie van de zorg slaat op down graden, en is een onderdeel of vorm van anderhalvelijnszorg, maar substitutie is meer; ook 3e naar 2e, 4e naar 3e lijn etc.
<i>RS</i>	Eens	Het is wel een spanningsveld;
<i>HM</i>	Eens	Anderhalvelijn richt op (meekijk) consulten. Ingrepen, noodzakelijke zorg, blijft in de tweede lijn.
<i>CU</i>	Eens	Diagnostische taken verschuiven naar de eerstelijns.
Inter view wee		1: Toegevoegde waarde voor client
<i>JD</i>		Snelheid, service, kwaliteit
<i>IM</i>		Dichtbij huis, zonder eigen risico.
<i>MB</i>		Goedkoop (geen eigen risico), dichtbij en vertrouwd (door de huisarts, niet naar het ziekenhuis)
<i>RC</i>		Goede service. Goede zorg, dicht bij de patient. Kwalitatitief goed.
<i>RS</i>		Zorg dichtbij en zorg die goed is voor de patient.
<i>HM</i>		Goede kwaliteit, goede service, lage kosten.
<i>CU</i>		Dichterbij, sneller, service, kwaliteit.

Intervie wee	2: Toegevoegde waarde voor organisatie
<i>JD</i>	Takenpakket breidt uit.
<i>IM</i>	ZuidOostZorg profiteert van Sunenz, en andersom, door expertise op het gebied van ouderen(zorg). Samen op zoek naar slimme en passende antwoorden op de vraag nu en in de toekomst
<i>MB</i>	ZuidOostZorg profiteert van aanwas door screening ouderen bij Sunenz, en aanloop naar het centrum vanwege de voorzieningen.
<i>RC</i>	Ziekenhuis: hoog complexe zorg (volume kleiner, complexiteit hoger) > topklinisch opleidings ziekenhuis
<i>RS</i>	Lange termijn visie hoog complexe zorg richting een specialistischer ziekenhuis. Beschikbaarheid voor kennisdeling richting eerste lijn. Bijdragen aan het optimaliseren van zorg in de regio door zorg te laten plaatsvinden waar dat hoort, en zo maatschappelijke verantwoordelijkheid te kiezen.
<i>HM</i>	1 = duidelijke focus hoog complexe zorg, 2 = kwaliteit, 3 = toekomstgericht (wat klanten willen, bereik vergroten)
<i>CU</i>	Ziekenhuis hoeft niet onnodig diagnostiek en behandeling (kostbaar apparaat en mensenwerk) in te zetten.
Intervie wee	3: Toegevoegde waarde; overig
<i>JD</i>	
<i>IM</i>	Voor de specialist in het ziekenhuis; kan zich focussen op complexe zorg. Huisarts werksatisfactie gaat omhoog, kennis en expertise wordt uitgebreid. Zorgverzekeraars krijgen doelmatige en efficiënte zorg.
<i>MB</i>	Voor klanten van ZuidOostZorg is het brede scala aan diensten dat aangeboden wordt een groot voordeel.
<i>RC</i>	Huisarts: betaalbare zorg, meewerken in ontwikkeling is meedenken en onderhandelen. Doelmatig en behapbare zorg.

RS	
HM	
CU	
Intervie wee	1: Locatie eisen
JD	Pand voldoet. Voldoet aan LHV eisen (goede verlichting, schoon kunnen werken, steriliseren, lab mogelijkheden). Totdat een patient 'slecht wordt'; dan kan ambulance ingeschakeld worden.
IM	Fris, ruimtelijk, licht en géén zorginstelling uitstraling. Van en voor ouderen (dus ook dóór ouderen).
MB	Pand voldoet en heeft zelfs een operatiekamer. Perfect, benadert ziekenhuisuistraling en kwaliteit.
RC	Huisartsen hebben te kleine panden om anderhalvelijnszorg aan te kunnen bieden vanuit die locatie. Gedachte is dat géén nieuwe locaties gebouwd worden, dus anderhalvelijnszorg bij de huisartspraktijk (of evt. in het ziekenhuis) plaats vindt. Huisartsen kunnen evt. verbouwen/uitbreiden.
RS	email: buiten de muren van het ziekenhuis. Verder geen eisen.
HM	Neutrale locatie. Inrichtingseisen nihil; wellicht nog minder eisen dan in een huisartsenpraktijk; het is meer een gespreksruimte, er vinden geen handelingen plaats.
CU	Buiten het ziekenhuis, buiten de huisartsenpraktijk.
Intervie wee	2: Benodigde middelen
JD	[no comments]
IM	Kleine verrichtingen kamer.
MB	Weinig tot geen, afhankelijk van specialisme. Spreekkamer van specialist in 1 ½ lijnscentrum is minder ingericht dan huisartsenpraktijk

RC	Specialistisch apparatuur; ECG apparaat, longfunctie test. Ook een uitgebreid Huisartsen Informatie Systeem (HIS).
RS	e-mail: financiële middelen en meer ondersteunend personeel in de eerstelijns.
HM	Weinig tot geen, afhankelijk van het specialisme. Sommige specialismen hebben specifiek apparatuur nodig.
CU	bevoorrading
Intervie wee	3: Benodigde diensten
JD	Kennisniveau van artsen moet up to date zijn. Specialistische schoonmaak wellicht noodzakelijk. Ontvangstbali en wachtkamer zijn geschikt.
IM	[not asked]
MB	
RC	Coöperatie huisartsen voor communicatie richting zorgverzekeraar en andere partijen. ICT ondersteuning. Praktijkmanagers (die ook facilitaire diensten inregelen).
RS	e-mail; geen gedachte bij
HM	ICT
CU	Schoonmaak, ICT, etc. (kort genoemd)
Intervi ewe	1: Hoe ziet de facilitaire organisatie er uit?
JD	geen facilitaire organisatie. Centrummanager regelt facilitaire zaken tot de deur. Huurders regelen zelf of via centrummanager ondersteunende diensten. Bepaalde diensten worden gezamenlijk afgenomen.
IM	Sunenz verhuurt ruimten. Via SLA kunnen huurders kiezen welke diensten ze afnemen bij Sunenz, en welke ze zelf inregelen. Huurders betalen x bedrag aan servicekosten voor 'gastvrijheidspakket'; breedste zin van het woord; algemene receptie, veiligheid, gladheidsbestrijding, groenvoorziening, ramen wassen, schoonmaak algemene ruimten

MB	schoonmaak, textiel, vullen van disposables, ICT
RC	huidige en toekomstige situatie; regelt de huisarts of praktijkmanager zelf. Kleinschalig dus dat doen huisartsen erbij.
RS	integraal, ondersteunend, faciliterend van het primaire proces.
HM	[not asked]
CU	Startende organisatie; er verandert nog veel. Kleine organisatie; dus mensen doen veel zelf.
Interviee	2: Rol van facility management
JD	strategisch (locatie), tactisch (pand inrichting) en operationeel (dagelijkse werkzaamheden).
IM	Op tactisch niveau betrokken (bij nieuwbouw etc.)
MB	(ondersteunend) secundair; schoonmaak, textiel, vullen van disposables, ICT
RC	operationeel
RS	verschuiving zichtbaar van operationeel naar tactisch; servicelevels en serviceniveau afspraken.
HM	[not asked]
CU	Ondersteunend; dingen moeten geregeld zijn. Operationeel gefocust; er kan snel worden geschakeld, geen grotere contracten, flexibiliteit. Behalve schoonmaak niet centraal geregeld.
Interviee	3: Toegevoegde waarde FM (zonder voorbeeld)
JD	groeiwens ondervangen
IM	Toegevoegde waarde is gevraagd en ongevraagd advies vanuit het gastvrijheidsconcept en wet- en regelgeving. Breder is het levensplezier en hospitality.

Mark van Bracht	FM voegt waarde toe, mits goed ingericht en servicegericht is, bijv. door bewegwijzering en toegankelijkheid te optimaliseren, backoffice te organiseren. FM inzetten om beleving van de bezoeker te vergroten	
Ron Cator	ondersteuning in lijnen, niet in stenen. ICT, vertaalprogrammatuur: ondersteuning in samenwerking.	
Reitze Sybesma	wordt onderschat; is cruciaal. ICT en infrastructuur hebben en krijgen meer belangrijke rol.	
Herm Martens	ICT ondersteuning (grootste ruimte en groeimogelijkheden), PR (imago ondersteunen), (administratieve) ondersteuning en logistieke ondersteuning (flexibiliteit, meerdere locaties)	
Caro van Uden	lastig te beantwoorden, maar wat nodig is moet geregeld zijn (veel doet men zelf). Flexibiliteit is een toegevoegde waarde.	
Interview	Nummer 1	Uitleg
JD	NU: kosten verlagen	[no comment]
JD	1 1/2: healing environment	het ultieme doel; een omgeving die in alle facetten bijdraagt aan de genezing van de patiënt.
IM	tevredenheid verhogen	
MB	tevredenheid verhogen	klanttevredenheid is het allerbelangrijkste, het hoogste doel
RC	ZH: flexibiliteit verhogen	
RC	HA: productiviteit verhogen	meer omzet
RS	NU: kosten verlagen	kosten stijgen, met name bij ondersteunende diensten, dus tactisch strategisch inkopen en anders (zakelijker) omgaan met leveranciers is noodzakelijk.

RS	1 1/2: kosten verlagen	blijft een issue.
HM	innovatie stimuleren	Innovatie als in verbetering in de maatschappij of op de werkvloer, maar ook innovatie als in onderzoek en het verbeteren van de zorg (vanuit de academische functie).
CU	tevredenheid verhogen	de andere omgeving en sfeer van de stadspoli maakt mensen tevredener (FM specifiek)
Intervie wee	Nummer 2	Uitleg
JD	NU: tevredenheid verhogen	[no comment]
JD	1 1/2: kosten verlagen	Wellicht investering noodzakelijk, maar uiteindelijk is kosten verlagen het doel; zorgkosten verlagen is opgelegd door de overheid. Kan ook gevolg zijn van 1 1/2 lijnszorg.
IM	healing environment	dat is het geloof; nieuwbouw veel architecten en werkgroepen ingeschakeld om juiste middelen, materialen en kleur in te zetten
MB	healing environment	juiste kleuren, uistraling en beleving van het centrum.
RC	ZH: kosten verlagen	geen groei toegestaan, als je minder moet je kosten verlagen
RC	HA: kosten verlagen	
RS	NU: healing environment	Healing environment
RS	1 1/2: flexibiliteit verhogen	Veranderingen gaan gewoon door, flexibiliteit blijft dus belangrijk.
HM	tevredenheid verhogen	Triple aim. Vooral gericht op patienten, maar ook op medewerkers.
CU	duurzaamheid	hoge kwaliteit producten, die lang meegaan. Niet kopen of gebruiken wat je niet nodig hebt.

Intervie wee	Nummer 3	Uitleg
JD	NU: productiviteit verhogen	[no comment]
JD	1 1/2: flexibiliteit verhogen	Flexibel kunnen inspelen op de wens van de patiënt. Dat mogelijkheden biedt om zorg naar de eerstelijns te trekken waar mogelijk.
IM	duurzaamheid	Sunenz heeft rol en verantwoordelijkheid in duurzaamheid, zowel duurzame zorg als duurzame inzet van middelen en duurzame inkoop.
MB	productiviteit verhogen	iets moet duidelijk zijn en logisch in elkaar zitten.
RC	ZH: imago ondersteunen	
RC	HA: innovatie stimuleren	
RS	NU: flexibiliteit verhogen	Mindere mate in het gebouw, in hogere mate in de mensen: we weten niet hoe de toekomst eruit gaat zien.
RS	1 1/2: cultuur ondersteunen	Cultuur is dat mensen meebewegen: duurzaam inzetbaar zijn en doorontwikkelen. Professionele verbetercultuur: aanspreken op gedrag, proces optimalisatie, samenwerking, eigenaarschap
HM	risico's beheersen	Daar houdt het AZM zich vooral mee bezig. Echter, (persoonlijke) voorkeur gaat uit naar healing environment (staat wel op de agenda)
CU	productiviteit verhogen	het ondersteunen van, zodat het proces beter verloopt.
Intervie wee	Nummer 4	Uitleg
IM	kosten verlagen	doelmatiger zijn, bijdragen aan uit de pan lopende kosten door slimmer en goedkoper te organiseren

<i>Intervie wee</i>	Nummer 5	Uitleg
<i>IM</i>	innovatie stimuleren	om doeltreffend te zijn heb je andere, nieuwe, slimmere, manieren nodig.

APPENDIX 5: TABLES

GP's top three		
1	<i>Manager GP</i>	Current situation: reduce costs Integrated situation: support healing environment
2	<i>Manager GP</i>	Current situation: increase satisfaction Integrated situation: reduce costs
3	<i>Manager GP</i>	Current situation: improve productivity Integrated situation: improve flexibility
CH's top three		
1	<i>Policy maker CH</i>	1st line; improve flexibility
	<i>Policy maker CH</i>	2nd line; improve productivity
	<i>Manager CH</i>	Current situation; reduce costs
	<i>Manager CH</i>	Integrated situation; reduce costs
2	<i>Policy maker CH</i>	1st line; reduce costs
	<i>Policy maker CH</i>	2nd line; reduce costs
	<i>Manager CH</i>	Current situation; healing environment
	<i>Manager CH</i>	Integrated situation; improve flexibility
3	<i>Policy maker CH</i>	1st line; support innovation
	<i>Policy maker CH</i>	2nd line; support image
	<i>Manager CH</i>	Current situation; improve flexibility
	<i>Manager CH</i>	Integrated situation; support culture
ICC's top three		
1	<i>Manager ICC</i>	Increase satisfaction
	<i>GP ICC</i>	Increase satisfaction
2	<i>Manager ICC</i>	Support healing environment
	<i>GP ICC</i>	Support healing environment

3	<i>Manager ICC</i>	Improve sustainability
	<i>GP ICC</i>	Increase productivity
IH's top three		
1	<i>Specialist IH</i>	Support innovation
	<i>Coordinator IH</i>	Increase satisfaction
2	<i>Specialist IH</i>	Increase satisfaction
	<i>Coordinator IH</i>	Improve sustainability
3	<i>Specialist IH</i>	Control risks
	<i>Coordinator IH</i>	Increase productivity

Table 1. top-3 added values FM per participant from case perspective (inter case overview)

1	<i>Manager ICC</i>	increase satisfaction	vs	1	<i>Specialist IH</i>	support innovation
	<i>GP ICC</i>	increase satisfaction			<i>Coordinator IH</i>	increase satisfaction
2	<i>Manager ICC</i>	support healing environment	vs	2	<i>Specialist IH</i>	increase satisfaction
	<i>GP ICC</i>	support healing environment			<i>Coordinator IH</i>	improve sustainability
3	<i>Manager ICC</i>	improve sustainability	vs	3	<i>Specialist IH</i>	control risks
	<i>GP ICC</i>	increase productivity			<i>Coordinator IH</i>	increase productivity

Table 2. Cross case ranking overview IC (ICC vs IH)

1	<i>Manager GP</i>	Current situation: reduce costs	vs	1	<i>Manager CH</i>	Current situation; reduce costs
					<i>Policy maker CH</i>	1st line; improve flexibility
					<i>Policy maker CH</i>	2nd line; increase productivity
2	<i>Manager GP</i>	Current situation: increase satisfaction	vs	2	<i>Manager CH</i>	Current situation; healing environment
					<i>Policy maker CH</i>	1st line; reduce costs
					<i>Policy maker CH</i>	2nd line; reduce costs
3	<i>Manager GP</i>	Current situation: increase productivity	vs	3	<i>Manager CH</i>	Current situation; improve flexibility
					<i>Policy maker CH</i>	1st line; support innovation
					<i>Policy maker CH</i>	2nd line; support image

Table 3. Cross case ranking overview not IC (case GP and CH) current situation

1	<i>Manager GP</i>	Integrated situation: support healing environment	vs	1	<i>Manager CH</i>	Integrated situation; reduce costs
					<i>Policy maker CH</i>	1st line; improve flexibility
					<i>Policy maker CH</i>	2nd line; increase productivity
2	<i>Manager GP</i>	Integrated situation: reduce costs	vs	2	<i>Manager CH</i>	Integrated situation; improve flexibility
					<i>Policy maker CH</i>	1st line; reduce costs
					<i>Policy maker CH</i>	2nd line; reduce costs
3	<i>Manager GP</i>	Integrated situation: improve flexibility	vs	3	<i>Manager CH</i>	Current situation; improve flexibility
					<i>Policy maker CH</i>	1st line; support innovation
					<i>Policy maker CH</i>	Integrated situation; support culture

Table 4. Cross case ranking overview not IC (case GP and CH) integrated situation

	GP	ICC	CH	IH
1	GP	GP	Patient	GP
2	One and a half line	One and a half line	Hospital	Patient
3	Foundation	Specialized / Specialist	GP	Specialized / Specialist
4	Society Center	Hospital	Home	Hospital
5	Efficient	Patient	Costs	Home

Table 5. Top five not predefined words per case

	Case 1	Case 2	Case 2	Case 3	Case 3	Case 4	Case 4		
	Manager GP	Manager ICC	GP ICC	Policy maker CH	Manager CH	Specialist IH	Coordinator IH		
<i>IC definition 1</i>								Total	%
Cooperation	8	4	1	10	10	2	2	37	4,23%
Knowledge sharing	1	0	0	3	0	1	0	5	0,57%
Decentralization	0	0	0	0	0	0	0	0	0,00%
Centralization	0	0	2	0	0	0	0	2	0,23%
<i>IC definition 2</i>									0,00%
Substitution	0	0	0	0	1	0	1	2	0,23%
Hospital	18	21	21	38	32	24	38	192	21,97%
Community care center	20	1	1	3	0	0	0	25	2,86%
GP	65	66	32	54	16	44	30	307	35,13%
Specialist	10	20	27	7	17	17	20	118	13,50%
<i>FM added values</i>									0,00%
Productivity	2	0	0	1	3	0	0	6	0,69%
Costs	9	5	3	11	27	12	0	67	7,67%
Risks	2	1	4	2	2	2	1	14	1,60%
Appreciation (value)	0	0	0	1	0	0	1	2	0,23%
Flexibility	6	0	0	3	5	3	2	19	2,17%
Culture	0	0	0	1	7	0	6	14	1,60%
Image	1	0	0	2	4	2	0	9	1,03%
Innovation	0	1	1	2	2	4	0	10	1,14%
Satisfaction	3	0	4	1	4	2	5	19	2,17%
Sustainability	0	5	0	2	5	0	8	20	2,29%
Healing environment	0	0	1	0	2	3	0	6	0,69%
									100%

Table 6. Overview of mentioned predefined words

APPENDIX 6: SUMMARIZES OF INTERVIEWS

Interview Jurjen Duker – Gezondheidscentrum Kloosterveen

Locatie: transportweg 8, Assen

Datum: 22-06-2015

Tijdstip: 09.00 - 10.12 uur

Organisatie

Gezondheidscentrum Kloosterveen

Multidisciplinair zorgcentrum eerstelijnszorg; tien disciplines: apotheek, diëtist, ergotherapie, fysiotherapie, huisartsen, kraamzorg, logopedie, podotherapie, psychologie en verloskundige zorg.

Jurjen Duker is centrummanager, in beginsel voor de stichting en daarnaast praktijkmanager huisartsen binnen het gezondheidscentrum. Als centrummanager houdt hij zich bezig met het beleid en de visie van de stichting en zorgt hij voor cohesie en samenwerking tussen verschillende disciplines, binnen en buiten de stichting.

Anderhalvelijnszorg

Jurjen is bekend met anderhalvelijnszorg. Het staat op de agenda van gezondheidscentrum Kloosterveen. Het begrip anderhalvelijnszorg is lastig te definiëren. Voor Kloosterveen betekent anderhalvelijnszorg een verschuiving van tweedelijns taken die eenvoudig uitvoerbaar en laag in risico zijn, naar eerstelijns zorgcentra zoals gezondheidscentrum Kloosterveen. Het betekent dat eerstelijnszorg aanbieders meer (poliklinische) taken gaan uitvoeren, en ziekenhuizen minder. Ziekenhuizen kunnen zich op deze manier specifiek richten op complexe en acute zorg.

Jurjen benadrukt dat de term anderhalvelijnszorg in zijn ogen van tijdelijke aard is. De gedachte hierachter is dat wat nu als tweedelijnszorg wordt gezien, in de toekomst vanzelfsprekend eerstelijnszorg zou kunnen zijn. Als voorbeeld wordt het verwijderen van een moedervlek en sterilisatie genoemd; waar het nu vanzelfsprekend is dat deze zorg in de tweedelijns wordt afgenomen, zou het in de toekomst vanzelfsprekend kunnen zijn dat deze zorg in de eerstelijns wordt afgenomen. De overgangsfase kan als een anderhalvelijnszorg fase worden bestempeld, waar de verschuiving van relatief eenvoudige handelingen verschuift van het ziekenhuis naar het gezondheidscentrum.

Een toenemende kennisdeling en samenwerking, dat volgens literatuur gevolg is van invoering van anderhalvelijnszorg, is volgens Jurjen niet per se aan de orde. Hij onderschrijft dat door het huidige Nederlandse zorgsysteem samenwerking tussen eerste- en tweedelijns al een vereiste is en dat de verschuiving van zorg zelfs een verminderd aantal contacturen tussen specialist en huisarts zou kunnen veroorzaken.

Jurjen geeft aan dat huidige benamingen binnen het zorgstelsel wellicht gewijzigd zouden kunnen worden. Hij stelt een systeem voor dat bestaat uit 3 'lijnen', waarin de eerstelijns de huisarts in de buurt is (tien minuten regel), de tweedelijns het gezondheidscentrum en de derdelijns het specialistische (trauma) ziekenhuis. Volgens deze, van defensie afgeleide, structuur denkt hij dat de zorg beter zou werken.

Toegevoegde waarde

Toegevoegde waarde van anderhalvelijnszorg voor de cliënt zijn samengevat in drie begrippen: snelheid, service en kwaliteit.

Kloosterveen kan anderhalvelijnszorg aanbieden vanuit het huidige gebouw, met de huidige diensten en middelen. Jurjen geeft aan dat met poliklinische ingrepen schoonmaakdiensten wel anders ingericht moeten worden. Verder ziet hij geen belemmeringen in gebouw of diensten.

FM

Huidige situatie:

1 = kosten verlagen

2 = tevredenheid verhogen

3 = productiviteit verhogen

Anderhalvelijnszorgsituatie:

1 = healing environment

2 = kosten verlagen

3 = flexibiliteit verhogen

Interview Ida van Marion

Locatie: vergaderruimte ZuidOostZorg

Datum: 7-7-15

Tijdstip: 12.45 – 13.30 uur

Organisatie

Ida van Marion is regiodirecteur, verantwoordelijk voor extramuraal, alles voor de klant thuis, en het onderdeel expertisecentra. Sunenz, het anderhalvelijnscentrum, valt onder extramurale zorg.

Sunenz is een anderhalvelijnscentrum gericht op gezond en vitaal ouder worden.

Anderhalvelijnszorg

Volgens Felix van de Wissel: anderhalvelijnszorg is de zorg die je uit de tweede lijn kan halen en in de eerstelijns kunt plaatsen, waarvoor de huisarts ondersteuning en specialistische kennis nodig heeft die niet regulier in de eerstelijns zit ingebed, waarin de specialist uit de tweedelijns een rol kan spelen. Het is dus verplaatste zorg.

Toegevoegde waarde

De filterfunctie binnen de zorg zal verbeteren; alleen waar noodzakelijk doorsturen. Dat levert uiteindelijk een geldbesparing op.

Anderhalvelijnszorgcentrum draagt bij aan doelmatige zorg, zoals is overeengekomen met verzekeraars.

Bedient de regio met haar regionale focus, maar is ook wijk en inloopcentrum, voor alle hulpbehoevende ouderen

FM

Top drie toegevoegde waarden, volgens Prevosth en van der Voordt, betreffende anderhalvelijnszorg:

1 = klanttevredenheid verhogen

2 = healing environment

3 = duurzaamheid

Extra:

4 = kosten besparen

5 = innovatie stimuleren.

Interview Mark van Bracht – Sunenz Drachten

Locatie: Tjonger 82, Drachten

Datum: 24-6-15

Tijdstip: 13.40 – 14.25 uur

Organisatie

Sunenz.

Ik spreek met huisarts van Bracht die niet in loondienst is, maar als zelfstandige verbonden is aan de anderhalvelijnszorgorganisatie.

Anderhalvelijnszorg

Anderhalvelijnszorg is zoals Felix van der Wissel het gedefinieerd heeft.

“De eerstelijns zijn dat wij als huisartsen, tweedelijns zijn specialisten en het brandpunt daar waarbij wij elkaar ontmoeten noemen we de anderhalvelijnszorg. Dat, die anderhalvelijnszorg vindt niet plaats in de praktijk bij de huisarts, vindt ook niet plaats in het ziekenhuis maar vindt buiten die muren extern plaats”

“Anderhalvelijnszorg is dus die zorg die buiten de muren van het ziekenhuis en de praktijk, uhm, samenkomen waarbij samenwerking is tussen de eerste en tweede lijn, en eigenlijk is het zo dat de huisarts in, in de lead is en gebruik wil maken van de tweedelijns expertise. En de tweedelijns expertise kan zijn een specialist, dat kan zijn een gespecialiseerd huisarts, dat kan ook een verpleegkundig specialist zijn of het kan een physisian assistent zijn”

Toegevoegde waarde

Toegevoegde waarde van anderhalvelijnszorg voor de patiënt is goedkope zorg (geen eigen risico) en een bekend gezicht; het gaat dus om toegankelijkheid.

Toegevoegde waarde van anderhalvelijnszorg voor de ZuidOostZorg is aanloop, aanwas, en follow up van screening. Daarnaast zijn de twee modules, huisartsenbedden en ouderenzorg, een voordeel én het ‘mall effect’ dat de supermarkt, kapper en andere voorzieningen hebben op de aantrekkingskracht van ‘klanten’.

Toegevoegde waarde van FM zit hem vooral in de kleine dingen; de service, hospitality en de toegankelijkheid van het gebouw (orde, entree, bewegwijzering).

FM

Top drie toegevoegde waarden, volgens Prevosth en van der Voordt, betreffende anderhalvelijnszorg:

- 1 = Tevredenheid verhogen (klant)
 - 2 = Healing environment
 - 3 = Productiviteit verhogen (door effectiviteit)
-

Interview Ron Cator

Locatie: kantoor Martini ziekenhuis

Datum: 25-6-15

Tijdstip: 10.05 – 11.00 uur

Organisatie

Huisartsenpraktijk en Martini ziekenhuis; dhr. Cator is parttime huisarts, en parttime medewerker martini ziekenhuis waarin hij verschillende taken verricht, gericht op eerste en tweedelijns samenwerking. Het ontwikkelen van anderhalvelijnszorg regio Groningen is een van zijn taken.

Anderhalvelijnszorg

“Anderhalvelijnszorg is het geheel van bindende werkafspraken tussen de eerste en de tweedelijns met als doel om op de juiste plek en tegen de laatste kosten kwalitatief goede zorg te leveren”

Buiten de muren van het ziekenhuis, onder regie van de huisarts, door een gezamenlijk initiatief.

“Het is gewoon goede zorg, dicht bij de patiënt, kwalitatief goed, betere service voor de patiënt in ieder geval”

Toegevoegde waarde

Voor de cliënt : dichtbij, kwalitatief goede zorg en betaalbaar.

Voor de huisarts: heeft er baat bij dat zorg betaalbaar blijft. Wil graag meedenken, zodat zorg doelmatig en behapbaar blijft. Onderhandelt graag mee. Wil ook wel extra taken doen, zo lang daar financiering tegenover staat.

Voor het Martini ziekenhuis: inzetten op hoog complexe zorg voor het top klinische ziekenhuis dat Martini is. Volume van zorg, door afstoting van laag complexe zorg, zal afnemen, maar complexiteit toenemen.

FM

Top drie toegevoegde waarden, volgens Prevosth en van der Voordt, betreffende anderhalvelijnszorg, in het ziekenhuis:

- 1 = flexibiliteit verhogen
- 2 = Kosten verlagen
- 3 = Imago ondersteunen

Top drie toegevoegde waarden, volgens Prevosth en van der Voordt, betreffende anderhalvelijnszorg, in de huisartsenpraktijk:

- 1 = Productiviteit verhogen
 - 2 = Kosten verlagen
 - 3 = Innovatie stimuleren
-

Interview Reitze Sybesma

Locatie: kantoor Martini ziekenhuis, derde etage

Datum: 25-6-15

Tijdstip: 13.10 uur tot 14.00 uur (persoonlijk gesprek tot 14.45 uur)

Organisatie

Reitze Sybesma is organisatorisch manager van een aantal resultaat verantwoordelijke eenheden. Duaal management met medisch manager, waar het gaat om de cardiologie, maag darm leverziekten, kaakchirurgie, bijzondere tandheelkunde en, vanaf heden, de medische psychologie. Vanuit alle deelgebieden te maken met anderhalvelijnszorg.

Anderhalvelijnszorg

Toegankelijke zorg, gericht op self management, georganiseerd rondom de patient behoefte.

“Het inrichten van anderhalvelijnszorg is het faciliteren ook van de eerstelijns dus dicht bij de patiënt, ook meer de zorg ook organiseren, en met de eerstelijns ook die zorg organiseren en ook weten wanneer je elkaar, en hoe je elkaar ook kunt vinden.”

Concreet voorbeeld is telezorgtoepassingen

Toegevoegde waarde

Voor de cliënt: kwaliteit, service, dichtbij; daar waar het kan in de eerstelijns, of terug naar de eerste lijn, verdere behandeling door de huisarts en of de praktijkondersteuner, met advies uit de tweede lijn indien nodig (kennis en kunde).

Voor het Martini ziekenhuis: lange termijn visie op hoog complexe zorg richting een specialistischer ziekenhuis. Beschikbaarheid voor kennisdeling richting eerste lijn. Bijdragen aan het optimaliseren van zorg in de regio door zorg te laten plaatsvinden waar dat hoort, en zo maatschappelijke verantwoordelijkheid te kiezen.

FM

Top drie toegevoegde waarden, volgens Prevosth en van der Voordt, betreffende anderhalvelijnszorg, in de huidige situatie:

1 = Kosten verlagen

2 = Healing environment

3 = Flexibiliteit verhogen

Top drie toegevoegde waarden, volgens Prevosth en van der Voordt, betreffende anderhalvelijnszorg, in de toekomstige situatie:

1 = Kosten verlagen

2 = Healing environment

3 = Flexibiliteit verhogen / cultuur

Interview Herm Martens

Locatie: kantoor MUMC – Academisch Ziekenhuis Maastricht

Datum: 29-6-15

Tijdstip: 10.35 – 11.15

Organisatie

Herm Martens is van origine dermatoloog bij het MUMC (voorheen AZM) en houdt zich bezig met het opleiden van nieuwe dermatologen, anderhalvelijnszorg en e-health binnen de dermatologie.

Het MUMC is betrokken in het project ‘Blauwe Zorg’, dat gericht is op de ontwikkeling van

anderhalvelijnszorg in regio Maastricht.

Anderhalvelijnszorg

“Anderhalvelijnszorg is voor mij het stukje ruimte tussen de huisarts en de specialist. En dat is eigenlijk een grijs gebied, waar een hele hoop toepassingen mogelijk en denkbaar. De huisarts heeft de regie. (..) Centraal staan kwaliteit, service en kosten”.

Men wilde meer naar een continuïteit van zorgspectrum, dus zonder die echte afgebakende lijnen.. De huisarts wordt als belangrijkste aanspreekpunt en regiehouder neergezet. Dus de anderhalvelijnszorg is eigenlijk het gebied waar in de kennis en expertise van de tweedelijns zo dicht mogelijk naar die eerstelijns toegeschoven wordt.

Dat heet anderhalve lijn, soms heet dat Blauwe zorg, in andere regio's heet dat eerstelijns plus, nou daar zijn allerlei benamingen voor.

Toegevoegde waarde

Toegevoegde waarde voor de client: dichtbij, hoge kwaliteit, service en dus hogere tevredenheid.

Toegevoegde waarde voor het ziekenhuis: een betere verdeling tussen laag complexe zorg en academische zorg, waarbij het ziekenhuis een dubbelfunctie heeft, en waarbij je intern kan specialiseren op die hoog complexe academische zorg en daar meer ruimte en mogelijkheden voor creëert, terwijl je er misschien op een ander manier ervoor kan zorgen dat die grote groep van laag complexe zorg geholpen wordt. Door patienten tevredener te stellen, o.a. door ze dichtbij huis te helpen, creëer je meerwaarde en een goede naam. De kwaliteit blijft minimaal gelijk, het liefst omhoog.

FM

Top drie toegevoegde waarden, volgens Prevosth en van der Voordt, betreffende anderhalvelijnszorg:

1 = innovatie stimuleren

2 = tevredenheid verhogen

3 = risico's beheersen

Interview Caro van Uden

Locatie: kantoorpand ZIO – Wilhelminasingel 81 in Maastricht

Datum: 29-6-15

Tijdstip: 13.55 – 15.35 uur

Organisatie

ZIO (Zorg in Ontwikkeling) – voorheen stichting RHZ Heuvelland – is een eerstelijns zorgorganisatie in Maastricht en omgeving (Heuvelland). ZIO staat voor optimale kwaliteit van zorg en bereikt dit mede door de eerstelijns zorgaanbieder (bijv. de huisarts, praktijkonderteuner, fysiotherapeut en diëtist) in zijn of haar praktijk adequaat te ondersteunen.

Bij ZIO zijn aangesloten: * de huisartsen uit Maastricht en Heuvelland verenigd in de vereniging RHZ
* de fysiotherapeuten uit Maastricht en Heuvelland die zijn aangesloten bij stichting Fy'net. * de diëtisten uit Maastricht en Heuvelland die zijn aangesloten bij Dienet.

Het beleid van ZIO wordt vormgegeven door het beleid van aangesloten eerstelijns zorgaanbieders.

Een onafhankelijke raad van toezicht houdt toezicht op de bedrijfsvoering van ZIO.

(bron: zio.nl)

Dhr. Van Uden is directeur bedrijfskundige ZIO, en houdt zich (onder andere) bezig met 'Blauwe Zorg' in de stadspoli's.

Anderhalvelijnszorg

Vanuit het gedachtegoed dat veel zorg plaatsvindt in het ziekenhuis, terwijl dat niet persé noodzakelijk is; anderhalvelijnszorg. "Specialistische zorg, die niet in het ziekenhuis geboden wordt, en ook niet in de huisartsenpraktijk maar daar tussen, waarbij de huisarts hoofdbehandelaar blijft en consultatie inroept bij de medisch specialist indien nodig".

Anderhalvelijnszorg centrum in Maastricht is de stadspoli. Daar vinden géén behandelingen plaats, alleen consultatie/gesprekken door een specialist. Die bepaalt vervolgens, in overleg met de huisarts, of het nodig is dat de patiënt naar het ziekenhuis gaat. Door deze tussenoplossing worden 80% minder doorverwijzingen uitgeschreven.

Toegevoegde waarde

Voor de patiënt: dichterbij, sneller, service, kwaliteit.

Voor het ziekenhuis: kan zich richten op academische specialistische ziekenhuiszorg. Daarnaast kan het leiderschap tonen in het nemen van maatschappelijke verantwoordelijkheid; gewenst gedrag uitoefenen dus.

Voor ZIO: het uitoefenen van de ideologie achter Blauwe Zorg: niet je eigen winstmaximalisatie, maar een goede zorgvoorziening in Nederland is belangrijk.

FM

Top drie toegevoegde waarden, volgens Prevosth en van der Voordt, betreffende anderhalvelijnszorg:

1 = Tevredenheid

2 = Duurzaamheid

3 = Productiviteit verhogen

APPENDIX 7: AGENDA EXPERT MEETING

20 augustus expert meeting anderhalvelijnszorg

09.00 - 11.00 uur

Zernikeplein 11.

1. Introductie

- Voorstellen
 - Coline van de Belt; studentonderzoeker master FREM
- Korte bespreking doelstelling onderzoek en meeting
 - Experts' visie
 - Discussie interview resultaten
- Case toelichting

2. Voorstelronde

- FME
 - Msc. Business Studies, onderzoeker, leraar en projectleider onderzoekscentrum
- ICE
 - MSc. Health Management, project leider in een ziekenhuisorganisatie, ervaringsdeskundige ontwikkeling en implementatie anderhalvelijnszorg
- RP
 - Ir., Humane Voeding, werkt voor een organisatie die als belangenbehartiger de belangen van de patiënt in de zorg versterkt

3. Expert discussie

- Definitie en invulling anderhalvelijnszorg
- Benodigde diensten en middelen anderhalvelijnszorg
- Discussie top-3 toegevoegde waarden (n.a.v. meegestuurde lijst, graag van te voren individueel vast stellen en beargumenteren)

4. Discussie over uitspraken van geïnterviewden

5. Evaluatie en afsluiting

- Aanvullingen en opmerkingen

Bijlagen:

1. Onderzoeksopzet
2. Interview gids

APPENDIX 8: STATEMENTS DISCUSSED DURING EXPERT MEETING

Statement 1: there is no difference between FM added values (Prevost and van der Voordt, 2011), between the not-integrated and the integrated situation for healthcare organizations.

Statement 2: integrated care will destroy hospitals because of the limitation of health care supply.

Statement 3: integrated care is about organizing care where it belongs, by the use of guidelines, protocols and agreements

Statement 4: FM is day-to-day management and less interesting, especially for the healthcare specialist

Statement 5: IC centers need a different atmosphere then not-integrated care organizations. It needs to be welcoming, domestic, not sterile and comfortable.

Statement 6: IC is a temporary term. When second line healthcare tasks are substituted to first line, and people are used to it, the term integrated care will disappear.

Statement 7: a critical success factor of IC is that it needs to take place on a neutral, independent, location, outside the walls of the hospital and outside the walls of the GP's center.