In need of a collaborative response
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Citation for published version (APA):
George, J. R. (2017). In need of a collaborative response: An analysis of collaboration between public health, primary care and social care in deprived neighbourhoods

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CHAPTER 5

WHAT IS THE WAY OF WORKING OF HEALTH AND SOCIAL CARE ORGANISATIONS IN UTERCHT AND AMSTERDAM TO REDUCE THE HIGH LEVEL OF USE OF HEALTHCARE SERVICES IN DEPRIVED NEIGHBOURHOODS? A REPORT ON ACTION RESEARCH IN TWO CASE STUDIES

Jennifer van den Broeke, Thomas Plochg, Hanneke Schreurs, Sabine Quak, Mascha Egberts, Ellen van der Vorst, Arnoud Verhoeff, Karien Stronks.

Summary

Residents of deprived neighbourhoods are twice as likely to be chronically ill, are more often overweight, have a more unhealthy lifestyle, and more often experience problems with work, living conditions, income and parenting. Even when the higher burden of disease is taken into account, their use of healthcare services exceeds that of residents in more affluent neighbourhoods. Increasingly, integration of fragmented healthcare provision (and occasionally social care provision) and a greater emphasis on prevention and self-management is being proposed as a strategy to reduce the increased use of healthcare services. In two projects in Utrecht and Amsterdam, experiments have been carried out with an integrated preventive, health and social care programme to reduce the high uptake of healthcare services in deprived neighbourhoods. In this article, we evaluate the first phase of our intervention, exploring the way of working developed by clarifying the problem definition of each project and developing the programme theory. The project in Amsterdam Noord focuses on adults with multiple issues and the approach is top-down in nature, predominantly supported at the management level. In Utrecht Overvecht, the project is geared towards adults with vague complaints, and has been developed more bottom-up from the work floor. The aim of both projects is to encourage professionals to develop new competencies that enable them to work in a more generalist, coaching and population health oriented way to provide more adequate care and support to clients from deprived neighbourhoods. We hope that this description of programme theories will encourage and support others in developing initiatives to decrease high levels of care utilisation.

Main points

- In two projects in Utrecht and Amsterdam, experiments were carried out with an integrated preventive health and social care programme to reduce high levels of care use in deprived neighbourhoods.
- The goal of both projects was to encourage professionals to develop new competencies that would enable them to work in a more generalist, coaching and population health oriented way to provide more adequate care and support to clients from deprived neighbourhoods.
A report on action research in two case studies

- Support for the projects was provided by clarifying the problem definition of each project and developing the programme theory based on action research.
- This description of the programme theories can support others in developing initiatives to reduce high levels of care use in deprived neighbourhoods.

**Keywords**
deprived neighbourhoods, integrated care, generalist, coaching, population health oriented, action research

**Introduction**

Residents of deprived neighbourhoods are twice as likely to suffer from chronic illnesses, are more often overweight, follow a less healthy lifestyle, and more often experience problems with work, living conditions, income and parenting.[1-7] Even when these factors are taken into account, the uptake of care in these areas is higher than in non-deprived neighbourhoods.[8] Box 1 describes a typical patient. It seems that the cumulation of medical and societal problems is responsible for professionals experiencing their workload as being relatively burdensome.

**Box 1.** Description of a typical patient based on various interviews with professionals active in deprived neighbourhoods.

A typical patient from a deprived neighbourhood visits the general practitioner for the same reasons as a patient from a more affluent area. Nothing complicated, the same coughs and colds. But the population from a deprived neighbourhood shows much more morbidity – there are many more illnesses. Far more people with obesity, with unhealthy lifestyles, diabetes, and a smoking addiction. A typical patient has a much greater risk of developing cardiovascular diseases, or cancer, and also visits the general practitioner’s practice relatively often with complaints. On average, these patients have a lower level of education, a lower intelligence, and an unhealthier lifestyle, which results in them suffering from more illnesses, but also in them dealing
with these illnesses differently. This tells us more about what people are capable of, and this is often accompanied by financial problems. Problems with housing, debts, emotional problems, relational problems, parenting problems, problems with the neighbours, with organisations, often psychiatric problems too, and much work disability, which ultimately leads to people not taking care of themselves. Yes, there are too many problems that cannot be solved by just one professional from one specific perspective.

**Sources:** Interviews with professionals held in deprived neighbourhoods in Amsterdam and Utrecht between 2010 and 2012.

Based on these experiences of care providers and on data from empirical research, all kinds of initiatives have been started in recent years to reduce utilisation of care in these neighbourhoods and to lower the workload of care providers. In the literature, various solutions for the high workload have been determined, such as the chain approach[9], the *expanded chronic care model*[10], community-oriented integrated care[11], and the integration of care and prevention.[12,13] All these approaches have in common the integration of the fragmented healthcare provisions (as well as occasionally social care provisions), and a sharper focus on prevention and self-management.[14] In practice, experiments are carried out using these approaches. Examples include ‘From Complaint to Strength’ [*Van klacht naar kracht*] in Rotterdam[15] and ‘Big!Move’[16] in Amsterdam and Utrecht. Although this type of solution has been embraced in terms of policy, it is not yet clear what results have been achieved.[17] An evaluation study is required to gain insight into this. However, research in which the effectiveness is studied purely based on the results provides no insight into the process. The intervention simply remains a *black box*, making interpretation of the results difficult.[18] Evaluation research whereby both the process and the results are measured is required.

Two recent experiments incorporating an integrated preventive health and social care programme in deprived neighbourhoods provided a good opportunity to obtain this evaluative knowledge. These projects have taken place within the context of covenants between Agis Health Insurers [*Agis Zorgverzekeringen*] (taken over in 2011 by Achmea) the Amsterdam city region (*stadsregio* Amsterdam)
and the municipality of Amsterdam (Towards a vital and healthy Amsterdam) \textit{[Naar een vitaal en gezond Amsterdam]} for the Amsterdam Noord project on the one hand, and between Agis and the municipality of Utrecht (Utrecht healthy!) \textit{[Utrecht gezond!]} for the Utrecht project. In this article, we report on the first phase of the study, in which the way of working developed in both projects is explored. The aim is twofold: 1) to describe the way of working as implemented in both projects; 2) to use this description to, on the one hand support the projects, and on the other hand to make possible an interpretation of the final conclusions of the evaluation of the results. This is expressed in the following research question: ‘Which way of working has been jointly developed via the public health-, care- and social care sectors in the projects ‘Healthy Neighbourhood Overvecht’ \textit{[Gezond Wijk Overvecht]} and ‘Better Together in Noord’ \textit{[‘Beter Samen in Noord’]} to reduce the high level of care in Utrecht and Amsterdam’?

\section*{Method}

\textit{Action research, programme theory and dialogue sessions}

To achieve the research goal, an action research methodology was chosen.\cite{19} This type of research generates knowledge and insights that are used both to feed the development process and to evaluate the projects.\cite{20} Because the way of working in both neighbourhoods is still being optimised, this design is the most appropriate. The research results are then used in the second phase to derive specific research questions to be answered in a number of sub-studies.

The way of working for both projects is made clear by clarifying the problem definition for each project separately and developing a programme theory. A programme theory can be defined as \textit{a set of assumptions about the way in which a programme, i.e. the project, will result in expected social benefits and about the strategy and tactics to achieve the goals}.\cite{21} Programme theories are represented in various logic models.\cite{18} In this study, an adaptation of the W.K. Kellogg Foundation Logic Model is used.\cite{22} The figure below shows the problem definition and the programme theory in a logic model:
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To clarify the problem definition and develop the programme theories, so-called dialogue sessions were organised. In line with the twofold aim of the research – the evaluation and support of the development process – the choice was made to hold these dialogue sessions with the implementers of the projects.[18] For the project in Utrecht Overvecht, the Process Manager for Health Promotion [Processmanager Gezondheidsbevordering] and the head of Health Promotion of the Area Health Authority [hoofd Gezondheidsbevordering, GG&GD] took part, in varying combinations, and the Project Leader, Integrated first-line [Projectleider Geïntegreerde eerste lijn] and the area director/account manager for Care [gebiedsregisseur / accountmanager Zorg] on behalf of Agis Health Insurers. For the project in Amsterdam Noord, the Project Leader Reinforcement first line [Projectleider Versterking 1e lijn] of Agis, the Programme Manager Care and Poverty Prevention [Programmamanager Zorg en Armoedebestrijding] from Stadsdeel Amsterdam Noord, the manager of the Social Support Act [Wmo] programmes of the Care & Living Together Service [Dienst Zorg & Samenleven], the project manager innovation in major cities [projectmanager innovatie, grote steden] of Agis and ‘quartermaster’ took part in the dialogue sessions in varying combinations. To enhance the readability of this article, these project leaders and project managers are hitherto all referred to as project coordinators. Of the research team, the main researcher and the daily project leaders (together referred to as the researchers) took part.

Research method and data collection

The programme theories took shape by means of a dialogue between project coordinators and researchers. The basis for the dialogue was formed by empirical data collected by the researchers about the projects, which were then analysed and presented in (concept) programme theories. Data were collected through field obser-
vations, qualitative interviews and talks, document analysis, scientific literature, dialogue sessions and feedback group sessions, and a work conference (see table 1). Over time, newer versions of the (concept) programme theories were continually made for each project separately. In July 2011, a final version was defined by researchers and project coordinators jointly.

To assist the project coordinators, various activities took place within the action research. For example, during the dialogue sessions, based on the (concept) programme theory, both the discussions that took place and their aim were reflected upon, as well as the logical relation between these two. This way, the problem definition and the way of working were constantly being fine-tuned. In Amsterdam, this reflection process led to the specification of two target groups in the problem definition. Additionally, the various perspectives of the parties involved were clarified. Because the main researcher spoke to the various project coordinators and other project staff during the data collection process (see also Results below), any possible confusion that may have arisen when the same concept was used with different meanings – for example ‘neighbourhood-based’ – was made explicit and, where possible, eliminated, by citing literature for example.

Results

Figures 2a and 2b form a visual representation of the problem definition and programme theory in both cities, as defined in July 2011. In compliance with the logic model, the programme theories are described below regarding the following: points of departure, actions and desired end result. The problem definitions are first outlined.

Problem definitions

In both projects, the ultimate aim is to achieve a reduction in the level of use of care of a specific group of residents from deprived neighbourhoods who have multiple problems, both medical and societal.
Table 1. Data collection

<table>
<thead>
<tr>
<th>Data collection Methods</th>
<th>Period</th>
<th>N</th>
<th>Participants</th>
<th>Aim</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field observations: meetings</td>
<td>January 2010 – December 2011</td>
<td>31</td>
<td>Main researcher (as non dependent observer) Project coordinators Members of the Platform HNO: professionals from 4 health- and social care organisations Members of the Director Group HNO Members of the KMA: directors from 10 health- and social care organisations</td>
<td>‘Open’ observations were done and the description by Lasker of aspects of network relationships were used as categories in the observations. Attention was also paid to ‘behavioural features of process’[19]. Aim of this data collection was to provide content to the programme theories (PTs) and to collect information to reflect upon in the dialogue sessions.</td>
<td>The researcher took notes. Manual qualitative content analysis. (Analysis done on partnership development within the Platform and Director Group between the different involved organizations, concepts used, and the activities that were initiated at these meetings). Inter-rater reliability: the project leaders also were present and made minutes. After observation took place the researcher and the project leaders would discuss (verbally or by e-mail) what had been observed. It was checked if the same value was given. If there were differences in observations, this was discussed and adjusted and checked again at the next observation.</td>
</tr>
<tr>
<td>Field observations: neighbourhood conferences and symposia</td>
<td>February 2010 – December 2011</td>
<td>9</td>
<td>Main researcher Project coordinators Professionals from different organizations within the neighbourhoods</td>
<td>Aim of the observations is to get more knowledge about the actions for more detail in the PTs. Again the collected information was used in the dialogue sessions, sometimes as ‘feedback’.</td>
<td>The researcher took notes. Manual qualitative content analysis.</td>
</tr>
<tr>
<td>Interviews and conversations</td>
<td>October 2009 – June 2012</td>
<td>22</td>
<td>Main researcher Research coordinator Project coordinators Apprentice (student) Professionals Key participants</td>
<td>Interviews with professionals: to gain more insight into the problem. Conversations with key participants (Agis, local government of Amsterdam, FIT study) and project coordinators to provide content to the programme theories (PTs) and to reflect upon in dialogue</td>
<td>Semi-structured qualitative interviews with professionals. Conversations with project leaders and key participants. Interviews and conversations were recorded and ad verbatim transcribed. Manual qualitative content analysis.</td>
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Table 1. Continued

<table>
<thead>
<tr>
<th>Data collection Methods</th>
<th>Period</th>
<th>N</th>
<th>Participants</th>
<th>Aim</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dialogue-sessions and round table meetings</td>
<td>January 2010 – June 2011</td>
<td>48</td>
<td>Researchers Project coordinators Members of the round table (Agis, dept. of Public Health of the municipality of Amsterdam and dept. of Public Health of the municipality of Utrecht, local authority of Amsterdam)</td>
<td>Aim of the dialogues sessions: reflect upon and sharpening of the problem definition and the PTs.</td>
<td>Dialogue-sessions: recorded and ad verbatim transcribed. Round table meetings: notes and minutes. Manual qualitative content analysis to create a new concept of the PTs. The list of indicators was discussed in the dialogue sessions and at the round table meetings.</td>
</tr>
<tr>
<td>Conference</td>
<td>November 30th 2010</td>
<td>1</td>
<td>Researchers JB, KS and TP Project leaders and directors of Agis and dept. of Public Health Utrecht Members of the Platform and Director group HNO and professionals</td>
<td>- create indicators - both projects getting acquainted - explanation of research role(s) - sharpening the problem definition and the PTs</td>
<td>The list of indicators created was discussed in the dialogue sessions and at the round table meetings.</td>
</tr>
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**Problem definition for the Amsterdam Noord project**

Based on local demographic and epidemiological data of use of care and the Wmo, the project coordinators defined the problem situation that formed the core of the project (see table 2). In addition, they held area meetings with professionals and involved persons from care-, health- and ancillary institutions. From their findings, the project coordinators formulated a problem definition.

The project coordinators concluded that residents of the pilot areas “(...) are more than averagely affected by complex problems, not only in the field of healthcare and welfare, but also in the areas of income, housing and education”. They attribute the higher rate of use of care and the higher utilisation of the Wmo scheme in this neighbourhood partly to the complexity of the problems, which results in higher than average referrals to second-line healthcare, and contributes to more restricted financial means of the residents and their low levels of self-reliance, as well as a low capacity for retaining control of their lives. Additionally, according
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Table 2. Overview of the local demographics, epidemiological data of care and ‘Wmo’-use Amsterdam Noord, used by the pilot coordinators in the preparation of the problem definition.

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Figures</th>
</tr>
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<tbody>
<tr>
<td>‘Wmo’-use</td>
<td>Residents of the neighbourhood have the highest ‘Wmo’-usage compared with the average use in Amsterdam: 19.5% of the total number of clients that make use of individual transport services</td>
</tr>
<tr>
<td></td>
<td>19.4% of the total number of clients that make use of living facilities (based on the number of residents this would be 11.8%, based on the number of people 65 years of age and older 16.4%)</td>
</tr>
<tr>
<td>Healthcare costs</td>
<td>In Amsterdam Noord the care costs are significantly higher than the national Agis-average. In Amsterdam Noord the net return (income minus expenditure) of Agis is 50% below the national average</td>
</tr>
<tr>
<td>Use of ‘2e-lijnszorg’</td>
<td>Compared to residents living in the deprived neighbourhood of Amsterdam-zuidoost, residents in Amsterdam noord more often use ‘2e-lijnszorg’.</td>
</tr>
<tr>
<td>Elderly</td>
<td>% people 65 years of age and older vs. 11% average in Amsterdam: Volewijck 13% Nieuwendam-Noord 13% Banne Buiksloot 15%</td>
</tr>
<tr>
<td></td>
<td>NB relatively many indigenous people 65 years of age and older with low SES; Project coordinators chose the three neighbourhoods Banne-Buiksloot, Nieuwendam-Noord, and Volewijck because the concentration of problems there was highest.</td>
</tr>
<tr>
<td>Unemployment</td>
<td>% unemployment vs. 7.4% average in Amsterdam: Volewijck 10.9% Nieuwendam-Noord 11.4% Banne Buiksloot 10.2%</td>
</tr>
</tbody>
</table>

Source: Strategy plan Better together / Plan van aanpak Samen Beter.[23]

to the project coordinators, the inadequate communication between professionals from various domains contributes to a “mismatch of complex demand and a badly organised supply”.

Summing up then, the problem definition of the project in Amsterdam Noord can be expressed as follows: A group of adult clients exists that have multiple problems in the field of healthcare and wellbeing. This group is not able to adequately take control of their own lives or their own health. Insufficient structure is available for collaboration between professionals, who are unable to find or access each other easily in cases where they share clients. It is not clear which professional has the ‘lead’ where several professionals are involved. Professionals restrict themselves to actions within their own domain and lack the skills and/or information to be able to work in an overarching manner.

For a number of reasons, the project is then aimed at two specific target groups,
i.e. the vulnerable elderly (75+), and single men (50+) drawing social security benefits. The reason for this choice was based on the level of the sickness and care load found in these groups. Furthermore, it was also a practical choice as plans already existed for developing health policy for these groups and because the size of the groups was considered manageable. For the group of elderly, use could also be made of the experience gained from, and the expertise contained in, the FIT project\(^2\). The expectation is that the way of working developed for these groups can ultimately be applied to other target groups.

**Problem definition for the Utrecht Overvecht project**

As in Amsterdam, the project coordinators in Utrecht Overvecht entered into discussions with professionals to come to a specification of the problems to be tackled. One difference with Amsterdam was that the project coordinators in Utrecht ultimately formulated the problem definition in collaboration with professionals.

Based on these discussions between project coordinators and professionals, it was concluded that residents in Overvecht have on average many physical complaints whose cause is typically psychosocial and affects multiple areas of life simultaneously (see table 3). For example, the health problems are often linked to debt-related problems, unemployment or problems concerning child rearing. Here too, the professionals concluded, undesirable care patterns exist that partially explain the behaviour of residents. Professionals perceive that residents approach them with ‘vague complaints’, often unable to make clear what the causes of these complaints might be. Additionally, they often look for causes and solutions outside of themselves. In the eyes of the professionals, residents take insufficient responsibility for their own health and do not realise that they themselves are the ‘producers’ of their health. In response to this, and on their own admission, professionals tend to solve the problems of the residents rather than assisting the residents in solving the problems themselves.

\(^2\) FIT stands for ‘Function retention in the elderly in the first line In Transition’[‘Functiebehoud bij ouderen in de eerste lijn In Transitie’] and is a research project based in Academisch Medisch Centrum, subsidised by the Netherlands Organization for Health Research and Development [ZonMw]. See www.effectieveouderenzorg.nl
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For additional research into the problem, project coordinators and professionals commissioned a project entitled ‘One Language’ [‘Eén Taal’]. In this project too, discussions were held with professionals, leading to the conclusion that professionals consider that they have too little time to identify the problem clearly and also often lack the appropriate expertise to do so. They also indicated that they did not know each other well, or at all, which led to care not being well-coordinated, a situation not improved by a lack of a common vision. Additionally, professionals perceived working with these clients as being burdensome.

Summing up then, the problem definition of the project in Utrecht Overvecht is as follows: A group of adult clients exists that have multiple problems and risks in various areas of life (in all kinds of combinations). This group is not able to adequately take control of their own lives or their own health.

The target group specifies having complaints that are considered by professionals as being ‘vague’. Insufficient time is available for professionals to clarify the problem,
they do not always have the appropriate expertise for this, they do not know each 
other well (or at all), which results in the care not being well-coordinated. There is 
no common vision. Professionals tend to solve the problems for clients rather than 
assisting the clients so that the clients are able to solve the problems themselves. Work-
ing with this target group is perceived as being burdensome, which leads to the risk of overload.

Ways of working and actions taken
In Amsterdam Noord and Utrecht Overvecht, various solution strategies were 
chosen for the specified defined problem situation. The strategies differ in both 
ways of working and actions (see figures 2a and 2b).

Way of working for Amsterdam Noord

The project coordinators in Amsterdam proposed that to reduce the high level of 
use of care of clients in deprived neighbourhoods, professionals would need to 
adapt their way of working and to start collaborating. The client will need to be 
given the key role and the care must be organised around the client rather than 
vice versa. Furthermore, the starting point must be that the clients tackle their 
own problems themselves. For this to succeed, professionals must work in a gene-
ralist, coaching and population health oriented way (see Box 2). This has come to 
be known as the ‘integral approach’ (see figure 2a). Before professionals can adapt 
their way of working, certain structures need to be put in place to enable colla-
boration. Because such structures are rare or even non-existent in Amsterdam 
Noord, creating these structures forms part of the project.

Box 2. Definitions of the main concepts

Working in a generalist manner concerns individual-based thinking and ac-
ting (holistic), providing a wide range of services (a mix of prevention, cu-
ration and care; both on an individual and collective level) and coordination 
of the service provision in terms of content.[25]
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Figure 2a. Problem definition and program theory pilot project Amsterdam Noord as a logic model

**Problem**
A group of adult clients exists that have multiple problems in the field of healthcare and wellbeing. This group is not able to adequately take control of their own lives or their own health. Insufficient structure is available for collaboration between professionals, who are unable to find or access each other easily in cases where they share clients. It is not clear which professional has the ‘lead’ where several professionals are involved. Professionals restrict themselves to actions within their own domain and lack the skills and/or information to be able to work in an overarching manner.

**Desired end result**
Better quality of life and better health of target group
More adequate use of supply
Target group takes more responsibility for own life

**Short term outcomes**
Change in thinking and acting of professionals
Change of organisation of collaboration
Change of supply

**Actions**
Establishment WZC Waterlandplein
Neighbourhood meetings professionals
Supplying parties united in Krijtmoellan
Joint efforts by Agis, Amsterdam Noord and local government aimed at realising structures for collaboration, integral collaboration and changes of thinking and acting of professionals

**Working principle**
Joint efforts by Agis, Amsterdam Noord and local government aimed at realising structures for collaboration, integral collaboration and changes of thinking and acting of professionals

**Explanation**
The pilot project in Amsterdam takes place under the name ‘Beter Samen’ (BS). When the pilot project started the health care insurer simultaneously developed a structure that facilitates professionals from different disciplines to collaborate. These activities took place with Strengthening Integrated Primary Care [Versterking Geïntegreerde Eerste Lijn (VGEL)]. VGEL in Amsterdam amongst others lead to the development of a multidisciplinary Neighbourhood Health Center [Wijk Zorg Centrum (WZC)].
**Figure 2b.** Problem definition and program theory pilot project Utrecht Overvecht as a logic model

**Explanation** The pilot project in Utrecht takes place under the name ‘Gezonde Wijk Overvecht’ (GWO). When the pilot project started the health care insurer simultaneously developed a structure that facilitates professionals from different disciplines to collaborate. These activities took place within Strengthening Integrated Primary Care [Versterking Geintegreerde Eerste Lijn (VGEL)]. VGEL in Utrecht amongst others lead to the development of Stichting Overvecht Gezond!.
Population health oriented working requires on the one hand that care and support is carried out based on information on the pattern of health and care at the level of groups of residents with specific characteristics (such as medical care, public health, socio-economic status, physical environment, individual behaviour and genetic structure). On the other hand, it demands that the client is placed in his/her context.[26-28]

Working in a coaching manner implies assisting the client in following therapy and in changing behaviour, whereby the focus primarily lies on health and behaviour and less on sickness and care.[29,30,16]

Actions taken in Amsterdam Noord

The project coordinators specified two ‘major lines’, which will be explained in more detail below. The actual content of these lines is the responsibility of the managers of the healthcare and welfare organisations, to which end a network organisation has been set up. The managers of 10 organisations participate in the network: the local hospital, mental health institutions and healthcare and welfare organisations, a foundation of health centres, and two independent general practitioners. The network organisation was named Krijtmolen Alliantie (KMA) and was formally authorised by the members by means of a collaboration agreement, signed in November 2010. Quartermasters were at hand to assist the KMA with programme management, supervised by the project coordinators as the official commissioners. Unlike in Utrecht, there was less direct contact in Amsterdam between the project coordinators and the professionals / managers of the healthcare and welfare organisations.

The first ‘major line’ is the so-called ‘1 client - 1 plan - 1 client supervisor’ work protocol (specified as 1-1-1 in figure 2a). This was further developed within the KMA and its aim is to allow professionals to work in a generalist and coaching manner. This work protocol supports professionals by identifying the problem situation of clients that have multiple needs. The work protocol is generalist because it requires the professionals to consider both medical and societal problems. Additionally, it requires the professional to adopt a coaching attitude: in conjunction
with the client, a treatment plan is drawn up; the professional is responsible for the execution of the treatment plan. The implementation plan dated 7 April 2011 states the following: “Put an end to sending the client all around the houses, by introducing a coordinated approach, 1 living plan, (1-1-1) with a ‘warm’ transfer (continuum of approach) and 1 client supervisor, 1 contact person, care provider who assists the resident of stadsdeel Noord to gain control of their own lives. (…).” This way of working has been experimented with within ‘client trajectories’. Additionally, plans have been developed for a supplementary training course for professionals.

The second ‘major line’ is a revised work structure for healthcare and welfare organisations to make working according to the work protocol possible. Within the KMA, this has been implemented under the name of Buro Zorg integratie Noord (referred to in figure 2a as Buro Zin) – coordination of the work protocol from one central point. An active target group approach plays a key role here, as well as the setting of goals based on area data. This can be referred to as population health oriented.

At the same time as the founding of the KMA, the project coordinators, advisors of the Regional Support Structures [Regionale Ondersteuningstructuren], active professionals and the quartermaster jointly organised various area meetings in which professionals became acquainted with each other and with what they had to offer each other.

Way of working in Utrecht Overvecht

Just as in Amsterdam Noord, the aim of the project in Utrecht is to reduce the high level of care utilisation through a change in thinking and behaviour. More specifically, this philosophy is geared towards stimulating population health oriented care, as well as supporting the clients in developing healthy behaviour and taking responsibility for their own health and welfare. As with the definition of the problem situation, this vision has also been developed jointly by project coordinators and professionals. By organising meetings between professionals, according to this vision, care and support should be made possible and the vision can be developed further. (see figure 2b)
Actions taken in Utrecht Overvecht

As both the project leader and the process manager have a facilitating role, they maintain close contact with the professionals and managers of healthcare and welfare organisations in the area. The collaboration between project coordinators and professionals in Overvecht also takes place within a network organisation. In the network, known as the Platform, professionals working in four different organisations in Utrecht Overvecht take part: the welfare organisation, the mental health organisation, the biggest home help organisation, and the first-line organisation (integrated multidisciplinary centres). The project coordinators from the municipality Area Health Authority [GG&GD] and the health insurer also take active part in the network organisation. A so-called supervising group (regiegroep) has been set up to facilitate the embedding of the actions at policy and management level. The managers of the 4 organisations, the head of Health Promotion, and the area supervisor take part here and have final responsibility for the project.

Project coordinators and professionals have together come up with concrete initiatives within the Platform. The potentially most successful initiatives are then further developed into actions. The project coordinators played a facilitating role here. Based on the above-mentioned vision, actions are taken geared towards clients with lighter forms of ‘vague complaints’ such as fatigue, stress, or slightly sombre feelings. The approach taken in these actions is closely related to the complaints, for example the identifying of a shortage of vitamin D, offering some form of relaxation or contact with fellow-sufferers, without losing sight of the ultimate goal, in terms of: ‘How do you get a client to take control of his/her own life and health?’ and ‘How do you get a client to make use of what is being offered?’. In the case of clients with more serious problems, the emphasis has been on organising a smooth collaboration with care providers. For example, a method for peer coaching has been developed for professionals who have encountered difficulties with clients with complex problems. Based on these actions, thought is given to, amongst other things, how to work in a needs-based way rather than a supply-based way, and to how supply can be organised so that it is available at times of demand. This method of care provision and support can be summarised as working in a coaching, generalist and population health based manner. Area
meetings have been organised for professionals, where they can meet each other, share knowledge and develop a common vision. Furthermore, plans exist for a training trajectory.

**Desired end result and impact**

Although the problem definitions, ways of working, and actions to be taken differ for both projects, the desired end result for both projects is a change in the ways of thinking and behaving of professionals in supporting the client and helping to resolve their problem situation. Summarising then, it is thought that the high utilisation of care in deprived neighbourhoods is partly the result of ineffective actions on the part of professionals, as they focus only on the problems that lie within their own domain. The new way of thinking and acting means considering and diagnosing the client/citizen in the context of all their societal, social and health problems, thereby leading to a more effective treatment. To achieve this in the specific areas, professionals must have competencies that consist of knowledge, attitude and skills within the domains of generalist, coaching and population health based ways of working (see Box 2). In the long term, it is expected that a different way of thinking and acting on the part of professionals will lead to more effective use of the care being offered, that clients will assume more responsibility for their own lives, and that residents will enjoy better health and a better quality of life (see figures 2a and 2b).

**Discussion**

This article explores the way of working of two projects (one in Utrecht and one in Amsterdam) whose aim is to reduce the high level of care use in deprived neighbourhoods. The problem definition differs in each neighbourhood, as too does the corresponding way of working. The project in Amsterdam Noord focuses on adult clients with multiple needs in the area of welfare and healthcare who are insufficiently able to take control of their lives to deal with these problems. It has been found that the local healthcare and welfare system does not provide adequate support for this group. The envisaged improvements to the system involve
an approach that consists of developing a work protocol (1-1-1) and a network organisation, coordination for the work protocol, and supplementary training. The project in Utrecht Overvecht focuses on adult clients with a cumulation of problems and risks in multiple areas of life (in all combinations), which manifest themselves in the healthcare and welfare system as complaints that are perceived by professionals as being vague. Together with professionals and providers, a common vision has been developed in which the improvement of health of the clients plays a central role, primarily due to the fact that professionals assist clients in making an active contribution to their health in terms of behaviour and lifestyle. In addition, the improvements envisaged involve actions, a network organisation, area meetings, and a training trajectory.

The aim of this article was to provide a description of the way of working as has emerged in daily practice in two settings. On the one hand, this description – clarified through the use of two programme theories – is used throughout the project period to support the development of the projects. On the other hand, the programme theories that have been developed will be used in the future to produce additional research questions and to derive a correct interpretation of the project results. In the context of this research method, we have to state that a certain tension exists between supporting the development and evaluating the projects. For example, at this moment, the programme theories have not been processed very extensively regarding the ‘short-term results, ‘desired end result, and ‘impact’. From the perspective of the evaluation study, a more extensive processing was desirable, but in terms of execution, a more tangible form was not possible at that moment. For example, throughout the process, it was evident that the formulated problem definitions were not yet sufficiently sharply defined in the eyes of the researchers. However, a further clarification of the problem definition occasionally produced some irritation among the project coordinators, because they considered this no longer relevant at this stage of a project that was developing at high speed. Additionally, the choice for the elements in the programme theory – way of working/actions to be taken/short-term results/desired end result/impact – were primarily based on the way the projects developed. From the perspective of the research goals, a different approach was possible, for example one that is linked directly to concepts used in the international literature.[18] Many models in the
international literature place much emphasis on the ‘input’ or ‘available resources’ in a project and much less on ways of working, as is the case in the theories described here.

However, using the method of action research has been fruitful in the development of the projects. For example, the dialogue sessions provided the project coordinators the opportunity to reflect on these developments and on the relation with the envisaged end result. Amid the everyday hustle and bustle, the project coordinators experienced this process of reflection as a welcome aid. The fact that the researchers were able to clarify the perspectives of the various parties involved – who occasionally used the same terms in different ways – was also perceived as being supportive. Based on the literature, the researchers were able to provide insights that served to clarify the concepts, particularly concerning the envisaged end result – the integral thinking and acting of professionals. Additionally, the organisations involved in the project liked the fact that the researchers were, as it were, an ‘independent’ party. Finally, the study – in agreement with researchers and project leaders – was used to manage the organisations (for example, as a big stick; by distributing a questionnaire).

The most important added value of the results of the action research from the perspective of the researchers is that, based on the programme theories, research questions can be formulated that are closely related to the development in the projects (for example, how professionals experience integral thinking and acting) and research questions that are related to the results of the projects (for example, use of care).

Within both projects, the emphasis lies on prevention and adopting a generalist approach to problems, which is appropriate in a society-wide trend that is nourished by the current economic, ecological and social crises.[31] In this trend, increased importance is attached to assuming responsibility for preventing problems rather than solving them after the fact. Such a development is visible in sectors such as the environment and social security, and also applies to the healthcare sector.[32,33] Additionally, it is in line with the ZZ→GG [illness & cure → health and healthy behaviour] principle as propagated by the RVZ.[14] At the same time, little is known about how this change in the field of healthcare and welfare can be given shape effectively. Based on the presented programme theories, a number of
general lessons can be derived that are relevant in this context.

Firstly, the projects show that it is important to formulate a good definition of the problem to be tackled. The general defined problem of a high level of use of care was translated in both neighbourhoods into a more precise problem definition. On the one hand by delimiting the target groups more sharply, based on the analyses of area data and the professionals’ reflections on these. On the other hand, by specifying the nature of the problem accurately, especially through the reflections of professionals. This process of ‘making precise’ and ‘delimiting’ proved essential in the design of both projects. This analysis makes it possible to look for solutions in a focused manner, increasing the chance that the envisaged effects will also be achieved. The goal-resource logic that the programme theory enforces was an aid in this process, as too was the availability of data on preventing health problems in the population at the neighbourhood level.

Secondly, the emphasis in each of the two projects lies on getting professionals to think and behave differently. The point of departure is the idea that professionals consider, diagnose and treat clients/citizens with all their societal, social and healthcare problems as a whole. In the past, to make such a change possible, it was often proposed that the structure of the healthcare system had to be modified – summarised as the ‘integrated approach’. A characteristic of this integrated approach is that processes, structures and systems are designed in such a way that clients receive coordinated and professional services that are geared to one another.[34] In both projects, in addition to the integrated approach, the strategy of changing the way of thinking and acting of professionals was chosen. Professionals are challenged to work in a more generalist, coaching and population health based way, supported by – especially in Utrecht Overvecht – actions and plans for training. Attention for personal/professional competencies do not stand in isolation from each other, but are increasingly being proposed in scientific literature. [35-38]

Finally, the results underline the importance of contextual differences for the way of working in both projects. For example, in Amsterdam Noord there are many solo general practitioner’s practices, while in Utrecht Overvecht multidisciplinary centres are combined into one foundation. With its greater number of welfare and healthcare providers, the local healthcare system in Amsterdam Noord is
more complex. Additionally, in Amsterdam the management structure is different through, among other things, the existence of the so-called districts (stadsdelen). Furthermore, the centrally managed municipal services of Care, Housing and Society (DWZS) [Zorg, Wonen en Samenleven], Work and Income (DWI) [Werk en Inkomen] and the Public Health service of Amsterdam (GGD Amsterdam) have different roles than is the case in Utrecht. In Amsterdam Noord, this seems to have led to the approach to the development of the project (at least in the initial years) being predominantly top-down – the project is predominantly supported at the management level, where the municipality, municipality services, health insurer and healthcare providers encounter each other. In Utrecht Overvecht, the approach is more bottom-up – the project develops primarily at the work floor level in the neighbourhood, while the necessary preconditions are created at the control and management levels. The scientific literature shows that both intrinsic context (such as management dynamics) and extrinsic context (such as the complexity of the healthcare system) influence collaborations and results.[38] This underlines how important it is to take the local context into account so that an optimal approach can be developed.

Summing up then, a renewed approach is envisaged in two projects to reduce the relatively high level of care use in deprived neighbourhoods. The programme theories as described in this article form the basis for the further evaluation of the effects of both projects. By relating the future results to the interim steps in the programme theories, we envisage being able to specify the possible effects of the projects in the long term, and thereby to derive conclusions that are generalizable to other situations. Additionally, we hope that this description of the programme theories will stimulate and support others in developing initiatives to tackle high levels of care utilisation in deprived neighbourhoods.
In need of a collaborative response

**Literature**


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