Hug the system

Towards integral collaboration between healthcare institutions, clients and families with the family care method

Master thesis

MSc. Organization Studies

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A B S T R A C T

This study explores which factors influence collaboration intensity, and how they exert this influence. The research builds upon the study of Azerki (2012) by investigating whether the factors he found to be of influence in the formation process of chain collaboration, have influence on collaboration intensity, too. This research is done in the context of the family care method. With a qualitative research design, thirteen interviews were conducted with seventeen participants. Analysis of the data resulted in the identification of a number of underlying mechanisms for the relationship between the factors for chain collaboration and their influence on collaboration intensity. An answer to the research question is given by providing propositions. The mechanisms and accompanying propositions can be categorized in four overarching themes: facilitation, implementation, motivation and broad integration. Implications of the research and directions for future research are given.

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1 | Introduction

1.1 | Research matter

1.1.1 | Informal care in the Netherlands

Informal care - "long-term, intensive, non-organized care, provided not as part of a caring profession to a care recipient by one or more members of his environment, whereby the care provision results directly from the social relationship" (Beneken genaamd Kolmer, 2004, p. 10) - has caught an increasing amount of attention over the last decades, both in literature and in practice. During the twentieth century since the end of World War II, characteristics of an individualizing society - such as efficiency and personal responsibility rather than solidarity and social security - also entered the health sector. "Changes of attitudes to care in the community, as well as the trend in the 1990s towards reducing health care expenditure, have led to the full-time care of chronically ill individuals increasingly becoming the responsibility of family and friends." (McNally, Ben-Shlomo & Newman, 1999). Statistics show that there is an increasing amount of extramural care and people with severe illnesses taken care of by family and friends instead of professionals or voluntary care givers (Emanual, 1999).

This development can also be observed in the Netherlands. Ageing of the population and increasing health care costs cause a growing pressure on the Dutch government to exploit alternatives for long-term care (De Boer & De Klerk, 2013). In 2015, as part of the Social Support Act (Wmo), compensations for personal care and support have been decentralized from the General Act on Exceptional Medical Expenses (AWBZ) to the municipalities. An assumption accompanying this transition is that people in need of help should initially call upon their own network for support. By stimulating citizens to contribute more to care and well-being (Wetenschappelijke Raad voor het Regeringsbeleid, 2006), a more significant role will be given to informal care – of which the Dutch government presumes it will lead to less public costs (De Boer & De Klerk, 2013).

In 2015, 14.3% of the Dutch population (16 years and older) provided informal care, of which 14.7% has been reported as being overburdened (CBS, 2016). The process in which providing care 'absorbs' the care giver has been investigated in several studies (Knipscheer, 2010; Oudijk, De Boer, Woittiez, Timmermans & De Klerk, 2010; Timmermans, De Boer & Iedema, 2005) and can be referred to as role captivity (Aneshensel, Pearlin & Schuler, 1993). Care givers that experience role captivity report decreased well-being, the occurrence of conflicts at home or at work, and difficulties regarding their independence (De Boer, Oudijk, Timmermans & Pot, 2012). A factor that has been found to play a substantial role in the burden experienced by care givers is the extent of coordination in the

collaboration with professionals (Broese van Groenou, 2010). This can be supported by several recent studies that have shown that coordination and integration of care within diverse sectors of the Dutch healthcare system are areas for improvement (e.g. Inspectie voor de Gezondheidszorg, 2015; Place, Hulsbosch & Michon, 2017; Van Dijk, Groenewoud, Stadhouders, Van der Wees, Tanke & Jeurissen, 2015; Van Rooijen, Knispel, Van Hoof & Kroon, 2016).

1.1.2 | The family care method

Expertisecentrum Familiezorg (hereinafter referred to as Exfam) is a network organization that contributes to the support of people in intensive care situations. Exfam has developed a method according to which a care recipient and his or her surroundings are seen as a system. Assumptions within this method are that (1) when a person becomes ill, this influences not only his or her life, but also the lives of his family members or partner, and (2) the center of care should not solely be the care recipient or the care giver, but also the relationship between them.

The family care method has been developed on the basis of decades of research into the *family system* (the relationship between care recipients and care givers), the *care triad* (the relationship between care recipients, care givers and professionals) and the *arena of care* (the relationship between care recipients, care givers, professionals, managers, market and government). The family care method is built upon the foundations of this relational approach and provides tools that can be used to apply this approach in the practice of health care – such as creating genograms to gain insight in family ties and using questioning skills and open communication strategies. People that apply the method thus act according to the family care foundations and use the accompanying tools.

The foundations of the family care method

- Open communication reduces the level of stress;
- Emotions are non-negotiable;
- Blending is the starting point for the perfect encounter;
- Integrity means attacking the ball instead of the player;
- Common goals are the guidance of a conversation;
- Removing the feeling of guilt is necessary to interact without judgement;
- Separating facts from opinions improves gaining insight;
- What we think of each other is irrelevant;
- Self-knowledge is necessary to get to know someone else;
- Care takes place in private spheres;
- Intuition exists.

Fig. 1 The foundations of the family care method (Expertisecentrum Familiezorg, 2017)

The desired and ultimate goal of the family care method is to uncover the client's – both care recipient and care giver[1] – needs. Needs of care recipients are related to, for example, physical illness, safety, managing money, food, accommodation and company (Walters, Iliffe, Tai & Orrell, 2000). According to Wingate & Lackey (1989), care givers' needs include emotional support, instrumental, community and professional support, health information, and involvement in patient care. A need can be seen from two different perspectives. From an egocentric point of view, a need is the honest, personal desire of the concerning person - regardless of whether this desire is in accordance with the desires of the other people involved in the care situation. From a rather holistic, relational point of view, the need is a desire for the whole care situation in which meeting desires requires alignment. To efficiently provide and coordinate care, personal desires need to be identified in order to determine the needs of the whole care situation and aiming to meet those needs. Acting upon the foundations of the family care method and using the accompanying tools supports the ability to do this: it enhances the means or skills that someone possesses (Oxford Dictionaries) to get to know someone else's true thoughts, and to align them with the desires of others to identify the needs of the whole care situation. This ability is seen as a common property of the people involved in the care situation – not as a possession of a certain person. It thus concerns a 'shared' competence to find out what is needed in the care situation concerned.

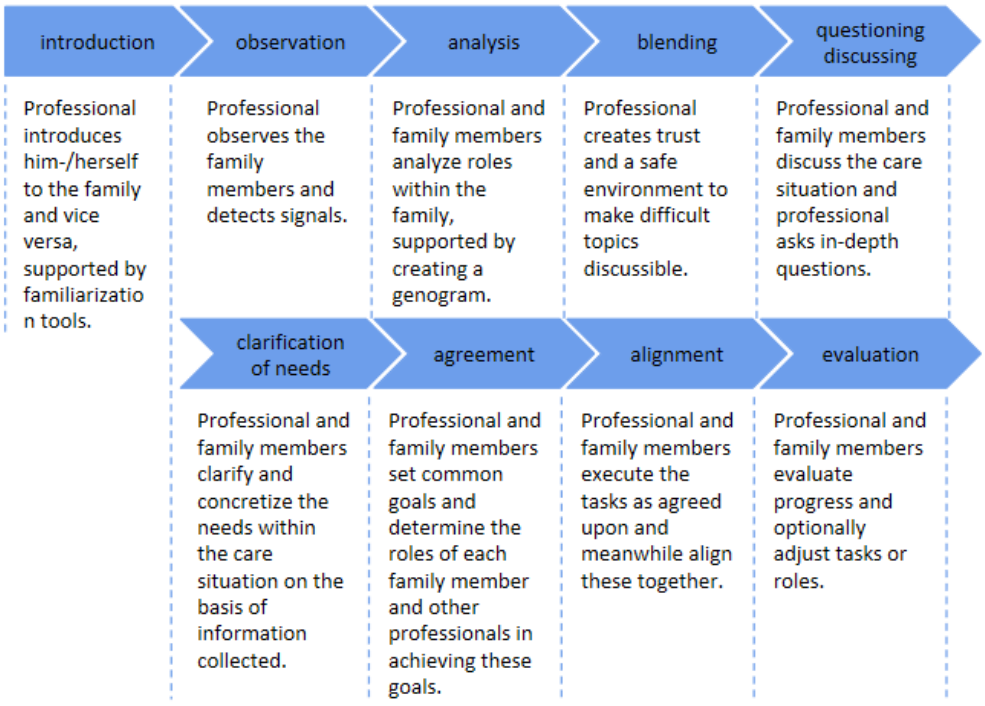


Fig. 2 Content and structure of the family care method (based on Expertisecentrum Familiezorg, 2017)

[1] Within the family care method, the *client* is not merely the care recipient. According to the assumption that when a person becomes ill, this influences not only his or her life, but also the lives of his family members or partner, the care giver (thus, for example, the family member or the partner) is also client. Hence, in this study, the client is both the care recipient and the care giver.

In general, the method is used in two different ways. The professionals that work at Exfam are experienced consultants, trained in the family care method, and are also able to train other people. In some cases, families directly call upon the professionals that work at Exfam to help them in their care situation. On the other hand, health care organizations incorporate the method by letting Exfam train their professionals in the method. The workshops are built upon the content (and the foundations) of family care as elaborated on in the former paragraph. These professionals take back their skills and knowledge regarding the method to the health care organizations and apply it on care situations with their clients. In some cases, these healthcare professional join the 'train the trainer' workshop (which aims on making health care professionals able to train others in the method) and train their colleagues. This functions as a form of implementation of the method within organizations. A visualization of this process is displayed below.

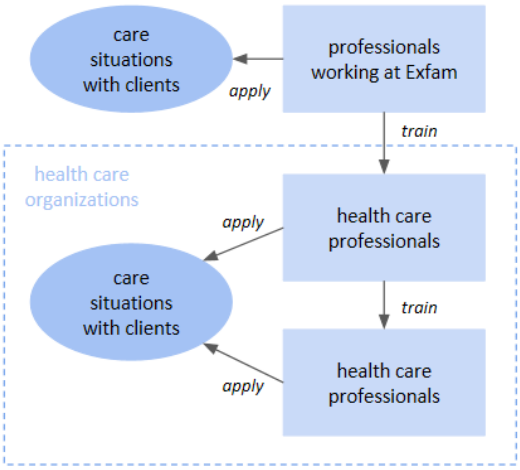


Fig. 3 Implementation and application of the family care method (based on quantitative data collection)

1.2 | Research problem

As explained above, the family care method can be applied in a care situation in which health care professionals, care recipients and care givers work together to coordinate and provide care. This then means that collaboration takes place between the multiple parties that are involved in the care situation. Within this chain collaboration, people with different backgrounds, interests and links to the care recipient must work together to coordinate and provide care.

Since the ultimate goal of the family care method is to discover the needs of both care recipient and care givers, a tailor-made approach in working methods is required to adjust to the needs of the client. To align these in order to identify the need of the whole care situation, the aim of the collaboration should be organization-transcending. Activities of the different parties should be integrated to pursuit goals in benefit of the client. These characteristics of collaboration that the family care method requires

can be associated with an *integral* approach. According to Goedee and Entken, this is the most intensive form of collaboration (2015).

Following this reasoning, we can say that applying the family care method requires an integral form of collaboration. However, according to Exfam's observations, in a number of cases in which the family care method is applied, the characteristics of an integral form of collaboration are not clearly visible (yet). Some collaborations appear to show characteristics of rather less intensive forms. These are identified by Goedee and Entken as *coordinated* collaboration (meetings are facilitated and collaboration partners focus on a shared result, but there needs to be taken effort to keep the subject on the agenda) and *basal* collaboration (meetings are facilitated, but participation is non-binding) (Goedee & Entken, 2015).

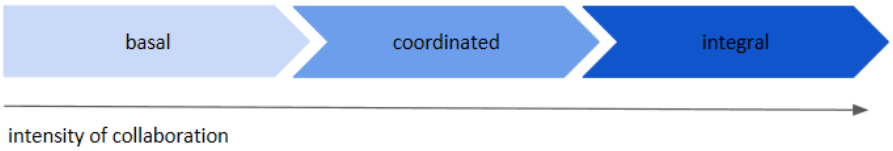


Fig. 4 Three intensities of chain collaboration (based on Goedee & Entken, 2012)

When we assume that application of the family care method requires an integral form of collaboration as stated above, the question rises whether it indeed true that in certain cases – where health care organizations claim to use the family care method – there is no assurance of an integral approach, and on which factors the presence of integral collaboration could depend.

1.3 | Research goal and question

Azerki (2012) investigated factors that have influence on the formation of organization-transcending chain collaboration in the context of domestic violence. He based his research on extensive literature review on factors relating to effectiveness, politics and human action, and on qualitative data from interviews. Sixteen different factors were found.

Factors influencing chain collaboration (Azerki, 2012)

- Efficiency
- Stability
- Service provision
- Learning
- Reciprocity
- ICT solutions
- Necessity
- Government demands
- Legitimacy
- Resource provision
- Leadership
- Bottom-up initiatives
- Structure creation
- Culture creation
- Prior history
- Confidentiality

Fig. 5 Factors influencing chain collaboration (Azerki, 2012)

Among these, service provision, confidentiality, history and stability turned out to be of greatest importance in the formation process of the collaboration. The outcomes of this study illustrate the complexity of organization-transcending chain collaboration and indicate how various aspects can exert their influence on collaboration. Azerki's work offers useful leads to investigate how different forms of collaboration are influenced by various aspects and how collaboration can depend on certain factors.

Since in the present study we want to find out on which factors the intensity of collaboration depends, it seems valuable to adopt Azerki's factors as an initial framework to investigate whether and how they affect the intensity of collaboration in the context of the family care method.

The accompanying research question is as follows:

Which factors influence the intensity of the collaboration between health care professionals, care recipients and care givers in the context of the family care method?

1.4 | Relevance

From a scientific perspective, this study contributes to literature and theory on chain collaboration. It builds on existing knowledge about factors influencing the formation of chain collaboration by investigating whether these factors have an impact on chain collaboration that moved beyond the formation stage, too. Furthermore, this study more specifically aims on finding out how these factors exert their influence on the intensity of collaboration.

From a practical perspective, this study aims to provide insight in which factors are of importance for collaboration between (healthcare) professionals, care recipients and care givers to be effective. This can be used to improve, for instance, the implementation process of such a collaboration - specifically for those who work with the family care method, but perhaps also for other collaborations.

The increasing amount of care givers and the percentage of overburdened care givers display the urge to find out how to make collaboration and integration within the healthcare sector more efficient. Gaining insight in which factors have an impact on how collaboration between professionals, care recipients and care givers can take on an integral form is therefore a valuable step in the right direction.

2 | Theoretical framework

The introduction section has drawn an outline of the research problem and the goal of this study – to investigate which factors influence the intensity of collaboration – and introduced the research question: *Which factors influence the intensity of the collaboration between health care professionals, care recipients and care givers in the context of the family care method?*

This section elaborates on the concepts in the research question as framed above: factors influencing chain collaboration, the intensity of chain collaboration, and the context of the family care method. Regarding the latter, since the context of the family care method involves an intervention, this section elaborates on intervention theory. Operationalization of the concepts can be found in Appendix I.

2.1 | Intensity of chain collaboration

According to Goedee & Entken (2015), the concept of *chain* concerns "the way in which different chain partners, by working together towards joint result, can add value" (p. 8), whereby chain collaboration is associated with "the achievement of a joint result whereby partners are connected with each other" (p. 8). In this study, the chain collaboration refers to the care situation in which the people involved (care recipient, care giver(s), professionals) work together to coordinate and provide care.

Forms of chain collaboration can be expressed in terms of intensity, in combination with the level of adjustment to client needs. Goedee & Entken distinguish three different forms: basal collaboration,

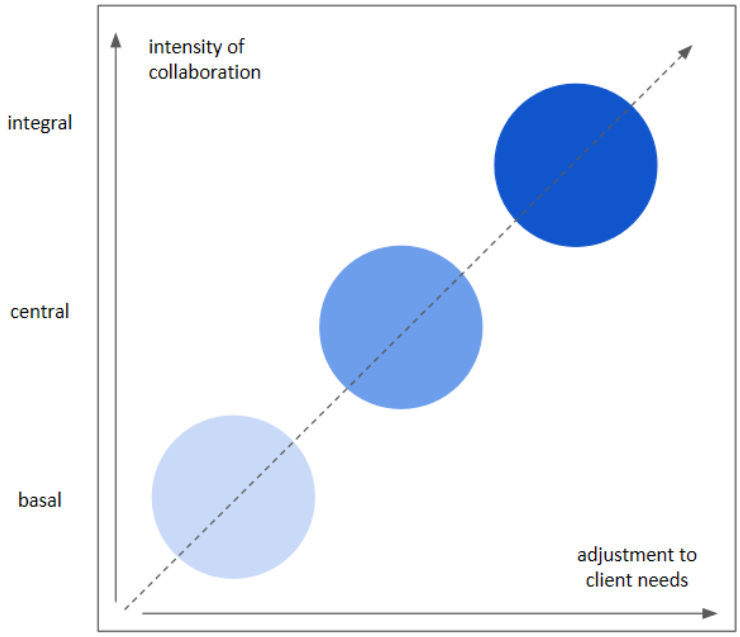


Fig. 6 Intensities of chain collaboration (Goedee & Entken, 2012)

coordinated collaboration, and integral collaboration. The latter is seen as the form of collaboration with the highest level of intensity, whereby activities of employees from different partner organizations are integrated with each other. A major characteristic of this collaboration form is that organization-transcending goals for the benefit of the client have to be pursued (Goedee & Entken, 2015).

Kumar (2004) distinguishes three types of orientation: sales orientation, market orientation and client orientation. The latter implies that the client's needs are a guiding principle in the collaboration. Since understanding the client's needs is of particular importance, emphasis lies on contact with clients. The strategic focus associated with client oriented chain collaboration involves a dialogue to investigate client demands and desires. The chain collaboration operates on case level and is structured on the basis of client specifications – which can be characterized as an outside-in approach (Goedee & Entken, 2015). In this study, based on the characteristics of the family care method, it is assumed that the chain collaboration in the family care method should be client oriented.

In conclusion, based on the characteristics of the family care method and the collaborative aspects involved – high intensity of collaboration and high adjustment to client needs – it is assumed that the family care method requires an integral form of collaboration.

2.2 | Factors influencing chain collaboration

This study uses *the factors that influence the formation of chain collaboration* – as identified by Azerki (2012) – as a general guidance in the quest to identify the factors that influence the intensity of collaboration. In Azerki's research, these factors "represent the elements that have been of interest in instigating and finalizing the formation of Antwerp's CO3 project" (p. 14).

CO3 was a pilot project in Antwerp in which representatives of various organizations intensively worked together to set out action plans for cases of domestic violence. The chain collaboration enabled them to work on entire families instead of individuals - as the organizations did before the CO3 project. Azerki's research reconstructed the formation of the CO3 chain collaboration, thereby aiming to identify which factors contributed to the formation, and how they contributed. Based on an extensive literature review, Azerki identified factors which he preconceived to have led to the formation of chain-collaboration. He investigated these by conducting interviews with people involved in the CO3 project. This resulted in a list of (1) preconceived factors that indeed led to chain collaboration, (2) preconceived factors that were not relevant, and (3) additional factors, discovered through the interviews.

For the sake of consistency, the indicators for the different dimensions as construed by Azerki will in this research be used for the operationalization of the factors – with the exception of the dimensions Prior history and Confidentiality, which Azerki found later in the process and were thus not

operationalized beforehand; for these dimensions, indicators are developed on the basis of Azerki's explanation of the dimensions. The following paragraphs provide definitions for the different factors and elaborate on how the different factors influence chain collaboration.

2.2.1 | Efficiency

The factor *efficiency* refers to "situations in which there is a possibility to increase the efficiency of multiple organizations in terms of transaction costs" (Azerki, 2012, p. 30). Inter-organizational relationships can be formed to reduce the costs of individual organizations in terms of, among other, costs per client and waste (Oliver, 1990) and costs induced by uncertainties (Barringer & Harrison, 2000). Azerki reported efficiency as an important reason to engage in the CO3 project, but rather as a secondary goal than as main goal. Saved time and money should not make room for budget cuts, but support the quality and quantity of the organizations' services.

2.2.2 | Stability

The factor *stability* refers to "situations in which organizations respond to environmental uncertainty by forming inter-organizational relationships" (Azerki, 2012, p. 30). Cooperation can enhance predictability and stability in the acquisition of resources (Barringer & Harrison, 2000), but also in reducing the uncertainty of complex and dynamic (public) issues (Sandfort & Milward, 2010; Van Delden, 2009), for example by the sense of mutual solidarity (Child & Faulkner, 1998). Azerki reported stability as one of the most important influencing factors for the CO3 project. The chain collaboration provided means to enhance closer control of development in families.

2.2.3 | Service provision

The factor *service provision* refers to "the opportunity to improve public services by cooperating in inter-organizational relations" (Azerki, 2012, p. 31). The provision of social services can be improved by better cooperation between public services (Van Delden, 2009), which can be measured by, for example, quality of services, response time and customer satisfaction (Provan & Sydow, 2010). Azerki reported service provision as one of the most important factors in de the formation of CO3. Aligned activities and joint decision-making were expected to lead to action plans that were "better informed, more comprehensive and more balanced" (p. 59).

2.2.4 | Learning

The factor *learning* refers to "the opportunity to learn from other organizations" (Azerki, 2012, p. 59). Inter-organizational relationships can increase organizations' absorptive capacity (Barringer & Harrison, 2000), support the development of innovative solutions (Dyer & Singh, 1998; Powell, Koput & Smitt-Doerr, 1996), and enhance anticipating a changing environment (Child & Faulkner, 1998). Azerki reported learning as a relatively unimportant reason for engaging in the CO3 project. Some informants,

however, valued learning as an important side effect of the collaboration – enhancing a broader perspective, supporting (personal) acquaintance, and aligning expectations.

2.2.5 | Reciprocity

The factor *reciprocity* refers to "situations in which various organizations have mutually beneficial goals or interests" (Azerki, 2012, p. 32). Organizations can engage in collaborations because of their desire to serve a common goal (Van der Aa & Konijn, 2001). Azerki reported reciprocity as an important factor in the formation of CO3. The shared goal but the different parts of information caused the organizations to separately work on related matters. Engaging in a chain collaboration allowed these organizations to work together on an entire system to serve the common goal.

2.2.6 | ICT solutions

The factor *ICT solutions* refers to "the presence and development of suitable information and communication technologies" (Azerki, 2012, p. 32). ICT solutions may be a catalyst of inter-organizational collaboration (Van Duivenboden, 2000) and support the infrastructure that the coordination of inter-organizational collaboration requires (Janowski, Pardo, & Davies, 2012). Azerki reported that ICT solutions were not considered an influencing factor in the formation of the CO3 project, however, a proper ICT solution is needed to be able to collaborate efficiently and handle information safely. Furthermore, ICT solutions can contribute to a better evaluation system.

2.2.7 | Necessity

The factor *necessity* refers to "the presence of legal mandates to start a cooperation between organizations" (Azerki, 2012, p. 33). Collaboration may sometimes be forced by (government) regulations. Meeting such regulations can sometimes be required for receiving (financial) support (Hall & Tolbert, 2005) or to convince others of a project's feasibility (Reilly, 2001). Azerki reported necessity as one of the most important influencing factors in the formation of CO3. Means of formalization of the cooperation were used to ensure investment of the different organizations to the project and prevent the participation in the project from being non-binding.

2.2.8 | Government demands

The factor *government demands* refers to "the norms and minimums that are set by authorities with respect to the performance of organizations" (Azerki, 2012, p. 34). These measures can be used to explain the outcomes of investments in the public sector and can be of financial or non-financial nature (Provan & Milward, 2001). Cooperation to comply to government demands can be a stimulus to start a chain collaboration (Goedee & Entken, 2008). Azerki reported that government demands were not considered a factor of influence in the formation of CO3, however, this might have been influenced by

the fact that in Belgium, such performance standards are very uncommon. This might differ for the Netherlands.

2.2.9 | Legitimacy

The factor *legitimacy* refers to "situations in which organizations are pressurized to jointly adhere to norms, rules, beliefs, or expectations" (Azerki, 2012, p. 34). According to Gray and Hay (1986), the perceived legitimacy of a project and the legitimacy of the people that organize it – as well as the opinion of the internal and external stakeholders (Bryson, Crosby & Middleton Stone, 2006) – are crucial to the successful implementation of the collaboration. Azerki reported that legitimacy was not considered an important factor to form the CO3 chain, but it was, like the factor learning, found to be a positive side effect. Participants in the project started to understand, appreciate and support each other's activities.

2.2.10 | Resource provision

The factor *resource provision* refers to "the need to make investments in order to set up collaborations". These investments do not only involve financial and material resources, but also human resources (Reilly, 2001) and the commitment of time, energy and dedication (Huxham & Vangen, 2000). Azerki reported resource provision to be one of the most important influencing factors for the formation of CO3. In addition, participants mentioned that after the formation of the project, continuous investments were important to keep the project running.

2.2.11 | Leadership

The factor *leadership* refers to "the influence of leaders in forming closer collaborations between organizations" (Azerki, 2012, p. 35). Since chain collaboration are built upon relationships rather than on contractual agreements, leaders are required that can connect the partners, nurture the relationships between them, and at the same time keep the collaboration going (Bryson et al., 2006; Goedee & Entken, 2008; Keast, Mandell, Brown & Woolcock, 2004; Vangen & Huxham, 2003). Azerki reported leadership to be one of the most important influencing factors in the formation of the CO3 chain, and that leadership on a policy level as well as executive leadership during the formation process was needed.

2.2.12 | Bottom-up initiatives

The factor *bottom-up initiatives* refers to "the influence that people towards the hierarchical bottom of an organization can have as starting points for inter-organizational collaboration" (Azerki, 2012, p. 36). Sandfort and Milward (2010) suggest that first line practitioners may initiate (closer) collaboration between different organizations and partners because they experience existing problems closely. However, in order for them to be able to take initiative, they need sufficient decision-making power (Clegg & Hardy, 1999). Azerki reported that bottom-up initiatives were not considered by the

participants to be a factor of influence in the formation process. Azerki mentions however, that beforehand, signals from operational level actually have influenced the engagement in closer collaboration.

2.2.13 | Structure creation

The factor *structure creation* refers to "the deliberate attempts that are made to infuse order and structure in inter-organizational collaborations" (Azerki, 2012, p. 36). According to Goedee and Entken (2008), activities that are involved in structure creation may include creating decision making schemes and roles. Initially shaped models may change over time as the outcome of interaction between collaboration partners (Huxham & Vangen, 2000). Azerki reported structure creation to be an important influencing factor in the formation of CO3. The initial structure included process steps and a division of roles and tasks and has been adjusted after the implementation according to preferences of the partners and experiences on operational level.

2.2.14 | Culture creation

The factor *culture creation* refers to "the conscious efforts to instill a culture of cooperation in inter-organizational relations" (Azerki, 2012, p. 37). A shared knowledge base and a common vision are required for chain collaborations to be formed (Goedee & Entken, 2008; Gwinn & Strack, 2010). Azerki reported mixed findings for this factor; most participants did not recall any intentional efforts to create a certain culture, but some participants mentioned the formation and training sessions and sharing points of view as contributing to mutual trust and shared culture within the collaboration.

2.2.15 | Prior history

The factor *prior history* refers to "the presence of prior inter-organizational collaboration, and prior efforts and ideas to work in a more integrative matter" (Azerki, 2012, p. 68). This factor was not preconceived in Azerki's literature study, but was perceived by the participants to be an important factor in the formation of CO3. Prior collaborations had already built up trust between organizations and could develop further and become more intense, and moreover, awareness of priority areas and the value of working in a chain had already been risen.

2.2.16 | Confidentiality

The factor *confidentiality* refers to "professional secrecy and providing the necessary background information on the subject" (Azerki, 2012, p. 69). This factor was also not preconceived in Azerki's literature study, but was perceived by the participants to be an important factor in the formation of CO3, too. Distrust about the way confidential information is handled in a chain collaboration had been an insurmountable obstacle during an earlier attempt to implement a chain process model. Certain measures had been taken and arrangements were made in the CO3 project to account for this – for

instance by stressing the importance of differentiating between what is 'necessary' and what is 'nice' to know for other parties – but resistance against information sharing continued to exist.

2.3 | The context of the family care method: intervention theory

Since this study aims to identify the factors that influence the intensity of collaboration in the context of the family care method, it is important to explain this context. The introduction section elaborated on the content and structure of the method, whilst in this paragraph, attention will be paid to the aspects of the method that are relevant in the light of the research question, namely, the aspects that are related to the application of the method, for which collaboration is required.

As a framework for this paragraph, Intervention Mapping (Bartholomew, Parcel, Kok, Gottlieb & Fernández, 2011) is used. "The purpose of Intervention Mapping is to provide health promotion program planners with a framework for effective decision making at each step in intervention planning, implementation, and evaluation", whereby "health promotion has been defined as combinations of educational, political, regulatory, and organizational supports for behaviour and environmental changes that are conducive to health" (Bartholomew et al., 2011, p. 3). It takes an ecological approach, whereby interventions are seen as events in systems. "Other factors within a system can reinforce or dampen the influence of an intervention on the specific behaviour or environmental change being targeted" (Bartholomew et al., 2011, p. 10).

The approach of Intervention Mapping and the research problem of the present study have in common the aim to include factors, 'outside' of the intervention, in investigating the effect of an intervention. Whereas Bartholomew et al. (2011) include factors, categorized in levels in a socioecological model (see figure 6), in their approach of intervention planning, the present study mainly focuses on which of those factors specifically influence the intensity of collaboration that the intervention requires.

Fig. 7 Schematic of the ecological approach in health promotion programs (Bartholomew et al., 2011, p. 11)

Intervention Mapping involves six steps, of which each comprises several tasks (see figure 7). Altogether, the steps and tasks provide a blueprint for the design, implementation and evaluation of an intervention. These steps are valuable to include in this research, since it gives an overview of which components an intervention consists of and explains how 'outside' factors (as mentioned above) interfere with the intervention itself.

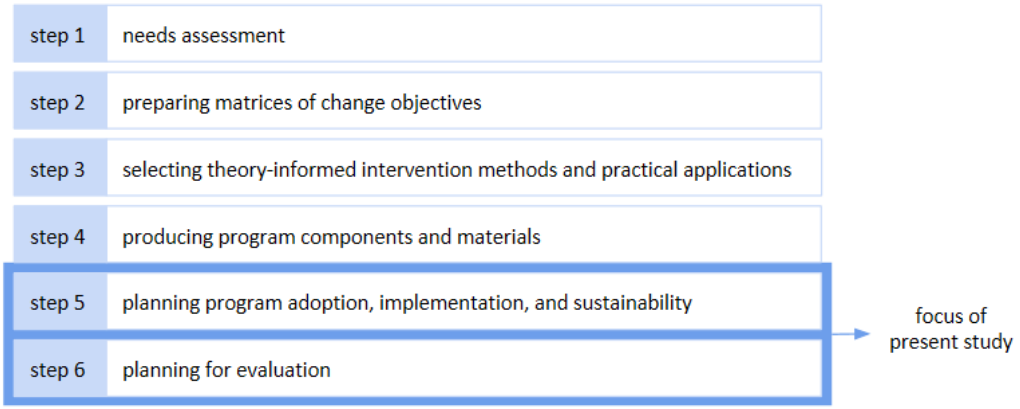


Fig. 8 The six steps of Intervention Mapping (based on Bartholomew et al., 2011)

Regarding the family care method, roughly speaking, the first four steps are concerned with the design of the method, whereas steps five and six are rather involved with the implementation and evaluation. Since the present study is mainly concerned about the intensity of collaboration that is required when applying the method, the focus lies on step five and six: "planning program adoption, implementation, and sustainability", and "planning for evaluation".

2.4 | Conceptual model

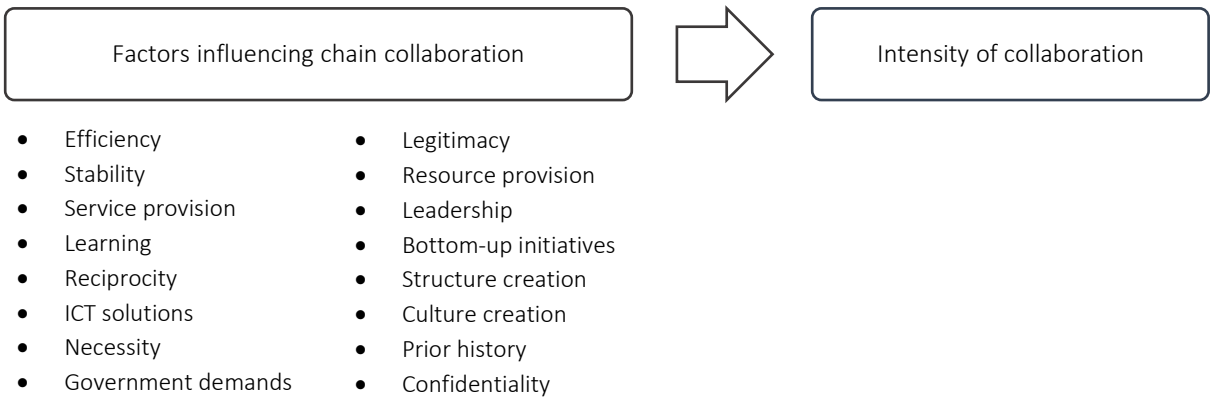


Fig. 9 Conceptual model

The theoretical mechanism for this study is the following proposition:

P1: The factors that influence the formation of chain collaboration as identified by Azerki (2012) will have an influence (+/-) on the intensity of the collaboration between health care professionals, care recipients and care givers.

3 | Methodology

This chapter displays and elaborates on the research design, data collection and sampling strategy, data presentation, data analysis and data interpretation. Furthermore, it elaborates on how the quality of this research can be assessed by evaluating its credibility, transferability, dependability and confirmability.

3.1 | Research design

The aim of this study is to identify the factors that influence the intensity of collaboration between health care professionals, care recipients and care givers. A general guidance in this quest are the factors that influence the formation of chain collaboration as identified by Azerki (2012). Azerki investigated how preconceived factors led to the formation of organization-transcending chain collaboration. The goal of this study is to further develop that knowledge by investigating how these factors may influence the intensity of chain collaborations that have moved beyond the stage of formation.

A rather in-depth, but also a highly exploratory approach characterizes this investigation. Since answering the research question involves the experiences and understandings of participants to be described and explained, a qualitative method best fits this research (Matthews & Ross, 2010; Van Tulder, 2012). In addition to that, one could speak of this study as evaluatory research, which can be used "to assess how well a process (..) is working (..), to consider how a process or intervention might be improved" (Matthews & Ross, 2010, p. 133), regarding the practical relevance for the family care method. The unit of analysis in this study is the process, whereas the unit of observation is the individual.

3.2 | Data collection

Regarding the qualitative approach of this study, data collection is done by conducting interviews. The selection of interviewees is done through purposive sampling. However, along the way a theoretical sampling approach has been adopted - "as 'theory' begins to emerge from the initial data, further cases are selected to explore and test the emerging theory" (Matthews & Ross, 2010, p. 168). Target groups were care givers (e.g. family members), professionals and the director and counselors of Exfam. To reach these interviewees, a brief introduction about the study and the author has been sent to people from these groups selected by the director and counselors of Exfam, with a request to participate in the study. A total of 17 people participated in 13 interviews. The interviews with the director and counselors from Exfam have been conducted after the interviews with the care givers and professionals to prevent any bias with regard to the investigation. While to a certain amount, control over the content discussed in

the interviews is necessary, the approach within the interviews should also allow for derogating from the questions and in-depth questioning. Thus, the interviews conducted are semi-structured. However, a number of interviewees (in particular the care givers) were in a vulnerable position and had a severe story to tell. Listening, gaining trust and comforting them were crucial aspects to let the interviews work out well. This resulted in a rather narrative interviewing approach for the interviews with these participants.

3.3 | Data presentation

The deliverables of the interviews were (1) audio recordings, and (2) notes. Audio recordings have been transcribed and notes were used to create a reconstruction of the interviewee's story, so that data can be presented as similarly and coherently as possible. The interviewees with whom the interview has been reconstructed on the basis of notes, have been asked to validate the reconstruction. The concepts and their operationalization function as a general guidance for the data presentation. The underlying mechanisms for relationships between the investigated factors and the intensity of collaboration, and the frequency with which participants mentioned them, are recorded in a coding scheme, which can be found in Appendix II. After analysis, the suggested relationships and underlying mechanisms are presented as propositions as visualized below.

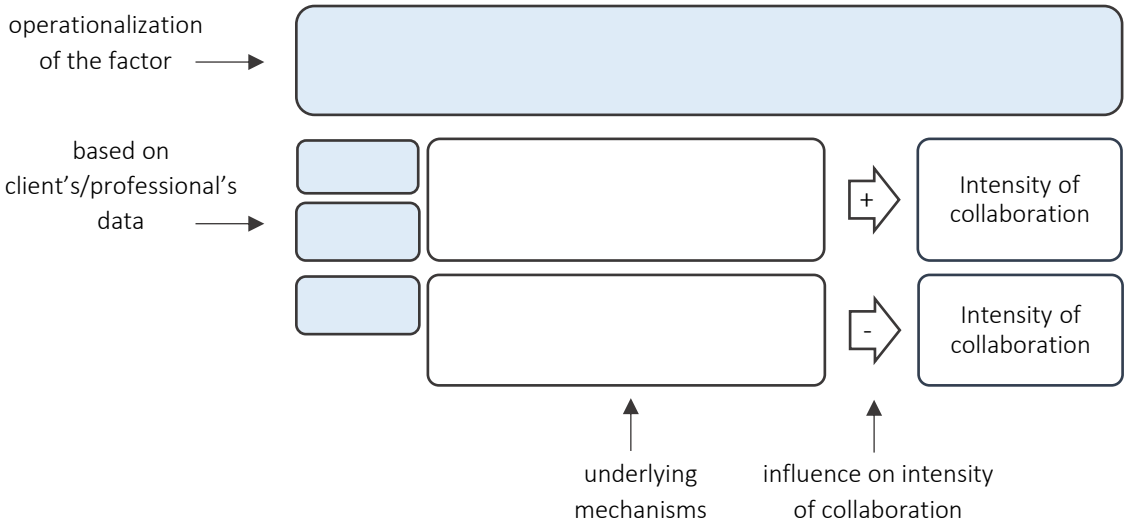


Fig. 10 Visualization of relationship and underlying mechanisms

3.4 | Data analysis

The data has been analyzed using thematic analysis - "a process of segmentation, categorization and relinking of aspects of the data prior to final interpretation" (Grbich, 2007, p. 16). The raw data plays an important role in this process: interpretation, summary and categorization should constantly be

checked with the raw data to verify, look at it in different ways and make links between the different pieces of data (Matthews & Ross, 2010). Azerki's factors function as 'label' under which the various bits of data have been placed. On the basis of open coding, categorizations have been made among these bits to find patterns. This also allowed for code counting to see how many participants have incorporated a certain category in their story.

3.5 | Data interpretation

The three stages of Ritchie and Lewis (2003) have been used to next interpret the data: to read raw data and note down interpretation, to look at interpretation across interviews, and to identify categories for the next level of conceptualization. Subsequently, the relationships between the initial themes and the categories are to be identified, which is done by mapping them. This map is then analyzed again to make statements about the concepts and how they relate to each other. In this way, mapping contributes to the analysis itself as well as to the presentation of the results.

3.6 | Quality indicators

3.6.1 | Credibility

A number of aspects in the methods of this study contribute to its credibility (or internal validity). First, concepts in this study are operationalized on the basis of existing literature. In addition, the indicators used for the dependent variable have been used in research before (Azerki, 2012). Second, participants from different parties involved in the family care method (care recipients, family members, professionals) have been interviewed to collect different points of view. Third, familiarity with the research matter and the culture within the chain collaboration, before the actual data collection takes place, is seen by the author as an important aspect for this study. Frequent visits and consultation of employees of Exfam have substantial priority to obtain valuable information and to build trust. And last, peer scrutiny has played an important role in ensuring credibility. However, some aspects of this study have a negative influence on its credibility. First, data collection for this study does not involve random sampling, since the 'population' for the sample of participants is determined by employees of Exfam. Second, there is no triangulation in this study; only interviews have been conducted to collect qualitative data and no observations or other methods of qualitative data collection have been used (Shenton, 2004).

3.6.2 | Transferability

It is not possible to demonstrate the transferability (or external validity) of the conclusions of this study, since the research takes place in a specific context and with a small number of participants. However,

transferability may be enhanced by providing the reader clear insight in how the research is conducted. Moreover, the provision of ample information about the context of the study is essential for the ability of the reader to assess whether any transfer is possible (Shenton, 2004).

3.6.3 | Dependability

By describing the research process and methods in detail, dependability (or reliability) can be enhanced to a certain extent. Operationalizing the concepts in the research question – and recording this operationalization in a table – also contributes to this study's dependability, as does the reflection and discussion on the research. However, various authors on qualitative methods argue that dependability in qualitative research cannot be ensured (Florio-Ruane, 1991), since "the investigator's observations are tied to the situation of the study" (Shenton, 2004, p. 71).

3.6.4 | Confirmability

Enhancing confirmability (or objectivity) is associated with "the use of instruments that are not dependent on human skill and perception" (Shenton, 2004, p. 72). Regarding the qualitative approach of this study and the necessity for interpretation of the data by the author, confirmability cannot be guaranteed. It is important that the author of this study observes and reflects on her own choices and interpretation critically, and acknowledges these in the discussion.

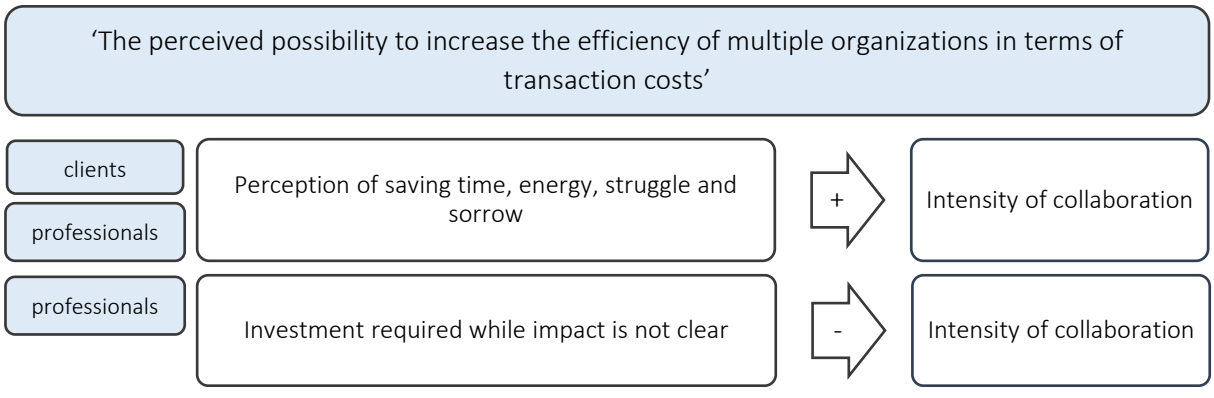
4 | Results

This chapter elaborates on the results of the data collection and data analysis. It explains the relationships that are found between the factors influencing chain collaboration and the intensity of collaboration and displays underlying mechanisms. Propositions that can be drawn from the results are visualized in conceptual models as explained in the method section. A coding scheme of the data can be found in Appendix II.

4.1 | Factors influencing the intensity of collaboration

4.1.1 | Efficiency

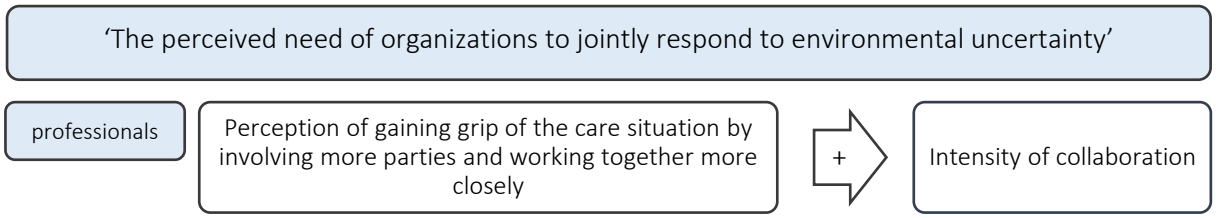
The majority of the participants in this study perceive an intensive collaboration between health care professionals, care recipients and care givers that the family care method requires to deliver efficiency in terms of the time, energy, struggle and sorrow that are saved. However, the perception that professionals have about the efficiency is often blurred by the idea that the family care method is 'just another' or 'yet another' method that needs to be learned and that requires time and effort. This can affect the amounts of time and effort people are willing to put in the collaboration in a negative way. Some participants mentioned that the impact of the method only becomes clear when it is shown and professionals can experience it. This can give insight in the efficiency of the method and how the method can even save time and effort. Furthermore, some participants state that evaluation of the application of the method could also highlight the efficiency and impact, however, in most cases, there is no evaluation scheme for the application of the method yet. Paragraph 4.1.13 will elaborate on this further.



4.1.2 | Stability

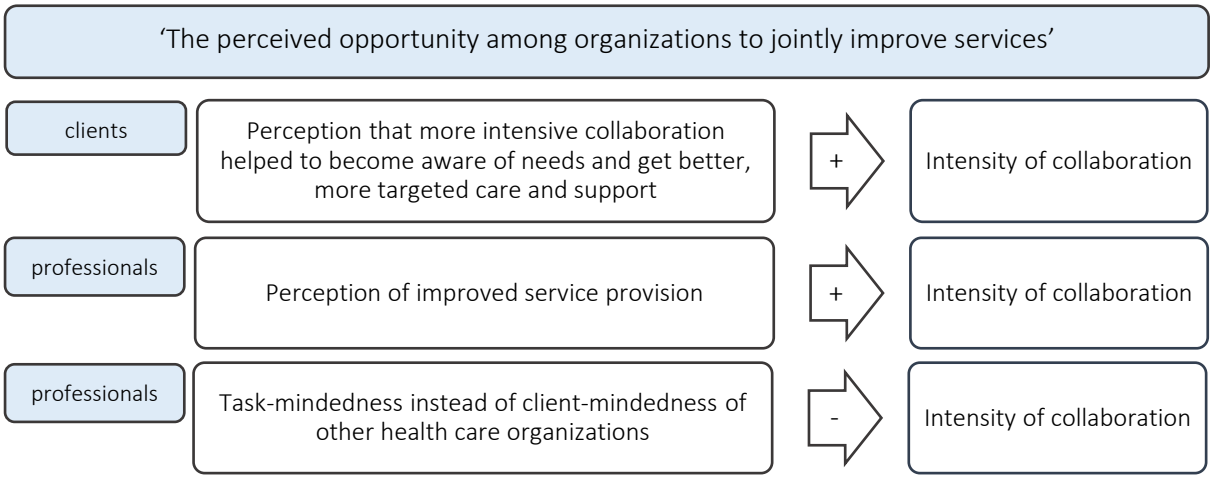
Whereas stability was one of the most important influencing factors for the formation of the CO3 chain, with regard to the present study, it is not perceived by the participants as a factor that plays a major

role. Some participants mentioned that intensive collaboration is indeed perceived to provide stability in terms of gaining grip of a care situation by involving more organizations and working together more closely with collaboration partners. However, it needs to be mentioned that – as was also the case with the CO3 chain – more intensive collaboration may enhance closer control on development in families, which may support the coordination and provision of care.



4.1.3 | Service provision

There are mixed results for the perception amongst the participants about service provision. In general, clients are positive about how their more intensive collaboration with professionals helped them to become aware of their needs and get better, more targeted care and support. The professionals' perspective, however, agree on the idea that more intensive collaboration can indeed improve their service provision, but this is inhibited by the fact that many other organizations do not share this idea and are not feeling responsible for an improved coordination of service provision. Many healthcare organizations are task-minded instead of client-minded and stick to their own activities without aligning these with the activities of other organizations. According to some participants in this study, it is difficult to apply system-thinking when other organizations that are involved in a care situation do not put effort in this.

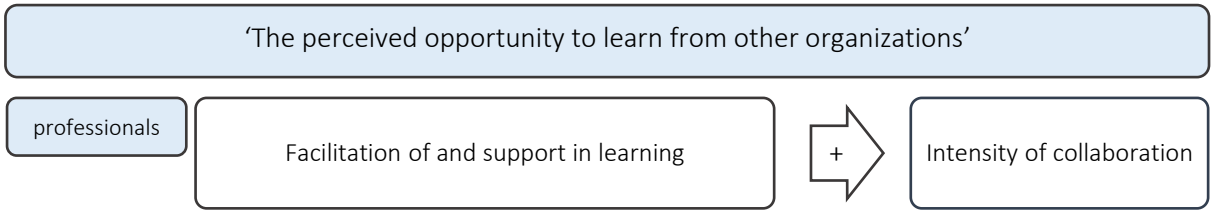


4.1.4 | Learning

In general, the participants perceived learning as an important factor for collaboration. The most frequently mentioned idea is that learning to apply the method and improving this can only be done by sharing experiences with colleagues. Unfortunately, the majority of the participants from healthcare organizations stated that this is done insufficiently within their organizations. They provided the following explanations:

- People may have the perception that their organization does not provide a safe environment to train the method;
- People may have the perception that the culture of their organization does not provide room for failure;
- People may be afraid to ask each other questions;
- People may not prioritize learning, or their organization does not stress learning as a priority;
- In some cases, the most experienced professionals that are trained in family care are deployed to solve difficult situations or have troublesome conversations with clients. This may have a drawback since the learning experience in that case stays with the already very experienced professional, while other professionals could use such situations to develop themselves further in their ability to correctly apply the method.

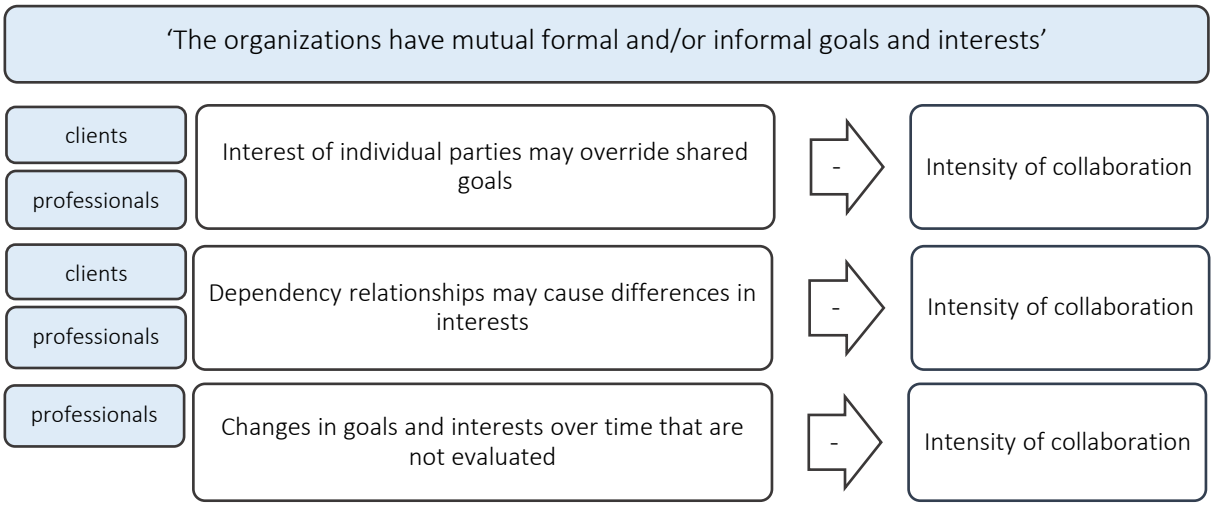
Some participants also mentioned the ambition of their organization to further develop the self-reflection of and within teams. This would enhance both individual and team learning. Furthermore, some participants elaborated on how people from their organizations share experiences with other organizations by visiting their locations. In this way, professionals can gain insight in how other organizations (from other sectors) apply the method, from which best practices can be developed. More intensive learning may in this way imply a more intensive form of collaboration (and vice versa).



4.1.5 | Reciprocity

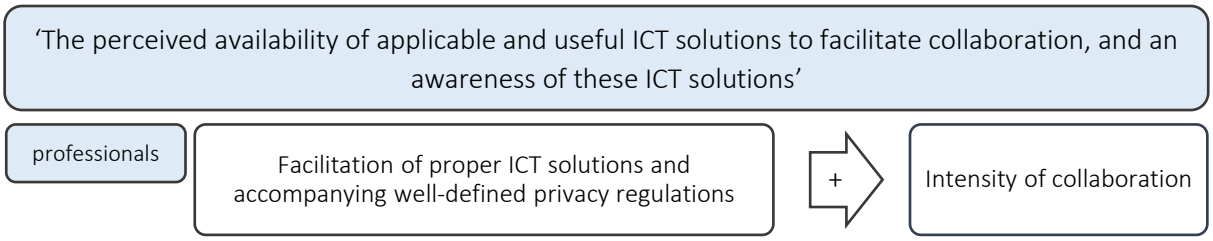
Reciprocity was found to be a factor of influence for the intensity of collaboration. Collaboration requires shared goals, but according to a number of participants, in some cases, the interests of the

individual organizations override these. This shows some overlap with service provision: some organizations rather focus on their own activities than aligning them with those of the other involved organizations. Furthermore, some participants reported that they are not able to assess whether their collaboration partners have the same goals over time, because not enough time and effort is taken to evaluate this continuously. Another important key point of this factor is the inequality between the partners in collaborations between professionals, care recipients and care givers – and this is where this type of collaboration may distinguish itself from chain collaborations like the CO3 project: the care recipients and care givers are in need in help, while the professionals are not. This creates a relationship of dependency which may automatically cause differences in the goals and interests of the collaboration partners. Healthcare organizations and professionals should account for this in the collaboration and in their application of the method.



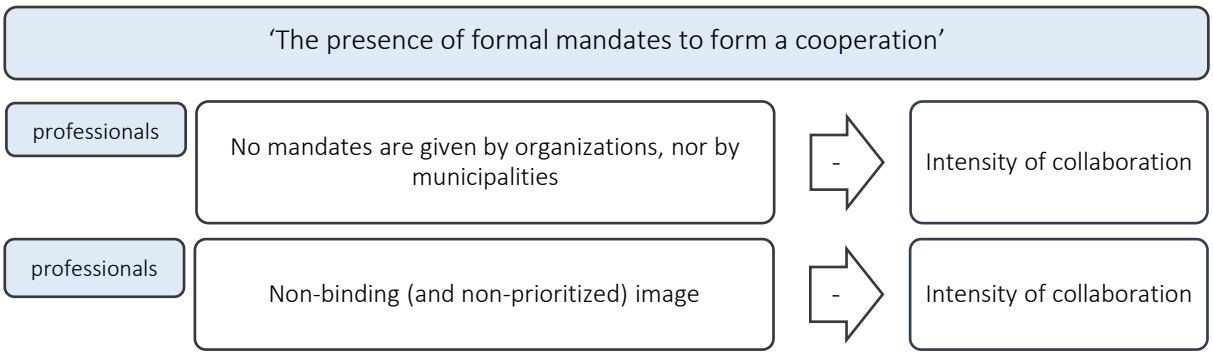
4.1.6 | ICT solutions

Surprisingly (or not), in general, ICT solutions were not perceived by the participants as an important factor for the collaboration. Some participants mentioned that their organizations make use of a well-working digital system in which client reports can be shared with families or other relevant parties. These systems do have some interference with privacy regulations, but overall, there are no immediate concerns. The majority of the participants stated that the application of the family care method primarily involves face-to-face contact and that this is the most important form of contact with clients, taking into account their digital skills. However, it needs to be mentioned that ICT solutions would become much more important when different healthcare organizations start to share information about clients to coordinate and align their activities in order to optimize their service provision.



4.1.7 | Necessity

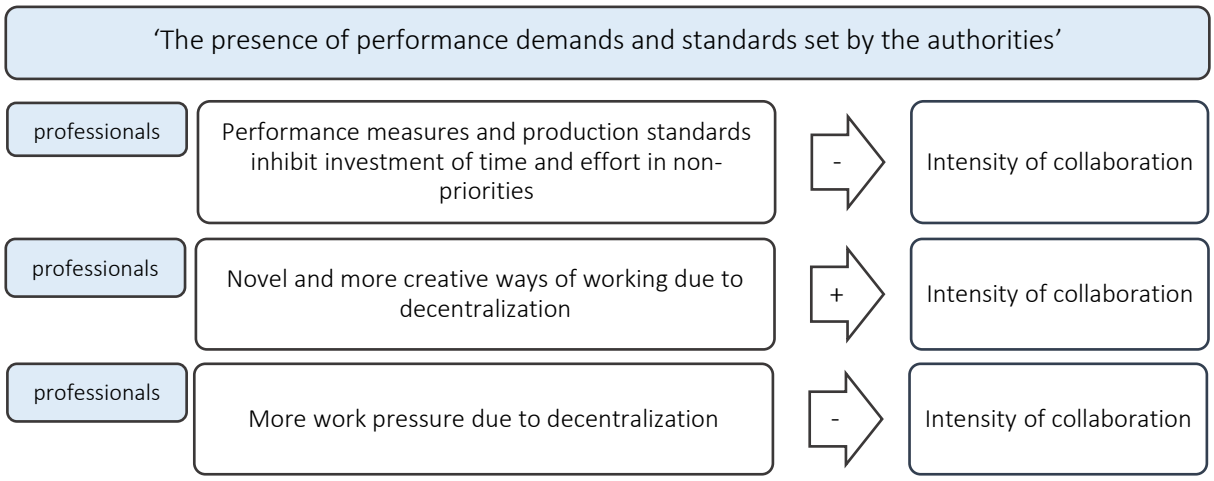
Azerki reported necessity as one of the most important influencing factors in the formation of the CO3 chain. Means of formalization of the cooperation were used to ensure investment of the different organizations to the project and prevent the participation in the project from being non-binding. In contrast, according to the participants of the present study, no obligations or mandates for integral collaboration with respect to the family care method were given by organizations, nor by the municipality. This may have caused the organizations and their professionals to perceive collaboration in the context of family care as rather noncommittal or voluntary – while the method does have wide support and acknowledgement of the Dutch government. Results of this study show that the application of the family care method is not perceived as a priority by a lot of professionals, while the organizations they work for claim that they do apply the method. The non-binding image that the method wears in some organizations may prevent professionals from feeling the urge to actually adopt an integral form of collaboration.



4.1.8 | Government demands

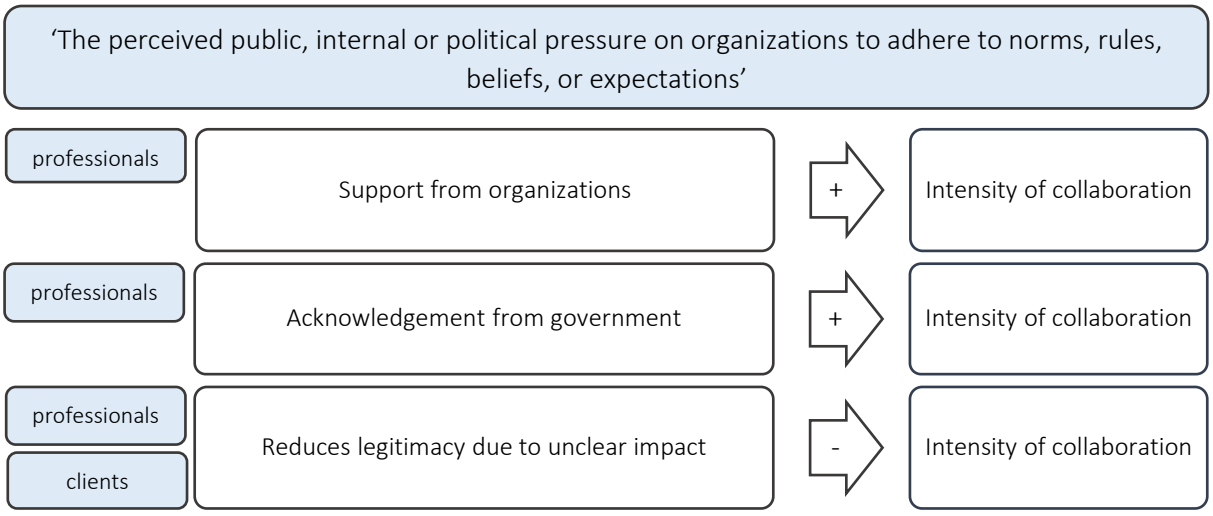
Overall, results show that government demands are perceived to be an important factor for the intensity of collaboration. First of all, production standards and performance measures cause professionals to deliberate on where to invest their time and effort in. According to the participants, when the application of the family care method is not considered a priority, professionals experience it as an extra burden and will be likely to 'postpone' investing time and effort in it, and thus not take on an integral form of collaboration. The workload for healthcare organizations has increased even further after the

decentralization of compensations for personal care and support to the municipalities (as part of the Social Support Act (Wmo)), especially due to the expanded administrative demands from the government. However, some participants mention the positive stimulus that the decentralization has had on healthcare organizations to adapt different, novel and more creative ways of working. Furthermore, one participant mentioned that by making healthcare professionals responsible for (a part of) the administrative tasks, he or she gets a more complete overview of the client and the care situation. On the contrary, while the decentralization may have been a positive stimulus, some participants state that the government has provided healthcare organizations with insufficient tools to cope with the changes.



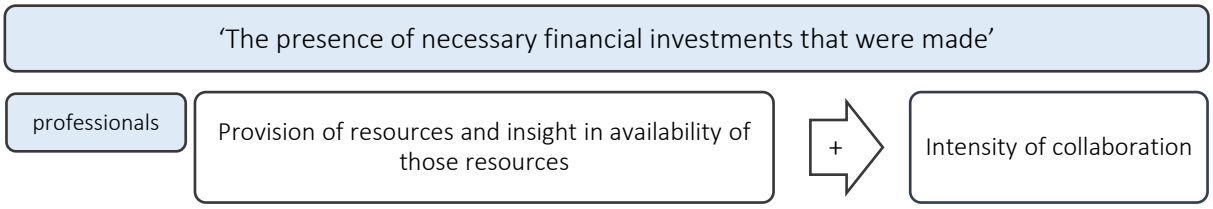
4.1.9 | Legitimacy

Results show that legitimacy is an important factor for the intensity of collaboration because it can enhance the willingness of professionals as well as care recipients and care givers to engage in a collaboration. According to the participants, the family care method is recorded in the policies and strategic plans of some of the healthcare organizations which enhances its legitimacy. Furthermore, as has already been mentioned in paragraph 4.1.7, the method is widely acknowledged by the government. On the other hand, negative or inaccurate perceptions about the method – as discussed in paragraph 4.1.1 – can reduce the method's legitimacy and thus time and effort that people are willing to invest in a more integral form of collaboration.



4.1.10 | Resource provision

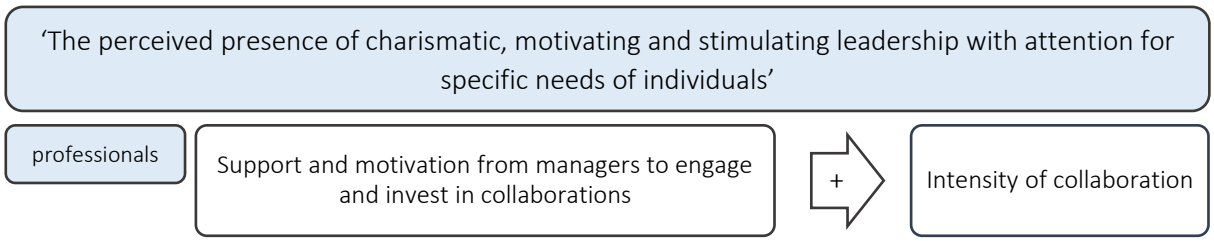
Resource provision is indeed considered a factor of influence for the intensity of collaboration. However, it is remarkable how little the participants were able to say about the actual availability of resources for the benefit of the collaboration with regard to the application of the method. Some participants stated that organizations provide no special resources for this target, but the majority of the participants mentioned that within their organization, there is no insight in resource provision for a more intensive collaboration. Hence, it is in most cases not clear how many human resources can be invested in the collaboration, too – while professionals already feel the need to deliberate on where to invest their time and effort in, as discussed in paragraph 4.1.8.



4.1.11 | Leadership

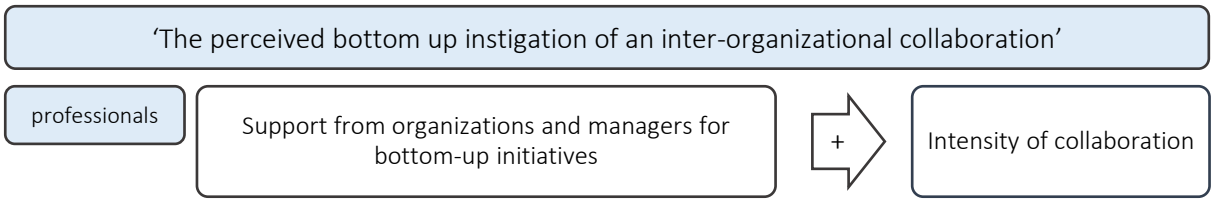
Azerki approached this factor as the presence of a leader that is part of the chain collaboration and manages the relationships between the partners and keeps the collaboration going. In the application of the family care method, according to the participants, the professional that initiated the collaboration usually takes the lead. The participants could not give answers on how leadership develops itself when multiple healthcare organizations participate in the collaboration with care recipients and care givers – while this could be a crucial factor for the application of the family care method amongst multiple healthcare organizations in a care situation. Important to elaborate on, however, is how participants described the role of the manager within healthcare organizations. It is remarkable to see how many

differences the professionals among the participants reported in the extent to which their managers support the family method and motivate their employees to apply it. Even within organizations there are considerable differences. This may affect the effort that professionals are willing to invest in more intensive forms of collaboration.



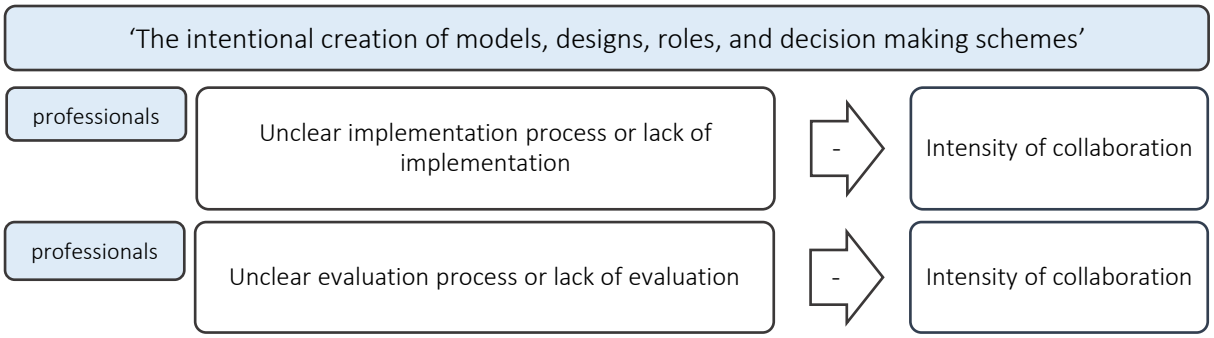
4.1.12 | Bottom-up initiatives

Results show that bottom-up initiatives are perceived to be an important factor for the intensity of collaboration in the context of the family care method. Acting upon the family care foundations and using the tools sometimes requires, for example, making adjustments to standard procedures or making changes in where time and effort is invested in. This may imply extra alignment, and thus more intensive collaboration. The majority of the professionals among the participants reported that their organization provides sufficient room for initiatives. Again, we see a difference between managers (also within organizations) in the extent to which they support and encourage bottom-up initiatives.



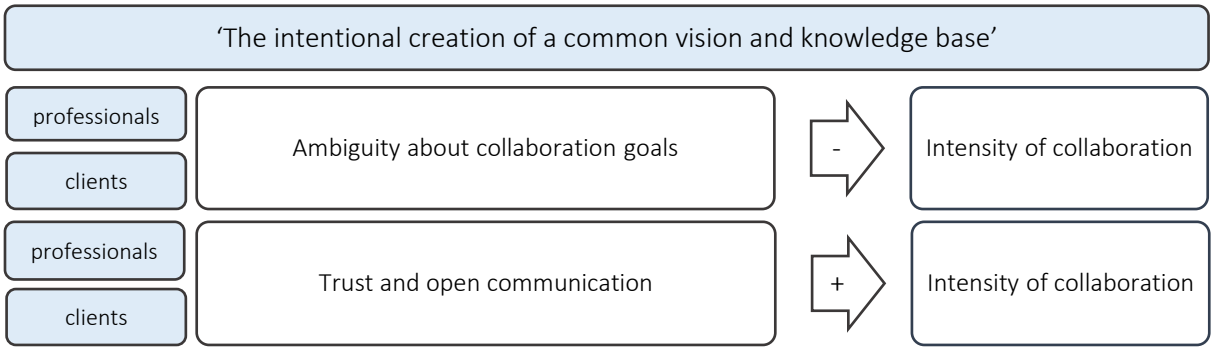
4.1.13 | Structure creation

Results show that structure creation is considered to be of high importance for the intensity of collaboration. Unfortunately, the majority of the professionals among the participants in this study report that they did not recognize an intentional implementation process with respect to the family care method within their organization. Moreover, these participants mention that within their organization, no structures or schemes exist to properly evaluate the method. The participants assess implementation and evaluation with regard to family care as crucial factors for gaining the required intensity of collaboration.



4.1.14 | Culture creation

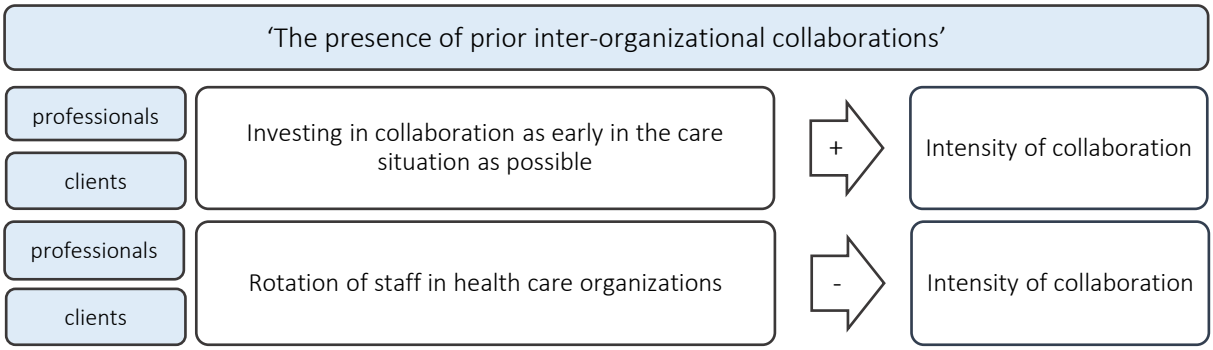
The most striking point related to culture creation was that the majority of the participants – both professionals and clients – mentioned that for many people it is unclear what the family care method actually means. There exists ambiguity on both the term and the content. For example, some professionals noticed that for a substantial number of care givers, the term 'family care' suggested that (part of) the care would become the responsibility of the family. Ambiguity among the perceptions of collaboration partners about topics and goals may inhibit integral collaboration. This factor also shows overlap with the factors legitimacy and efficiency, since ambiguity about the term and the content of the method may lead to inaccurate or negative perceptions and resistance to the application of the method and engaging in collaboration. Another point that was found to be important for the intensity of collaboration is the creation of trust and an environment of open communication. Collaboration partners should take this into account, as well as the organizations when implementing the method.



4.1.15 | Prior history

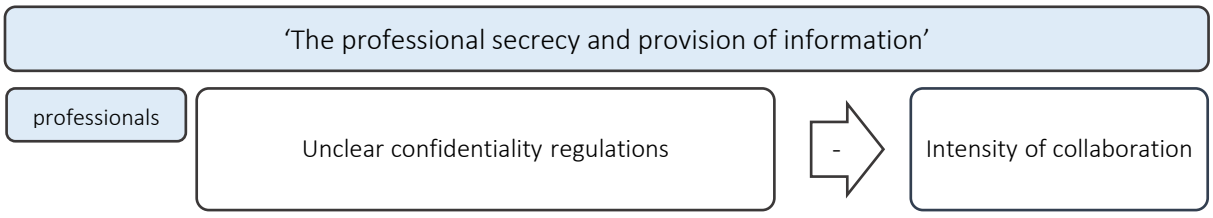
Results show that prior history is considered as an important factor for the intensity of collaboration. Professionals as well as clients report that care recipients and care givers are often hesitant to share their stories due to bad experiences with healthcare organizations in the past. Clients report that they had to share their story too often with too many different organizations and professionals. Exfam reported that when clients reach out to them, they often already have a long history of struggles and sorrow in finding the help that they actually needed. This shows that the application of the family care

method and an intensive collaboration between professionals, care recipients and care givers often happens 'too late'. Collaboration intensity can take on more intensive levels if application of the method happens as early as possible. Another key point related to prior history is the extent to which organizations use rotation of professionals in the workplace. Clients among the participants reported that they notice that provided care is of less quality when staff is rotated frequently due to the relative little knowledge they have about their clients. Rotation may in this way inhibit a more intensive form of collaboration. This notion is supported by professionals among the participants.



4.1.16 | Confidentiality

This factor was reported to influence the intensity of collaboration in a way that creating an environment of open communication at the same time requires strict confidentiality. Some participants mentioned that in any case, the privacy of the client is leading. However, there also exists a notion that healthcare organizations may use privacy as an excuse to prevent themselves from sharing information or putting effort in this. As was the case in the CO3 chain, confidentiality can form a severe obstacle when different healthcare organizations need to share information about a client in order to be able to coordinate and align their activities.



5 | Conclusion

5.1 | Summary of the study

Informal care has caught an increasing amount of attention over the last decades. Statistics show that there is an increasing amount of extramural care and people with severe illnesses taken care of by family and friends instead of professionals or voluntary care givers. The increasing amount of care givers and the percentage of overburdened care givers display the urge to find out how to make collaboration and integration within the healthcare sector more efficient. Expertisecentrum Familiezorg has developed a method according to which a care recipient and his or her surroundings are seen as a system. Regarding the characteristics of the family care method, integral collaboration between health care professionals, care givers and care recipients is required. However, according to Exfam's observations, in a number of cases in which the family care method is applied, the characteristics of an integral form of collaboration are not clearly visible (yet). Azerki's (2012) study illustrates the complexity of organization-transcending chain collaboration and indicates how 16 different factors can influence this form of collaboration. The present study uses Azerki's factors as a framework to investigate whether and how they influence the intensity of collaboration in the context of the family care method. The accompanying research question is as follows: *Which factors influence the intensity of the collaboration between health care professionals, care recipients and care givers in the context of the family care method?* The theory section elaborates on the content and the structure of the method, as well as on the implementation and application. It includes theory on intensities of collaboration and explains why the family care method requires an integral form. It elaborates on the factors influencing chain collaboration and explains the context of the family care method on the basis of Bartholomew's et al. (2011) Intervention Mapping. A rather in-depth, but also a highly exploratory approach characterizes this investigation. In addition to that, one could speak of this study as evaluatory research. The unit of analysis in this study is the process, whereas the unit of observation is the individual. Regarding the qualitative approach of this study, data collection is done by conducting interviews. The selection of interviewees is done through purposive sampling. A total of 17 people participated in 13 interviews. The method section elaborates on the credibility, transferability, dependability and confirmability of the study.

5.2 | Answering the research question

In the results section, relationships are explained that are found between the factors influencing chain collaboration and the intensity of collaboration on the basis of their underlying mechanisms. Propositions were drawn from these results and visualized in conceptual models. The factors influencing

chain collaboration show coherence and overlap in the influence they exert on the intensity of collaboration. Further analysis of the results has led to a categorization of the factors with overarching themes. These themes are not necessarily mutually exclusive, nor do all factors necessarily have to be placed under one certain theme only. The paragraphs below elaborate on the four themes and display the propositions that form an answer to the research question:

Which factors influence the intensity of the collaboration between health care professionals, care recipients and care givers in the context of the family care method?

5.2.1 | Facilitation

According to the participants, some (organizational) aspects are prerequisites for enabling people to collaborate. They can be seen as 'hygiene' factors that are required to facilitate collaboration. These include *ICT solutions*, *resource provision*, *bottom-up initiatives* and *confidentiality*. There should be made available time and money to invest in collaboration – as well as a proper ICT solution to facilitate information sharing. Furthermore, the extent to which resources are available should be made clear to the healthcare professionals. Without knowledge about resource provision, it becomes too difficult to actually decide on whether to invest time and money in a certain activity – even when this activity is seen as a priority. Furthermore, as collaboration requires information sharing, a certain level of confidentiality has to be guaranteed. Participants assess confidentiality as a 'needless to mention' aspect of their work. However, when collaborating with other parties, guidelines for confidentiality should be facilitated in a way that it does not inhibit optimal information sharing.

P1: Provision of resources and insight in the availability of those resources, facilitation of proper ICT solutions and accompanying well-defined privacy regulations, and support from organizations and managers for bottom-up initiatives ***positively*** *influence the intensity of collaboration.*

P2: Unclear confidentiality regulations ***negatively*** *influence the intensity of collaboration.*

5.2.2 | Implementation

Virtually all participants indicated that they did not recognize a clear collaboration implementation process when they started working with the family care method. A number of factors investigated, including *culture creation*, *structure creation* and *learning*, involve the implementation of collaboration that accompanies the family care method. With regard to structure creation, many professionals indicate that within the organizations they apply the method, no roadmap for implementation of collaboration with regard to the method was available, nor were there any monitoring tools or

evaluation schemes. Regarding culture creation, participants indicate that in their perception, there exists an ambiguity among the professionals that work with the method about the meaning of family care and the goal of their collaboration with care recipients, care givers and other professionals. With regard to learning also, many participants indicate that "there is still a long way to go". Learning is seen as a very important aspect for fostering intensive collaboration, as well as for the transfer of knowledge and skills regarding the method. However, many health care organizations that work with the method pay insufficient attention to assuring that learning is facilitated and supported.

P3: Trust and open communication, and facilitation of and support in learning ***positively*** *influence the intensity of collaboration.*

P4: Ambiguity about collaboration goals, unclear implementation processes or a lack of implementation, and an unclear evaluation process or a lack of evaluation ***negatively*** *influence the intensity of collaboration.*

5.2.3 | Motivation

In this context, motivation can be defined as "an individual's degree of willingness to exert and maintain an effort towards organizational goals" (Franco, Bennett & Kanfer, 2002, p. 1256). In order to enable health care professionals, care recipients and care givers to collaborate, all these parties should have a certain level of willingness to invest time and energy in the collaboration. Factors that are involved in this process are *efficiency*, *legitimacy*, *leadership*, *necessity* and *government demands*. The perception that the participants have about the efficiency of intensive collaboration with the family care method is positive, however, for people that do not work with the method yet, its efficiency (resulting in saving time, effort and money) has to be shown in order for them to be willing to engage in an intensive collaboration. In addition to this, it is important that collaboration for the use of the method seems legitimate – it should be supported by health care organizations and key figures and its effectiveness should be highlighted. Leadership is an important aspect to foster motivation, whilst an important supporting role is played by institution boards, directors, managers and team leaders. At the same time, necessity and government demands can foster motivation in a rather extrinsic way: when mandates or regulations exist, organizations and professionals may become more willing to comply and prioritize intensive collaboration.

P5: Perception of saving time, energy, struggle and sorrow, support from organizations, acknowledgement from the government, support and motivation from managers to engage and invest in collaborations, and novel and more creative ways of working ***positively*** *influence the intensity of collaboration.*

P6: Unclear impact, a non-binding image and a lack of madates, pressure of performance measures and production standards, and work pressure due to decentralization ***negatively*** *influence the intensity of collaboration.*

5.2.4 | Broad integration

The application of the family care method may, in the majority of cases, require collaboration between families and multiple health care organizations. This involves the factors *service provision*, *stability*, *reciprocity* and *prior history*. Participants indicate that a poor integration between different health care institutions inhibits the effect and efficiency of the method, and blurs the perception that service provision and stability can be improved. With regard to reciprocity, it seems difficult to work with organizations that do not prioritize integral collaboration. Some organizations are rather 'task-minded' than 'client-minded', which consequently results in segmentation and pigeonholing instead of integral collaboration in a client-oriented chain. A broader integration of organizations in different health care segments and application of the method by more health care institutions would foster the effectiveness and efficiency of collaboration. Additionally, better integration might exploit the positive effects of prior history (experience in working together, trust) and decrease its negative effects (prevent sorrow and bad experiences of clients by intervening in an earlier stage).

P7: Perception that more intensive collaboration improves service provision and gaining grip on care situations and investing in collaborations as early as possible in a care situation ***positively*** *influences the intensity of collaboration.*

P8: Task-mindedness (contrarily to client-mindedness), interests of parties overriding shared goals, differences in interests caused by dependency relationships, changes in goals and interests over time that are not evaluated, and rotation of staff in health care organizations ***negatively*** *influence the intensity of collaboration.*

6 | Discussion

6.1 | Implications of the research

6.1.1 | Categorization in overarching themes

The aim of this study was to find factors that influence the intensity of collaboration in the context of the family care method. The 16 influencing factors for chain collaboration, as identified by Azerki (2012), were the guidance in this quest. The results display whether and how these factors exert influence on the level of collaboration intensity. Further analysis of the results led to a categorization of the factors in four overarching themes; *facilitation*, *implementation*, *motivation* and *broad integration*.

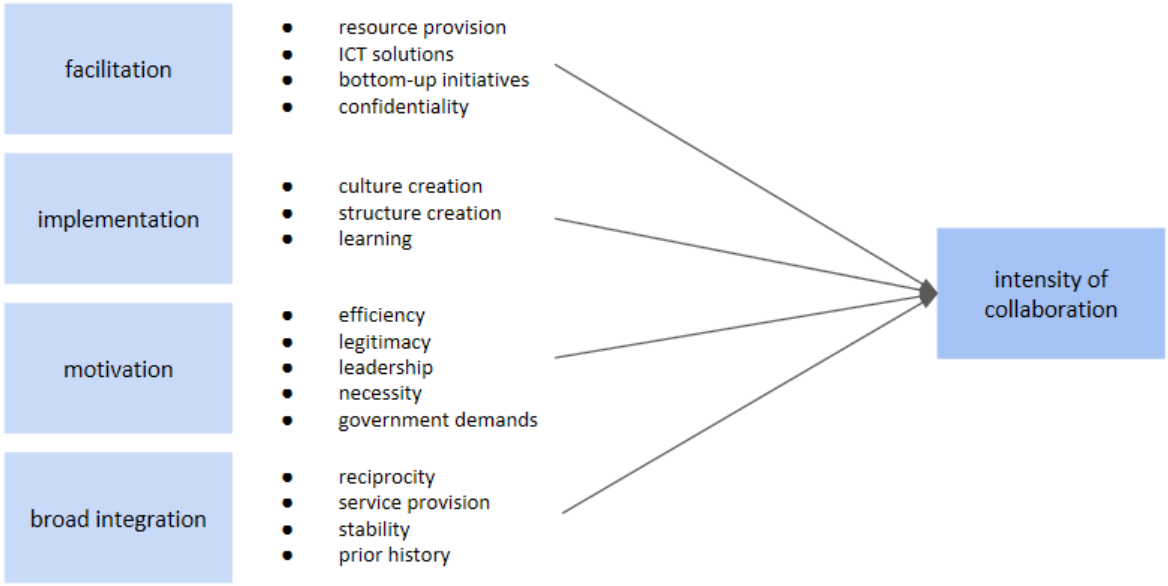


Fig. 11 Categorization of the factors influencing the intensity of collaboration

This categorization does not mean that the themes are mutually exclusive, nor that certain factors may not be identified under other categories. However, it may be valuable to further investigate the categorization quantitatively (by, for instance, performing a factor analysis) to discover whether the themes *could* be mutually exclusive.

In the context of this study, the themes can be used to reflect on the status quo, or in other words, to evaluate the current level of collaboration intensity that is needed to correctly apply the family care method. The aspects that need to be highlighted are discussed in the following paragraphs.

6.1.2 | The importance of availability of resources (and providing insight in this)

Based on the results, it is obvious that the majority of health care organizations does not provide adequate information about the availability of resources to invest in collaboration. A higher level of collaboration intensity, or in other words, an integral form of collaboration, requires an investment in time, money and energy. For the family care method to be correctly applied, health care organizations should have the commitment to make these investments in order to make integral collaboration possible. Information about available resources should be communicated to the professionals clearly and in time.

6.1.3 | Implementation is more than a 'transfer'

Based on consultations with professionals of Exfam, a study of documentation and the outcomes of the interviews, it seems like there is no well-defined roadmap for and execution of implementation of the method and required form of collaboration within organizations. If a comparison is made between the 'transfer' of the method to and through organizations with, for example, step 5 and 6 of Intervention Mapping by Bartholomew et al. (2011), no implementation or evaluation stages can be identified and distinguished, nor is it clear which activities at the health care organizations are involved in implementing the method.

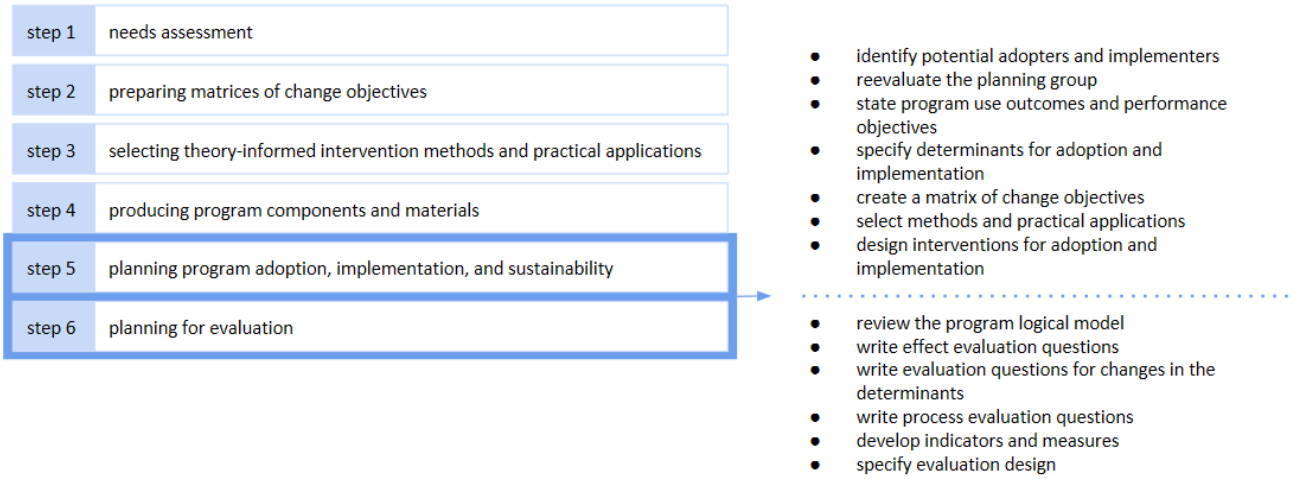


Fig. 12 Tasks for stages 5 and 6 of Intervention Mapping (based on Bartholomew et al., 2011)

The way in which the family care method find its way to organizations is via the professionals that are certificated in the method. As elaborated on in paragraph 1.1.2 and displayed in figure 3, Exfam educates professionals in the family care method through participation in a number of workshops. These professionals may become a trainer themselves and educate other professionals through participation in workshops in their turn. Trained professionals receive guidance from Exfam in how to train others (with teaching material and didactical tools). This is how the family care method 'spreads'

itself: it is transferred from person to person. A number of health care organizations have incorporated the method in their policies and strategic documents, but rather as a vision or ambition than in concrete consequences and activities. A number of the interviewees were well-experienced in the method, but indicated that they were one of the few people in their organization that are committed to it and apply it on a daily basis. To conclude: in the majority of the health care institutions that claim to work with the method, the method is not implemented organization-wide. This inhibits the required integral form of collaboration, which in its turn may negatively influence the effectiveness of the method.

Based on the outcomes of this study, the advice for Exfam would be to ensure organization-wide application and integration at the health care institutions, by means of a well-described and monitored implementation process. Exfam could develop an implementation process itself, make the health care organization responsible for delivering an implementation specialist, or it could, for instance, hire an organizational consulting company.

6.1.4 | The crucial role of the municipality for motivation and broad integration

Apart from the importance of intrinsic motivation, extrinsic motivation plays a major role in creating the willingness to collaborate. Striking is the fact that the Dutch government widely acknowledges the family care method and keeps providing subsidies to Exfam, whilst it does not exert pressure on health care organizations to apply the method. Furthermore, the government acknowledges the importance of intensive collaboration between health care organizations, whilst is does not exert pressure on these institutions to integrate their activities. In a situation where health care organizations need to cope with budget cuts, it may require an extra 'push' to take action on the urgency of integral collaboration. This is where this study sees an important role for municipalities. In a landscape where health care institutions need to collaborate intensively but where there is no entity with ultimate responsibility to carry out or take the lead in this integration, intervention by the municipality is crucial. Currently, the majority of municipalities neglects this responsibility.

6.2 | Limitations

This study is subject to a number of limitations. This paragraph aims on elaborating those identified by the author.

First of all, this study depends on qualitative data collection through interviews only; there has been no triangulation. Furthermore, the sampling approach for this data collection was purposive sampling whereby participants were selected by Exfam counselors. On the one hand, this consequently resulted in respondents that were familiar with the family care method and were able to answer questions comprehensively, while on the other hand, this may have caused certain biases in their answers. In

addition, this group of participants is not controlled for a correct representation of the population of clients and health care professionals. Moreover, comparing the data collected from clients on the one hand and professionals on the other was difficult, since the data collection was not case-oriented: the clients and professionals that were interviewed do not work together (are not 'linked' to each other) in cases. This difficulty was partially accounted for by separating the outcomes of the data collection among clients and professionals – which is made visible in the visualizations of the results.

With regard to the operationalization of the factors influencing chain collaboration, a limitation might be that the operationalization by Azerki (2012) is used for this research. This was done considering the benefit for consistency, however, this operationalization is focused on the dependent variable in the research of Azerki, and therefore probably too specific to use in the present study.

Furthermore, the scope of the research has to be taken into consideration. Since this study concerned the factors influencing chain collaboration and their influence on collaboration intensity, focus lied on variables 'outside' the family care method. Obviously, they show overlap with aspects that concern the content and the structure of the method, but they were primarily involved – as has been indicated in the theory section – in the adoption, implementation and evaluation of the method. This implies that little attention is paid to investigating and evaluating the content and structure of the method. Whilst critically looking at the content and structure, however, could also have implications for the outcome of the present study. The content and structure obviously interferes with the factors investigated in this study, thus future investigation of the method itself could be a valuable follow-up.

Moreover, this research involves a large amount of independent variables, namely, the sixteen influencing factors for chain collaboration. Regarding the exploratory approach, this was beneficial for the amount of identified mechanisms of which can be suggested that they underlie the relationship between the factors for chain collaboration and their influence on collaboration intensity. On the contrary, this broad approach somewhat inhibited digging deeper into the different factors. It would be valuable for future research to narrow down to the most important factors to investigate their relationship with collaboration intensity and underlying mechanisms more in-depth.

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Appendix I

Operationalization

Concept	Definition	Dimension	Indicator
Factors influencing chain collaboration	Elements that are of interest in the formation of chain collaboration	Efficiency	The perceived possibility to increase the efficiency of multiple organizations in terms of transaction costs
		Stability	The perceived need of organizations to jointly respond to environmental uncertainty
		Service provision	The perceived opportunity among organizations to jointly improve services
		Learning	The perceived opportunity to learn from other organizations
		Reciprocity	The organizations have mutual formal and/or informal goals and interests
		ICT solutions	The perceived availability of applicable and useful ICT solutions to facilitate collaboration, and an awareness of these ICT solutions
		Necessity	The presence of formal mandates to form a cooperation
		Government demands	The presence of performance demands and standards set by the authorities
		Legitimacy	The perceived public, internal or political pressure on organizations to adhere to norms, rules, beliefs, or expectations
		Resource provision	The presence of necessary financial investments that were made
		Leadership	The perceived presence of charismatic, motivating and stimulating leadership with attention for specific needs of individuals
		Bottom-up initiatives	The perceived bottom up instigation of an interorganizational collaboration
		Structure creation	The intentional creation of models, designs, roles, and decision making schemes
		Culture creation	The intentional creation of a common vision and knowledge base
		Prior history	The presence of prior interorganizational collaborations
		Confidentiality	The professional secrecy and provision of information
Azerki (2012)			

Table 1. Operationalization scheme

Appendix II

Coding

Efficiency		Stability	
code	count	code	count
'just another' method	4	provision of grip on the care situation by multiple organizations	2
correct application limits time, energy, struggles and sorrow	10		
becoming aware of impact by experience	4		
not sure about efficiency without evaluation	2		
Service provision		**Learning**	
code	count	code	count
organizations not feeling responsible	5	positive learning effect of deploying trained professionals	1
task-minded instead of client-minded	5	negative isolating effect of deploying trained professionals	4
difficulty of system-thinking when other organizations don't	4	learning by doing	3
		learning by sharing within organization	7
		learning by sharing with other organization	2
		fear of asking questions	3
		self-reflection in teams	1
		no priority on learning	2
		no room for failure	2
		need for safe environment to train method	1
Reciprocity		**ICT solutions**	
code	count	code	count
absence of shared goal	4	presence of sufficient digital system	3
no evaluation of goal alignment	2	interference with privacy regulations	1
inequality of collaboration partners	3	inequality between collaboration partners in digital skills	1
involving partners in other activities	1		
Necessity		**Government demands**	
code	count	code	count
no mandate from organization to apply method	4	negative effect of production demand	3
no mandate from municipality to apply method	5	positive push effect of transition	4
		negative administrative workload effect of transition	4
		positive	1

		administrative workload effect of transition	
		fear for failure due to legislation and evaluation	1
		insufficient grip/tools provided by municipalities	2
Legitimacy		**Resource provision**	
code	count	code	count
included in organizational plan	3	resource provision is ambiguous or unclear	7
acknowledgement by municipality	4	insufficient resources	3
Leadership		**Bottom-up initiatives**	
code	count	code	count
make individuals and teams aware of own responsibility	4	sufficient room for initiatives	7
motivation by manager	2	substantial instead of hierarchical discussion	1
guidance by manager	1	hierarchical discussion	1
guidance by (trained) professional	1	differences between managers within same organization	2
differences between managers within same organization	2		
Structure creation		**Culture creation**	
code	count	code	count
no implementation steps	7	ambiguity about term	9
no evaluation schemes	7	trust	4
not applied to administrative procedures	1		
negative effect of rotation of staff	4		
Prior history		**Confidentiality**	
code	count	code	count
willingness to share stories	3	client's privacy is leading	2
collaboration 'too late'	5	privacy legislation as an excuse	2

Table 2. Coding scheme