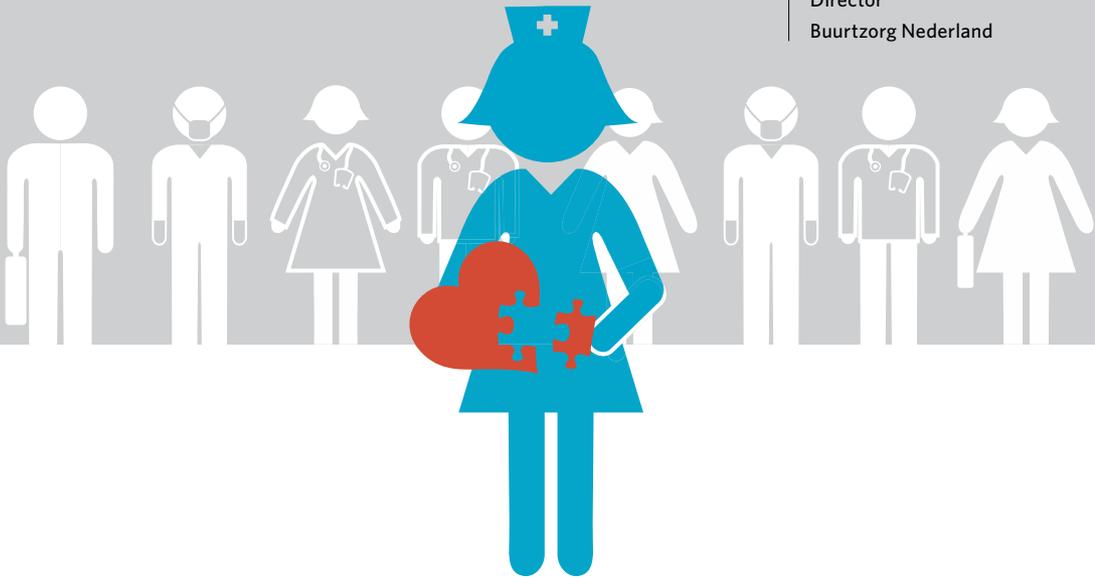


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## BUURTZORG NEDERLAND: A NEW PERSPECTIVE ON ELDER CARE IN THE NETHERLANDS

*In 2006, Buurtzorg Nederland (neighborhood care or community care) was founded as an alternative to the bureaucratic way of delivering home care in the Netherlands. Because of the way big home care organizations are structured and managed, community care became a preferred method of delivering activities such as helping with bathing, giving an injection, or caring for a wound. These services are often performed by low-educated nurse assistants. Care has become very fragmented and ineffective. Some patients have to deal with more than 30 different nurses in a month, and nobody has the “total picture” of the patient.*

Many patients become frustrated because they are not receiving the right care, while nurses become frustrated that they cannot perform their job properly.

### HISTORY

Until the 1990s, the Netherlands had a very good system of primary health care. General practitioners (GPs, or family doctors) worked closely with community nurses and social workers. These community nurses were employed by local private “cross organizations” (green, white, or yellow cross; depending on the religion of the recipient). A national cross organization took care of the national standards, which were very high. Only the best nurses came to work as community nurses, after they had worked for some years in a hospital and had completed an additional two-year degree. They worked in small teams in a village or part of a city, being responsible for home care in that area, as well as prevention and health care for children from 1 to 4 years of age. During the nineties there was great political pressure to organize home care on a larger scale, and a lot of home help organizations, nursing homes, and even hospitals merged. The high standards of community care disappeared, and community care became more and more organized as a profit-making business. The autonomy of the nurses decreased, and the policy in the organizations was based more on economic principles than on principles of good care. The more that human resources management was introduced in these organizations, the less it was practiced.

### THE BUURTZORG REVOLUTION

In 2006 Jos de Blok, a former community nurse, manager and director of different

home care organizations, thought that it would be possible to use the old community care principles again, supporting them with new ideas about how to manage an organization, and use information technology (IT) and the Internet as a strategic, tactical, and practical instrument. He also thought that the care would be far cheaper if it was delivered from a professional perspective instead of a market or economic perspective, and, more important, the level of care should improve and nurses would “get their profession back.” He started with one team of nurses in January 2007. The GPs supported this idea, and within a year 12 teams in different places were working this way. The reactions were very positive, and even Prime Minister Balkenende visited Buurtzorg and took it as an example for the future of home care in Netherlands. Buurtzorg did not need to market or to advertise for nurses. At the end of 2010, almost 3,300 nurses were employed throughout the country in 330 teams taking care of 40,000 patients a year. Buurtzorg became the fastest-growing company in the Netherlands. It also won a prize as best employer of the year. Based on research done by Ernst & Young and Nivel, there were some remarkable results: the costs per patient were half compared with other homecare organizations and the satisfaction rate was the highest in the country.

### PATIENT CASELOAD

The nurses on the teams are all highly educated. Almost 65 percent have bachelor degrees and are able to take care of any kind of patient who needs care at home. Buurtzorg delivers care for:

- > Patients who are terminally ill

***The organization's philosophy is that you don't need to control professionals; all relationships are based on trust and respect. Therefore, Buurtzorg is a value-driven organization; we all share the same values, the so-called DNA of Buurtzorg.***

- > Patients who come from the hospital after surgery, have cancer, etc.
- > Patients who have chronic diseases
- > Patients who have dementia
- > Patients in vulnerable situations with comorbidity

The nurses are generalists who can handle activities from low-level care to highly technical care such as infusion therapy and palliative care with morphine therapy. To get a good picture of the patient's life, the nurses also help with personal care if needed.

The nurses of Buurtzorg see it as their professional duty to enable patients to lead a normal, independent life as long as possible.

So they use all the available resources in the environment of the patient, including family, neighbors, or even volunteers to make patients less reliant on the nurses' care. Of course, such an outcome is not always possible. Chronically ill people and patients with dementia sometimes require more care. But even then, with good guidance and support to the family, it is possible to deliver less nursing care than other organizations are delivering, with better satisfaction rates.

If we compare Buurtzorg with other organizations, the various patient groups are divided differently. An average home care organization has only 10 percent of nurses with a bachelor's degree. Because of the higher education of its nurses, Buurtzorg handles many complex care situations with patients who leave the hospital, terminally ill patients, and patients with comorbidity problems.

#### **HOW DOES BUURTZORG WORK?**

Buurtzorg is a nonhierarchical organization. Teams with a maximum of 12 nurses take care of a neighborhood of 15,000 residents, working closely with the GPs and other primary health care workers such as social workers, physiotherapists, ergotherapists, psychiatric nurses, and informal caregivers. An average team supports between 40 and 60 patients at a time. The nurses take care of the assessment, planning, and coordination of the patient care and discuss the continuity with one another. Every patient has a personal guide. In weekly meetings the nurses discuss the patients, the cooperation with others, and the organization of their work. There is no leader within the teams; they work on the basis of consent. Everyone has to take responsibility.

Registration of patients' information, time registration and communication are supported by a Web application called the Buurtzorgweb. The nurses can log in when they want—some do the administration in the evening at home. They can find all the information they need on the Buurtzorgweb and communicate with colleagues from other teams. On different patient groups there are expert groups—nurses who have a certain specialization and develop standards for Buurtzorg as a whole. The web works as a real community. Because of the web and the self-supporting teams, no managers are needed and the back office is very small: 20 employees for 3,300 nurses. The organization's philosophy is that you don't need to control professionals; all relationships are based on trust and respect. Therefore, Buurtzorg is a value-driven organization; we all share the same values, the so-called DNA of Buurtzorg. Most of the professionals who work in health care want to do their work as well as possible and are intrinsically motivated.

The nurses want to be accountable for what they are doing, for the patient but also for each other. Buurtzorg built its own quality system on the basis of trust and professionalism.

The teams can get support from a coach. This coach can support 30 to 35 teams. When a new team is starting, the coach helps this team to recruit new colleagues, learn to use the Buurtzorgweb, divide the different roles in the team, and build their network with other caregivers, both formal and informal. In this way every team learns how to deal with problems it faces and develop an excellent, mature team. The role of the coach is also to support the teams so that they can find their own solutions. Each team

is different and may have different solutions. Most important are the results: for the quality of the care, the satisfaction of the nurses, and the financial results.

### **BUURTZORG AND QUALITY: SUPPORTING REFLEXIVE QUALITY**

Until a few years ago, every health care organization had to have a quality system based on the ISO (International Organization for Standardization) systems of factories. A lot of these organizations became a bit like factories, thinking this was the way to organize to deliver good-quality care efficiently.

Buurtzorg believes that the quality is made in the relationship with the client. So highly educated nurses who reflect on their work with colleagues are a better guarantee of quality care than describing all the processes in detail. Of course the processes have to be adequate, but reducing complexity reduces the chance of failures. The primary process in elder care or community care is quite simple; we should keep it that way. The quality system of Buurtzorg is based on three perspectives:

1. The experience of the patient
2. The effectiveness of the professional interventions based on the Omaha system
3. A national standard for quality indicators

The activities of those three perspectives, together with a description of the different roles in a team and the organization as a whole, comprise the quality system. The quality system is continually evolving and is fed by the nurses themselves. It leads to standards and best practices for different patient

groups. The system can also be used as an instrument for benchmarks.

In 2010 there were different discussions with insurance companies and the Ministry of Health to make the Omaha system a national standard. The Omaha system, developed in Omaha, Nebraska, is a classification and intervention model. Using this system can deliver data for developing high quality standards based on experience of the nurses.

### THE ORGANIZATIONAL STRUCTURE

The organization is built on the principles of self-organization: self-steering teams, coaches who support them when needed, and a back office that works as a help desk and takes care of administration. The IT solutions are bought as SAAS (software as a service). Buurtzorg pays the IT company a certain amount of money for every hour of care delivered.

There are three policy areas: operations management, innovation, and quality and strategy. A team of three directors take care of the main strategic and tactical questions, most of the time with considerable influence from the teams on developing strategy. There is no management team, and most of the meetings are informal—remarkable for an organization with a 2010 income of 80,000,000 euros and 130 million in 2011.

The cost structure is quite simple: For the most important costs we put a norm and connect it to the income per hour. For example, we get 56 euros per hour from the insurance company: The money we pay for housing may not be more than one percent of the turnover. In this way all the teams can easily count their own results and know that their

productivity should be approximately 58 percent. So everyone feels responsible for the results: as a team and for the organization as a whole. The financial result/profit in 2010 has become 8 percent of the turnover.

### OTHER INITIATIVES BASED ON THE SAME PRINCIPLES

In 2010 Buurtzorg started Buurtdiensten. This is the home-help part of elderly care. In the Netherlands, 2 percent of the citizens need some kind of home care. Of this 2 percent, almost 30 percent get a combination of community nursing and home help care. Buurtzorg wants them to work closely with each other on the neighborhood level. So they use the same housing facilities. In 2010 we started with 25 locations. The principles of organizing are the same, although the education level of the nurses is lower than in Buurtzorg. Buurtdiensten helps patients with cleaning and some support in daily life. The intention is to start Buurtdiensten the way Buurtzorg started in the past. **A**

#### Jos de Blok



Jos de Blok is the Founder and Executive Director of Buurtzorg Netherlands. Trained originally as a nurse, he has worked in the health care field for over twenty years, both as a community nurse in home care, as well as, in several senior management positions including three years as Director Innovations/(para) medical services.