

# Interviews transcripts

## Consultancy report Welzijn op Recept

\*All interviews have been conducted in Dutch. The transcripts have been translated to English which can lead to unclear and out of context phrasing.

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## Interview with Ingrid Hertogs

**File:** Interview Welzijn op Recept-20211115\_100241-Opname van vergadering.mp4  
**Duration:** 45:00 Minutes  
**Date:** 15/11/2021

Gijs Latten: Welcome Ingrid, thank you for coming. I will get my questions. We will go through the questions, and you answer them and if there are any more questions, I will go further into it. Okay, are you aware with the intervention, Welzijn op Recept?

Ingrid Hertogs: Yes, I participated in soundboard group some 3 or 4 years ago and therefore I am enthused, just like yourself, thinking that there is a great potential. Since then, we have a close collaboration with the people of WoR in Schiedam, and we've started a project as well to make the wellbeing come more to its own together with the social district team in Schiedam.

GL: Yes, all right and you are in direct contact with Jan Joost or Miriam as well?

IH: No, they are more present in the background. Sometimes Jan Joost will gather some information about how it is going, and he gives some advice and tips about the number of patients and how I could improve this. Usually, those are very useful remarks.

GL: Where are you active as general practitioner?

IH: In Schiedam.

GL: How many times a week do you make general referrals?

IH: To WoR?

GL: No, in general.

IH: Oh dear, I think about 15 times a week. But if you consider referrals to blood research is also a referral. Is it to primary or secondary care?

GL: Every referral that you make. To get an overview.

IH: Actually, I think even more, like 20 times. To physicians, dietician, specialists. I am active in a special group; I don't see the easiest patients. That is important to know. I have been a GP for 20 years and I have got a GP in training. So, the assistants can subtract many things that they can resolve themselves. So, I have got the more the complex cases.

GL: And what kind of, if I can say it like this, what kind of specialisation do you have?

IH: I think that I am good in distinguishing the link between physical complain and other factors like stress.

GL: Okay, so that I connected to recognising psychosocial complaints?

IH: Yes

GL: So, you think that you are able to recognise psychosocial complaints? So that you are able to make the distinction when someone has psychosocial complains or just pure physical complaints that are not rooted from other causes?

IH: Yes, that is learned in our study to become a GP and it is the question how much you will do with that. I am educated in Maastricht as student medicine and there is that two-track policy implemented from year one. For my it was more of a second nature and sometimes you see with colleagues it gets reduced.

GL: Do you think that there is enough attention during the study in order to recognise psychosocial complaints?

IH: Yes, I see that In the GP training there is lots of attention to find out what the reference frame of the patient is, where he/she comes from. I have a GP in training for two years now and you can see that those are the topics that are being trained. Yet, I do find that those GP's in training see a very different population of patients than most GP's in training because I work in a deprived area. Therefore, they see heavier problems. It is really different.

GL: And if you make that comparison, do you see that back in the psychosocial complaints of those different groups in relation to your own GP's in training and those that don't work in deprived area's?

IH: I don't understand the question. Could you repeat it?

GL: You mentioned that those GP's in training come from a different environment than your own work field. Do you see this in the psychosocial complaints and the experience that they have in comparison to your own?

IH: I have been lucky. Both GP's in training are open and interested in psychosocial complaints. I could be that the study emphasises this in a good way. Actually, when you start as GP, it is nice to have someone that has a complaint like sore throat, very clinical. Thinking what could it be and what kind of research should I do. You can spend a lot of time doing that but it is also nice if you can broaden that and look for other factor that could play a role that could be the cause of that complaint. That is definitely something to take into account. GP's in training are very focused on the clinical part and the observers, GP's that have just finished the study, have issues with this. This is something that requires attention in order to ensure people will start referring to WoR. Because they are so focused on the complaint and what clinical procedures are linked to that. If they can identify this, they are very happy and the other underlying factor get forgotten. This is easier for GP's that are more experienced.

GL: That makes perfect sense. How many times a week/month do you refer someone with psychosocial complaints?

IH: To GGZ or to..?

GL: To well-being organisations

IH: Well, a week I think twice. I would prefer even more times.

- GL: Considering the talks I had with Jan Joost, that is considered quite a lot.
- IH: I think now it is between 1 and 2 times a week, but I have been doing this for 3 years already. So, that makes it a little different. I have 3 contact days with patients instead of the usual 5. I really have to be locked in and focused because sometimes afterwards I realise I should have discussed this now and now I have to discuss this the next time. Actually, in the practice we should make distinction in the focus of different groups of patients. Besides that, I am busy to include practice supporters of the GGZ in the process. They also observe a large group of people, where for example diabetes is uncontrollable, and where they think that it doesn't matter what I say I will not improve. And those are the people a practice supporter should think, wait a minute, we are not going to talk about the diabetes. We are going to talk about what is necessary to be more physically active. If someone has other factors that play in their life it is important to focus on those first.
- GL: Basically, regaining that piece of wellbeing that is being blocked by those underlying factors.
- IH: Yes, I would like to expand that. I am the longest setting GP at the moment, that is a challenge for me. How do you ensure that the younger GP's pick this up more quickly?
- GL: All right and are there some things that you specifically do to ensure this to create awareness with these younger GP's?
- IH: Yes, but this remains difficult. We have made a video about WoR, we thought this would be easier to understand and that I would be more personal than reading. Furthermore, in a form that I show. Yet, I may still be too little and unstructured. I wrote down some things about how do you ensure that this is embedded in the practice. To learn a new GP what to do. There is already so much happening for such a new GP.
- GL: Yes, I think must be repeated. You said that you also sometimes afterwards think about actions you could have undertaken. It is important to have that constant focus on the problem and have it link back in the practice maybe by hanging a poster of the steps needed to make it visual as well. A video is also very practical however I reckon it should be repeated on multiple levels.
- IH: Exactly, then you have to try, I am 52, I try to do step of all the written stuff and go more digital. My younger colleagues work more digital so they will not return to use all kinds of papers. So, I have to think about how they do that with processing information.
- GL: Definitely, and I assume to you use referral system Zorgdomein?
- IH: Yes, that is true for every other referrals but not for WoR.
- GL: No exactly, that is also the bottleneck at the moment between primary care and the referral to wellbeing care. Another thing I wanted to ask is if you ever refer patients from which you think that they have psychosocial complaints to other institutions?

- IH: In the practice we have POH/GGZ which is an easy solution for psychosocial complaints when we think a psychologist is needed to we need extra advice and that means to make someone ready for a referral to the GGZ. That is one piece and the other one is that there maybe much unclear about depts or other factors they get referred to the social district team. However, in January 2020 we started with the project social square. Actually, I want one entry point and after that more specific action is undertaken. We have made agreements with the GGZ that I just make referrals to the social square and we do that now through Siilo. The GP's fill in the form. We had a afternoon in which coaches and district team sit together and then we could basically take the patient by the hand and say that they have to be there and there and they would take it from there. Then , the lockdown began and then we decided that we would safely communicate through Siilo. We take a picture of the form which we send to POH somatic or the POH/GGZ dependent in which route to take and they put in the general Siilo environment. The GP decided if the matter lies in wellbeing or more related to the social district team. Another branche is the language department which tackles issues of people with language barriers. This woman who does this also has office hours in the practice, so she is also involved in the discussion.
- GL: First of all, very interesting to hear all of this. I am going to continue on with the questions in order to manage the time that we have to ask all the questions. With your main referral system, Zorgdomein, can you refer to wellbeing care? So, that would be no than.
- IH: No indeed. However, the municipality is working on that for three years and it should be ready by now because we made a deal with Zorgdomein. Only the setup on the backend is unclear. I don't know who is going to receive the messages, now I know who the message is sent to. Before we want to do this I want to know who will receive the message and who is behind it. How do I ensure that the patient ends up in the same group.
- GL: With Zorgdomein, so there has been arranged to make the link with wellbeing care?
- IH: Yes, that was the idea. I have not seen the proposal as of now but the option is there only there is no link to wellbeing care being that click. The problem currently with the social district teams. And the difficulty there is that the wellbeing is not part of the social district teams and is differently financed. How would they ensure that they will end up with the referral? It is a different organisation, in Schiedam that's DOC and that show the great division of all those organisations. In every municipality it is different. I want when you receive the referral, that you will deliver it to the right person. There has to be one exit after which it can be seen how to continue from there.
- GL: That's true. Obviously, we had discussion with Jan Joost about this extensively and that is something that repeatedly comes back. After the referral is made, there is a great division and that losses some communication and quality along the way.
- IH: Yes, definitely. Because of COVID we went digital through Siilo. When I get home I sent some documents and someone else will receive it in the evening meaning they are not at their workspace. That is a disadvantage. You get through Siilo things sent while not being at your workplace.
- GL: So, the best thing would be if everything will be put into one system.

- IH: yes, and that it is connected to the HIS which is not the case with Siilo. You have to you still have to fill something in on paper and typing that takes time. The good thing about Zorgdomein is that you have the data from the HIS which does not take much time creating more chances. For starting practices, that is an opportunity as they do this already.
- GL: I find it really intriguing about what you said about the Siilo app as that is one of the system that we are researching potential alternative. Also, the things the GP's would like to see and expect of such an app. Therefore, it is good to hear this from you as well. What are more thing that you expect from the Siilo app in order to make this app work as smoothly as possible?
- IH: Sometimes you must save in time because if you don't and come back to it, it will be gone. Not sure about how long the storage capacity will be. We keep another database in which we fill in and keep track of how many referrals we do and what is the complexity. Not really scientific. We do that from 2020 and see who refers and to where and you can see changes over time. That the age lowers and the the GGZ refers more. It is difficult to keep that data in the Siilo app. Another thing would be to have an option to say your out of office. Therefore, after activation you lose track because so many other messages come in. Such a feature would be useful.
- GL: It would make it more efficient and less time consuming and for the flow of the entire process.
- IH: Furthermore, you could think if it would be possible to make a connection, but people would have to link that back to the HIS so I don't know really.
- GL: Are you happy with the current referral system, zorgdomein?
- IH: Yes, I think it is a good system because you can, it can cost some time, but you can upload PDF. First I have to put it on my own hard drive and afterward delete it which is also not really efficient. I work on a server, but if you want to add to that that is possible. First that was not possible but it is now but that also takes a lot of time but I find it a good system in which you can switch things off and on that you do not want to include in your message. That is really important when you refer to the social domain, they are no doctors and with the GDPR that is critical to keep in mind. Some things have to be off, otherwise you risk making mistakes.
- GL: So, some sensible and private data that you can switch off and on and then send to the social domain.
- IH: You should actually have most of it off because what you want to send is the patient information, telephone, etc. However, you don't want to, and you want to know if a patient has any additional medical issue. Yet, this should not be automatically added because you risk sharing data that shouldn't be shared with the social domain.
- GL: Maybe a little bit too much
- IH: It is really important that we keep that in mind.

- GL: Yes, that is understandable as the GDPR law covers this with strict boundaries. Are you willing to switch to a totally different referral system if in this system the referral to wellbeing care is completely implemented? With a certain one click does all system.
- IH: I am not too sure about that. I have Siilo now and zorgdomein. I know that Vecozo is also working on something similar.
- GL: That is also one of the system we are further researching.
- IH: That seems intense as you have to monitor, and I know from my own motivation that I am enthusiastic but I think that my colleagues will totally not be onboard with this. Unless, they are already doing something with this.
- GL: Then you are talking about Vecozo right?
- IH: Yes, we now work with zorgdomein, Siilo and zorgmail and also with zorgmail you could chat but that doesn't work. I tried it on phone. You can also chat with zorgdomein but I just doesn't work. I have to do things for it that make it unpleasant to use. I haven't tried it in a long time now. Also, meeting through zorgdomein is possible but that also doesn't work very good.
- GL: So to say, the communication tools within the referral system could use some form of improvement.
- IH: I find it difficult. If you look at it from a macroperspective, Zorgdomein is too big of a player with too much power and can ask a lot of money so you actually want to split. However, for development sake it would be best if there are multiple parties. Yet, it is really difficult to make the change in there and the organisation as it makes it really slow.
- GL: Exactly, that is also the real question that we see as research group. Now, it is Zorgdomein who has to show willingness to change. However, they have the monopoly in the healthcare. Thus, must there be a change to a different system like Siilo or a new one like Vecozo? That is the question we as researchers are asking ourselves. Therefore, I find it really interesting to hear your take on this. Was it only in your municipality that arranged this deal with Zorgdomein? Or was it more on a national scale?
- IH: I know that the municipality of Schiedam has long struggled to finance it and they found it too expensive, but that is what I heard. You should ask that to them really. Before the summer there was an approval and at the end of august, we would see each other to talk about it. Yet, I haven't heard anything from them anymore. So, where does this leave us really in the progression. Additionally I would only be with the social district teams and not with wellbeing care because they don't have a contract and they are not sitting together. Meaning that it would still not be linked and unlogical. This all has to do with that division in finance from the municipality and the costs of Zorgdomein.
- GL: Yes because if the finance is not there for the wellbeing organisation it is near impossible to put the expensive Zorgdomein on it as there is a big gap in finance there. We also do interviews with the municipalities, and those things are coming to light there as well.

IH: And what also is really important and that I shouldn't forget to say is, which is currently not properly fixed, is the feedback from the person who you refer to and how does this person give the feedback back to you? And which medium could we use for that? That is a really big point of interest what still happens too little. Every time we talk about it and still it does not work.

GL: Would you say, I could refer more if it is clear to me what the effect of my referral is to the wellbeing care?

IH: Yes, that really helps. Success stories for example which are mentioned in the manual or this has gone to plan and then you think to yourself that it has effect.

GL: And that should also help with the overall awareness of the whole intervention. Do you have not feedback at all at this moment? How does that work?

IH: I am once a month with the meeting where that is discussed. We first had a meeting once a week and now we have it once every two weeks as it takes an hour for everyone. However, with the next meeting this is a big agenda point as this should be much better.

GL: During these meetings, the feedback was discussed?

IH: Yes, that is correct. It is important to know how we note that down and ensure others get informed as well so that really is a big topic. You can also link back through the group chat, that is also possible. However, to get that in the system is time-consuming because when a lot of things are discussed in a group chat, it is difficult to look back for that.

GL: So that is also sensitive information than?

IH: Yes

GL: And with that information you should handle discretely as well with the boundaries of the GDPR law. Therefore it would be best if also that communication would be linked into one system where the initial referral is as well.

IH: You have to ask yourself, do you want to link that back to everyone in such a group or just to one specific person who ensures that it ends up in the file of the patient? For example, a note what says that it is handled by person x or person y. Because if you then look in the HIS you can see who has handled it and what the remarks are so you don't have to search in each different system for who did what and made what remark.

GL: So you mean when it is within the HIS?

IH: Specialists do this and that is an advantage, we get things in our mailbox and then you can choose whether you put it into the patient file. So, that is really good to see and that is then again linked to Zorgmail.

GL: Do you also have talks with patients that you referred to wellbeing care after they have been there?

IH: It is a bit more personal. The GGZ has this talk with the patient more frequent. Pre-COVID, we had once in every six weeks such a meeting. It is really pleasant to hear about this. I usually text the other parties about how a patient is doing and if he made it to that party.

GL: That is understandable. It doesn't seem really personal anymore when you don't receive feedback from it. I reckon it should help to create a little more awareness to give younger GP's more awareness about this.

IH: Yes, I totally agree. I am writing it down because I had a few other things as well that I wrote for another matter like the feedback.

GL: We heard this from Jan Joost as well that the feedback a big issue is.

IH: Yes true

GL: So, that makes it an important piece of a potential new system or the current system that is Zorgdomein that we will advise as research team. Therefore, we will use these interviews to highlight those important points and that those get taken into consideration when a new system is introduced or an altered version of Zorgdomein.

IH: It really needs to be structured care. It shouldn't be dependent on all kinds of subsidies. It should be a way of life.

GL: Yes exactly. We talked a lot about different systems. You use Zorgdomein primarily but also Siilo and Zorgmail. Do you write stuff down as well to make notes or to document things?

IH: The documents that I need to fill in, I store those.

GL: All right, and imagine that all those matter would be implemented into one system, do you think that you would gain a lot of extra time from that if all that would be integrated into one system?

IH: If it would come from the patient, but you could also turn it around with the environment of personal boundaries. If you think from there you could come up with somethings. I would be pleasant if it was in one place and I don't have to search for hundreds of documents to find the right information. That takes too much time because we have a lot of patients. It would be best if the ICT side could be solved in a lean way.

GL: Right, if you see x number of patients in a day, there is not much time. Apart from the fact those are all individuals with different complaints and problems, it is extra time consuming to use all kinds of different systems to look for the right information.

IH: You really need to do as much as possible from the HIS. I think the HIS should be the basis of a unified system.

GL: It clearly should be the basis of a referral system as the information is stored in there and from there the link should be made between all lines of care and not though all kind of different systems.

IH: You need the grant, we added this to our forms, and sometimes I forget that as well because you have a conversation in a different setting. I send myself a reminder to fill this in, when I have the time, I try to do this with the patient present and I have to take a picture of it to add it into the Siilo app. All that in the 15 minutes that you see the patient. Therefore, sometimes I do those things afterwards and sometimes you don't have the permission of the patient. So, we are getting more used to implement this into our consultancy to do those steps. So, there is still something to gain in terms of a smooth process that could be achieved through a unified system.

GL: It obviously takes time to get used to this. You are talking about the use of the Siilo app then?

IH: Yes, that is how it now goes.

GL: And you have been using the Siilo app since January 2020?

IH: Yes.

GL: Okay, so it still needs some time to get used to it and how it fits in practice. Yet, it would be optimal if everything can be done in one big line one after the other. I can imagine that the way you use different systems is different as well and that is something you have to jump between every time. Talking about the ease of use, what system is of your preference?

IH: With Zorgmail I have to manually fill in every data. I have to make a letter in the HIS and have copy paste that in Zorgmail. That just takes way too much time and it makes me very annoyed. Within Zorgdomein, this is all much easier. I do almost everything through Zorgdomein except when patients don't have an email address, then I print it for them. I try to do as much through Zorgdomein.

GL: That is a really clear answer. And the use of the Siilo app, is that in terms of ease of use, is that user-friendly or are there also things that you think should be different?

IH: You can't send the data. For example, when I have a meeting with a specialist, I open the app on my desktop to make the text larger. Then I can copy paste a document into there but you still have to manually input the personal patient data. So, that is not so pleasant. The advantage is that you can call through the Siilo app. I really like that feature.

GL: You can call the patient in the app?

IH: No, to the specialist. You don't always have everybody's phone number but when you have the Siilo app you can figure out the contact data of that person.

GL: Oh okay, so that is possible within the app.

IH: Yes, through the app contact is made. Sometimes I think, I must have contact with this person and I call them through the Siilo app.

GL: That sounds real handy indeed.

IH: So, that is another advantage. To quickly make personal contact, not fact-to-face, but through the phone. It works really well for me. So, those things are complementary. For referring, is Zorgdomein real handy but for quick discussions and contact I find the Siilo app very effective. The disadvantage is that you manually have to input the data and you can make mistakes with typing the name or other data there as well.

GL: Are there any other systems that you have worked with? And what is the reason you have chosen to work the Siilo app and have you considered other systems as well?

IH: With the start of COVID, it was sort of a brainwave to go for the Siilo app. As it was a safe way to pick the communication and referring up and thus, we chose for Siilo. We didn't consider other systems.

GL: Are there other features with any referral system that you miss and that creates a real bottleneck? Are there things missing in any of the systems that you currently use?

IH: With Siilo, I know who the recipient and that is. With Zorgdomein, that is difficult. In the hospital it goes through an entry and gets properly divided. Nowadays, you also have an extra consultant who checks it in the hospital who you can ask questions on paper. That is a good way. From there you get a reply and gets added to the file. That is a big advantage of Zorgdomein. For such activities, Zorgmail doesn't work too well for that. You have to print it which is not practical. Furthermore, with Siilo, that is possible, but it gets complicated when people send a document you have to save it on your server and then upload it in the patient file. There are too many clicks in between those steps. I just want it in my to-do list. That to-do list is there everyday and ensures I don't forget anything. In all those other ways, there is more room for error. Thus, a big advantage of Zorgdomein.

GL: I think we can use a lot of information in our research. Thank you for the willingness to do the interview. The information you provided will definitely be included in our recommendations of several referral systems. We will figure out which will suit best with the wants and needs from different parties. We did a few interviews already and I think adding yours to the bunch will create a good overview of those wants and needs.

IH: Yes, very nice. I would like it to read your results.

GL: That's understandable. I will discuss this internally and you will get notified of this. The research will be concluded at the end of January, so you know when it will all be finished.

IH: All right, really nice.

GL: Thanks again for the interview.

IH: Your welcome, and good luck with the research.

GL: Thank you.

IH: All right, bye

GL: Bye.

## Interview with Tessa Lommerse

**File:** Interview Welzijn op Recept-20211208\_110151-Opname van vergadering.mp4  
**Duration:** 33:10 Minutes  
**Date:** 08/12/2021

Gijs Latten: Thank you for joining me and making some time for the interview. Then I will start by asking the questions and we will further go into the topics that are discussed.

Tessa Lommerse: Yes, that's okay.

GL: Can you give a short introduction of who you are and where you work?

TL: I am Tessa Haas-Lommerse and I am a GP in Kerkrade.

GL: Are you known with the intervention, Welzijn op Recept?

TL: Yes, we are currently with another practice participating in a pilot to see if it will be effective to apply in Kerkrade.

GL: For how long is this cooperating going on with WoR?

TL: A year, just over a year now.

GL: How is your general opinion about it up until now?

TL: Very good, I think this is a gap in the market for GP's.

GL: What are the advantages that you have encountered up until now?

TL: That the referral to the social domain is much easier now. Furthermore, you are aware of the feedback and how the process is going for a patient and how their feeling about it is. They also get more support for joining activities and other things.

GL: How many times do you refer somebody in general?

TL: Hmm, then I would be talking about the entire team at the practice, because the GGZ does it more often than me.

GL: Could you make a rough estimate of it?

TL: I think a couple a week, 1 or 2 a week.

GL: That includes the referrals to wellbeing care?

TL: Ahh okay you mean the referrals in general?

GL: Yes, the total amount of referrals made in order to get in overview of the total situation. To get a ratio of the referrals towards the social domain compared to referrals to the primary care.

TL: Of the entire practice?

GL: No, your referrals.

TL: Let me see, I work three days a week, and per day total amount of referrals I think two or three. It changes a lot actually, some days more than others. There are also days that I make no referral at all. On average I have to say two.

GL: It is more to create an overview of the situation; it doesn't have to be the hard numbers.

TL: No, I don't have those in my memory.

GL: That's understandable.

TL: And to the social domain, just for me. That is not weekly, but rather once a month.

GL: Do you know how to recognise psychosocial complaints? When a patient comes in the practice do you know how to identify the psychosocial complaint and distinguish them from other complaints.

TL: Yes, I believe I am capable of doing that. You never know 100%.

GL: So, you are confident you are able to accomplish and distinguish this?

TL: Yes I think so.

GL: Which referral system do you use? I assume that you use Zorgdomein as general referral system.

TL: That's correct, yes. (I use Zorgdomein)

GL: How do you setup the referral towards the well-being care?

TL: We use a form that we have gotten participating in the pilot. That is based on the national form of WoR. We put our own logo on it and altered the questions a bit.

GL: How does the form end up at the social domain? Do you send this through Zorgmail or another platform?

TL: Just through a normal email actually.

GL: Do you like working this way or do you want to see this implemented into Zorgdomein?

TL: In Zorgdomein would be perfect and I plead for that as well. However, there are some extra costs linked to that transition.

GL: Yes exactly, that is also something we are researching in our report. How much time do you think you are losing with the current way of working? And how much time do

you think you would gain when transitioning to an implementation in a unified system?  
Do you think it would be significant?

TL: I think about five minutes per person.

GL: Do you think you would make more referrals to the social domain when that option would be present in Zorgdomein?

TL: No, I don't think so.

GL: Okay, as a GP you see a lot of patients daily, weekly meaning that time is limited. What is the timeframe in which you see the patient?

TL: 15 minutes.

GL: Okay, and can you do all the things you want to do and ask and mention everything in those 15 minutes?

TL: Well, those five minutes I mentioned are for the entire practice. The assistant also endures work from this and I don't do that myself.

GL: Do you think that pressures the workload? That it could be easier if it could be solved through the use of a platform or Zorgdomein.

TL: Yes I do. I also think less mistakes will be made. There are certain steps to be undertaken before in is digitalised on mail. First of all, there has to be a form in the room. Secondly, you need to fill it in and correctly as well. Then, it has to go to the assistant. The assistant has to scan the document and send it on mail.

GL: In your point of view, do a lot of errors occur during that process?

TL: It does happen, yes. And a lot? What is a lot?

GL: Based on the number of referrals made towards the social domain. So, if that is not much to begin with and there are some errors than it can be concluded that the number of errors is significant.

TL: Yes indeed.

GL: What would help you in order to prescribe more wellbeing recipe's?

TL: What helps me currently is a folder about WoR as it is not something patients tend to decide on the spot. They have to think about it. A folder does help with that and it has to be really simplified.

GL: For the patients you mean?

TL: Yes.

GL: Do you experience times where you forget about the option about referring to wellbeing care using WoR? Or do you always remember it in the back of your head the option to refer to wellbeing care?

TL: Yes, because we have this pilot, I have it more in my head than another GP would have it. It does matter. I think if you look at other GP's, they would definitely benefit if it would be implemented in Zorgdomein.

GL: So in your practice, WoR is generally present there and all the GP's make use of it?

TL: Mostly with me. With other GP's I see it happening less often.

GL: Okay, is this than also discussing internally between the GP's? Do you mention that you use it and share your experience?

TL: Yes, definitely. However, it does not stick to them always.

GL: What do other GP's think about it. Are they excited about or what is their response on it? And what is the reason they might not use it?

TL: What leads to this situation in my opinion is that they do not receive the feedback. I see that more compared to them as I am more closely linked in the feedback by the wellbeing coach. What also would help is if there was to be a feedback loop in the mailing about the patients.

GL: How is that feedback loop in place currently? How do you receive feedback about the patients you refer to wellbeing services?

TL: Currently, in our practice our contact from the GGZ has a feedback meeting once every three months in which they have a conversation with the wellbeing coach.

GL: Okay, so that is then afterwards discussed with you as well I assume? About how those experiences were.

TL: I ask that myself as I know when those meetings are. Sorry I need a minute to give some attention to my child, I am sorry.

GL: That is no problem, take your time.

TL: Sorry, I'm back.

GL: All good! To continue, the patients, do you notice that they are aware of WoR or rather that they have no clue what it entails?

TL: No, do know very little about it unfortunately. That is the reason they have to think about it very often.

GL: Yes, that's understandable. That is the reason I'm asking as well. Would it help if the patients would be more aware about what WoR entails and what the positive effects for them as patients are?

TL: Yes, absolutely!

GL: In your practice, do you guys actively, apart from those posters you mentioned, try and bring more awareness to the patient about the existence of WoR?

TL: No, to be honest, we don't.

GL: Would it help if WoR offers more supplies like the posters to create more awareness about the topic?

TL: Yes, but I am immediately think about in what way they could do that. Yeah, I wouldn't know right now. We have a little text on our website but that doesn't get read very often. Most people don't look for it.

GL: I suppose then that I should be a bit more practical, more tangible. Just like something you use know in the form of the folders, to understand it more easily.

TL: Yes.

GL: Do you notice it helps if you suggest the referral to wellbeing care and you advice this to them, do you notice that this helps them in deciding?

TL: Yes, I do. Not directly, but it helps them to think about it.

GL: I can imagine that it is an important decision they must make at that point. If they know little about it, it will be more difficult for them to make that decision if they know little to nothing about it.

TL: Yes, exactly.

GL: So, there is a lot of hesitation from the patients if I hear this.

TL: Yes

GL: Is that partly due to mistrust or lack of knowledge?

TL: The trust is there but they are just unaware about it and know nothing about it. Moreover, they don't expect it that a GP shifts focus to that side of the care spectrum. I think it is mostly about that.

GL: You mentioned about the feedback that you receive, is there more regular contact with the social domain apart from the sending of the referral document?

TL: No, well yes now in the pilot you have twice a year an intervision to see how things are going. So that, but normally that is not the case.

GL: Do you think it would be wise to have a more frequent conversation regarding that feedback from the wellbeing coaches?

TL: Yeah, well look, GP's already get so much like schooling. Maybe in the form of a newsletter or something like that. To see what is going on and what is available.

GL: Okay. Now coming back to the topic of the referral system Zorgdomein. What are critical features you are missing within the system? What would you like to add to make the referral system more complete?

TL: To Zorgdomein?

GL: Yes.

TL: Well actually, nothing to be honest. I am really happy with it.

GL: Are you aware about other referral systems like Vecozo or Siilo?

TL: Yes, I know Vecozo, but not as a referral system. And the Siilo we use but not to refer but to quickly come in contact with the specialist.

GL: Okay, so you that as well sometimes?

TL: Yes.

GL: Does that link to the wellbeing services as well when using that?

TL: No, it doesn't.

GL: Is that a possibility within that platform?

TL: No, I don't think so. I am not sure, because it think you to be BIG registered for the Siilo app. Not sure if that's possible.

GL: Okay. In the practice, are there other care facilities present like a physician or a wellbeing coach to closely communicate with?

TL: No, there is only a pharmacist present. You do have a cooperation, not necessarily under one roof but with a couple of care institutions.

GL: Okay, does that cooperation work the same as the cooperation with the wellbeing organisations?

TL: No, not as closely. It is more from the need of the other primary care specialists. That is how it began in order to come more into contact with each other and so I joined as well. It includes, a physician, dietician, psychologist, dentist, occupational therapist and a GP.

GL: So, that is a more closely cooperation than with the wellbeing services if you compare them.

TL: Yes, that's true.

GL: What would be the reason for that, you think?

TL: Well, I think those are all smaller companies working alone and from that point of view wanted more contact with each other. And if you look at the wellbeing organisations, those are more institutionalised. So, I think that is the reason there is no initiative from there. While I reckon they could easily join the cooperation.

GL: Absolutely. What is for you the biggest bottleneck in referring to wellbeing care?

TL: I wouldn't call it a bottleneck, but I would be way easier if it would be through Zorgdomein. As there would be less steps in the referral process. Leading the less errors being made and less fraud sensitive.

GL: I get that yes. Currently, do you think it is too busy in your practice? We see too many patients and we need to find a solution to create more time.

TL: Too busy I wouldn't say but create extra time would be preferable but overall no.

GL: In your opinion, how would you be able to create more time for creating awareness for patients as well as other GP's to make them more knowledgeable about the topic and intervention?

TL: You mean that they would more swiftly think about it?

GL: Yes.

TL: I might seem weird but something that catches the eye. Like pencils or notice pads.

GL: So, something visible and tangible?

TL: Yes, something visible on the desk or something.

GL: You also mentioned those posters, I assume those are present in your practice.

TL: No, the folders you mean?

GL: Yes, those folders is what I meant, excuse me. Would something like a poster help as well?

TL: Yes, maybe in the waiting room.

GL: Would that help even before the patient enters your office, for them to think about it and get acquainted with it?

TL: Yes, that's definitely an idea worth thinking about.

GL: Obviously, it is difficult to make the distinction between psychosocial and other complaints. If you decide that a certain patient could best be referred to wellbeing care, what kind of comments do you make to this patient if you can share that with me here obviously?

TL: To prepare him for the referral?

GL: Yes.

TL: More about what the end goal is. That they are less at home bored and depressed. Less stress about thing going on in their lives.

GL: How do patients react when you mention this?

TL: Very different. Obviously, some feel nothing for it and maybe if misjudged it. And others react more positive yet still unaware about it. Yet, enthusiastic.

GL: Do you notice that patients have clue what it is you are referring to and mention a psychosocial complaint?

TL: Yes, that is very common.

GL: Do you think this creates a hindrance for the people who are less open for this?

TL: Yes definitely.

GL: Would that maybe be because it might hurt their personal feeling?

TL: No, I wouldn't say it like that. That is not the problem.

GL: You mentioned that there is more cooperation with primary care compared to wellbeing care. Therefore, there is the connection in Zorgdomein towards the primary care and not to the wellbeing services. Imagine there is a connection on another platform to the wellbeing care, are you prepared to work with two systems?

TL: Yes, as long as it is connected to the HIS it would be no problem for me.

GL: What are for you the criteria in such a situation?

TL: So, the connection to the HIS is important to exchange data about the patients. Yeah, I think that would be the most important.

GL: Would also the option to communicate through chat or something else be preferable on such a platform. Or maybe the number to call to quickly come into contact with the specialist that you refer your patient to.

TL: No, I don't think so. I should be a central contact person, I think. It would be clearer for everyone and if you know at what days they are available you can plan it with them.

GL: So, you mean a contact person from the wellbeing organisation to contact with you and the individual wellbeing coach?

TL: Yes, that is also a possibility, or the wellbeing coach themselves.

GL: Okay, so for you that would make no difference?

TL: Well actually it would make a difference. As the wellbeing coach knows more about the problems of the patients. If you make the call you want to know the details. And the contact person would probably know less about it.

GL: Exactly, and with that contact person in between a vital bit of information could go missing and the quality of care could decline.

TL: Yes.

GL: Okay that's clear. I have here the question about the satisfaction of the current referral system, but that was already clear you are happy with that.

TL: With Zorgdomein you mean?

GL: Yes.

TL: Yes, I am very happy with Zorgdomein.

GL: Regarding the social domain, are you as satisfied with that as you are with Zorgdomein? Or do you want it that to switch more towards the way Zorgdomein has it?

TL: Yes, that would be ideal. Especially if it is linked to the HIS. Then you have all the data in one place and saves time. Maybe also a standardised email format to send out.

GL: That would then be possible in Zorgdomein if I am correct, right?

TL: Yes.

GL: That would definitely be time saving for but also for your assistant who endures work from the lengthy process of referring to wellbeing care right now. What more things could you time with the time you save when the referrals wouldn't take as much time as they currently do? Like longer talks with patients or something else?

TL: The most time is with the assistant, so that would mean that the phone would be more available.

GL: You talked about the form when referring to WoR. You send that through email to the wellbeing services, right?

TL: Yes.

GL: Are there things the patients should bring as well or is everything arranged for the patient to go to the wellbeing coach?

TL: The patient doesn't have to bring anything. They do get a folder containing additional information about the process they are going through and the contact of the wellbeing coach, but the patient doesn't have to do anything with that.

GL: Have you ever experienced that a patient afterwards changed his mind about going to the wellbeing coach? So that he didn't go to the wellbeing organisation as he thinks that it is not what he wants after all.

TL: Yes, that the patient cancelled the appointment with the wellbeing coach. That the appointment has been made and that he doesn't show up or calls to cancel the appointment.

GL: Do you see that patient back in the practice after they didn't go to the wellbeing coach?

TL: Sometimes, yes. The pleasant thing with this pilot is that we do receive feedback which we didn't get at first. If the patient stays away, you have no idea what they might have done. If they even went or not at all, you just don't know.

GL: So, if there is no feedback link and the patient didn't go, you wouldn't be notified and have no idea that they didn't go?

TL: Correct.

GL: Okay but now this is arranged and now you receive this information.

TL: Yes, exactly.

GL: If I hear this, it is correct if I say that there is three months in between each feedback meeting, right?

TL: Yes, that's true.

GL: It seems to me that this also delays the process considerably.

TL: Those messages come through Zorgmail in the HIS and if that could be implemented just like Zorgdomein. That would be a good addition as that would speed up and simplify communication about those critical topics.

GL: If the patient comes back in your practice and you know that he or she didn't go to their appointment with the wellbeing coach, do you then talk about it with them and their reasoning on why they didn't go to their appointment?

TL: Usually I do, but it depends.

GL: What are possible reasons for patients to eventually not go?

TL: I think foremost the unknowingness about the whole intervention. They don't know what it is and say they don't feel the need for it.

GL: What is your reaction on this? Do you send them back to the wellbeing coach with a new appointment or do you leave it for what it is?

TL: I give a little more explanation about the intervention and the benefits for them.

GL: I understand that you can't force them to go. However, you keep informing them about the situation and how you diagnose the problems they endure.

TL: Yes, exactly or we try it another time. We let them come for regular inspection and try it again at a later stage.

GL: Do you think if they would go to the wellbeing coach and their psychosocial complaint would disappear, that they wouldn't have to come to you as often?

TL: Yes, absolutely.

GL: So, eventually, this keeps coming back to you what also could be resolved within, let's say, two sessions?

TL: Yes, but that is not the case with everyone. Not everybody is that easy.

GL: Okay so that will conclude the interview. Thank you very much for participating in the interview for the report.

TL: No worries, I just hope it will be useful for you.

GL: Yes, it definitely will be useful. We have now interviewed a couple of GPs and it is interesting to compare the answers given and see how this fits in with certain referral systems. It also shows us other bottlenecks the GPs endure during the proceeds of WoR.

TL: Okay, well good luck with the report!

GL: Thank you very much. Once again thank you for participating and have a good day.

TL: Yes, you too. Bye.

GL: Bye

## Interview with Tilly Groot

**File:** Interview Welzijn op Recept-20211215\_120329-Opname van vergaderingmp4  
**Duration:** 21:58 Minutes  
**Date:** 15/12/2021

Gijs Latten: Welcome and thank you for making time. I shall begin with the questions. Can you give a short introduction to who you are, what you do and where you are active?

Tilly Groot: My name Tilly Groot, GP in Aalsmeer. Busy practice with 6000 patients. 18 years I've been a GP in this practice. That is my job in a short intro.

GL: Sound busy. You are aware with the intervention Welzijn op Recept?

TG: Yes. Since two years.

GL: So, you are already more familiar with the way of working of WoR?

TG: Yes.

GL: All right, all good. How did you get to know WoR?

TG: Through our district cooperation connection. There it started and also through social work.

GL: How many referrals do you make in a week in total, so all referrals combined?

TG: To specialists and whatever?

GL: Yes, the whole bunch.

TG: Well, a whole lot, I wouldn't know. More than 100.

GL: How many of those do you refer to wellbeing care?

TG: Well, look we mention this in consults as well, that this exists. The referrals are not yet really easy to do. We can send it to an email address. However, that is still not in my habit of doing. Also, because some education about it missing. So, I think that I refer one a month to wellbeing care.

GL: Do you think that would be more if the option to refer would be more implemented in the system? I assume that you also use Zorgdomein as main referral system?

TG: Yes, definitely.

GL: Do you notice that the patients are less aware of the existence of WoR and what it entails and what they do?

TG: Presumably fear as they hear social care, they think they will fall into the poverty level and all that kind of stuff.

GL: Do you have this often when you give this option to the patient?

TG: Yes. Yes. They don't want to go there.

GL: Do you tell them what the possibilities are for them and that they will have to come to you less often as well?

TG: Yes, so the story about positive care is what we use in order to persuade them. However, there is little to no time in the practice to extensively discuss this. So, you have to plan another meeting with them solely to discuss that matter. Look, the negative image of social work is still difficult to get rid of.

GL: How do you think this negative image can be brightened?

TG: With us, they have changed to name to participate instead of social work. So, that brightens it a little. Moreover, I think it has to be clearer with your office and waiting room where the patients come. There has to be more visibility.

GL: I see. You mentioned a couple of thousand patients you have in your practice, right?

TG: Yes.

GL: I can understand that it is difficult in the short time you see the patient to make the patient knowledgeable about WoR. Do you think that stuff like hanging posters, folders around will help them make the decision?

TG: Yes definitely. I think it will help even more than digital. I feel it is more effective when you can give them a tangible piece of information.

GL: How is currently the referral process towards wellbeing services?

TG: I make an encrypted mail in which I write the name for WoR.

GL: We as research team, have had conversation with Zorgdomien as well. We have seen a demo presentation and there it was shown that there is a button to the wellbeing services. However, there are almost no wellbeing organisations connected to this. Do you notice this as well?

TG: I haven't heard that participate is connected to this. It would be nice if it would be. Obviously, they would have to let us know that they are available on Zorgdomein. I shall take a look right now and try to find it.

GL: It was a heading called wellbeing actually.

TG: Here it is, wellbeing and aids. Wellbeing and courses, lifestyle, other wellbeing questions, quality life care. So, there are a lot of lifestyle and wellbeing care heading on Zorgdomein.

GL: Do you also use that heading when referring on Zorgdomein?

TG: No, because I know that here in the area there are no institutions linked to that heading so it doesn't really serve a purpose right now.

GL: That's also the reason why it is still in the start-up fase as there are no actual organisation in this heading.

TG: Yes, exactly.

GL: What is for you the biggest bottleneck in referring to wellbeing care.

TG: That it is not in my routine, that there are no good folders to share, that I can't easily have to link to wellbeing in my mail and also my employees aren't familiar with it. It would be good if you would have a map per chamber where we have the aids for wellbeing care to give that constant reminder. You can digitally find it but if you don't do that it will quickly fade so it has to become part of your system. We are still very medical and that doesn't really help as well.

GL: Understandable. What do you think about the current referral system? So, that would be Zorgdomein. Are you satisfied with that system or would you like to see some changes there too?

TG: Yes, very happy with Zorgdomein. Only referring to wellbeing care, you need to send all kinds of not medical things as well.

GL: What are extra handles that need to be executed in order to refer to wellbeing care?

TG: You need to ensure that you have proper security for the emails. With sensitive data. With Zorgdomein you don't need to worry about that.

GL: Does all of the patient go with such a referral to wellbeing care? I can image that not all information is relevant for a wellbeing coach.

TG: No, you need to ensure you don't send everything with such a referral.

GL: Do errors occur during this process?

TG: Yes.

GL: What are the consequences of such errors?

TG: Well, that the wellbeing coach gets all kind of information that doesn't belong with them.

GL: Does that get linked back to you when this happens?

TG: Well, currently that doesn't happen as I only do a name and date of birth and phone number. But when it goes through Zorgdomein, you need to ensure that certain data doesn't get send with the referral to the wellbeing coach.

GL: Do you receive feedback about the referrals that you make towards wellbeing organisations?

TG: No, once per quarter there is a meeting in which some cases get discussed but still haven't receive any feedback.

GL: Do you miss this?

TG: Yes. Definitely.

GL: Would you say that it would help you and other GP's in making better referrals to wellbeing care if you know the results and effectiveness of your referral?

TG: I think so. I also think it should easily be found in the HIS. For example, a hobby or a plan of action which you can refer back to. The practice is still very medically focused and not really wellbeing focused.

GL: So, that would be something that you would like to see changed?

TG: Yes, that would be excellent.

GL: You mentioned that your practice is very full. So, I can imagine that the workload is high as well?

TG: Yes.

GL: What would in your point of view help in order to lower the workload?

TG: To lower my workload, it would help if there would be more district nurses, more GGZ care.

GL: Do you lose a lot of time communicating between those different parties?

TG: It is a catastrophe that the communication is so bad and there is little to no communication present.

GL: So, that would definitely be a bottleneck for your time?

TG: Yes, definitely. I think so.

GL: Do you see patient in your practice back a few times where you think to yourself, if they went to wellbeing care they wouldn't have to come here so often or maybe not even at all?

TG: I think if people have like a pet and socially interact more, they wouldn't need to come to me at all, so yes.

GL: What is in your point of view the number of people that could be helped by going to wellbeing care?

TG: The people who feel lonely, depression, inactivity.

GL: Are those people often elderly or middle-aged people or more younger people as well?

TG: Unfortunately, now due to COVID, I see more and more younger people with these problems.

GL: Do you see more younger people coming with psychosocial complaints?

TG: Yes.

GL: What are for example complaints that the endure?

TG: Mainly, headache, bellyaches. Those kinds of things. Luckily those have no physical reason but are signs of psychosocial issues.

GL: How do you enter such a conversation? Do you do research first or?

TG: Yes, definitely. We first make sure that it is nothing related to the body and if they start to come week in week out, I start by broadening the conversation and guiding them towards other ways that might help them, including wellbeing care.

GL: Do you notice that more elderly or younger people are open toward the idea of wellbeing care?

TG: That doesn't matter.

GL: If I hear this correctly. You see some patients coming back over and over. Would you say that you could save time here as well if they would come back on a less regular basis?

TG: Yes, I think so.

GL: Do you use besides Zorgdomein, other platforms as well to communicate, to refer, to quickly get into contact with a specialist?

TG: No, luckily has Zorgdomein filled this gap in the market so that I really nice as otherwise it would be a chaos.

GL: So, you don't use other platforms. You do everything on Zorgdomein and encrypted email?

TG: Yes.

GL: Imagine, there would be a platform that operates in the same way as Zorgdomein and they would have the implemented option to refer to wellbeing care. Would you be prepared to work simultaneously on two platforms or make a switch to another platform as a whole?

TG: Well, you know if it works the same as Zorgdomein by having the connection to the HIS with no extra clicks, then it wouldn't make a big difference for me.

GL: So, you say it doesn't matter for me as long as it is linked to the HIS?

TG: Yes. Because right now I have to setup the mail and copy and paste and that just costs a lot of time.

GL: You do that yourself?

TG: Yes. That is why it isn't done because it takes too much time and if you can do it in Zorgdomein, you have quickly referred someone.

GL: Are there other GP's in your practice that actively work with WoR?

TG: No, that is a bit of a struggle because as owner of the practice you are at the centre of it all and you need to send a positive message towards them about WoR but that is almost impossible. That implementation towards other GP's is difficult as it isn't implemented in Zorgdomein.

GL: Is that a decision per GP to choose and not to do it?

TG: Well, that is not a decision, there is just no time.

GL: If I understand correctly, the workload is so big that there is no room for these extra handles required for referring to wellbeing care?

TG: You could arrange extra education about it and relate points to it as well and then you would maybe get more referrals to wellbeing care.

GL: Sounds logical. However, in the practice it will be difficult as the workload is high already.

TG: Yes.

GL: Are you located in the problem area?

TG: No.

GL: Do you have conversations with other GP's in the practice about the wellbeing care? And what is their opinion about it?

TG: Well, they haven't followed the courses yet so for them to do this on the side is not appealing to them, so they stay in their somatic treatment. So, you would have to follow the courses in order to get the implementation.

GL: You mentioned that it would save time if there would be an easier and quicker connection to other institutions as the GGZ. Are there any of these institutions present in your practise?

TG: No. There is no room.

GL: So, solely GP's?

TG: Yes.

GL: How many GP's are located at the practice?

TG: Five.

GL: Okay, so they have a total of 6000 patients?

TG: Yes.

GL: Wow, that is a whole lot! Those are patient that are registered with you as GP and can come to you for complaints at any time?

TG: Yes.

GL: How many patients do you see in a day? Is that every 10 minutes someone else?

TG: Yes. That's 30 patients a day.

GL: I can see why it is important for you to have all that data on a central system which you can extract the right information from. Otherwise, it would be impossible.

TG: No that's true. Yeah, that's right! I have two minutes left as I have to be somewhere at 12:30. So, ask me one or two more important questions and then I need to go.

GL: Okay, I will look for the most important ones still left. Are you familiar with Vecozo from the health insures?

TG: Yes, I'm very familiar with it unfortunately.

GL: What do you think about that?

TG: Very bad! I have to make accounts and two-step verifications for all of my employees. It is something I don't like at all, no way! I am really against it.

GL: So, you are dissatisfied about it?

TG: Yes!

GL: Are you currently working with it or is it still a pilot?

TG: Unfortunately, we are otherwise I don't get paid.

GL: How is that arranged? Is it because the costs end up with the insurers?

TG: Yeah, Vecozo is the system in which you have all your contract with your insurer.

GL: So, you are sort of forced to use it?

TG: Yes, otherwise I can't pay my employees.

GL: Are they prepared to listen to you as GP's?

TG: Vecozo?

GL: Yes.

TG: No, not on an individual level.

GL: Okay then I think I have sked most of what I wanted to and it will still be useful to see how the answers compare to other interviewed GP's and what conclusion can be drawn from it.

TG: All right sounds good, I enjoyed it!

GL: Thank you for making some time for me in order to do this interview besides your busy schedule and good luck with all of the patients in your practice.

TG: Yes, no problem and you good luck as well with the report!

GL: Bye, thank you very much and have a good day!

TG: Yes, you too, bye!

## Interview with Marcel Hoogerheide & Jacqueline Tanis

**File: Interviews onderzoek Welzijn op Recept-20211104\_140936-Opname van vergadering**

**Duration: 61:25 minutes**

**Date: 04/11/2021**

Hidde van Poppel: Yes, thank you very much, great,

Marcel Hoogerheide: Give them a heads up already.

HP: Yeah, okay! Super! uhm. Okay, well then. uhm. Have a look, because it is. I actually have some different questions for, for, for both of you. erm. So maybe I'll start with Jacqueline.

MH: She's talking most of the time you will notice.

HP: Um yeah, good. So you already say you are actually with your feet in different organizations. I hear youth work. I hear older vital care. What exactly is your function in it?

Jacqueline Tanis: I'm a wellbeing consultant and so when it comes to Welzijn op Recept, that's the most important. Yes.

HP: Well-being advisor, OK, Well-being advisor and then how do you deal with. Are you dealing with referrals? Or are you more responsible for it everything organizational? Are you doing that organizationally?

JT: Actually both, because I am involved in the project group. So everything that enters goes through me. So if I get a referral, I get a notification for that. Even if it is for one of my colleagues. Because we have divided the cores (cores of wellbeing care) on our island per wellbeing advisor and there are still four of us now. So no, I also go a bit that the overall view I would say. And I. I can then tick live in VIP which consultant will continue to handle the referral.

HP: Ok, so that does. That you yourself. That you do yourself sometimes.

JT: When it comes to my core, I also take yes.

HP: Oh yes, well, very well. And then that is immediately a nice bridge to to VIP live. How? How do you get these referrals? How does that process of VIP live work? So a primary care provider who would like to refer you to your organization? How is this going to be? In its operation?

JT: Yes, we have. I don't know if that's part of your question, but at least made some sort of instruction card for the referral, whether that is to the doctor or the practice nurse. They have one of our laminated cards with the codes on which they can report. Then in the first instance I get an email that there is a new referral in VIP live. But apart from that, I can always log in to VIP live to see if that. Or that I am still up to date or that there are new references.

HP: Okay and and and so I assume via VIP live that is also all GDPR proof. And and and the e-mail, there is no data in it.

JT: Actually, the email really just says. I doubt whether the name of the GP is in the mail. That belief was expressed in the will in the e-mail to indicate which GP referred. But there is no client data in it.

HP: And what do you think of this system yourself? Because I hear that already. I hear from Jan Joost that it is a real problem for many wellbeing organizations. Referral or non-avg proof is possible because there is simply no system on site. But does this system actually do that well?

JT: In that sense it was also a solution for us because, we had previously collaborated with general practitioners, through which we get referrals from before we worked with Welzijn op Recept and it was always a bit of a frenzy of: How can we transfer that data securely to each other? So that was a godsend for us. So it will soon be good, although I also see problems in this system. That may come later. Um, but no good. So there is no GDPR data in the mail and I log in to the VIP Live site. And I also have an authorization code for that via my phone. And then I see all the references.

HP: Safe indeed. Yes, because a major problem we encounter is that until it is not in the daily system of a general practitioner to use a different system, GPs then Zorgdomein, Zorgdomein is so complete that they don't often use another system and that's why references might be too low. Do you also experience this yourself?

JT: I do notice some practices that are newly joining. Oh this I have to find out what it's like in VIP life. Most are familiar with it, but once the first referral has been made, it's good. That is also quite easy, because what I understand is on their side there is a link with their patient system, so that they do not have to retrieve the feedback live via VIP, for example. But I don't really want to be sure if that's the case, but that's how I understood it a bit.

HP: Well, maybe we'll hear that from GPs too. We are going to interview them as well, so hopefully we will certainly get more information about that. Because that is also an important thing, the feedback, how does that work?

JT: Or um, well, we just have an overview with references and then you can click through to patient level. There we see all the data so that we can make contact and you can click through and you also see an overview with actually briefly what someone's situation is or why the person is referred. And so it's a field of actions I'll just say. And then we can. I will only give feedback after I have already visited. We have agreed with the referrers that we will only provide feedback on that.... We want to keep that pretty concise. We work here ourselves with with with regicare in which I report extensively, and I do not continue that entire report. I will make a brief summary for the referrer with the data that I judge it to be really interesting for the referrer to read, for example not from me. I have made an appointment for a first visit. I'm not putting that in there.

HP: No, I get that. So you call Regicare that's where you actually shift and use the process and progress in the client's events.

JT: That's our client registration system on our side.

HP: Yeah okay um. And then, because I assume that started before the beginning process. But also eventually if such a client, as a client is hopefully cured or at least very far on the right track is almost out of your process, then I assume that it is all referred back via the same system.

JT: You mean to close it now or? I can link back as often as I want. One client is in the picture longer than the other and I think I can use feedback infinitely often.

HP: Okay okay, and then they just go to the doctor. That is also all GDPR proof. Then I assume.

JT: Or a good OK I have. With feedback I have an option to whom I say to whom the message is addressed. So I can. I make a choice for each practice to whom I send the message.

HP: Ok and what do you think. Do you find the biggest bottlenecks with this system? What are the biggest bottlenecks for you with VIP live and perhaps also with regicare?

JT: And yes, you mentioned that right away. The most important thing for us is that it's the kind of double registration. And we have no link with Regicare. So we really have to cut, paste around and shorten a bit to do each feedback in VIP live because there is no link. And what I sometimes find a handicap of VIP stays in, especially as the registrations increase, the list gets longer to find out what the status is of a certain referral.

HP: And and Marcel. What are yours? I think you are also quite familiar with VIP life, if I have understood correctly.

MH: Well, as a system less than Jacqueline. What I could do much more with was that there would be a feedback instrument and a referral instrument that is secured and that is in line with general practice. Look at first until recently. A few years ago, for example, the Zorgdomein did not have the functionality to link municipalities to general practitioners, but that is now available. And I expect within Goeree because there is also a great need for other projects. This can work from Zorgdomein of the general practitioners, because those reports are then correct. And now you often see that in this case, foundation Zijn, you have to meet the GP's interests. In the pilot, otherwise he really won't participate. And also logical. So you are very much in line with the working life of the GP. But because of this, the parties around it have a double registration. They would have had otherwise. Because if we hadn't had a connection via Zorgdomein or VIP live, then people would search via the Siilo app or in other ways to obtain a secure construction of both referral and feedback. And of course the same applies to e-mail traffic, because you now have that with VIP live and delivery at Zorgdomein can be arranged securely and a general practitioner is allergic if it is not secured.

HP: Yes, and it makes sense of course.

MH: That's not possible either. So slightly smaller parties who want to go with such a. Of course you can always call, but you can't do whole referrals with that. And that Siilo app.. Yes, it is used. I know that GPs sometimes use it among themselves and that some wellbeing organizations also use it. But that's actually for lack of better. Let me just stop there. Or it is limited. That is limited.

HP: Okay.. and a limited one. How, why exactly limited?

MH: I'm often on your phone or on the tablet and okay, that is a lot less convenient. Of course, you don't always work there. You do not see your entire report on your phone or tablet.

HP: I hear municipalities pass by here quite often. What exactly is your position within the municipality? How did you? I just heard a financing. I'd like to talk about that for a while as well. But how? What exactly is your point of contact in the municipality? How do you stand in the community and how? If I understand correctly, you are actually connecting municipal well-being coaches and primary care.

MH: Or well that was. That was not so difficult in this case, because the greeting was now the other way around. But at a certain point the municipality, together with the His foundation and the Grote

Zorggroep, formed In Op Goeree Zorggroep Haringvliet. They felt that something had to be done in the field of Welzijn op Recept. And then I came into the picture and then we started working together. So with us the congregation is always present. Municipalities paid, municipality paid and well-being. And so yeah. You have. You actually have all the parties on board that you want on board. Look at the costs and the costs for the municipality are not much different for the time being. They have not had to incur any other costs at this point. Am I right Jacqueline?

JT: No, not yet

MH: But that also has to do with the fact that I'm just connected there from support hours. And those are the ROS supporting hours. Hours that are free so to speak. And we did make a budget, because we also wanted to have a sponsor, a steering group and a sounding board group. And that that. You have to incur costs there, but we we. Now I believe I had a budget of 1000 euros for the past year. From November 1, 2020. Look what municipalities always want to look at is every euro I put into it. What exactly does that mean to me? Yes, that would be in early years. If you do a very, very, very good thing to think of a very large municipality, you might get between 60, 70, 80, and 100 references. Then you are doing very well. Yes, then you go to the municipality if you go by numbers. That will not make you warm. It is much more about the cooperation between all parties and then of course you often have a little later. It all takes a little longer before you see some results and you see the effect of closer cooperation. And that's often in other things. It is also possible that the GP, so not the municipality, is able to get rid of his patients much better within the care group. I just made that up. Then the municipality says, what's in it for me? Connecting municipalities is always a big concern. But at Goeree they have done that from the very first moment. And. And also, in thinking along, but also in and this should be more. And but maybe it's good to tell you why you also name this under the positive health. Because that is of course much broader, because that is what the municipality can also do. Something that is implemented in the municipality, that is, after all, what they stand behind.

JT: Yes our base is of course the municipality I mean they. We make performance agreements with the municipality on various subjects. And that's what this is part of now. But last year we didn't get any extra hours for that, so it's kind of at the expense of other things. So I'm looking at all the references we had that we had from. From the GPs who. Some of them were already there. Now we have connected a new practice from which we did not receive any references before. So then you can imagine that as a result we get more cases, which means that she has to make money on all sides. Then at some point you will indeed reach the point where the municipality says yes. Is that on. It's up to us to pull that cart? This is logical, but they do have an interest in ensuring that the resident of Goeree also turns out to be as vital as possible towards the future. So it is indeed already positive health. Was already on our map before the Welzijn op Recept was introduced as a project. It fits together very well and the municipality has them too. The municipality also sees the importance of that all healthcare parties on the island start working with that philosophy. And because it fits very well, also in the preventive field. So that fits together really well.

HP: Okay. I don't know how it is normally, because we don't have a lot of information about it yet. But it sounds quite unique that a municipality is pulling that cart so much after it came to be that they are so open and so eager to invest that funding in positive positive health or healing. And namely what I have heard and especially from Jan-Joost. Our information from which we have received our information so far, but that municipalities are very reluctant to do so because yes... In their eyes it is a cost item that does not pay for itself so quickly. I know of course it is very important that your residents are vital, but does that deliver bottom line? Do you know what that? It's hard to see in the short term. And then it would be seen as a cost. But I don't really hear it at all in this municipality. I don't want to say that. But the beginning is the start-up. It was actually very good that they were very open to that and that people really wanted to cooperate.

JT: Yes, that's true.

HP: Yes and is this? Do you see this more often in multiple municipalities? Or or do you say no, this really is Goeree has it.

JT: I don't have much insight into that, actually I did. No, I did look for how other municipalities work with Welzijn op Recept. But not so much the role of the municipality in this. Because sitting there is not important for me to know exactly. But I really like that the lines of communication with our client are short. Because, well, everything we do must of course fit in with the agreements we have with the municipality. So the more they provide space there and the better we can do our job. So that? Well, that's a really nice win-win actually.

MH: But a colleague that we've hooked up, an outside consultant. He has a lot of contact in the municipality of Nijkerk. Mariëlle Schipperen, she also said yes, it takes a lot of effort for us to involve the municipality. And that's it. So it's exactly what we just said. And that's also a way of looking at things and that's of course the same. If, of course, you have to deal with a (medical) prevention agreement within the municipality. Yes, you know, prevention is also such a vague thing. I mean, are you doing it? And what does it yield? A question about prevention. If you don't do it for a few years, then you also know why you should do it again in the end. So yeah, that always makes it a bit complicated.

JT: I think we were also just lucky with our contact person at the municipality who, for example, when we started working with positive health, she also participated in our training. So she's really dived in from a what does that mean? And there is and now even sees an opportunity for certain departments of the municipality to be trained in this way. Because if you want us to connect with each other, it's nice that you all work from the same kind of philosophy. And then I'm talking, for example, about departments such as the Social Support Act or yes, social affairs anyway.

MH: Yes, and what, for example, could be the very interesting development for a municipality. Look, we now have this pilot I said let's see if we can get it off the ground a bit. The focus is on 18+ and you usually get really older people. Now we are also thinking about it. That's nice for the sequel. And if we also go with 18- , we are already doing a step by step in which you can be a foundation if you open the floodgates in one go. Not all those registrations. So that would be very inconvenient. Plus the municipalities make their budget and of course also for the year ahead, so that's all you have to do. That is what played a part in such a (POAGGZ) youth foundation. He especially needs to know the field. And so there are a lot of young people who are not so much interested in an indication of whether there is some kind of conversation with a psychologist, but who can also often be supported by just people who listen to each other. Can that model of positive health or Welzijn op Recept? Or which links with exercise, sport or whatever you can of course handle. And if you continue to reason if you would also broaden it, you would, because there are also questions. Would medical specialists be able to join and treat older people. They come home to a hospital. The same goes for people with dementia. I mean yes, it must all be manned, so then there are a lot of opportunities to start from and then Welzijn op Recept becomes part of the total. Then there are many opportunities for a municipality, and certainly for a municipality as a Goeree, with people who are not so much inclined to seek help elsewhere on the island, but who prefer to stay in their place.

HP: I get that too.

MH: Yes, there is some logic to it. And the idea of those municipalities is that it is indeed also a bit of luck with that. But in the past we have had two pilots from the Kool and the municipality of

Hoekse Vaart, who were allowed to run twice and who was paid by the health insurer at the time. They won't do that anymore. A third time.

HP: I'd like to come back to that for a moment. And I can say one more thing. Personally, I am a huge fan of the prevention method and whether it is prescription wellness or whether it is another method. I think it can really be very important for the health of your municipality, of your population. Ehm, so one more time about municipalities. Have you? So do you have any contact? Perhaps you have some insight into how out in other municipalities these prevention things, prevention methods and way of and well-being are arranged.

MH: Oh yes, you mean by municipalities

HP: whether there is actually cooperation between these you, so your municipality and other municipalities with regard to, for example, information, alternation between well-being method, well-being and positive health methods. are preventive methods. Is there any cooperation there?

MH: Would I wouldn't know that from the council. And of course that will be some. But yes, that is of course a bit of an open goal.

HP: No, what I mean actually is more precisely the wellbeing organizations or those between the municipality. So now not the town hall itself, but the wellbeing organizations in various municipalities. Or that they work together.

MH: Yeah yeah,

JT: Yes. For example, we already have the wellbeing organizations that work with Welzijn op Recept, or in any case the healthcare professionals who work with Welzijn op Recept or positive health sorry. There is also a national platform for this, where questions can also be asked in which cooperation can take place. If there are new initiatives there where they ask for a response, for example, it is there and we match each other and sometimes we become. That's exactly how it happened this week. Then they plan to roll out elsewhere. And then they apparently find us to also spar on for example: how does that work in practice? And what did you run into? And how can we learn from you? And vice versa, of course.

MH: Yes, in a way that you can see on that national website that of Kennisnetwerk. Of course also have all those municipalities that are registered. Yes so yes. Look for example the Voorne-Putten and I think also Brielle. Yes there, the municipality is not so keen there, because it is more focused on the result. Well. How's that going to work out? Maybe another finance system, I have no idea. But you know, that depends a lot on the municipality. And that is also the question of how they are of course organized with each other. How? Look, if such a Welzijn op Recept going be much more important and used in a municipality? Instead of a controlled growth. Suppose of course you start focusing very much on Welzijn op Recept, then the municipality will have to think deeply about how to continue. If I get a hundred well-being recipes in one go, then I'll have to drop other activities somewhere else. So those the choices that a municipality stands for. Exactly exactly and that is of course interesting and exactly other municipalities work and then you really have to know how a municipality does that. Look and if you interview Mijs, for example, Mijs Broeders van Goeree. He is part of our project group. And of course he will also have consultations here and there. Or at least know from colleague municipalities how things are going. So may I hope. The intention is of course not all so to speak, that will not, will not be due to her. But everyone does it a bit in their own way, right?

HP: That's one of my questions actually, because we found that too. That it does indeed differ a lot per municipality in the way in which things are arranged and that it is. You have also experienced that, actually that is true?

MH: This municipality wants to participate for example. Joining consultations and showing active thinking. For example, we thought it would be nice if we could make a professional as a professional video with a GP in which we explain some more about Welzijn op Recept. Then the municipality would be willing to make some budget free for that. Well you know those kinds of things and just turn towards foundation Zijn. If we come up with some more wellbeing arrangements, we will still need or will be looking for some money. Yes, that is how it is looked at, but it shouldn't increase to hundreds more (well-being arrangements).

JT: Yes, no. And I also think because we now have a project group that we have been part of for a while and we get to know each other a bit better and we also know where to find each other more for say the by-catch or in a direction towards the future. If you know each other a little better and also know where you might get some expertise. That is in any case. For me it has worked in such a way that it has been very much lowering the threshold to work together, also a bit in the area around it.

HP: I think that is a key part of the whole success. In fact, those relationships that must be built. And that means between well-being and the municipality, well-being and primary care. And yes, everything in there actually really is.

JT: I also definitely think that Welzijn op recept has changed the perception on a wellbeing organization. For example, how a number of care organizations are looking at us. What we can mean to them and vice versa. And that makes it feel more like working together than before.

HP: Oh, I find that very interesting.

MH: Yes, also in professionalism. Like: wow, that is really a very professional club. Yes, so that. It always has been. But if that is not in the head or eyes of a care organization....

JT: Exactly and certainly as long as you don't have a collaboration yet. Then and then the thoughts you have about it cannot be undermined. I have often come across that clubs thought that we would be volunteers ourselves. So it's not professionals, but really a volunteer club. And that our offer was always related to the deployment of volunteers. Well of course that is part of our way of working. But fortunately, there is much more than that.

MH: Look. I think and I think Hidde that the strength will also be in the combination. I mean positive health is known on the island and embraced by GPs. If you're going to talk to a doctor about prevention, they'll say something good, but positive health, he understands that. Also made by the GP too so if that method is also part, as an intake interview model within Welzijn op Recept, yes, then there is... then of course you have a way in. Because otherwise you naturally run the risk that such a general practitioner thinks, just as often with mental health care. What are those guys doing over there with my patient? You know I'll send you then? I send to some kind of black hole. Then they will do something with it and then I hope it will be okay and then I get them back. Now you send them to a club, you know. At some point a club with which you can have secure contact. It does say something about your professionalism. Then subsequently, they also use a method that you know. You know, those are all. And and and and and things that confirm a success I think.

HP: Yes, certainly all the confidence actually I think mainly

JT: To give as an example. I came to work for the foundation three years ago. I tried to contact a GP practice, at least the practice nurse. And they were still very hesitant about that: yes, but don't you just sit there fishing in my pond as if we were competitors. And that is exactly the practice nurse who now says: how do those GP practices do it when they don't refer people to you? Because she says I really couldn't live without it. So. Well, that is a very clear picture of how that can change the moment you can work together and thereby also show in which area we could all be of added value.

MH: And in this context, it's fun again. It would have been nice too, but of course you don't know that when you do a study like you. Which would have been nice to interview us as a club, for example. Because in the beginning we had a discussion with the policy officer of the care group, who we really had to explain about 150 times what Welzijn op Recept was. Until at some point she realized. And it wasn't so much her fault, but the unknown. Until she got it right. And she now travels through the country as a kind of ambassador for Welzijn op Recept. So, she has regular conversations with the GPs. She drops the concept and then also knows names and numbers. Then, you have to be able to switch quickly. So if you want to do something with each other, you have to be able to call quickly or that people respond quickly to the mail. Well, we have that together, so that makes a difference because that actually means that the relationship of trust that the policy officer has of care group and that through that trust relationship the entrance is actually opened for Jacqueline, who then actually substantiates what is already there. Well, and then also say that policy officer. But now Jacqueline also knows much better what how the GP's stance is and what they like to hear. It's like gosh. Wouldn't I also once at a Hagro or at some gathering? Or could you not even take a few minutes off for us to tell you something about Welzijn op Recept?

HP: Okay wow? I must say this is really very interesting and valuable information. No, I really mean that. It's exactly the things we're interested in. Do you know how? What are the initial problems in starting positive health and how does that process continue? I can well imagine that for a general practitioner or an employee of a care group, yes that it is just scary or unfamiliar at first. Yes, then I will not just let my patients out of my hands.

MH: Yesterday we had an interview and then we emphasized seriously. First of all, make sure that you have good feedback, so that it is properly arranged. You can, everything can still be so beautiful. And of course, if you have one or two referrals in a year, you can do it like this. And if you do the same at that practice, but first make sure that you have arranged that properly. And make sure you have a wish. Eight steps of John Kotter probably know from the study you should not look at that. It's actually about getting off. And that's not surprising, of course, but I think the first two are the most important. In other words, one sense of urgency is that we look at things in the same way and we also like them. And second are we in a guiding coalition or do you have one? But if you look at that project team now, that's a guiding coalition. They attract things, they also chase, they can also be critical of what is happening around us, but they can also say yes with each other. Let's first make a good impression, what we want, also a professional structure with a steering committee and a sounding board group. Not all that spectacular, because you have to keep it small and practical. Well, that's how we're all in it. Not too complicated, of course, however a great complicated project plan was written, but then a kind of implementation plan was made in which we simply do things together based on concrete actions.

MH: So it is so that's important. And what do we have for each other for your support? And do you have so many people who, as a yes, convey that to Jacqueline, to her organization Marie-Antoinette Westra to the care group and then the municipality, well, then that municipality comes. Of course, those people all know each other on such an island. That also helps. But there can also be a downside that you screw up though if it does. Then it is also so, isn't it? Yes, for example. There are also administrative meetings that take place at that time. Well, but that feedback from

those administrative consultations between the municipality, the care group. They are also shared. Because then you also know a bit about what is agreed at the administrative and management level. So in that sense you do have a view of the world around you. And if we make it even crazier, we have 9 months we were already working on that pilot and then we came up with a moment together. Let's not celebrate so much that we're getting started. And then what, then you still have nothing. When you start with something beautiful. Then you have nothing. But let's celebrate when we're off and on almost the end of the pilot and we're talking about a meeting celebrated with the alderman and a few other people.

MH: And also Jan Joost Meijs and in a PR a nice article on the site. That also says something about how the club looks there. So to things, just like they say in Rotterdam, don't talk but polish. First show that it's worth something. And the club has actually indicated very quickly. Well, if we think it's going to go a bit. So now the first 3 have 4 referrals within the first 3 months. Because of course you have to make the success factor very large. Then we actually already declare that we will just continue with the pilot. And so it is possible and the process steps from an evaluation and a report. And things like that too. But actually that has been the line from day one. Because you can't actually not do it because you've embraced positive healthcare and of course are also doing something on prevention and vital care. So you can't really say we won't do it, can you? And now you've almost contacted the whole island, haven't you, Jacqueline? (the GP's on the island)

JT: Yes, there is one that we have yet to address and then and the rest has all been referencing or. In any case, the conversations have been planned there because they have indicated that they want to join.

MH: Not all roses, of course.

JT: It wasn't so much at the start of the pilot that our goal was to have all GPs connected in that year. Our goal was to start more small and make that a success, so that actually the loss of the GPs who wouldn't participate yet, that that would be obvious. And that's exactly how it worked.

MH: Yes you, and we're also searching. So at some point we were able to find a grumbling GP willing to sit in the sounding board group. He liked that too. It is useful if you also arrange an evocation fee and so that. That is also part of the budget that the municipality has given and that you do not want the general practitioners for nothing, because they are asked for everything, but then they better start doing something else. So we do have one, we have also worked on each other, but of course that does not involve a lot of money. Well, that's really nice that such a doctor, who also grumbled a bit in the beginning, actually hangs a very nice story there, but is also very critical of: gosh, I am really a GP searching. How do I get that into my brain? How do I get to think about that? Because I have patients with so many complaints. Well what you then? But then you can also talk to him. Talk about further.

HP: And hopefully that will come with time. It's just really hard. That's for a GP to incorporate it into your methodology. Your way of working is just uncomfortable and I think that takes time. I still find it interesting. So of course you have the various parties, the municipality, the care group and so on. And if you are talking about such a pilot. What does that communication look like? Is that just? Do you all have different contacts in those groups who then simply consult with each other, e-mail, meet? Or is it right? Is it arranged in such a way that, for example, the well-being group that visits this really depends on general practitioners? does it all go together? Or is it really about a shared how? What does that actually look like? Or am I asking a very difficult question?

JT: Uhm, you have a very comprehensive question there. Uh, no, I think the core of the past year has just been our project group, so that we all contributed from those different angles. And Marcel

has also called us together every time and also looked at the things around it. How can we design properly after such an evaluation. Are we thinking about this? Let's think about that. So I thought that was really added value that you don't just do this with the performing parties, so to speak, but that there is also someone who knows a little bit overall and also better how things went in other parts of the country. And yes, we did not actually make very clear-cut agreements in this regard but shared with each other if there was a success. If there was a question, if there was one and one uncertainty, I think we always got along well. It's a small group. And I have always felt that it has always been super accessible. Marcel, you and I also regularly have an interval on Monday afternoons, don't you? Just uh, sit down and spar with each other. How are things going now? What do we have to do? What are the problems and how can we solve it?

MH: Well, for example, you also agree that you will only do 18+ within your pilot? Yes, then you happen to get someone in of 18-. Well, we do, we don't? Now you discuss that and that does not always have to be with the whole club together. You can also do that among each other. But I mean also with other parties. You can switch with Jacqueline or Jacqueline with me, but you can also switch directly with Marie-Antoinette or look. And then that will come back again in such a consultation. But not that exciting either. Yes, and for example we once thought what ever thought, should we write a communication plan? Well, at one point we thought; it is a lot of work though. And what we have, it actually works. And maybe we should keep it small with each other. So write down a few lines on one A4 sheet, but that you agree on that with each other. You can now also argue for a long time about structures and methods and things like that. In the end, of course, what matters is that such a pilot adds something to such citizens and to mutual cooperation. And there and then you come a little easier because I also visit the POH youth on the island and am involved. That pilot yes I will meet you again in this case the care group. And won't you run into Jacqueline? It is, but at least you know about it, there is a nice link to do. Couldn't we even talk about that for once? So explain those connections that are a bit easier. But we didn't. Yes, we do have formal agreements. Yes, logical. Jacqueline is going to contact her doctor, but...

JT: Whatever you just said, in practice it just would be. If I noticed that there was some resistance after all, then I realized that I was not as welcome to have a chat as I would have liked. Well then. Then the Marie-Antoinette of the care group that made it could clear the path for me. Yes, it is different. Or that you sell your own work or that someone else advises you. Ha, that's a big difference. Well, sometimes it wasn't necessary and other times it was. And so we have actually found a way to do this as optimally as possible without having agreed on that.

HP: Okay. Well, I am. I'm very good looking. How that goes makes it. I immediately think of my research, makes it very difficult for our research to give national advice when I notice that it is actually very, very local. A local process with me, but with only a limited number of people who you should like to keep close, build trust. And where you say we have actually hit our own way a bit. Learn as we go and keep it small. And I'm afraid it will be the same for every municipality. Is that: actually every municipality wants to find its own way? It has a bit of its own structure in it. We have to stick to that. That makes it for our research. Will it be very difficult to take a look? How are we going to make that a national advice for that? But it is very interesting information.

MH: Apart from that, but you also have. You also have, of course, those projects where they are very abrasive with the neighborhood team or not so much with the well-being worker but work together with advisors from the neighborhood team. You also have well-being packages that include sports, one calls it exercise on prescription and the other says yes, that's just from that construction and that way from that doctor. It is important for a GP that he only knows the front, he must know who can I contact now? People with psychosocial complaints or questions or other than what I can solve with my POH-GGZ in their general practice, where can I send them? And if

that's what the portal is for, Welzijn op Recept, and what happens behind it, he doesn't really care. Then we think that would be interesting for a GP. But we are not there.

JT: If I think in many cases there is now a health, say at the top of the trapeze and underneath there is everything. I think and then and that fits with well with Welzijn op Recept is that it goes down with well-being so that well-being comes at the top and health is below that and exercise is below that. But that is of course a subject that is quite sensitive. If you think of health and you think of physical health, well then that is quite a tipping point to see it differently. Then it is now and certainly for general practitioners that, I have actually experienced that. And that's going well now I would say.

HP: Good so okay okay. Yes No. I did indeed. For general practitioners, it is their bread (healthcare instead of well-being). And so, I can imagine that that's really the new way, so when well-being might be on top or that it. Yes, it just takes a lot of getting used to. Seems to me.

JT: Of course, it's nice if you can all just say that we won't need the plasters anymore, but that you will start looking at her much sooner. How do you ensure that plasters never have to be applied?

MH: But for your research there is of course a very large common denominator in it. You must have support. Here I have to get a club together. You need to make sure you have secure connections. You have to make sure that what you offer is also in line with the need for feedback. Well, you know, those are basically all of those things naming what you and the national advice is. Just like with so many parties. I don't know if you follow the (inaudible) waiting times a little bit, but do you know that? That is also. Do you want to do something about waiting times? Have you and no one can solve that alone? Need to know each other and understanding with each other, trust, collaboration, that's in your core. But I can imagine if you now retrieve information that you are overwhelmed, but, for example, a handbook that has written Welzijn op Recept. You have, of course, described all those steps. Look and of course also made a strategic choice by saying yes then the Welzijn op Recept as an instrument is of course not all that exciting. It's about working together. Well, that is of course a strategic choice. Because. uhm huh? It goes further than just uh, yes, letting someone do something with their own well-being and have some help with that. So, well, that goes on.

JT: In that sense you could say that a reference is not quite the right and proper term. At least that gives me the idea of referring to you and you're done. But this actually feels much more like a collaboration than then: a referral and you let go.

MH: And, for example, is the simple one-on-one GP practice with a POH. He has been in touch for years. That way with well-being. So yeah, that one is like is redundant huh? So double up? Yes, they are actually moving forward. And of course, with such a pilot that we are currently running. Are you going to measure a bit more on the result and monitor a bit more here, if of course it is added value, but in itself that is something that in some people, especially municipalities that are a bit smaller, there will probably be practices if well-being has not been completely reorganized to nothing. And if you then ask Welzijn op Recept that they think oh god are they going to do something else now? .... Yeah it is a nice assignment you have yourself.

HP: Yes, I certainly think so too. And I? I have also always a Miriam and Jan Joost of course also said that it really hopes it again really. I think you have a very nice assignment and therefore a lot of potential. I just want to be short, because I see that we are almost at the end. Or I don't know if you should go straight to you. But I just want to ask you a little bit about the costs. Because I assume that at the moment everything is financed by the municipality, except for the pilots that were just discussed. That was financed by the health insurers. Or what was that exactly?

MH: No, look, you got you. You have the support funds of the ROS. But of course, they are not infinite. Oh, so that, you can do that in a limited number. And the question now becomes: How do we go there now or further? And temporarily says it is useful if you have someone there who is independent in it. Then we talk about my role. But yes, how are we going to pay for that for the coming period? And how many hours is it? You can also look at that and does it have to be external? Do you have to finance that separately towards the municipalities, the municipalities? In that sense, he could be the client or the one who has to pay for it? But we have yet to talk about that. A health insurer is not in the picture. But I do believe in other places in other places, but that changes a lot, but not now, she says. So this is prevention. I'll just say, not healthcare

HP: Yes, yes, well that's that, I think that's one of the big problems with

JT: Although some GPs also clearly state in an evaluation interview, it relieves us in several areas, so to speak. But I don't know how that works with other municipalities or other well-being organizations that work with this. At a certain point there will also be a point where you can actually see that it also offers results for primary care, but that another party actually pays for it. We are now also going to anticipate the coming year to simply invest ourselves because we want to continue to prove that this, that this concept works and that all its manpower is insufficient to be able to handle the extra referrals next year. Well, then we're going to succumb to our own success. So then we move forward. But yes, in the end there has to be a party that will also finance it.

MH: They are too. They have, of course, been in talks for years. The VNG and health insurance Netherlands, in particular, take a look at the separation between zero-line, first line, second line and third line, because that will of course certainly disappear the connections. Everyone just calls out in the country, medical and social domain. But yes, that actually means that a lot of things are going from the medical domain to the social domain and with that, it would be very strange that the social domain would pay for all that and there will soon be a distribution key. But then you also have to be able to show that what you do adds something.

HP: Yes indeed, I will be saving the costs in the healthcare domain for a while by taking preventive action but those costs. In that case, the other domain should actually pay for the well-being domain, while they carry out the action correctly.

MH: Yes if you would rephrase it very simply.

HP: It is indeed very, very simply defined. Also from me. In short but ok yes.

MH: Everyone will understand if you normalize more, so no longer focus on illness, but on health and behaviour. That there will be a shift, if everything checks out, it will be cheaper. But yes, those who get that, so the municipality and well-being there, it costs more. They should invest more. Because otherwise it will not work, because then you will have that they say yes, and you will have to do a lot more that preventive field with each other. All are early detection and prevention blah blah blah. And if that doesn't work, yes it will automatically go back. Of course we don't all want to. Can't anymore. Yes, well, well, there are of course also those conversations between well-being and health insurers when I know that Jan, Joost and Mirjam do have conversations about that and that I think there are also pilots for those pilots about purchasing policy from the health insurer.

HP: Yes, we have to find an answer to that, do we want to, do we want to grow, do we want

MH: That's one more thing. Yes Yes,

HP: I'm afraid our research isn't going to find an answer to that.

JT: Haha come on, remain a bit ambitious.

MH: If the top is still.

HP: Yeah, well maybe.

MH: Maybe I'll tell you it doesn't go through.

HP: We have until the end of January, so I. I don't know if we're all going to fit that in, but I would too. We certainly will. We will definitely name it. That in any case.

MH: Yeah, but of course there's been a demand for the national ROS'en is my club. There is also a national demand from the Kennisnetwerk, so information is also coming your way. But then. Then I think you already have a nice job with the holidays

HP: Oh, but that's okay. We are already prepared for that. Then you just want to make a very good investigation for you and of course for ourselves.

JT: So yes. Win win

HP: Win-win. Well, that's how we see it. I still have some time for you. Coincidentally also interested, the social district team. How do you actually connect with that? And how that actually works in the municipality.

JT: Um, we don't officially have neighborhood teams yet. But because we do have our own village centers from a well-being point of view, we know the other care parties well, so to speak. Where we now meet is often at the GP, but I do see possibilities that there could be many more referrals from other parties. So and and that possibility is technically not there yet that also one and a physiotherapist or one, an occupational therapist or home care? Or I don't know much about any party. Could also refer this way but that is still. That is still in the future, but I actually see countless possibilities.

HP: Okay, good and. They are real, because that is still a little unclear to me. They are really completely separate from the well-being, your well-being organization. If I understand correctly.

JT: Apart from yes, of course we also contact them. And in the first instance we will actually also receive a referral, just first make an inventory of what is going on and see what the client/patient wants and our functions always have temporary functions. We take people with us for a while and that can be done at different intervention levels, but the intention is also to let go at a certain point. And if it turns out at the beginning that something else is needed than what we can do. We are not practitioners, so then we refer back again. But I think with a lot of Welzijn op Recept references such as the, if the suspicion lies there that someone has psychosomatic complaints and that you can solve much more by investing in that they get a certain meaning out of life or that they make their contacts or that they can work as volunteers themselves. Or just name which way you could go. Then we can just make that reference ourselves. Just say guide to the end. But sometimes something comes up during a conversation that the GP has not had time for and which means that we have to refer again.

HP: Okay, that's true, that makes a lot of sense indeed. Uhm, I'll have a quick look through my questions, but I think I'm. I have very, very much information. And of course, I am very happy about that. Umm, me. Yes, I honestly think that for now I just think that we can really make great progress. And maybe I'd like to ask the couple still coming here. After this, another question pops into my mind, then maybe I can send an email. I really appreciate.

MH: We really have if you really want to catch up on the content and functionality of VIP Live. Then we can also help with contact persons at the care group. She is very busy, but I think that she would like that now.

HP: Marcel, we would really like that very much actually. Because part of our research is analyzing the various referral systems. And we also want VIPLive. We actually want to analyze four or five of them and VIPLive is part of that too.

MH: Just wanted to send me a short email with a question about what you want. And then I'll pass it on to her. And then she also knows a bit where she stands and she can contact you directly. And then I can get away.

JT: I do have one comment about VIP Live just practicality. Let me know if that's what you're looking for. What is also a hurdle on our side of VIPLive is that we can really only see at a glance which references have been made and not the stage they are in. So I sometimes have to, especially now that the line has become long, but do I have to click, click, click through to see what the status is? And I think that is a handicap of the system as it looks on our side.

HP: Okay, it is indeed, that's very interesting too. Yes, no, this is what I think is very valuable to put the referral systems against each other like Zorgdomein, VIP live. We also need to know exactly, furthermore, to see which those were. Those were two we want to do. Yes, that that's super fine, this information really. I still see, I get even more out of it than I already had.

MH: Yes, maybe you should take a look at the email I sent you from Zorgdomein. I think there are also contact details in Felicia's Yap. For example, there are still a few people from the care domain who have already had an appointment in the region. And maybe they can also be interviewed...

HP: Wow super, yes, I got the email. I haven't really looked at it yet, but I'm going to sit down and think about it in a moment. Yes.

MH: Do you have to look now where I sent and then? Is something else. But I don't remember a general story oh, there are those people in it. And whether they want to put their contact details at the same time. But even that is the same route as you, say, I would also like to have contact with those ladies that I switch with them or I can pass on their contact details, then you have the right route. Then I can take a break

HP: Thank you very much for your effort Marcel, that helps me a lot.

MH: Well it's also nice to talk about things that are going well

HP: Well, those are the things you need to share!

MH: Exactly, you always get something in return

HP: Yes, great, I have to let it all sink in for a while and then pick it up further

MH: Yes of course, I will send the recording to you

HP: Yes please!

MH: Then I get two more emails, 1 from VIP Live and the other from Zorgdomein. But then you just have to see if you want something with that.

HP: Yes, great, I'm going to discuss that with my research group and then I'll come back to you eventually.

MH: Yeah that's good, put them to work. I may not email them until tonight or tomorrow but..

HP: Yes that's good, no problem at all, not in a hurry.

MH: No good, well Jacqueline see you tomorrow I think

JT: Hahaha, yes good. Hidde, good luck with your research

MH: You'll let us know about the results of the investigation, right?

HP: Yes, we want to keep everyone who works with us informed about our results. We may even want to write a publication. In addition, I would like to thank you very much for your time, effort and valuable information.

JT: No thanks!

MH: Yes of course no problem.

HP: Have a nice afternoon, both of you!

MH: Thank you too!

JT: You too Hidde!

## Interview with Ania Bugula

**File: Interview Welzijn op Recept-20211220\_134727-Meeting Recording**

**Duration: 32:36 minutes**

**Date: 20/12/2021**

**Hidde van Poppel:** Yes, no, that's more than good enough time. I'll try to keep it short. All right, so I had sent an email, so I'm doing research into Welzijn op Recept and above all: how can I improve the connection between the general practitioners and the wellbeing coach through the system? And what does that look like now? How is that going at the moment? There I want to interview you, I want to ask you that system you already use and what your experiences are like and how you just work. At this time? So I have some questions. First of all, my question is: what can they do in your daily activities as a well-being coach?

**Ania Bugula:** Oh well for starters: I don't just work on the welfare coach I am mainly social worker activities, coach, so I have very much functions. I am also a project coordinator, activity coach, volunteer work coordinator and well-being coach at Welzijn op Recept. So I'm very busy every day. How am I going to plan my day and I have now made an appointment with myself that I will have a few hours for well-being on prescription clients on Monday, Monday afternoon. Then I make appointments and register what is necessary. So basically Monday afternoon is my Welzijn op Recept afternoon. Yes, and what does it look like? As I said, I make appointments, very often walk appointments or actually also on home visits and I also had to update the administration what needed.

**HP:** Okay, okay, clear and well, I'm going to focus mainly on Welzijn op Recept today. How do you get your referrals through a system? Is that? Does that come directly from the doctor?

**AG:** We have started optimizing since this year, have been working on this project since 2017. Last year we received extra help from the Kennisnetwerk to put this extra on the agenda of the general practitioners, because I depend on referrals from primary care. So these are general practitioners, physiotherapists and pharmacists sometimes too. So we're trying to broaden that a bit. And how do we get them registered? We have agreed that they will report clients/patients. At the moment via Zorgmail, so you will receive them via email. No, I'm saying it wrong. We want to go to the Zorgmail, which is already doing it. That's how home works, that's how he already had a primary care doctor in Aalsmeer, but within the company Participe we are still working on setting up care, so to speak. . And at the moment we work according to secure mailing, so registered secure mail, so I get a very short referral from well-being, from referral via mail.

**HP:** And what do you think of the current system? So you want to go to Zorgmail. Why would you like that? What are the advantages, the disadvantages of how it works now?

**AG:** Well, the advantages lie mainly with the GP, because then they can refer directly from one system, say, and now that they had to, they are involved themselves. In my opinion, if they themselves sit in front of the computer and speak to a patient, then they can directly, say, forward that registration themselves and because that is not the case now, they now have to send them by registered mail, which is more hassle and I have received feedback from a GP that he collects those registrations and then gives it to those assistants. The assistant will only prepare mail to us with those registrations.

**HP:** Okay, and that's going to be, sorry and those extra steps, so that processing of that being removed is taken away when you start working with Zorgmail.

**AG:** Yes, it is for the general practitioners, yes, it is easier for them.

HP: Okay and and and for you, changed for yourself, or then a lot.

AG: Well, you know, I don't know how Zorgmail works, because we don't have that. So it would take me some time to get used to the new system. So for me it will only be extra actions, because at the moment, if I mail there very securely, then I only have a button with registered envelopes in my Outlook to e-mail registered so I get extra action. I then have to open Zorgmail. But I don't know how, how much additional work I watch, because I don't know the program.

HP: No, you can.

AG: You know we said we're going anywhere to sun just yet, so we're yes, we've said that, but we're not working on it yet.

HP: Okay, and you've never used Zorgdomein or maybe VIP live yourself. These are also referral systems.

AG: No, I don't know that one

HP: No, okay, good, that's all right, that's nice too, because I've talked to a lot of people who use those systems to speak to someone who isn't in them, does it in a different way. You say: there will be an extra action for care, mail for you and yes, it has been researched. Indeed, that GPs with the time pressure that you have to make it as easy as possible. Otherwise, those redirects will stay away. Does that make sense to you in this situation, that you should make it as easy as possible for the doctor?

AG: Yes, if I put it that way, I'll leave it that way. Indeed, well, we will undoubtedly also use that Zorgmail for social work and advice for the elderly, because that welfare coach, say, Welzijn op Recept is not the only project with which collaboration with general practitioners. As social workers, we also get clients forwarded from the primary care physician. So I think if we use that, then of course Participe will be widely deployed, so I can't tell you how it works. I hope that isn't a lot of work and that it just makes it more efficient. And what you just said, indeed, the estimate is that if that is easier for GPs, it will also yield a number of clients. That it is easier and refer them faster. I don't know, those are the estimates.

HP: Yes, yes, no, we have heard a lot in other interviews that it really depends on whether the GP is comfortable with it and whether it is in their head. Because how did you actually approach it to enter GPs, to make the referral method work? You say it all started in 2017, how did you approach it then?

AG: I only joined Participe last year, say so I didn't experience that 2017, I understood that of the team, that what, that everyone, who was asked to be a wellbeing coach. But we got that kind of in there, everybody in there. I have no idea whether colleagues have followed training or I do not know how you have implemented it at the time and I do not know whether GPs have done that. I do know that the first year was still fifteen, thirteenth referrals but every year it did decrease.

Yeah, it's not really further. Yes, picked up, I don't know how to put it into words, they don't know, let's say developed into a major project. And in the past year, the coordinator of primary care in Aalsmeer has submitted a subsidy request to the municipality. to be able to make the working method efficient, to make it attractive, to make it workable, to really map these out, to ensure that registrations eventually start flowing from the general practitioners. And that's what we did last year. I was then the appropriate person, from the team, who was the, who participated in all kinds of meetings and contributed ideas from the point of view of the well-being organization. Then a number of general practitioners also raised their hands, say, we also want to be included in that optimization and that has brought us a lot, I think. Because we do have closer contact there, where discussed together, under

the guidance of Kennisnetwerk and then Joost and Miriam also made steps. I also have a moment as a well-being coach, I visited all the practices that participated in optimization. The story explained how it works and always discussed cases. Do you know what it can bring, such a Welzijn op Recept, discussed anonymously. We came up with this method together and I tested it again with the GP, to be extra sharp. Take all sides off, because that is as good as possible. Yes, it can work and that has ensured that they now know what to expect from us. We have exchanged data, at the moment in Aalsmeer we have two wellbeing coaches, so not the entire team is responsible for this. Me and another colleague, that makes a difference and I really enjoy working together. Because then you can also look critically at the process that affects our well-being care. You know, then your sparring partner also has a less vulnerable project than if only one person is responsible for only two.

HP: Okay, good, because that's interesting. So those referrals actually decreased for a while. And now you have come a little closer to that first line, have you had consultations, do you have more contact and now, now that is growing again, or is that no data yet?

AB: It's definitely growing, so yeah, because that's only then. Look, of course we have corona that is also a very culprit, because of course we want people on activities and we want to be able to do volunteer work. But how if, when we have lockdown again, huh, so that is too. I think that would have been even better, knowing for sure if we didn't have corona and he's walking there. So in that sense there is yes, sometimes an upward trend. And now we don't have that many registrations again, but I see it anyway, positive and the numbers also seem to show that that has made a real difference.

HP: Okay, and then I really have the consultation with the GPs. New working methods that you both want to use. Yeah, talking about that, that's worked to keep those referrals too busy to boost anyway.

AB: Sure, because then it's clear. Again, I said, they know what to expect from us. We from them, they from us and personal contact, I think it's really crucial that you, when you call someone, I also didn't come to the GP practice every time, I also asked: can I just say you, don't you know, sir and madam, the GP are all people and just you personal contact on short lines and at an accessible level. Not from Mrs. Professional, a Mr. Professional, but just colleagues and I also call to discuss. They call to discuss. We know where to find each other, I have discussed all contact details with the different GP practices again. Who should I call? How do I call? How should I consult? Do you want flyers do you want digital communication lines you know that and that? That? That's a lot of work for me, but I also see it as an investment in the future and it works.

HP: Yes, I immediately believe that it is really an investment what you say if you can better build the relationship and then you can, you know each other better and then hopefully those referrals will also go up. Yes, okay, good, interesting, very interesting, and then a little more of your own method as you: How do you finally give, how do you share the stories of your patients, you get a patient from a GP and how do you give feedback to the same doctor? Is that possible now, because those short lines exist, easier or, because I think it is very important that a general practitioner knows what is happening with his ex-patients.

AB: Yes, well, we have agreed so we will briefly take you into our working method. So we receive registration by registered mail from the GP. We take initiative. So the welfare coach calls the patient for an intake interview. If we call or try to contact three times and we have no answer. Then we report back to that patient that he doesn't show up and you can't get hold of. If we call and he doesn't want to, because the condition is that they report that to GPs, people who are curious and may only be a little motivated, because you can't pull a dead horse. So someone must have had a conversation with the doctor and we said yes, I think I do like what I want to try on I like. Interesting. Well, those people just follow the trajectory when they start the trajectory, we email the GP of: we spoke to Mrs. Boot and the trajectory continues.

Well, then the GP knows okay, he has arrived and that project continues and after the trajectory has ended, we also email and can very briefly, very briefly summarize what has happened and .. That GP knows how the trajectory went. And if the process does not work, we also report that or if someone can also be, that they are registered, that this is not Welzijn op Recept after all, but, for example, social work that someone has a lot of problems and that there is still no room is for social, social activation or activities, or voluntary work, we will also indicate that. We also ask patients if they eventually return to the GP because they have to go to the GP with something else. Then we also ask you to provide feedback to the general practitioner without any obligation. That also makes it fun for the GP to hear what such a trajectory has yielded for the patient, from the patient himself.

HP: Yes.

AB: When the process is complete, finish that with the client and say I report to your referrer, primary care provider who registered you. That trajectory is over and very short of that and that is the outcome

HP: Okay, okay, and and how do you give that feedback, does that also go through the secure mail or how you also secure mail?

AB: Yes, and if we still have questions or want to raise questions in the meantime, then the GPs. Let's say our telephone and email address, they can still reach them as always and so I have a list with all the data of all GPs and I also know which way, I can approach the GP for interim sparring or consultation. But feedback is always the same, secure email.

HP: Yes, okay and and and so now you do know which way to go, which doctor did you have that would have you bought that closed in those conversations that you where you, so the one that you have invested that time you have actually that one came out.

AB: Yeah, I just go to the, every time I go over, I discuss with my list and every time on my list I add extra information. A check with the doctor, if that is the case and those are the referrers, is that your mail, your telephone. After that was updated, I forwarded it to the coordinator of all general practitioners, because he has insight into all the data, to check whether there are errors. You know that, see if that last name is spelled correctly. She would then check that everything is correct and now we have collected all data and stored it securely in our environment.

HP: Yeah, okay, okay and and am okay, well, that's obviously a good outline of the whole situation. And then for you personally. Finally: how, could you, how you can improve the process? Well, you actually say all the references, luckily we now see an upward trend. How could it be even better for you, what should be done to make it work even better, for example, that you have more time left to help more clients or better connection with the GP? Would you need extra time for that? Would you need one and an extra system for that? Do you have any thoughts about that?

AB: There is always room for improvement. I am convinced that there is always room for improvement and at the moment I think we are being unprofessional. What to register in excel file. I think that's unprofessional, so I think real system should come. I don't know which one, but that would be much better. We've been working on the flyer for months and it has to be finished at one time and it also has to be distributed, I think, that's not finished either. Me, I think I have too many tasks. That would be nice as a colleague, because I now have a colleague who has eight hours, but the moment registrations come in that we could really get extra hours for it. You know a lot more colleagues, in any case Welzijn op recept there is already a piece of well-being in it. So we and care and well-being is in the name of the project, so to speak. We are indispensable to make that project a success. So I think that in our organization we should invest in this, invest in it. I work for Participe Amstelland, Amstelland broad, there four municipalities fall under Amstelveen, Aalsmeer, Uithoorn and Ouder-Amstel. I think

that as a participant we should put Welzijn op Recept on the map as a whole, as in Amstelland-wide. That you uniformly distribute it among the municipalities with the same method, the same flyer. So what I mean by that, flyer development based on facts and on general numbers of the organization. Because personnel changes within our organization are really huge. So I would simply say: yes, you would actually like to have a project coordinator Welfare on Prescription within Amstelland who is involved in putting Welfare on Prescription on the map within those four municipalities.

HP: Really standardize actually.

AB: Yes, exactly.

HP: Okay, well that's very useful information first of all. You were just talking about Excel, you use that to register client information or what was that exactly?

AB: Yes exactly, we use it for client information. We have an Excel with birth date, name, telephone, address, start of the process, next meetings, feedback. I also made personal cards, because I like that method. I have a map with dossiers with the personal cards so I know what client I referred when. So when doing a house visit I can quickly tell what the situation is and what earlier agreements me and the client made. My colleague does this in the same way. In our map we also have voluntary work, activity offers, flyers, our company cards. So whenever we have a client talk we have a kind of toolbox.

HP: Alright, and would you prefer to have a system in place to process and find all of this information in instead of using Excel sheets with this data on someone's personal computer account?

AB: Well it is in a protected digital environment, which is our company's environment. So the data is protected, but I just think it is not professional to use Excel sheets for these kinds of things. Especially as appearance it does not come over as professional. Therefore I think it should go from Excel to a new program. I know Adsysco has a lot of these programs, maybe one of their programs. However, there we need money for and extension of the systems. And we haven't gone that far. Behind everything there is money.

HP: Haha yes that is true. Now the last thing I want to dive into is the finances of your organization. All budgets and financing is done through the municipality?

AB: Yes well. Zorg en zekerheid (a health insurer) has told us that they find our project very important because well-being prevents healthcare. Therefore, that might become something. It would help a lot of someone could be busy with putting Welzijn op Recept in place. If that happens you might be able to look at it in a bigger picture and talk with health insurers about covering of costs instead of the municipalities as it is currently.

HP: Yeah indeed, because right now you don't have a coordinator for Welzijn op Recept. Who is your contact person right now for Welzijn op Recept. Is that Jan-Joost or Miriam?

AB: Yes but that was only for the time of the optimization. That was the past half year ago, but we have said goodbyes no since. Now we have to do it ourselves without any other support.

HP: Okay that's clear, now considering the municipalities. How do these financial things get talked about? Is that with all different organizations or directly with the municipality?

AB: Well as a well-being organization we have to write a quotation every year. A request for subsidization. Our municipality values Welzijn op Recept a lot because they also hear from the first-line healthcare that it is important. They see the added value, during the optimization they have shared

their ideas too. They are even open for extra financial support if we would ask for it. So yeah.. We're dependent on the municipality subsidization and we tell and ask them what we need.

HP: Okay so what I am getting out of that is that the municipality is very welcoming and happy about supporting the organization and Welzijn op Recept. However, the contact between you and the municipality is not very close, there are no short lines. Only the standard necessary communication.

AB: Yes and for my hours, I have the well-being hours included into my wage hours.

HP: Okay well then. I am just looking through my last questions. I would like to ask finally: how could your position and process be improved for you? What is the largest obstacle or bottleneck currently for you?

AB: What my biggest bottleneck is, is that we are four municipalities as Amstelland. However, we are all trying to find out ourselves the best methods. Instead of integrated services and working together we are all trying to create the wheel separately. Everybody have their own methods of working, while we are one organization. I think we should standardize and work together to share knowledge and see what the best methods of working are. That is what I hate the most currently. I think there should be an group that includes all four municipalities and GP's so we can learn from each other and discuss problems and ideas together.

Sometimes people from the other municipality come to a GP in mine and then I have no idea to which well-being organization I can send the person or who I should contact. This I think is really bad. We look very bad towards our clients, as well as to the first-line practitioners. I miss the standardization of Welzijn op Recept within Amstelland.

HP: I can imagine completely.

AB: So the Excel is not my biggest worry. I can use that, that is secured and I think it works fine. However if we want to be a professional organization I don't think Excel belongs to that when handling client information.

HP: I get it, and for your job it is much more restricting that you're not working together in a standardized way on Welzijn op Recept within the four municipalities of Amstelland.

AB: Yes, for Welzijn op Recept I think so. And that's not the only thing, for example the flyer I mentioned is taking way too long. So I think there is a load of things that should and must still be improved.

HP: Yeah alright I get it. Well okay, we're through, I just want to thank you enormously for your time on such a short notice. I am very grateful for that really.

AB: Well no problem. I enjoyed participating and I hope that I can bring some value to your research and conclusions.

HP: Yes I think so I have some really valuable information so thank you so very much.

AB: Yes well okay then I'm happy. Let me know how the results end up.

HP: yes I will of course do that... Well goodbye then and again thank you!

AB: Goodbye have a good day!

HP: Thank you, you too!

## Interview with Thea Martens

**File:** interview Welzijn op recept-20211215\_150236-Opname van vergadering

**Duration:** 35:30 minutes

**Date:** 15/12/2021

Interview transcript Thea Martens of Sociom

Hidde van Poppel: It is supposed to be recording now.

Thea Martens: Ah, yes I can see it.

HP: I have some questions for you, and I would like to go over them with you.

TM: Yes that is no problem.

HP: Thank you Thea. To start off, what are your daily activities and could you describe your function in the organization?

TM: I am a social worker, and my area is senior people. Next to that I am Welzijn op Recept coordinator, that is for a much broader target audience, all people 18+. However, most of the referrals are people who are above 60, so seniors.

HP: Alright, and you are part of the organization Sociom. Are you within this organization the only coordinator of Welzijn op Recept.

TM: Yes that is correct. I work in land van Cuijk with Welzijn op Recept, however for my senior social work I work only in the municipality Cuijk. Land van Cuijk has multiple municipalities within the area, and for this area I am the coordinator of WoR. In every one of the municipalities there is a social worker who takes up the well-being referrals per municipality.

HP: Alright, and you yourself do not take up any referrals?

TM: Well sometimes I do, but most of the time I don't.

HP: Alright interesting. Then I have to say you see a good cooperation within these different municipalities of Land van Cuijk.

TM: Yes true, actually my organization Sociom is Land van Cuijk broad, instead of only focused on one of the municipalities.

HP: Ah alright I get it. Well normally u don't hear that, often well-being organizations are organized per single municipality.

TM: Well maybe, but from the first of January we will become one single municipality. Five municipalities will then join each other into one big municipality: Land van Cuijk.

HP: AH alright okay. Then now I want to ask, what activities do you perform for Welzijn op Recept?

TM: Well it started in 2018, that's when I started with my activities. I went to a national conference in Nieuwegein. Then I wrote a plan on how I wanted to approach and adopt Welzijn op Recept. I started visiting GPs, as well as physiotherapists. However this proved to be very difficult to get inside the GP

practice. They don't know what it (WoR) is, so I was busy about a year with very little referrals. During this time all referrals were made per email or phone. That is difficult as well, because I am not always available on the phone so then it would take a long time before we got into contact. This was a slow and difficult start in my opinion. Then I got into contact with Sint Tijn. This is a overarching organization that supports GPs with information and possibilities. I came into contact with them, and from their working method of positive health, Welzijn op Recept fits very well as a part of that. Through Sint Tijn, I was able to reach GPs and have them join and adopt the Welzijn op Recept methods.

HP: Okay, well that sounds very interesting.

TM: Yes and from regional performance organization, they have made agreements with the health care insurers to give GPs extra time to start the conversation with their patients. And then when I started working together with the GPs, we actually became pretty close. From there I got into the HAGRO, this is a GP group where they have monthly discussions between registered GPs. This way, I got into there. I got fifteen minutes to talk and to try and convince other GPs to join me and to work together. This all went very fast because if you would see how many referrals we are receiving right now, it is crazy right now.

HP: Oh wow, that is great to hear.

TM: Yes yes definitely. And now, GPs are realizing more and more that positive health is just as important as medical health. That there is a total picture and that there is not just physical health. Now GPs are becoming more aware on how important this is. Now if you look at our organization, you are more in the preventive field of healthcare. Not in the more expensive healthcare.

HP: Yes well our research and interviews show that ideally, all lines of healthcare would be interconnected. But in reality this is still far from true.

TM: Yes true, and now all of the hagro's, can refer questions they have to us. Even if it is not a Welzijn op Recept question specifically. If it then comes apparent, that we can help them, we can guide the question through our organization to make sure it gets the right answer. Its really nice to see this cooperation now, how it has developed. This helps GPs a lot, because for example, if the GP gets someone in their office who needs help with trauma. The GP can refer the question or the patient to us and we will look into our organization who can help the client and what the client needs. This means we don't work with framed programs. Often well-being organizations offer programs like exercise or meetings. We don't do it like that, we try to look very broad on the social map (available social activities), so we can send our clients to a well-being activity that precisely fits their needs. This requires an extensive knowledge and available information of the social map in your region.

HP: I do often hear that well-being organizations are splintered so then people don't know to where or to whom or what organization they should refer a patient with specific complaints.

TM: Yes true, and another thing is that GPs often say that they don't think about the well-being referral possibility. They're not trained like that, and often they don't think about making this referral. Some GPs have it in their system but some don't. We have yearly feedback and reflection moments, and these often function as inspiration. Everybody is involved, GPs, Welzijn op Recept experts, the municipalities, the hagro's... and this was a very inspirational evening, and after that you see that the referrals come flooding in after that. So it is really important to keep the activities in the mind of the GP (in their eye). That is really important. Another thing that is very nice is, we work with VIPLive. We as Sociom, are in the referral possibility of VIPLive. So then GPs might be reminded extra when looking in VIPLive. So now we receive a referral, then my colleague can see the case. Then he can pick up contact and either refer the referral further down in our organization and when the case is closed the colleague can finish it. So this is very nice too.

HP: Ah interesting, now I want to zoom in a bit more into the referral process. My question is: what are your experiences with VIPLive.

TM: Well I find that difficult, what I do think is that VIPLive is very nice because you can quickly and smoothly make referrals and communicate with each other. Another positive thing for GPs is that, when working with a referral, it immediately goes into their HIS. Another positive thing is that I can quickly chat with GPs or other professionals. You don't have to try to reach each other in another way because VIP works so well.

HP: Well sounds amazing. Now I know that most GPs also use Zorgdomein. In this tool you also have the function of referring to the well-being sector. However the biggest problem is that this is more expensive. Do you know what the opinion of GPs is when comparing VIPLive to Zorgdomein? Do you know?

TM: No, im sorry I cant help you with that. I don't know.

HP: That's alright I get that of course. Then now you've mentioned a couple of positive notes on VIPLive, are there any negatives?

TM: Well.. Jeesh, I don't know off the top of my head.

HP: Well of course that is fine too.

TM: A problem for us currently is the amount of referrals. It demands more than we can offer because of the number of referrals. We are now looking whether we can get more resources to expand our activities with WoR, because we can't keep up with the referrals if it continues the way it has. We still want to be able to meet the full demand.

HP: Well wow. I still want to ask one question about the referral system and then I would like to dive deeper into the fact that your organization is receiving so many referrals, which is a good and positive thing! So my question is, how are the costs managed for VIPLive within your municipality.

TM: For VIPLive you mean? Im not sure what you mean. I have been wondering, who is paying for VIPLive, not Sociom, maybe Sint Tijn. I am not sure.

HP: Okay well yeah I was interested because I think you do have to pay to use VIPLive and to make referrals.

TM: I think that is paid by GPs and Sint Tijn. I should ask that sometime, because I don't know. Right now we are working with VIPLive via Sint Tijn.

HP: Okay and then just to be clear: Sint Tijn receives subsidy from the municipality or of health insurers?

TM: oh wow another good question. I would guess the municipality but I am not a 100% sure. I do think the municipality though. I cant imagine health insurers pay for this all.

HP: I will go after that, see if I can find it online. Like I said, I am really happy to hear that your referral rate has increased so much. Now you mentioned that Sint Tijn really helped you get inside the GPs' office. Was this the decisive factor that increased referrals by so many?

TM: Yes, yes that had helped tremendously, to be taken more seriously. Because they have a lot of contacts within the GP community. Sometimes a GP also does work for Sint Tijn, meaning that the GPs are really involved with the organization.

HP: Okay I see. So now, you told me that you have so many referrals. Can you actually handle the referrals that you receive?

TM: Well actually we cant hahaha. We don't have the manpower to deal with this many referrals. That's why we are now again in conversations with the municipalities. Luckily our municipality welcomes Welzijn op Recept with open arms and is a big fan of it. So that is a very good cooperation, and it also improves the municipality itself (well-being). So we as Sociom are financed by the municipality and from there we need to receive resources. So we are now making budgets and plans for that to expand our Welzijn op Recept activities.

HP: Well wow I am happy to hear.

TM: Something that is now difficult is how to measure the effects. What do the referrals bring? Does it really decrease the weight on medical healthcare? That is very difficult to measure and we are not so far yet.

HP: Yeah very true. That is also a big question in our research. We hope that by bringing more standardization to the Welzijn op Recept method we can actually start testing the results and become more aware of the effects of the method. Although this is very complicated.

TM: Yeah well I hope so.

HP: I am happy to find an organization like you that is actually drowning in referrals. That gives me another insight into Welzijn op Recept.

TM: Yes true, however we don't tell the GPs. Hahaha. Ill show you some results. For example, from 2018 records show: in Boxmeer where we started in 2019 with 7 clients in one year. Now for this year we have had 92 clients in Boxmeer.

HP: Wow my god. That is an insane increase.

TM: Yes yes it is crazy. Then in Cuijk, in three years we increased from 6 to 33.

HP: wow, what a news.

TM: And in Mill en Sint Hubert from 4 to 23. However this is also a very small municipality. Often referrals are dependent on the size of the municipality and whether GPs already know the social workers in the municipality.

HP: Wow that is so interesting. Now of course our for our assignment we would like to increase referrals. So has all of this insane increase of referrals really only had to do with being inside the GPs' practice and in good contact with the GPs? The mutual trust and GPs who have confidence in the Welzijn op Recept method.

TM: Yes for sure.

HP: How was that in 2019? Did you already work with VIPLive back then?

TM: Hmm I'm not sure. I don't think we had VIPLive back then. I think we started with VIP at the start of 2020.

HP: I'm asking because one of our hypotheses in our case is that a better referral system will increase referrals. However hearing from you, that doesn't seem like it is necessarily the case and other things are much more important. It sounds like the trust and the connection is much more important. Because whether it is Zorgmail or another way of referring seems to matter less.

TM: Well how I understood it, was that it is very important that a referral automatically is uploaded in the HIS, without extra actions. That's how I understood it. That seems to be very important. Next to that, we always hear that it should cost the GP the least time. If that's the case, they will use the methods and make the referrals. As long as it is easy to use and feedback is provided to the GPs, so they know what happens to their patients.

HP: Yes that is actually a big part of our assignment too. Not only making the referral but also creating a structure that enables the well-being coach to provide feedback to the GP about their patient. That is possible in VIPLive right? Or am I wrong?

TM: Yes that is possible in VIPLive. However, I don't know whether they receive it. Whether they read it or if they hear it when the patient comes back to the GPs' office. But this is standard actually. When a referral is made, we must always provide feedback to the referrer that we have received the referral and will be picking up their patient. Normally you do this at the start when planning the intake and afterwards if the process is finished. Sometimes you also give intermediate feedback when necessary but that is not done often.

HP: Okay well im happy to hear. Well looking at the time, I still have one question to ask. Which is: for every time you receive a referral, how do you document the client and the progress?

TM: we have a registration system within Sociom. In here, we create cases, if the client approves. In this case, all information and questions and activities are recorded. From this registration system we can exactly tell how many Welzijn op Recept referrals (requests) there have been over a period of time. We can extract that from the system. Another advantage is that I can look into the system when a colleague of mine is on holidays and one of her clients calls to our office. In that case I can quickly look into our registration system and find the specific case for this client.

HP: Ah alright, and is this a system created by Sociom? Or is this a bought system that is sold to other organizations too? Is it created specifically for your organization?

TM: Yes it was created for us specifically. But I think the company does sell all sorts of systems to a wide variety of customers. The company behind the system is Adsysco.

HP: Ah I know Adsysco, we have an interview with them too. Well I am very happy with this interview and I am very impressed with your organization. The amount of referrals and the way you handle things. So I have to say big thumbs up.

TM: Well thank you, that is always nice to hear. I really do feel like it makes a large difference for the people that we take care of. What helps with that I think is that we keep it accessible.

HP: And I hope and think that out of your case, we can get some more insights that we can use to improve our advices and report.

TM: Yes well I hope so too. And if you want you can always contact me with anything that you need.

HP: Well then I want to thank you a lot for your time, effort and story today.

TM: Yes well no problem. I wish you a lot of goodluck with the rest of your assignment.

HP: Well thank you so much.

TM: Well okay goodbye then

HP: Bye bye thank you!

TM: Bye!

## Interview with Marie-Antoinette Westra

**File: Interview over VIP Live-20211119\_130602-Meeting Recording**

**Duration: 28:39 minutes**

**Date: 19/11/2021**

Hidde van Poppel: Yes, yes, thank you. It's recording if it is good, is one. Have a look. OK, well fine. But my first question is actually a uh. Yes, just an introduction, uh as uhm as a regional manager. What? What exactly are daily activities?

Marie-Antoinette Westra: Or yes, that is really we, uh, what do you want with this question?

HP: tell me where and with whom? uh. Are you in daily contact? You just mentioned uh, so basically primary care. General practitioners, the municipalities, the welfare sector, so to speak.

M-A W: Uh, all healthcare providers involved in the implementation of our healthcare programs. So that's GPs and their employees. Practice nurses, assistants, physiotherapists, occupational therapists, pharmacies, Polo therapists, dietitians. Well, then we have the whole wellbeing happening. So that said he is now the uh. While the welfare organization is an advisor to directors of well-being organisations, municipalities, youth and family team, policy officer, policy officers, alderman, hospital, automation department, uh.

M-A W: Uhm, the elderly care has contacts with various elderly care organizations.

HP: And then you.. are you acting as a link between all these parties?

M-A W: Yes, actually. Yes yes so I am on the one hand I am really an account manager. I really do, but stings me and management there is regional management and on the other hand I also do a number of projects. For example well-being. Welzijn op recept was a project of mine. We are now also going to try to expand with exercise on prescription. So I am also in contact with the Sports Combination officials of the municipality about this. But we are also looking into whether we can improve, digitalize, the exchange of information with the elderly care in the neighborhood.

M-A W: But we also have project purple crocodile, so all the nonsensical administrative stuff that we're going to improve that for you too. And then? EH, well then I organize training and. Yes, that's a bit broad, we have his own company and are a very small team with 4-5 colleagues, some of which we are now also not. Yeah so it's really really really wide.

HP: Also take and got a good idea anyway. It is actually in the middle of all the different interests of primary, secondary and municipalities. Really a switch there.

M-A W: Yes, and then this is the real thing with us, say the Zorggroep Haringvliet. You have to think of it like ten years ago if people had asthma or they had CPD or diabetes, they were treated in the hospital and now they are being treated by the GP. But the GP has a lot of different people that you do this together with. And we are, say, the main contractor of the health insurer. Because the health insurer does not want to make separate agreements with all those parties or to check the quality. So we are basically prime contractor for the asthma, CPD, diabetes and cardiovascular risk management. So we get money from the health insurer and we also pay those care providers now and then and then. In addition, uhm, well, more and more GPs are coming so we are also going to say more and more that GPs facilitate us to ensure that they can focus on performing their work. So we take doing it too and also support practice managers to do it. A piece of elderly care, but for example. I am now also

discussing a lot with the GGD, because now the booster vaccinations we are coming up with. Well, how are we going to reconcile that? What about elderly care? Who's going to do what? What should the GPs do?

HP: Okay. Is that also very practical? Or is that really a lot? That you say that bureaucracy arranges the papers? So? Because I.. what is that word now.. Sorry I forgot. The bureaucracy I mean. I know that I have the GP, an hour of time is wasted on uh, signing things off, writing things like that. And do you take that off your hands? Or are you more practical-oriented than organizing the injection location and to organize that people are present who provide guidance and assistance.

M-A W: Actually one level higher. The moment the GGD wants something from the general practitioners, they come to us if the municipality wants something with the general practitioners. That's where they come to live with us. Or if we don't all sit down at the table with those GPs. But we then represent the general practitioners.

HP: Yes, as a union and also a little bit so yes I can see it. At least one piece doesn't look right.

M-A W: Well, and a lot of subjects on the side too. Then we can also simply represent the general practitioner. And on some topics we really need input from the GP. So then we go and get what they think from our supporters or we take a GP with us. Even if there is a new project or a new idea, well often.. Then we ensure that it is carried out so that you GPs do not have to repeat them.

HP: Okay so really. Uh yeah okay and very clear. I have a good idea from now on. I'm going to ask about Welzijn op Recept. In what way was it implemented? Did you do that? Uh, introduced to the GP and really actually realized referrals.

M-A W: Well, I'm involved in the whole drafting of the whole project plan. Uhm, finding two pilot locations and so to speak, introduced the communication to the GP. But we have also used the oil slick model, so to speak, so we now have something completely according to Rodgers. You first go to the early adapters who make sure you take over. And we are now at the. What is the last group?

M-A W: The Laggards, they say, Oh? Do we have Welzijn op Recept? Never heard of it. Well then I say look and now I can slide that in nicely. So it's real. Uh, some sort of two-stage rocket. I discuss with his practices and then I warm them up and then I make sure that a well-being advisor there gets a warm transfer. Because if they just call a practice, they don't say yes.

M-A W: But because we then prepare it well and discuss it and can also explain very well what the added value is of Welzijn op Recept. Because there are already general practitioners who work with it that is super boring after all. So we're going to try again. EH, those positive experiences in one in a story. Storytelling in any case to share. Because well, that just works well with GPs. If another colleague is enthusiastic about it, they will do the same.

M-A W: And also a number of GPs. Well, because they know me and know who I am. When I say well, you really should, it works very well. Well then they know that too. What do you say.

HP: Because that's interesting. I heard that before in an earlier interview that the GP and understanding prevent them from having difficulty such as when such a well-being coach would come for example without an acquaintance such as you are for GPs, that they do not go there just there don't have time for it, don't even bother putting it all on.

M-A W: GPs are very busy and I hear and everyone wants something from that. I used to be a doctor's visitor, but a long time ago and that was also on a blue Monday. But it is really very difficult to get into

a doctor's office. Because pharmacy wants something from them. Suppliers want something from them, everyone really and they just have to make choices. And if you are a doctor. You have 80 different patients in front of you in one day and that can be anything. And at that moment you have to choose. Then I go and then you just have to think about it oh yes, this is a patient, he could qualify there.

M-A W: And then you also have to think about it when I was visiting a doctor, then you have to do everything you can to get that pill in the pen for that condition. So then you leave information. You care about something on your desk the moment you're busy that you're oh yes, no, that's true. Yes well. And the same is true with Welzijn op Recept.

M-A W: Because so do we, for example. We are working on introducing a consultative consultation so that you as a general practitioner. If you want to ask the medical specialist a question we want to have that also through VIP does. Well, you know, there are practices now who are very enthusiastic about another. on the other hand other practices think its more hassle again or there they try it once. Do they get an error message, then they quit immediatly.

M-A W: Yes, so it's really a challenge to get ehm yes that euh accepted. So that's why I learned. But yes, you have to do it where the energy is. People who are enthusiastic. And then if that goes well, you can slowly build it up.

HP: Yes yes, because that is a really big problem when it is set up like this, in my opinion, it is not guaranteed that it is simply not a daily routine with a daily bee, it is from such a GP and that noticed, that brand You then go to the everywhere with the total number of referrals.

M-A W: Yeah, and so it's with us. You have to do that like a kind of diesel. And uh yes, so that really needs time. And that's why I think it's one. The pilot should be a project, but after that it should just move on to business as usual. Will it often be the problem if it is a project? Yes, a project has a beginning and an end. But you have to make sure that it continues afterwards.

HP: It's interesting, yes, and because you're actually using VIP live then. That's the one with the project, so that's what you've done. Or did you use VIP live, I assume?

M-A W: Yes.

HP: Yeah, and how was the, did you notice that it was going well that that good? We us? Yes, I, I actually assume that all care or sorry yes, very first we ensure that they are in the care term and that you then have to install something else, learn something else, when they want to use something like VIP live, for example. Or is that not the case?

M-A W: Well, it's worry. Zorgdomein of course has an enormous monopoly position in the field of referrals. Actually everyone refers to medical specialists with Zorgdomein. Staying in term four is our chain. Information system do you have they already explained to you what exactly does and is and what it means for us as a care group?

HP: Well, I know that combining several things more than Zorgdomein like billing, billing system also a feedback system I think, feedback from the patients and that the costs are also recovered. They declare these to the health insurers, but I'm not sure yet, you'd better tell me.

M-A W: I will try to explain. I know this sounds very old, but I once spoke with the director of Zorgdomein when the healthcare term was introduced so I also supervised the first hospital. And Zorgdomein was built to create customer loyalty by hospitals. Because if you just, of course, because

well as a hospital, you are also dependent on your turnover, on the referrals from general practitioners. So if you make it for the GP as easy as possible to refer, that is the turnover.

HP: Yes.

M-A W: So that is really real, say care, Zorgdomein and that care and me is really perfect about how you should refer to medical specialists. Well and VIP started in 2006, then a new health insurance law came into effect and then as a general practitioner you had to declare digitally well, and there were still GPs who worked with the green card. Then you had to submit those files was all very complicated and there are two men from general practitioners. They set up some very smart portal where you could send your declaration files to you. And that has become VIP. So they started with a kind of declaration portal that you as a general practice could do to your files and they would then do an insured check. They started working on that. Well and around that time too, there were care groups. So whatever we are and we, we are responsible for that quality and we have to declare so we have to declare for 23 GP practices but we also have to know, that practice that does too little foot examinations and that practice that does too little that well and that's where VIPLive jumped in, so what's most important to us is that VIPLive helps us with all the declarations because all those GPs have their own HIS, that's five different hisses, so they all work differently and the KIS is above of that. So that is very important, the declaration, but also management information so we all have a dashboard, with how many foot examinations there are, how much blood pressure and we can also see whether that blood pressure is good or too high or too low and in combination with medication . Well and how VIP works is actually very simple. They make to extraction once a week and they pump that into a database. And we look at that. So there is also a system in which the general practitioners have to enter data twice and their general practitioners within their own HIS, an information system and once again in their KIS a chain care information system for the group. But then, of course, that doesn't make you happy.

Well, so you can also say: yes, VIP, great fun, then you're in it, but I always have data that could be a week that can be a week old. And if I want to make a referral for the hospital, I don't have the up-to-date information. So VIPLive is now also working on making it their own name, the Zorgdomein link. Because Zorgdomein, if you refer to the healthcare domain, you always have the current information that you can find in your GP information system (HIS). And that is not yet the case with VIP. So that's really still a flaw, and if you make a referral for Welzijn op Recept, then you're not going to forward medical information or if you do that to the diabetes or to someone else. But a medical specialist, yes, you know, then you really just want the very latest information and the latest medication, so VIPLive doesn't work yet either. But it would of course be very interesting if VIPLive did, because then they would become a serious competitor for Zorgdomein. VGZ CZ is also developing a referral solution to also introduce, say, a competitor for Zorgdomein, so they are also working on making them an extra competitor. So and on top of that, VIPLive has also started to communicate with say all healthcare providers, so it is with the dietician the occupational therapist physiotherapist, you name it, and you can allocate them to that care network. well and then it is said but, it is also a small step to also make that reference to the social domain. Well and Zorgdomein I also recently had a presentation from Zorgdomein. Of course they also want to go to the social domain, because they see that VIP is coming onto the market there. Well, what you actually have is that in the beginning our GPs did very little with VIPLive, because the entire chain of care is mainly done by the practice nurses, but because we now also submit the mail and consultation, so that is a question to the medical specialist, a consultation and then you remain the primary practitioner as a general practitioner. That goes VIPLive and that does not go through the healthcare domain.

So that GP is now starting on VIPLive so actually they now have a button, Zorgdomein and they have a VIPLive button and they are also starting to find more and more VIP. But yes, that practice nurse actually worked more in VIPLive than in Zorgdomein. And we as a care group work with VIPLive. Yes, you know, then it is of course very easy to just refer to Welzijn op Recept via VIP live, because there are no extra costs involved. And well, that choice has been made, because I thought that was

interesting. What you said of yes, making the choice for a referring system. Yes, who makes that choice? Yes, it is either VIPLive or Zorgdomein, because every GP says: yes, bye, I don't want another system.

HP: I get that.

M-A W: And the moment they don't have VIPLive, if they do, then they'll be happy to stay in the Zorgdomein.

HP: Mmm also to recap. VIPLive is connected to all HIS systems

M-A W: Yes.

HP: And that doesn't cost an extra login for the GPs.

M-A W: Well, if you're one, that's the downside of VIPLive. You do have a singles sign-on so I have a patient and I push a button. Then I will come to a patient, but somehow you have to enter your password again, because you will also see medical information there.

HP: Oh yeah, okay, yeah, for privacy maybe that will be or something?

M-A W: Yes, but we take care of my. If you haven't and VIP has tried a few times to explain what the reason was, but I don't get it.

HP: Okay, okay, and then to follow, VIP is currently not widely used to refer to medical specialists. uh.

M-A W: No, not really.

HP: Just for the consultation that already.

M-A W: Yes, then it is important to look, you know this, because what matters is that Zorgdomein. If you make a reference to the care (via Zorgdomein), you extract the data directly from the HIS and with VIPLive an extraction is made once a week. So when you refer there, you always look at that extraction. So you don't have the live up to date information.

HP: And that is also partly the reason that people do not refer to medical specialists because that is then you want to have really accurate information, yes, okay.

M-A W: And also say in Zorgdomein. Yeah, you know, take Zorgdomein has been so developed and specialized there that you can see a whole range of care in hospital. And then you can also see exactly oh. But if you come for that surgery, then you have to do that first and we'll do that. And this is the waiting time and um if you look at say what is that called again when you say, but you have a certain process in the chain and actually, what they have done with Zorgdomein is that that chain is pushed together. I think it's a Porter you've also had and marketing with that you can say one side or the other in the chain. And because, say, Zorgdomein can even become such that people can immediately make an appointment in the hospital. It is the whole logistics between that GP in the hospital is completely put together. It just almost collapses.

HP: Mmm the treatment is, is that known? Yes?

M-A W: Find out my yes, you think. Zorgdomein is so well developed and specialized in that, and then you can see hospitals in it offer a whole range of care. And then you can see exactly too. But if you come for that operation, then you have to do that first and we'll do that through. And this is the waiting time. And uhm, if you look at it say uh, what's it called again? Uh, who if you say a but he has to.

M-A W: You have a certain process in a chain. uhm. And actually what they have done with Zorgdomein is that chain is slid together. I think it's Porter, then you've also been stuck in marketing with what you can, say one side to the other and in the chain. And because so to speak, it can even become so that people can immediately make an appointment in the hospital.

M-A W: It's the whole logistics between that GP and the hospital is completely reconciled. It just almost collapses.

HP: Yes, the treatments are so well known that follow-up appointments can already be planned actually.

M-A W: And then it's also the stupid uh. Or as a patient you get a number and then you can call and then you can use that number and we know it. They know exactly every day. For example, what if there would be an integration with the better near your app. So that all comes together. But of course they've been doing that for fifteen years. Yes and at VIP it is normal. Well, you control the messages and it comes the other way. There is no integration at all.

M-A W: Um uhm. Chain supply management.

HP: OK yeah, don't ring a bell for a while. But I think I do understand the concept.

M-A W: It is. You must have had that. I've done so well. I haven't done A, B and C anymore, so that's always a lot of fun. Because if you look at it that way, yes it works. So it's just a really smart one. And that hospital naturally goes as close as possible to the business of that GP in order to continue to generate turnover, but also to be able to improve their own work processes.

HP: And that's okay, that's a really big benefit to health and wellness, so actually there are in addition to that the late update times a week. Are there any other disadvantages with VIP and VIP live that you like?

M-A W: They're really still just in the baby shoes. But that concerns the process and being familiar with all treatments or even brand awareness. Well, in Zorgdomein the real thing is that the prices go and really sky high, but the support is very good. Yes, that's just very well put together. Yes, I think that remaining VIP is still an immature service organization and it has a very good will.

HP: Just that, well, I don't think there is any real competition for Zorgdomein at the moment.

HP: But you did say Zorgdomein, which is now also trying to get into well-being. Is that, even though something concrete has already been achieved there? Has it really already been seen?

M-A W: Oh yes, sure. I recently had a whole presentation of this from Zorgdomein. Let's see.

HP: I never have. I also do not know whether Jan that yes, who will be Jan Joost might be somewhat aware. I almost think so. But.

M-A W: Check it out, uhm provides fenced and social domain.

HP: Social domain I'll write it down.

M-A W: See if you can forward this. Oh yes, I, I'll send you this.

HP: Thank you very much.

M-A W: Or can I share it right via chat? Even easier. Well, we do, you notice that from a lot of things. Of course they would be keeping a close eye on each other too. And of course they try to steal everything from each other.

HP: So I can imagine. Yes.

M-A W: So I think it's also interesting from uh, if Jan Joost's assignment is yes, we have to make the decision. I then wonder whether he, uh yes, who makes the decision of which system you are going to use, because you have to connect with something that the GPs already use.

HP: Yes, I think to be honest, nationally, there is not yet a single system besides Zorgdomein that is used nationally. What every doctor is in. Frankly, I don't think there is.

M-A W: Yeah and then Zorgdomein, there are also certain regions that don't use it either. But there are almost none who don't use it. There are really very few, because we are now on again.

HP: We will also investigate Siilo. Maybe you've already learned about it. Probably by course sure.

M-A W: Yes and do you also know what the biggest differences are with VIP Live? Yes well ehm, the Siilo app is not patient bound, so it's just say Whatsapp. So it is not linked to one particular patient. After three months, the conversations disappear. So you cannot link it back to your HIS. You can't use it for your filing either.

HP: Okay, I think so, but will be major drawbacks frankly,

M-A W: I see, how Siilo is currently, that doesn't work for Welzijn op Recept. Because you want to make a referral in your HIS. And you want to see you too, oh, I have referred to here. Then you want it to be put into your information system (registration) and you want to use the registration for management information.

M-A W: You can always look back. Uhm and uhm. Do you know how? How a doctor builds a patient file?

HP: Uhm no, no.

M-A W: A general practitioner, who uses episodes, care episodes for example. I have diabetes which is a care episode. I have cystitis is a care episode. And such an episode is actually because the whole structure they are, say, a kind of maps.

M-A W: And then every time someone comes by for that diabetes, they say something about it. That can be medication, a result and a new diagnosis. After a referral and therefore also say with Welzijn op Recept. That is a particular problem. Somebody's tired or some headache or um, well, you also have a special code for the a sore here or there. Then everything related to that is linked below. You also do our Welzijn op Recept and then you make a referral with a certain question. And then later you also get back a report and you want that back there too (in the episode). And the advantage of VIPLive is that it returns a report that comes in your mail that you receive. And that mail also belongs to medical

specialists and the lab and you name it. That is a certain format file and your GP can also write that back directly in his HIS.

HP: That's very handy, does Zorgdomein do that too?

M-A W: Yes, that is just the same, however not with Siilo. Siilo is actually just a secured what WhatsApp is even completely separate, but put took care. Mine does that too, of course, but only when I hear it that way.

HP: Because uh, as an assignment it is very much about referring first, but also 50 percent of that is also the feedback. Well, then the in this case uh Siilo uh so in its current state would never qualify for okay.

HP: But that's uh, that's just as good to know that uh yeah that's just a good note too. VIPLive sounds very good, if we have a very good second option apart from referring to medical specialist because it is with those late updates. Do you hear from general practitioners in the field around you, but perhaps also from euh, from the right well-being coaches if you are in contact with them. What? What? What is the general sentiment there, the opinion, about VIPLive?

M-A W: Yeah, uh, they're there to be well-being coaches who don't know other than that. Yes, they just get an email. The reference is there. They can open it, and that's it. Tell me. Oh um. What is also a big advantage for us is that VIPLive also has a management dashboard.

HP: Oh you said yes, with all kinds of dashboards.

M-A W: Yeah, well well, it's for all uh everything again. We already have that for medical referrals. But we have so say for referring. I can be happy. If you promise that you won't take a screen print I want to show it to you I might have to uh.

HP: Then I'll just turn off the video recording.

M-A W: Might be useful if you turn it off for a while.

HP: Uh, one moment in time.

M-A W: The Zorgdomein is once again completely under the management of the hospital and we are now also in Rotterdam of a number of hospitals. They have also signed an agreement with VIPLive, so they are really going to work on that. Because the advantage is also that the entire region now works with VIPLive again. So also Hoeksche Waard, Rotterdam, Voorne-Putten so. The whole area all works with VIPLive.

HP: Because you say Zorgdomein is managed by the hospital, if you also have management information then perhaps you don't need it, but you do have it based on the information that the GP receives.

M-A W: No. But we don't really need that at all, because it's from the hospital and the GP practices themselves. They do have information about, say, referrals for their own quality report. But then it is also irrelevant whether that was through Zorgdomein or whether they printed a note in some other way.

HP: Okay, but okay well okay thats clear then. And you say that the whole region is now starting to take up the VIPLive service. Uhm first, why do they do that? And second, why is that a big advantage for you?

M-A W: Uhm, let's have a look. Uh, at Voorne-Putten they used VIPLive before we did. We now also have VIPLive. Hoeksche Waard started last January. Rotterdam, I don't know exactly when these started, now the care groups have a certain area. But there are also many other organizations hospitals, the elderly, care organizations. They have a different care area's and they overlap . And if so, say so. Uhm, because we now have, for example, we are also working on the exchange of information between the people in the home care and the neighborhood team via VIPLive. Uhm, and we're going to do that for Curamare and Careyn. These are two very large elderly care organizations and they therefore work at Hoeksche Waard and Voorne-Putten and Zorggroep Haringvliet. And that they again and that are again different care group also.

HP: Okay yes, I get that, then I understand why do you want it to be positive to get everyone on board. And the reason they switch is that to be able to join you or is that just a well-functioning concept?

M-A W: The concept is just it's just a well-functioning concept.

HP: OK, still very good.

M-A W: And so we've just picked one. And with all those organizations to do it now via VIPLive. And there has not been a project that preceded that with those older care organizations, but they just said we have VIPLive, do you want to join? Even with the idea of now we have nothing and are now getting to know each other. And you can better, for example in two years all together. If you are already working together digitally and switching to a different system together, then first start doing a very extensive process in a different one. And that you then implement something together. Because you notice, because you really notice that all kinds of different organizations that used to just didn't really work together. Or yes, that they really know how to find each other much better now.

HP: That's what we want I think.

M-A W: Corona also helped with that.

HP: Oh yes, yes, it probably will. Maybe yes, because that

M-A W: So is also. So I was at practices this week and they thought that the wellbeing organization had all volunteers working. I say no, there are hbo-trained welfare advisers well, they didn't know

HP: that the word of other euh. I rather have a wellbeing advisor um. Interviewed and she told about: that she arrives at a GP and who thought I was a volunteer. While that is of course not the case at all.

M-A W: And then there was Jacqueline Tanis?

HP: Yes indeed yes haha.

M-A W: And that's our one-two punch. Then I will prepare that and then she can finally go somewhere, well and then there comes Jacqueline. Well, that's super fun of course.

HP: OK, how funny. Well, that was uh. Yes coincidentally Jacqueline Indeed, I have more than planned. But that yes, of course it is also in how Goerree-Overflakkee

M-A W: No, so that is it. And I have to say that in the beginning I didn't know that there were not only volunteers working at the Foundation Zijn. So that's really fun too. And I think that together we can really contribute to a uhm to better care.

HP: Well-being. Yes, a good one. Yes that hope. Anyway, I think that's a good thing. I'm learning more and more about it and, yes, I just find it all very interesting. I'm going to ask a closing question, otherwise I'll keep you here all afternoon.

M-A W: Uh yeah. I think it's fun, but I also have other things to do.

HP: That's why I understand. Uhm, and that's what we're going to do, do I want to focus on the referrals? You actually say a VIPLive system that works well. You hear positive things about it in the field. Apart from the medical referrals that is still possible. There are still improvements. Do you think uh, with a system as good as VIPLive? Uhm, have references increased in recent times? Uhm as in well-being references. So really with Welzijn op Recept. Did I see that you don't have GLI either? Uhm, maybe in that in there. Oh, and what do you think the potential is of referring to wellness? Work with such a good working system. Do you think there will be even more growth there? Or do you think so?

M-A W: Um. Let's say VIP is a kind of social hygiene factor. It just has to work and it just has to do its job and I think if it doesn't work then less reference is made. But if it's just doing its job, I don't think it does any more referrals. So it's really a social hygiene factor. It just has to do it. If it doesn't work it's one, then it's working against us. But I don't think they will refer anymore. Yeah, maybe just something. Because like I said, it really has to be in your GP's pen and at that moment the moment he thinks about it and it goes to refer and it doesn't work. Then he gets angry and then he thinks look at it. And if that, if he comes up with it and he's going to do it, well then, then it works.

HP: Yes, yes, because Jan Joost, uhm, one of those things we do like that is the reference. Well, that's the thing that the referrals are too low and he thinks that would be a big help in that, a good working system. We therefore want to examine the system, but we also want to investigate other factors. Because what you're saying, I also think that a system alone won't be enough to boost those referrals over and over. And that is actually very much willing to research.

M-A W: Yeah, so actually you should almost look for it. And there are also studies for the prescribing behavior of the GP from how is it actually more general at the moment that you and that you want to do it? And the system doesn't work, well I've heard that too. I want to do a consultation and it doesn't work there. Or I can't log in. Well then they also think: I don't care anymore, before the next referral is made this will take more time again. That was really a missed opportunity, so you have to make sure it just works perfectly.

No dirt for the feet, but in order for them to refer, so even when they refer, it must also be followed in time. The quality must also be good. Um, well then that. And that makes them do it again. To ensure that they refer to the positive experiences of colleagues. Works very well, but you actually have to continuously collect good experiences, because you also saw. There are a few practices that do it and after and they really go like this (up). But we've been on top of that. And now the challenge is to get the positive experiences of those other GPs in particular to get those other practices too. But there are also GPs who say and I have to do so many and I don't feel like it at all. And um, because that is and there is also interesting. It's called Welzijn op recept And if you, as a general practitioner, prescribe medication, you are responsible. While if you make a referral, someone refers to the other healthcare professional. And then that healthcare professional is responsible for the treatment. So there are also general practitioners if they really want to do a lot and say: Welzijn op Recept, I am also responsible for that. You're looking at it, but I'm really not going to.

HP: I understand that is also a critical point in our research. Who is actually? Why would GPs want to? Why would they do it because prescribing a pill can work just as well for them.

M-A W: And it is. You also have to start a conversation with that patient, because if you tell them to the GP. Well, that's 80 percent of the village is eligible for that. But to get people to the point that they go to him and uh, that they want such a reference. That is something else entirely. Then you have to start a completely different conversation. And then giving a pill is that, that is much less work.

HP: Yes yes yes, then I immediately believe yes

M-A W: And I see. I think so say. The system is a social hygiene factor. It must work. If it doesn't work, it will hurt you a lot. And if it does work, you know well. That is a basic requirement.

HP: Yes. OK, yes, well I, uh, yes, I have to say I think it was a really insightful interview and I'm very happy that I was able to speak to an expert on this digital platform.

M-A W: Well that's not too bad, but um. But if you would like to add more after one more time thinking about the question or would or how about that? General practitioners automation, you can always send me an email. I am also very interested in the results of the research, so if you can share it from Jan Joost, we would like to see it.

HP: Yes definitely we will share the results of our interviews and research.

M-A W: Alright that sounds good, I will be heading on again

HP: Yes ofcourse, thank you very very much. For your time and your insights, it has been very valuable!

M-A W: No problem ofcourse, have a good day Hidde!

HP: Thank you and you too!

M-A W: Bye, bye.

HP: Bye thank you.

## Interview with Mariska Smit

**File:** Gesprek WoR-20211029\_140210-Opname van vergadering.mp4  
**Duration:** 29:12 Minutes  
**Date:** 29/10/2021

Jordy Gilberts: The recording has started. By the way, I adjusted the questionnaire I received from Jan Joost. Did you have a look at the one I sent you?

Mariska Smit: Yes, I did.

JG: All right, great.

MS: Not a lot will change right? We can do the adjusted version.

JG: Yes, that's right. Not a lot has changed, but there are some questions that have been merged and I added questions about the financial part. To start off, in general, can you tell something about Welzijn op Recept (WoR) in your municipality?

MS: Yes, first it is good to know that our municipality is a 100.000+ municipality, so it belongs to the G40. And it exists of an urban part, which is the city Alphen aan de Rijn and it exist out of some smaller cores meaning some separated towns where there is also a different way how GP care gets organised. Uhm... and for 5-6 years, yes 6 years, there is a chain consultation where the social domain and the medical domain make agreements together, also to meet each other and to exchange knowledge. The alderman is the chairman and WoR has one time been the topic as well... and it is mentioned that we see the value and how we are going to develop this. Next it has been placed in Zorgdomein. So, how does it work on our municipality? It comes, of course, especially from the GP's, but there is partly by health insurers and the municipality, if I remember correctly, because I was not active at that time, possibility is created that it gets adapted to Zorgdomein and from that time onwards - that has been a year of two three for sure - it is available digitally and it is found in different ways. There are general practices more active than others, that differs a bit.

JG: Yes, all right, because for the next question I was wondering how WoR is organised in your municipality, but you partly explained that. Which appointments did you make regarding WoR with which parties? So mainly about the GP's, WoR and also the well-being coaches.

MS: How I look to WoR; it is mainly a tool for the GP, so it helps the GP to put it - for the non-medical issues - in the domain where you might be able to answer the questions, and from that point of view, it is mainly the GP who uses it. Of course, it is the well-being coach that receives it and, we are not well-being, but as municipality we organise the well-being, which is our role, or it is a kind of project we agreed on to do which we also subsidize. So, Tommie (Tom) in de Buurt, is it called, the organisation, in our municipality which is a partnership between various parties including Mee, but there is also Kwadraad and a home organisation - but also well-being partly, named Participle - and they are who receive the digital referrals, so some kind of front-office where the referrals come together and the organisation expands it further. Like, hey what is exactly the question and what are we going to do with this and afterwards there will be a conversation. That is, let's say, the version that we organised the last few years. So, the involvement is mainly between those two parties actually and the municipality comes every now and then if we talk about preconditions or to make things happen or especially if we talk about scaling; a wider vision. And then, because your question is, how is it between various parties if you look at where you are right now; we recently started with subsidizing

parties of which are much more focussed on prevention, so what now takes care of Tom in de buurt, we want to expand a lot more. So, what kind of questions do we receive and that wouldn't be just about well-being, but also about doing sports, financial issues, about...well... culture... very broad issue and then is it for the one that receives the question, to expand it to the parties, so than there are soon a lot of new parties involved and then there is still one that, let's say, will be the main contractor who receives the question. Is it understandable if I explain it this way?

JG: Yes sure, it is definitely clearer. I was wondering if we focus on the referrals from the GPs to the well-being coach how are those referrals organised within the municipality?

MS: Digitally, uhm, the possibility has been created via Zorgdomein. I know that there are also GP's where there also for example, the well-being coaches – we call them different -, but their job; who are also present two dayparts in the general practice physically and that we say, well just walk by Tineke which is also WoR, but then not through the original idea as WoR at the time has been organised by the knowledge centre.

JG: Yes.

MS: The definition how you see WoR; I think we see it a lot broader. We care more about the tool/instrument that helps us to go from A to B .

JG: Yes, and that could be WoR or something different.

MS: Yes.

JG: All right, so from what I understood is that there is also distortion within the communication due to the AVG-proof privacy law and if we talk about the referrals between the GP and the well-being coach about going from A to B in general, how is it organised in the Municipality?

MS: From that has the municipality a lesser role. The referral is between the parties, well-being, and I call it more the broader domains, the social domain that takes care of it. I don't want to make assumptions, but I assume that the parties involved operate according to the applicable guidelines and privacy standards.

JG: Yes, and does the feedback from the well-being coach and the GP takes place through the same channel?

MS: Yes, very recently, not already 4 years, but recently made possible.

JG: And is it possible to read it in the HIS?

MS: Hmm, I think it stays in the social domain and it is of course per general practice how they organised it and how it unfolds and...uhm...and how the whole transition per GP's is; I can't tell. Also, if it takes place all the time is the question as well, but from a technical point of view, it is possible.

JG: Hmm okay and are you familiar about the satisfaction rate of the GP's and well-being coaches about the system? Did they mention what the advantages and disadvantages are?

MS: Uhm, well, the satisfaction; look, it has not a lot to do with WoR, but also with Zorgdomein. A lot of factors are present when referring, so that does not put WoR in a lesser position, but I think the focus prior to choose for WoR, so that you involve another professional or still involve WoR. Well, imagine you are in that position, I know there is a certain open space to send information, but...uhm... as I interpret it myself from all the comments, is that it is not structured, so that you have a big open

space where you paste everything or that it is possible to send the entire file. We talked about it, but I don't know the answer. Uhm, about the partnership, about the...let's say..., in general they talk about, well, one time a month that you send certain things to sufficient do the referral, that is possible, and that the referral comes back, that is also possible. What is recognized as a disadvantage of Zorgdomein, and that has nothing to do with WoR - but of course it gets involved -, is that there are certain licenses connected to Zorgdomein, so for example, within that kind of well-being organisation it is not the case that there is a team of around 20 people that decide on it, but it is connected to limited mailboxes. It is in the frame of privacy, but it is not always convenient.

JG: Yes.

MS: That kind of user-friendly shortcomings, but we have to let the parties gain experience in it. Talking about that it is probably used on a scale too small, to find out the dissatisfaction on a wider scale.

JG: Hmm, yes, it is indeed not especially about WoR, but in general about the system, so in general if GP's and well-being coaches named the disadvantages.

MS: Well, besides the system, what matters if it succeeds or not; the referral is very important to get motivated as a GP, like, ah from that patient it is arrived or I know now how it has unfolded or...uhm...that what of course positive is, but that has not a lot to do with WoR, is that you get to know each other better, so what do you do as well-being coach and that is not just drinking thee, but there is a lot more possible to get the conversation going to understand each other better. And...uhm... and I would not necessarily dare to put every factor I just mentioned on WoR itself because on what we talked about earlier, because you can also find other ways to try to bring those domains together.

JG: Yes exactly.

MS: And that gives energy/motivation and if it works as, it should work than...uhm...some factors can be better and then it is, well, I hope that we pick that up the coming time. It is a bit of a confusing answer, I'm sorry Jordy, but...

JG: No problem I understand, because it is not just WoR, but it is of course the focus. Just talking about the system if there are advantages and disadvantages.

MS: Yes exactly, it is more than just WoR, because if it is medical it doesn't have to be done within the general practice so yeah that is for sure an advantage, but there is a lot more necessary to let it work fluently. By just having WoR as a partner, you are not there yet.

JG: Yes, clear, about the costs. What does the system cost and who pays the bill?

MS: Costs I am not sure...uhm...who pays the bill... I can't say it is for sure, but I can think logically. First of all, the GP's paid Zorgdomein and I know that social partners also had a subscription there, so those costs are made by the partners and for social domain...yes...that will return to the municipality, that belongs again to our job.

JG: Hmm okay.

MS: But the parties are responsible themselves.

JG: Yes, and is there within the municipality also a social district team and how is the partnership between the well-being coaches and the social district team?

MS: We have an urban area and smaller cores around it and we have divided the municipality in 5 areas from which three are urban a two are more or less the cores, so outside, uhm, and you can see one of those areas as a neighbourhood – neighbourhood is not the right word, because than it is definitely on a smaller scale – but that is let's say the scale where we organised the social domain. So, if you talk about Tom in de buurt, you are talking about the north-west or centre or about one of the outside areas. So, it is also one of that kind of team that receives the question from the GPs in such area. That is, let's say, the team where Tom in de buurt is active, but also the connection to, you name it, police, youth care, housing, enforcement and that is the reason that, well we call it different, but you can see that as a social district team where the level is just a bit higher.

JG: Yes, so not necessarily a neighbourhood, but more a district.

MS: Yes, and maybe to add to...uhm... it is indeed a global organisation, but here are specific areas that need special care and that gets organised to that are if there is demand.

JG: Yes clear, let me see, where is the well-being coach active, so where is he/she in employed?

MS: At Tom in de buurt.

JG: Is that the only place?

MS: Uhm that is also again a partnership of various organisations and they also have the assignment to receive and process WoR's application, so it is Tom in de buurt that receives it yes.

JG: All right, clear, then I have some questions about the health insurer. Does the municipality have agreements from the health insurer in general? And also, specifically in the frame of WoR?

MS: Interesting, no but we have, we have the health insurers also as an important partner in the chain consultation. So, we also choose the terms of Zorgdomein and financed it. Besides that, the municipality agreed upon a covenant with the health insurer that we both feel responsible for the social task we have. We both see the value, but between the municipality and the health insurer about WoR...uhm...no we did not make agreements.

JG: Okay, so also no financial agreements?

MS: No. Is it mentioned in the manual, because I speak to them on Saturday? Do you have suggestions for it?

JG: What I understood is that the municipality mainly subsidises WoR. That is the biggest budget pot for WoR. Furthermore, I do not have insight in the financial process.

MS: No, it is good to know that it is organised differently in our municipality than in others. That we have an organisation Tom in de buurt, which already is a partnership with multiple organisations, is really unique. That is not in every municipality where there are, for example, 10 care providers. Here is a much clearer infrastructure.

JG: Yes, and that is exactly my next question. How is it organised in other municipalities, what do you think? And I was wondering, to which extent do you work together with other municipalities regarding WoR and other well-being organisation in general?

MS: Regarding WoR, we don't really work together, but we do with other well-being organisations with other municipalities because the municipality also has agreements with two neighbouring

municipalities which Kaag van Bramen and Nieuwkoop. Tom in de buurt is also active in those municipalities. So, the assignment that they have which will continue on Jan 1<sup>st</sup> in a different way also applies for them. It is a broader partnership.

JG: All right, so that is the only thing that is different?

MS: Hmm, the only thing that is different?

JG: Only agreement made with other municipalities.

MS: In this case yes, with more municipalities we discuss how to tackle issues. Alphen belongs to the G40...but if you have a look at partnership on this subject than is it with two municipalities the most intensive. But you also have an area from the care offices, which is Holland Rijnland here, that is also a partnership, but that is, thinking out of my head, with 18 other municipalities. You also have the partnership with the region with the GGD which is, I think, 15, but that is different though, where we also have various partnership. At this moment, WoR is very local and it gets a local approach as well. If you talk about it more regionally than there could be agreed upon certain conditions, but also about that I think there are tempo differences so that you still will.

JG: Yes, exactly and to come back to the health insurer, if I remember correctly, you pointed out that at this moment it is not clear what the agreements are between the municipality and the health insurer?

MS: Well, there is not an agreement with WoR at the moment, but that does not mean it will not come. I know that our health insurer in contact is with Jan Joost how to continue establishing.

JG: All right, exactly and with agreements in general, so not with WoR?

MS: Do you mean financial or content wise?

JG: Content wise as well as financial, yes.

MS: Well, we have that covenant since a year. The partnership has been made a lot earlier, but financial wise it is difficult to comprehend, because you use each other's knowledge and that includes hours of capacity and that kind of things. And besides that, we have a vitality platform in which various movement partners, sport clubs, GGD, banks, retail but also, for example, the health insurer are included to find out how we make our inhabitants healthier. We also have more the side of the medical partners, home care, GP's and the youth care at the table, but of course other issues play a role over there, but they also have their say, so you can interpret the word agreements in different ways. We know how to find each other; we are on speaking terms and we want to calculate the steps together. And because we have a relatively small health insurer whom is more preventive, we do not have to deal with other health insurers, so that makes it a very different question.

JG: Yes clear, yes. The questionnaire is finished. Do you have any questions for me?

MS: Uhm, well, If I remember correctly sit eh reason for this investigation how it is organised throughout the entire country including digitally and what steps can we take when an advice is given?

JG: Yes, it is indeed to map out how the process exactly works and, in my case, for the municipalities – various municipalities – and to have a look at the bottlenecks and how we eventually can solve the problems, because what is right now clear for WoR is that a better system/process is necessary to refer more easily. Therefore, we have to map out how the process exactly works according to the information that is available.

MS: Yes, and included the footnote that it does not include only the system, but also the entire context in which you use the system and to get to know each other and in that is the municipality Alphen aan de Rijn already very active for several years.

JG: Yes exactly, I understand. With the system we mean the digital system as well the actual process in general mainly between the GP's and well-being coaches. So indeed, not just WoR, but to map out how everything works precisely in this and other municipalities and, of course, involve WoR as well ultimately.

MS: Yes, and ultimately it is not the goal you pursue. The goal you pursue is that you want to help the inhabitant to answer his/her question in the best way possible and if that is with A, B or C is not important. Maybe that sounds anti-WoR but that is not the case.

JG: No, I understand. You want to help the person accordingly and solve your own problems and WoR should be a compliment to tackle such issues.

MS: Yes, indeed it should complement each other, but all right, that is my personal conviction. We have to find out if WoR can help us this way, but we should not shun other options, I think. But we are going to focus more to make this more standard.

JG: Yes, we as researchers are not biased towards WoR.

MS: Yes, I understand.

JG: But it is, of course, necessary that we have to know how to improve the system/process where WoR eventually in is involved. In case of the municipality, they just want to help the person. But yes, to map out why do you works this way and not in another way or with a different system.

MS: Yes exactly, well, very nice to do and good luck.

JG: Yes, thanks a lot for the interview. Can I reach out per mail if I have any questions?

MS: Yes, sure.

JG: I don't think it's necessary, but if there is something.

MS: For sure, you know where to find me.

JG: And at the start of the conversation, you would like to receive the answers?

MS: Oh no, just after you wrote it out and you are going to conclude certain things about Alphen aan de Rijn; I would like to read it as well to see if we understood each other.

JG: Yes, that is all right, I send it to you when ready.

MS: Yes exactly.

JG: All right, have a nice day.

MS: Same, have a nice weekend Jordy.

## Interview with Daniëlle Wensink

**File:** Gesprek Teams-20211112\_080532-Opname van vergadering  
**Duration:** 28:08 Minutes  
**Date:** 12/11/2021

Jordy Gilberts: First of all, can you tell something about Welzijn op recept (WoR) in your municipality?

Daniëlle Wensink: WoR is still in the so-called pilot phase which has been started at the start of this year. We used the first half of the year to form a strong base, write documents, make agreements about how do you refer, when do you refer and when do you give feedback. We started per July 1<sup>st</sup> officially with WoR referrals and at the moment we have 6 general practices in the municipality and three of them participate in it.

JG: All right.

DW: Yes, and we have a bit of a duo project leadership. I am from the municipality more about well-being coaches who, let's say, where I am involved and we have a project leader from the general practices.

JG: All right, because that is actually the next question; how is WoR organised in your municipality. Great. Are there other agreements that you have as municipalisation regarding WoR with the involved parties, so think about well-being coaches, general practitioners (GPs) and WoR itself?

DW: Yes, we have made in the first half of the year, agreements about how are we going to do this, so we have also confirmed this. Uhm...how do we refer, in which time frame do we tackle this, when do you want to give the feedback...we agreed upon the concept Positieve Gezondheid (positive health) as a overall common term as think and do vision. So, from that vision we have a conversation with the inhabitant with the intention that they fill in all the 'levensgebieden (areas of life)' and 'spider webs (spinnenwebben) at the start and at the end. We subsidize extra as municipality to have the well-being coaches and besides that, Menses made agreements with the general practitioners association so that they pay the project leader to run it all smoothly.

JG: Okay, you talked about a spiderweb. Wat do you mean exactly?

DW: Positive health has a questionnaire where you will score on different areas. You can put those scores in a spiderweb to find out where you score high or low. By having the conversation, we can focus our intervention more accurately. So, is it more about the movement or meaning or the quality of life?

JG: Yes... and the spider web is with the patient in this case...

DW: Yes, yes that is also very interesting because how do you call such a person? Do you call it a patient, client or customer? We choose to call him/her an inhabitant who has been referred by the GP.

JG: Yes, all right. And if we zoom in at the referral from the GP to the well-being coach; how is it organised in the municipality?

DW: Uhm...someone from the general practice, so, that can be a GP or a POH who has the conversation to find if someone is motivated and where a well-being recipe adds value. It goes already deep in such a way we are able to fill in the spider web that gets transferred like, hey this is the image of the inhabitant, or they just refer because someone is really motivated to have an intervention. They do that with a standard/default refer form which, together, we created where the basic data is processed.

JG: Yes exactly.

DW: For now, is it per GP and where the bottlenecks occurred what we saw as fact is that there is not one single system to transfer is fluently. One general practice uses OZO Verbindzorg as communication and places the documents in there. But the other one uses Zorgmail or Siilo what also gets used by a practice a lot, so that still differs a lot. We have connected one single well-being coach per one practice. There are three well-being coaches at the moment and three practices so every well-being coach has its own fixed practice. And yes, with the holidays, it gets transferred, but in principle, it is fixed, so, we are also able to see for each practice which way is communicating the most convenient. Based on that, we join it and therefore, we have different systems.

JG: All right, clear and if you work with multiple systems, does it make it more difficult or do issues occur? Because you already mentioned that it depends on the patient but also the health insurer.

DW: Yes, the general practice, according to what they are familiar with for which system. At first it does work, it just takes more effort for the well-being coach, especially at the moment that he/she takes it over from someone or that issues occur in such a way that it is better if another well-being coach starts the conversation. Yes, they all have a bit their own focus. Then you notice that that person less familiar is to work with the other system and that takes effort for them. My preference is for sure to work with one single system and we agreed upon in the region, administrative agreed, with a lot of organisations that we, ultimately, want to go to OZO Verbindzorg, but two practices are at the moment not there yet that they want that. One of them is starting to implement it, but the other one mentioned that they don't want it yet and we said, we won't let the success of WoR depend on that, so that's why we made that choice.

JG: Yes, and you talked about a form at the beginning? Is it used to refer?

DW: Yes, that form gets send digitally. It is not a very luxurious referral system, but it gets through OZO Verbindzorg where you are able to save the documents. In there, the referral is created immediately.

JG: Yes, because I know that with the referrals, one of the bottlenecks is the AVG proof law. Is it taken into consideration when referring? Does it limit the way of working?

DW: Yes, for sure. For example, a diagnosis is missing including a clinical picture...so just the problem that occurs at that moment. Before someone gets referred, the inhabitant gives permission to share their data.

JG: Okay...

DW: And immediately it is noted at the form.

JG: Yes, yes and if the form gets sent.... Because it goes from the inhabitant via the GP to the well-being coach, right?

DW: Yes, the inhabitant does not have to fill in the form itself.

JG: Ah all right, and the well-being coach starts a conversation I assume?

DW: Yes.

JG: And where do they note the diagnosis or doesn't it get mentioned at all?

DW: There won't be any diagnosis regarding syndromes, because WoR is not about the syndrome, but about someone who wants to participate in society again who is not able to do it completely independent, so...uhm... that is where we focus our conversation if someone has a physical or psychosocial issue. The diagnosis of that or, let's say, someone has a depression or whatever is not important we think.

JG: Yes clear. The feedback from the well-being coach to the GP is through the same channel?

DW: Yes, that is right and we for sure have, because it is not the norm at the well-being organisation...uhm...before they sometimes received an inhabitant that got referred by the GP, but the general feedback was not immediately in their way of referring, so that's why we made the form with fields the GP would like to be informed about. That is on what we focussed the first half of the year to know from each other very well what we really need, so indeed, the GP wants to know the diagnosis and everything while the well-being coach mentioned, yes for us it is not that important. But also, the other way around, that the well-being coach wanted to write down an extensive procedure while the GP just wants to know what happened to the client and if it is long-term or not. That way we also have the form to give direction about what is important to refer back/feedback.

JG: And is this also readable in the HIS?

DW: Yes, but it is not automatic, it has to be added by the general practice in the HIS. A lot of times, a POH is involved for the client, so than the POH does it.

JG: And you mentioned POH?

DW: Yes, practice nurse GP's (POH)

JG: All right and they are involved in the entire process?

DW: yes, we said that POHs as well as GPs are able to refer.

JG: All right, that is clear, but do you know what the satisfaction rate is among GPs and well-being coaches about this system? So, we just talked about the data that it would be easier if it goes through solely one channel, so that there are no more health insurers. But do you also know how they think about it and what the advantages and disadvantages are?

DW: Yes, we did a first evaluation and based on that we adjusted a few things, so I don't know how it is at this particular moment... but after a few weeks, we want to start a 2<sup>nd</sup> evaluation. However, in the first evaluation, it was very noticeable that well-being coaches complained about having a lot of administrative work to do, but GPs mentioned that they were very satisfied with what they received from the well-being coaches. So, that motivates the well-being coaches to continue regardless. And in addition, about the form; we changed a few fields, because when we started to refer inhabitants, you noticed that some categories did not fit very well with the questions, so we adjusted that. But yes, structured in a fixed way just referring to the well-being coaches with referring back/feedback to the GP.... uh...that you make a fixed structure, has already been proven that it works very well including the partnership.

JG: Yes, clear and is it also possible to delete the data in systems?

DW: No, they can of course...well...there is of course a referral system or...yes...OZO or Zorgmail; just send them a separate email instead of something that gets placed in the HIS. What we did right now with the national code is that we use the data/numbers, since we really want to know in what way the consults to the general practices are increased or decreased. But referring and feedback is not by default in that system and can't just be deleted automatically.

JG: Yes, all right. A question about the well-being coach. Where is he/she active? Is the coach active by the municipality or where?

DW: No, here by the well-being organisation and that organisation receives the subsidy.

JG: All right, so, not accommodated by the municipality. I have a financial question, what does the system costs and who pays the bill?

DW: What do you mean with the system?

JG: Referring back to the entire referral and feedback system at this moment?

DW: Okay, well that depends. Siilo is at this moment free, I think, that the healthcare professionals are able to use, that is paid from national subsidy. Zorgmail is something that...uhm...the organisation already had at their disposal, so not subsidized separately, but through general financing ways. And OZO Verbindzorg is paid at this moment by Menses health insurance. We are right now investigating if the municipality is also going to partly subsidize it.

JG: Okay all right. You talked about Siilo app a few times, is that a new app?

DW: Well, I think it is already around for some time, but it has been said that it is going to disappear.

JG: Is going to disappear?

DW: Well, at least, that is what is said; right now, we are able to do this and this works very well for us, but we have to find out how to also do this and that in the future.

JG: Yes, so you mean disappear within the municipality or in general?

DW: No in general, or that is not free anymore or something like that, I don't know.

JG: Hmm yes.

DW: For now, we are still going to use it, but it is possible that we say we will use whatever the general practices use. Siilo is used a lot in one practice in particular, but with caveat, like, let's see how e are going to do this in the future.

JG: Yes clear. Is there in the municipality also a social district team and how is the collaboration and the division of labour between the well-being coach and the social district team?

DW: Uhm...we choose to not have a separate social district team, but various subsidized parties who support us. We have a separate well-being organisation just for well-being collective activities, but also for individual activities that also support the associations. And at those well-being organisations are also the well-being coaches accommodated.

JG: Ah okay. With the parties I have to think of GPs, well-being coaches...

DW: The GP is not part of our social district team, he/she is active on the medical domain. In our municipality, it really is the social base as support and accompaniment.

JG: No exactly, but because you mentioned it was separated; I was wondering if the parties that are normally involved in the referring process, are now involved in the social part or part of the social district team.

DW: Yes, that is what we see in other municipalities in the region, because we as region vote for WoR or not and that is where I can see it indeed. Some people from the social district team are more directed towards well-being, but we have a separate duty for that. Those are merged and schooled differently causing more diversity as well. If we put everyone in one single team, we think everyone is going to look and behave the same which is not beneficial for every inhabitant.

JG: Yes, clear. We are almost done. I have a question about the health insurer. Did the municipality make agreements with the health insurer in general? And also regarding WoR.

DW: We have as individual municipality no agreements with the health insurer, but we do have in regional connection.

JG: Okay and specifically with WoR?

DW: Yes, the health insurer mentioned that they want to subsidize the project leadership of WoR with the GPs.

JG: Yes, so then there are also financial agreements...?

DW: Yes, but just for this period.

JG: Yes, because I have here a question if the agreements are mainly content wise or financial. We just discussed financial, but are there also agreements content wise?

DW: Yes, we have in general substantive projects that we coordinate together for, for example, prevention. Regarding WoR is it just solely financial project leadership and...uhh...GPs don't get a separate compensation as well.

JG: Hmm, so content wise/substantive mainly prevention and with WoR mainly financially.

DW: Yes, exactly.

JG: All right, let's have a look. To which extent do you cooperate with other municipalities so with WoR and other well-being organisations?

DW: Hmm yes, we have a frontrunner group in the region where.... I am counting right now...4 municipalities are participating in it of 8 in total...we have a regional connection of 8 municipalities and from 4 municipalities that mentioned; WoR is active at those 4 at the moment. Regional, we have had a conversation with the directors/managers and in that conversation is mentioned that we had to do something with WoR. That is how it started. There are 4 municipalities that wanted to participate. And with those 4 you see a very fluctuating image who is really involved.

JG: Hmm, do you think that the system or cooperation works different in other municipalities?

DW: Yes, yes because there were really the well-being coach is indeed part of the social team affiliated with the municipality; they have to comply a lot more to the registration and communication systems that are active in the municipality and there you notice it is difficult to customize also regarding the general practices. Here it is easier to organise since the well-being coaches are outside the municipality. So, you do notice it for some that it differs. We made the standard forms and agreements to make sure that we have the right...let's say...transfer it successfully. And...uhm...a few municipalities haven't made default/standard agreements. We want a GP and if you want to refer, you can come, but they don't have the forms we have, not even a conversation about what kind of system do we want to use for referring.

JG: Yes, and you notice that the social district teams work differently in other municipalities. Very interesting to investigate.

DW: Yes.

JG: That's it, do you have any questions?

DW: No, it is good that this gets researched, because I think that it is a fragile point that whole communication system.

JG: Yes, and in general also the referral system. Because I assume the municipality just want to solve the problem if that is with WoR or another organisation, but nice that there already have been agreements with WoR. Well, thanks a lot for your time.

DW: I assume that through Jan Joost Meijs who connected us, also gets the feedback of the conclusion, because I think that is a great idea.

JG: I could...uhh...I have to find out how exactly I am going to do it, but I could send the answers I am going to write down, so you can read what I wrote.

DW: Oh yes that is fine if it needs to be academically otherwise it is fine as well. But I am mainly curious about what is the conclusion from the entire research.

JG: Yes, no that is fine.

DW: Yes? Okay.

JG: You mean the conclusion of this conversation or the municipalities in general?

DW: In general, like, what is your conclusion, which system works the best, what do we have to plan or what do we have to do to make it better.

JG: So, the entire business case you would like to receive?

DW: Well, yes to be honest.

JG: Yes, yes, no problem. The business case will probably be finished in February though and it is written entirely in English.

DW: Oh, I don't mind.

JG: Yes, all right.

DW: I studied in Maastricht in the past and everything was in English as well.

JG: Yes exactly, I will note it and then...

DW: Yes, very nice, and it is possible that we can use it to our advantage, that would be nice.

JG: Yes, yes exactly. Well, thanks a lot for your time and have a nice day.

DW: Hey you too and good luck.

JG: Thanks a lot, cya.

## Interview with Parel Feddema

**File:** Gesprek Teams-20211126\_094033-Opname van vergadering.mp4

**Duration:** 21:03 Minutes

**Date:** 26/11/2021

Jordy Gilberts: I think it is recording.

Parel Feddema: Yes, I notice it indeed.

PF: Yes, so indeed, the municipality Amsterdam has since approximately 2016 implemented Welzijn op Recept (WoR) as intervention. It started in a few urban areas and continued to establish in the entire city. Uhm, yes what can I say. By the current alderman, who has this in her current dossier, is it recognized as very important. She went to London as well and came in touch with social prescribing where WoR also came from. And within the municipality it is part of a larger programme named 'Amsterdam Vitaal en Gezond' that focusses on multiple fields on...uhm...yes prevention. So, for example, you have the coalition elderly that focusses on dementia or fall prevention. You have the coalition [unintelligible 00:01:24] that WoR also is part, in which within that programme overarching agreements are made about the, for example, preventive health insurer. In Amsterdam that is Zilveren Kruis and how can you indeed take up the medical and social connection together so that the costs you make in well-being doesn't have to be made in healthcare and vice versa including, of course, for the inhabitant, for the patient to tackle the issues early to prevent worse.

JG: Yes exactly, yes. And my second question was, how exactly is WoR organised in the municipality, but you already mentioned it partly. And I was wondering, which agreements were made regarding WoR? Also, with the involved parties.

PF: Yes, we have a subsidy relationship with a few big well-being organisations...uh...so, in every urban area there are 1 or 2, in some cases, 3 well-being parties that carry out WoR. So, they provide the well-being coaches and they are in contact with GPs, with POHs to raise awareness of WoR. Yes, it is a subsidy relationship.

JG: Yes, which organisations?

PF: Uhm, I have to think about it, yes good question...we have COMBIWEL, we have CENTRAM, DOCK, DYNAMO, DORAS and CIVIC.

JG: Okay, a lot. Yes, yes, all right and if we focus on the referral from the GP to the well-being coach, how is it organised within the municipality?

PF: Uhm, well in principle, you can find it actually on our website. There is all the information, [welzijnsopreceptamsterdam.nl](http://welzijnsopreceptamsterdam.nl), there you can find a step-by-step plan. I can show you, that is maybe the easiest. They just have agreements about how it all works. Of course, in practice it is a lot more complex, but this is our site and you can, for example, find the step-by-step plan to find out exactly what is the referrer's and the well-being coach's role. In principle, when an inhabitant with psychosocial issues comes to the GP, he gets transferred in trust to the well-being coach. Then the inhabitant makes sure that he gets in touch with the well-being coach. In practice, we noticed that this can be very difficult for the people with psychosocial issues. So, in such cases, the well-being coach gets in touch with the inhabitant to plan an interview to find out what will help this person which gets referred back/feedback to the GP.

JG: All right, yes very effective to view the scheme in a visual.

PF: Yes, for sure and that is also very easily accessible for alle professional whom work with WoR.

JG: Does the feedback between the well-being coach and the GP takes place through the same channel? Is it readable in the HIS?

PG: Uhm, well I am not sure, because indeed the referral...the GP has to write a recipe and that usually goes through Zorgmail, the secured mail. And the feedback... I think it is possible by phone or also through Zorgmail and you would notice that it differs per practice and per well-being organisation or something even per well-being coach. Some have very strong connections with the GPs in there are, but yes, I can understand that they use the phone to call, but I think it can go both ways.

JG: Okay, Zorgmail is the system in this case?

PF: Yes, I think yes.

JG: Okay, so there are some laws, digital laws like AVG proof where one has to comply to. Is it noticeable in the municipality? Are there certain rules build on this law?

PF: Yes, for sure, no that is all privacy sensitive information. So, that's why indeed that the recipe goes through Zorgmail and we as municipality register the data alter on about the number of referrals or about in general, how many participants are man or woman, age bracket etc., but no personal data.

JG: Yes, all right, do you know how satisfied the GPs and well-Being coaches are about the system? Can they mention the (dis)advantages?

PF: About Zorgmail, you mean?

JG: Yes Zorgmail.

PF: No, that is not my field.

JG: And in general? In the process? Do they have comments about the (dis)advantages?

PF: About the way of referring?

JG: Yes, about the way of referring.

PF: Hmm yes, then you need someone from the field, I think. I am more a policy advisor and project leader of urban WoR which has nothing to do with the system itself.

JG: Yes, all right, maybe you know something about it. Because indeed, the other parties are researched as well by my team. What does the system cost and who pays the bills?

PF: With the system you mean Zorgmail or also the secured environment?

JG: Yes, Zorgmail especially, the system and the entire process in general.

PF: Which process do you mean?

JG: So, what the municipality is establishing, the feedback with the GPs and the well-being coaches and what the municipality organises regarding well-being, so, the Zorgmail and well-being. Yes, let's just start with Zorgmail, so who pays the bill regarding Zorgmail.

PF: Well, what we as municipality do is to subsidize the well-being organisation to provide WoR and how they want put it in practice such as working with Zorgmail; that depends on the medical side of course the GPs and on the other side the well-being organisations. We as municipality don't have a role in that process. To simplify it, we subsidize the organisation to take care of that, but we are not going to decide which system or other things. We do if we talk about the wider administration what we, of course, also subsidize and, yes, to discuss how things are going, if goals are being met, so more in that manner.

JG: Yes, but that is all right, clear. So, the municipality subsidizes the parties and they decide what to do with it.

PF: Yes, but in conversation and there are certain subsidize requirements they have to be met.

JG: Yes, clear. Where is the well-being coach active?

PF: At the well-being organisation.

JG: All right, short and sweet.

PF: Yes [laughter].

JG: Is within the municipality also a social district team and how is the division of labour between the well-being coach and the social district team?

PF: We have in the municipality Amsterdam, since April this year, a neighbourhood team and that is very accessible team in the neighbourhood. In Amsterdam, we name it neighbourhood teams and they are indeed the first INGANG for inhabitant that have psychosocial complaints such as debt, loneliness or other various things to such neighbourhood team. And because it just started in April, we are still developing how to manage the cooperation, so between the neighbourhood team and the GPs, between the well-being coaches and the neighbourhood teams. So, with them we are discussing, with the neighbourhood teams, and well-being organisation, and the GPs about how are we going to manage this partnership. It is of course very important that everything runs smoothly.

JG: Yes, exactly and the neighbourhood teams; they are organisations? So, they are specialized in being part of the social district team or I mean doing the tasks of a social district team.

PF: Yes, before the neighbourhood teams were active, there were social workers, so some kind of organisation that were responsible for such tasks and that got transformed into the neighbourhood teams. So, before we had individual organisation where the client was able to choose which organisation, he/she preferred. Right now, it is the neighbourhood team that looks for the best possible solution to solve the issue.

JG: Okay and I assume that it is a group of people

PF: Yes, every district there is a neighbourhood team.

JG: And this is in every area of Amsterdam? So, in every district there is a neighbourhood team.

PF: Yes correct, yes at this moment there are 33 but it will get more, but it just started so it still needs to be established.

JG: so, it was not by default part of the municipality?

PF: It is a new way of organising. Support was already established but the way of structuring/organising is new yes.

JG: Yes, clear. Did the municipality make agreements with health insurer in general?

PF: Yes sure, that programme Vitaal en Gezond indeed, where agreements get made with the health insurer, Zilveren Kruis about who does what and how we structure everything the best way possible.

JG: So, talking specifically about WoR, are agreements made with WoR?

PF: So, there have been agreements, Amsterdam subsidises the intervention WoR.

JG: All right yes, because the next question was if there were also agreements made financially, but that is the subsidy.

PF: Yes, that is the subsidy.

JG: Are there also made agreements content-wise with the health insurers and WoR?

PF: Uhm, we there is a very strong partnership with the health insurer and the...well, we have the Amsterdam General Practitioner Alliance where we have a conversation with how to manage this the best way possible since every party recognizes it as a very important intervention that works in a manner that... not always when people come to the GP are they in search of a medical answer, not everything is solved from a medical point of view. For example, if someone comes to the GP with physical complaints that does not have a direct medical cause; the complaint might have occurred due to loneliness or other...psychosocial...and also the health insurer is able to view this. So, country-wide but for sure also in Amsterdam it is recognized, that prevention is very important and WoR is a great solution for this.

JG: Yes, they specialize in people with physical complaints that seem to be caused by psychosocial issues.

PF: Yes, for sure.

JG: Do you work with other municipalities regarding WoR or other well-being organisations?

PF: Well, we are in touch with eh Landelijk Kennisnetwerk. Sometimes there are conferences, or investigations or other things that are in play nationwide. For example, with RIVM, or with VWS, so this way there is a nationwide connection.

JG: Hmm, yes all right. Do you think that the system works differently in various municipalities? So, that you do it differently than in other municipalities?

PF: Hmm I think there are differences locally, but that the intervention in principle is the same more or less.

JG: Hmm all right. That's it. Do you have any questions?

PF: No, uhm, well, you said that the investigation will be published?

JG: What I understood from Jan Joost is that the investigation will be used and published in the Landelijk Kennisnetwerk.

PF: Yes, all right.

JG: And we research how we can improve the system/process for our business case.

PF: Yes, yes very nice. And how did you encounter WoR?

JG: Well, they announced at Zuyd, I am a student at Zuyd Hogeschool and for the business case we considered several options and then we agreed as group to take on this challenge.

PF: Yes, very nice.

JG: Any through a different spokesperson, we came it though with Jan Joost. Before it was woman, but I forgot her name.

PF: Hmm, Miriam, I think.

JG: Yes, indeed Miriam.

PF: Well, very nice, it is very interesting and a broad topic. Great that you add value to a case like this.

JG: Yes exactly, and we are very motivated to do it well even though it is a lot of work. In February we have to be finished.

PF: That will get done for sure.

JG: Thank you for your time.

PF: You're welcome, good luck.

JG: Thank you.

PF: Good afternoon.

JG: Bye.

## Interview with Erik Kramer

**File:** Interview project Welzijn op Recept-20211119\_143042-Opname van vergadering.mp4  
**Duration:** 27:55 minutes  
**Date:** 19/11/2021  
**Organisation:** Zorg en Zekerheid

Lucka Koelman: Since we have several interviews with external parties going on, we decided for now that I will conduct this interview with you alone today. Since it will be recorded as well, we can continue the project together.

Erik Kramer: All right.

LK: Let me explain who I am and who we are as a group. I am Lucka Koelman and just like my fellow students we are students at the University of Applied Sciences ZUYD in Maastricht and for our final year project we are doing research for Welzijn op Recept.

EK: What are you studying?

LK: We are studying International Business

EK: Ok.

LK: Welzijn op Recept has a very interesting case for us. It is not necessarily internationally oriented, but it does fall within our project requirements at the moment. The aim of our research is to work together with Jan Joost, with whom you may be familiar...

EK: I have known him for a few years, yes.

LK: Yes, he mentioned that as well. He was the one who brought us to you. We are conducting research into how we can actually increase the number of referrals for Welzijn op Recept and where it currently goes wrong, especially the link between primary care and social care, to see what can be improved, and ultimately, we also want to recommend referral systems, and we are looking at various parties who may be involved, such as health insurers, to see exactly what their position is. So, if you don't mind, we have drawn up various questions in advance and I would like to stick to them, but in addition to that, I would like to use the discussion to see where we end up and perhaps where we can go further into detail.

EK: All right. OK.

LK: OK. Great.

EK: Who am I? Erik Kramer, I have been a procurement officer for primary care at Zorg en Zekerheid for some time now, uhm, particularly in the area of general practitioner care and multidisciplinary care, which involves general practitioners, which involves physiotherapists and so on. I have been involved for a long time in, uhm, both Positive Health and Welzijn op Recept, and I have known Jan Joost for a long time.

Uhm, one of the results of this is that in our region, which is roughly the area between Amsterdam, west of Utrecht and north of Zoetermeer, this is where most of the Welzijn op Recept locations are situated.

LK: Yes.

EK: Among other things, a little, relatively marginal. It is different everywhere, but it is still a bit marginal. A general practitioner is already happy if he makes twenty referrals a year, yes, that's kind of marginal.

LK: And uhm, how would you describe the position or the contact between Zorg en Zekerheid and Welzijn op Recept? Is it a continuous, regular contact?

EK: And do you mean with the Kennis Netwerk?

LK: Yes, with the Landelijk Kennis Netwerk

EK: Yes, that is very frequent. Last year we had some ups and downs, but I speak to Jan Joost with great regularity.

LK: OK. Yes, we know that Welzijn op Recept is known within a number of municipalities in the Netherlands, but we do see that, uhm, Jan Joost himself would like to see his position strengthened a bit more, and could you see how or what Welzijn op Recept could do to strengthen its position with the health insurers?

EK: Again, the Landelijk Kennis Netwerk. Yes, to me, Welzijn op Recept is a methodology and I see the Landelijk Kennis Netwerk as... I just have to keep things clear for myself.

LK: Yes, I will indeed stick to the Landelijk Kennis Netwerk.

EK: Yes, doesn't matter. But uhm, we actually asked Jan Joost this question: what can you do for us to ensure that more use is made of it in our region? He is writing a master plan to realise that, so I think the answer to this question is something Jan Joost knows a lot more about than I do. Uhm, in fact the answer is in the Landelijk Kennis Netwerk or in the master plan. I think Jan Joost is actually already doing quite a bit, especially in, uhm, bringing and keeping interventions like Welzijn op Recept on the agenda. Both at the local level and also at the level of the Ministry of Health, Welfare and Sport, as well as shortly with Movisie, uhm, so I think Jan Joost and Miriam are doing what they can. Apart from the master plan, I think it's now mainly up to the insurers to take the step and up to the municipalities.

LK: Yes, that's right. We are also looking into that.

EK: The biggest hurdle is not being able to let go of GPs. I think that is the biggest hurdle.

LK: Yes, we see that this is where it actually starts, with the GPs. So we were wondering to what extent the insurer is actually involved in the process of referring a patient.

EK: I am not involved in that. The GP refers. I'm not going to sit with him in the consulting room. I do not want to, I cannot, and I am not allowed to. I can tell for example..., but then you are talking much more about which implementation strategy you use. I always try to look at what kind of leaders there are. And then you can facilitate those leaders and hope that the laggards think: shit, why him and not me? With the frontrunners you also have to focus on results, and results can be: happier patients or more peace of mind, and I actually hope for both. In this case, I am mainly talking about GPs. Uhm, and as GPs, for the professional group, it works like this; if someone else has it better, believes they

do it better, then I want that too. In the profession, if someone stands out, then the followers are easier than the, say, mass pullers. So that's what we do.

LK: Yes.

EK: So, then you look at how you can respect the leaders, how you can talk to municipalities, and also make agreements about this.

LK: Yes, because we see, of course, that welfare is not necessarily reimbursed by an insurer but often comes from municipal costs.

EK: We don't reimburse welfare. That falls under the other of the three big laws; the WMO... We are responsible for ZVW, the WOZ and the WMO is actually up to the municipality. Uhm, only you have to do it here, that's the other aspect of course... You have to make permanent agreements with the municipalities about the care that is currently clogging up the GPs' care and how you can redirect it towards the social domain. There must be sufficient accommodation there to realise that and at the same time the social domain must also, yes I often call it participation but it is society where you do much more community building. Because otherwise you shift it from doctor to social worker. Yes, that's just shifting the problem and not solving it.

LK: No. No, exactly. That is why it is also important in the research that we are doing to see what exactly we are up against. What are the problems in the first link and how does the feedback flow?

EK: Look, if you look at the link, it is about, if I look at the core, a good digital referral method, uhm, at the moment two different components are being used, as far as I know: Zorgdomein with pre's and con's, and uhm, VIP collaborating with pre's and con's, uhm there will be another methodology somewhere, Vecozo is of course working on it, Vectus is developing something. But it won't be ready overnight. If I know the average of Vectus or Vecozo, I should say it could take 1, 2, 3 or 4 years. They are usually not that fast. Uhm... so that's a puzzle. Letting go of the doctor is a puzzle, and adequate linking of the social work is a puzzle in the first piece.

LK: Yes. Because we also see through the research that there are so many different ways of documenting, for example, which is often not even necessarily AVG-proof, which makes it very difficult to, uhm, get proper documentation up there in the first place. And we also see that, at the moment, one of the biggest seems to be Zorgdomein and we were wondering whether, in the work environment, you often hear about the advantages or disadvantages of Zorgdomein when it comes to feedback.

EK: The referral via Zorgdomein goes relatively smoothly. Of course, the GPs are also familiar with Zorgdomein. It is a terribly expensive system for the municipalities. Uhm, because the healthcare domain is of course, how do you put it, the healthcare domain assumes that if you put yourself in the shop window as a party to be referred to hospitals, you will earn money by doing so. Earned is of course a strange word, but you earn back the costs from the referrals you receive. That is generated business. From the perspective of the municipality it is of course very strange because, uh, it costs the municipality more money than it brings in, because every referral costs money. Rightly or wrongly, that's a separate issue. But with that, the funding model of Zorgdomein is in the municipal hand. And the feedback from social work to the GP is, in my opinion, not yet properly regulated.

LK: No, sorry for interrupting you...

EK: No, doesn't matter.

LK: Because what we hear then and what we also see in the research is that Zorgdomein is all about referring between GPs to hospitals and not necessarily to welfare.

EK: No, that is correct.

LK: Yes, and that is actually a big missing link. That's why we are also looking at other referral systems that could, what do you call it?....

EK: Offer, I understand what you mean. There's always, look, there's the problem in several axes. Technology is one. Uhm, and there is a say, independent of which system, so system independent. The language of the GP or the culture of the GP and the culture of the social worker are so fundamentally different that the GP really wants to have very concise feedback such as he receives from the specialist, uhm, preferably in a way that he can save fairly quickly or is saved automatically in his file, the signalsign by means of Zorgdomein. Social workers who either give no response or have a two-page document in GP terms: bla bla bla. While he thinks: "what am I supposed to do with that? I'm just asking... Yes". There is also a cultural aspect to this, but also, in my opinion, from a technical point of view, the feedback from the social workers is not correct.

LK: No.

EK: And for hospitals it works reasonably well, not always, but the feedback from social work to etcetera is a drama. Uhm, a system that works slightly differently is VIP, VIP cooperation, which in the end is from TSS, uhm, has the advantage of being owner of VIP Calculus, which is of course the declarations manager of the GP. They know them, they trust them. So everything with VIP is also in order. This is more or less how a family doctor thinks. Uhm, VIP is a good system. Uhm, I think you can do it very well, the payment is then on the side of the ZVW, if you organise it well. Uhm, because it's a whole package which is often done not only for the municipality but also for all the other, say, kis-like functions. Plus communication between more disciplines in the district. I don't know how the feedback from the social worker to VIP works from a technical point of view.

LK: No. But that is why we are indeed in contact with various possible referral systems and also with VIP. We are in the process of setting that up and those are indeed questions that will be asked to see to what extent it can be done well or should be done differently.

EK: Yes, yes.

LK: You also mentioned the Vecozo initiative. Is that something that you, as a healthcare insurer, are already involved in?

EK: No, that happens, uhm, as the insurer, but there are other people within my organisation who are involved in that.

LK: OK.

EK: In fact, the Dutch health insurers are the contractors for Vectus/Vecozo.

LK: Yes, we have read various things about that, but I was wondering whether you had heard more about it, or...

EK: No. There are things that I do not interfere with, or do not need to interfere with. I love it.

LK: I can understand that, yes. No, well, yes, I think it is very interesting to hear that, in addition to Zorgdomein, other referral options are also being used. I also think that this is very important for us to be able to investigate this in our project.

LK: What we were wondering is whether, from your position, there is anything else you would like to say about how, yes, the process is going at the moment. What is really mainly what you are up against as an insurer or are you completely uninvolved in this when we look at GPs and welfare?

EK: No, no I'm pretty much involved in this. I had a meeting yesterday, let me try to be practical. Yesterday I had a meeting about positive health. I had a kind of breakout room there as well, I don't know if you have those from time to time.

LK: Yes.

EK: I was sitting with a GP in Leiden who, uhm, has a practice with lots of students, really lots of students. A bit of a student hot-spot, you probably have the same thing in Maastricht, you have certain neighbourhoods where mainly students live. And there was a report earlier that the mental health problems among the students are really, really huge, especially in astronomy and Japan studies, I think, yes, they almost studied in the a6. But there are also a lot of personality problems, but also a lot of depression among people where the GP said: yes, I have so many of these patients where I think you are talking about headaches but actually you are talking about debts, stress and all those other things. But then she also said: yes, you know, there are also people who almost, and this is not only the case with students, but more frequent places, say: I've got a headache, you are the doctor, do something about it, I want a pill now or whatever, research, now! There is a certain amount of consumerism in all of them, and consumerism without effort means that if I can do it with a pill or something, then that is much easier than having to go the hard way with self-responsibility. That is the one aspect. The second aspect, you know, I can handle three or four of those difficult conversations a day, and then my head is full, and I think, you know, just do it. So that is where it starts. And this is coming from a young GP who still sees it and wants to and is able to and is well supported. Other types of GPs think they are the doctor for everything, and I sometimes kick them in the shins by saying that they behave like children, raking in everything on their plate as quickly as possible and then regretting that they are getting fat. So, letting go of GPs is for them the biggest problem of all. Uhm, so understanding that someone else can do something better than them is also outside the medical domain, a specialist we understand but that in terms of work they can do something better than them is bizarre. That a therapist can do something better than they can is bizarre. At each time, you have to, you have to see the patient, uhm, the GP, I had a conversation about it the other day; a conversation in which it becomes clear that loneliness, other things, uhm are central and what can we do about it together? Instead of saying: I know someone who can do something with you about that, as a GP.

LK: Yes, yesterday we had a meeting with Jan Joost, and we had a whole conversation about how it is actually implemented in the head of a trainee GP. That the solution really is a pill or a prescription and that the doctor can then move on to the next patient and that this is how it continues. And that often... And that frequently... and we have had contact with, or interviews with, various GPs and we have seen that they say: every now and then we think about how we could have handled things differently. That is what they say, but often it is just easier to prescribe something because you can then move on because the pressure is so high, and it has been put there.

EK: Yes, pressure is also high, but it is a bit like the characteristics of square wheels; if you don't take the time to change the process, you keep the pressure because there is more and more on your plate.

LK: Exactly.

EK: And if you then consider the patients who come to the GP more than 30, 40, 50 times a year, that is a fairly large group. If you do not do anything fundamental there, yes, it will stay that way.

LK: Yes, exactly. And that is also what we see and, uhm, it really starts with the... actually the classification, if a consultation hour is classified differently, you could already solve a lot of things.

EK: Yes, yes. But it's also consumerism, and I am going to be blunt about that... from your generation.

LK: I believe that too.

EK: I pay for it, so I am entitled to it, so just do a quick scan. Leading has become difficult lately.

LK: Yes, it has. I believe that too. Yes, of course it is due to different factors. But if they would look again at where it all starts, hey, how you might be able to rearrange it and maybe also look at how a training course is put together and whether there might not be adjustments that can be made in addition to referring medication or something like that, then you might be able to make some progress, which is what we see.

EK: Yes, definitely. And look, the last puzzle is, uhm, the fluctuating government policy that fluctuates municipal policy. We are now ahead of the municipal elections so actually from October, September no alderman wants to rule over his own grave so actually no more agreements are made and then elections come... so actually only in the middle of next year you can make agreements again for a period of three years so actually it is at a halt. It can be a 380-degree switch. Uhm, apart from that, municipalities still put the social domain out to tender occasionally. Where new people come in and say a GP with the practice and I do not know many GPs who are going to switch practices so you're in one place for 30, 40 years. The world around him is changing at a rapid pace, he must introduce himself again. So, both a new policy and a new tender do not help either. This is done based on 'I trust you, I've talked to you a couple of times about it, you are doing well, OK, I dare to hand over my patient to you'. And then suddenly Truus is gone, and then suddenly Truus is called... give it a name. This is the chain. This is what we have to deal with, but that makes it all more difficult. I think if we start with the GP and a good referral system, fine. The referral system only helps to a limited extent in Leiden, in Alphen they use Zorgdomein. That certainly leads to more referrals, but then you might go from, well, 8 to 16, or from 10 to 20.

LK: Yes. No, it is not that, or yes there is some difference, but that is not where it lies in general terms. No, and that is why the study is so important, also for Jan Joost, to find out about it, to map out the different parties. From the municipalities, from the insurers, from the GPs. To get a picture of where it all starts.

EK: Yes, and briefly my interest, because you have not asked that question yet, but it is quite crucial. We are, of course, engaged in several movements. One movement is called De juiste zorg op de juiste plek (The right care in the right place), making sure that when there is rampant growth for hospitals, care in hospitals stops and turns to replacement, relocation, prevention. These are the 3 themes. Prevent prevention, replace digital, move second line and first line. That means that more and more has to happen in the first line. There really are not any more GPs, staff really are not increasing, so there too you have to look at what kind of care is provided by GPs that is not useful and then, in fact, Welzijn op Recept is one of the methods to divert that to the do-it-yourself domain or to the municipalities. And in the end, all these movements mean that, even if you are a bit older, healthcare will still be affordable. I think that is the greatest concern of all. Affordable and people friendly.

LK: I think so too, yes.

EK: That is my interest. I have to make sure that there is sufficient GP care for our insured.

LK: Yes. So, you also think it means that there really is an essence to Welfare on Receptions?

EK: Uhm, there is an urgency.

LK: Yes. That is, I do not want to say good to hear, but important to hear at this stage. Good. In any case, I am pleased to have also received the perspective of you and Zorg en Zekerheid.

EK: That's good. Good luck with your research! When will it be ready, approximately?

LK: At the end of January if everything goes well.

EK: Well, I am very curious to see the report.

LK: Yes! If all goes well, when the investigation comes to its conclusion, we will also compile an article about it. I assume that Jan Joost will also share it with the people we have had contact with through him. So, I think you will see that.

EK: Definitely.

LK: Yes. Well, thank you very much!

EK: You are welcome and good luck! Until another time perhaps.

LK: Have a nice day!

## Interview with Erik Koekoek

**File:** Interview project Welzijn op Recept-20211201\_150205-Opname van vergadering.mp4  
**Duration:** 27:34 minutes  
**Date:** 01/12/2021  
**Organisation:** Zilveren Kruis

Lucka Koelman: We are International Business students and are conducting research for the Landelijk Kennisnetwerk, Jan Joost, I am not sure if you are already somewhat familiar with Jan Joost himself?

Erik Koekoek: Yes, I know him. Yes. Yes.

LK: Yes, I thought so. Uhm, we are actually investigating among other things how the referrals can be increased, how Welzijn op Recept can improve its position in the Netherlands and within the municipalities, and what obstacles are being encountered. And we are focusing in particular on, uhm, giving recommendations about a possible digital referral option to actually improve processes. So that is why I was interested in doing an interview with you as an insurer.

EK: Yes, very well. Uhm, could I just briefly explain something about myself? And by the way, just say "you".

LK: I will try. That is what I am used to.

EK: Well, I am Erik. I work at Zilveren Kruis health insurer. I have the job title strategic advisor municipalities. And that means that I focus on the cooperation with municipalities and on the intersection of the healthcare laws of the municipalities and the laws that we, as an insurer, deal with. Those are the Health Insurance Act, the Long-Term Care Act. Uhm, so that is very briefly what I do and, uhm, I also encounter Welzijn op Recept in that function, when it comes to the intersection of those laws, it is very much about residents who, uhm, are being helped from, either by welfare or by the GP or by the psychiatrist, for example. And what we are looking for in particular is better cooperation between the professionals from the medical care domain. At the moment we simply see that they still do not know each other well and still do not know how to find each other and know what other parties have to offer, and well, as Jan Joost himself is always very good at describing, 20 to 50% of the patients in the GP's practice have psychosocial problems that cannot be solved by the GP or in the primary care but simply have to go back to the social domain, and the infrastructure for that is lacking.

LK: No, exactly.

EK: And Welzijn op Recept is a very good instrument for this, uhm, I have also been in contact with Jan Joost for a while and we have been trying to support each other.

LK: Yes, that was actually one of my first questions; how familiar is the insurer with Welzijn op Recept, is it close contact on a regular basis? How exactly does that contact take place? If it takes place at all.

EK: Yes, of course it depends on who you ask within the insurance company. As an individual, I am quite familiar with Welzijn op Recept. I have known Jan Joost since 2016/2017 approximately and I first spoke with him about this concept. So I am quite familiar with it also within Zilveren Kruis in general we know it quite well. Uhm, at the same time we also say of course it is not the only instrument there is to promote that cooperation, there are several models we know in our field that also revolve around cooperation between GPs and social work, the social domain. Uhm, but Welzijn op Recept is

in any case a very nice proven method and it has a wide range by now, over 100 municipalities. But we do not tell GPs "You must do this", it does not extend that far, so I am not going to say anything about that. We are well known with the process.

LK: But from your perspective, there is not necessarily any urgency to get Welzijn op Recept into the picture? At the moment? Or are there also other uhm....

EK: Yes, exactly. Not necessarily Welzijn op Recept as a methodology or as an intervention perspective, but uhm, the urgency of strengthening the cooperation between the medical and social domains. And that, from my role, is a very broad one: it concerns young people who come into general practice where there is also a problem with youth care, it concerns adults with psychosocial problems, it concerns adults with psychological problems where the mental health services are concerned, and it concerns the elderly. So for a lot of target groups, a lot of our policyholders who have a problem, those health problems end up at the GP and that is therefore the place to go for all types of issues. And for all those groups, you would like the GP to be able to make easier use of what is available from welfare.

LK: Yes. Yes, and that is exactly what we are researching; how can the process be improved, because at the moment, it seems not to be going well. There are simply a number of elements missing that would make it easier to do this.

EK: Is that what you see? Does that come from your research or is that, uhm?

LK: Well, we see that, we are at this moment still mapping out the current situation and we also look at different parties involved. You as an insurer, but also the general practitioners, the welfare coaches, the municipalities. And so yes, at the moment we are mapping out everything and of course we are already seeing various things emerging. But uhm, the intention is that by the end of next week or the week after, we will be able to make a real assessment of which aspects are really emerging in each party, which will allow us to describe a real analysis.

EK: Yes.

LK: And uhm, yes, we are in regular contact with Jan Joost because we are conducting the study for him as well, and he indicated that it is certainly interesting to talk to different insurers as well. And uhm, he also mentioned that there is some interest in Welzijn op Recept, but from his perspective he does not necessarily see it being implemented within the insurers.

EK: No. No, that varies. What I can send you or at least explain verbally is that in our procurement policy, for GP care, we also have a separate module that deals with cooperation with the social domain. We also refer to, among other things, Welzijn op Recept, but also to Krachtige Basiszorg, for example, this is another method that is applied in our area of work. What we are doing, at least in our procurement policy, is giving GPs the opportunity to make use of that and that they can be compensated somewhat extra, because it also costs time of course. So that is something we are already doing actively and including in our purchasing policy. I cannot fully judge how other insurers manage that, so it may well be less.

LK: No, but this was something that, how it came across to us, Jan Joost did not fully understand. How it was done exactly. Because one of my other questions was "To what extent is the insurer involved in the referral process between a GP and a welfare coach?"

EK: Yes. Well after all, we are not involved. You did indeed mention in the e-mail that referrals and healthcare domain were involved; I looked it up and, well, I do not know exactly, but I saw something that referred to a certain region where this is already being done, and where this is also the

arrangement. For us, it is true that the GPs all work with Zorgdomein, so that is quite easy. What you would like is for welfare to be linked up to Zorgdomein and for the referral to arrive via that line. But then again, those are investments that would have to come from the municipalities to make that connection possible.

LK: Yes, exactly.

EK: So I can get involved in that, and I do focus on the discussions with the municipality: will we indeed use and deploy Welzijn op Recept and can we realise from the preconditions that the GP and welfare can also work with it, and after all, that aspect of Zorgdomein is not part of the agreements, but it does make me think a bit: maybe I should include it, to see if we can make agreements with municipalities about investing in it. But in practice, up to now, I have not been involved in that. It is not something that the insurer directly interferes with as to how the referral ends up in welfare, and whether that's by fax, by phone, or a note that you take to the well-being coach, or digitally. No, in the implementation in that sense we do not concern ourselves with that.

LK: No, it is not necessarily a factor that is missing from, if I can put it that way, from the side of the insurer, but it's more that, uhm, Zorgdomein is actually the largest, what we see at the moment, in the field between the GPs and the hospitals, for example. And then there is a lack of function to refer to welfare and, uhm, the problem is that there is not yet an option for welfare. And if we look at other referral systems, we see that there are some being used throughout the country, but no concrete system that is already being used. That is why we now want to compare different systems to see which one fits the bill and how it can best be done in terms of costs. The municipality, for example, does not want to be the only one paying for all the costs in the end. That is also something that is encountered. Uhm, and what we have discussed before with Jan Joost is that either Zorgdomein must be persuaded to make this function possible, or one has to ensure that the GPs all switch to a different system, but that is also very difficult to achieve.

EK: Why would GPs have to switch if Zorgdomein basically offers the functionality?

LK: Well, if Zorgdomein would offer this function, it would solve a lot of things, because then it would be easy to do with one click, for example, and then it would all be in the same place. We have already done some interviews with and around Zorgdomein and it takes a lot to get that function really in place and that of course also involves money issues, and we see that the municipalities do not want to be the only ones paying for those costs.

EK: No. Now I am just looking at something. Uhm, in my experience. I am just looking through my mail because I sent something around to a few people yesterday. I came across something about Zorgdomein, that they just work with it, but... let's see.

LK: Yes, we are indeed trying to assess to what extent Zorgdomein can realise that. But at the moment we do not have the level of detail that we would like, but we are working on it.

EK: Ok. Uhm...

LK: But if you know more about it, that would be very helpful.

EK: I think it is a little article on Zorgdomein itself, but I got that from it, let's see, I will send it to you. I will do that right away.

LK: Yes, that is very useful.

EK: I gathered from that it just happens to be there. But let's see. What is your mail address because I cannot see it?

LK: Uhm... I will just give my ZUYD address which is... 1858106

EK: Yes, I have it already. No, I typed in your name, but it did not show up.

LK: No.

EK: Then I will just take some pieces out of that mail. Well, it is coming to you now.

LK: Very helpful.

EK: I thought I could at least deduce from that article that Zorgdomein has that functionality and I would also make that commitment if I saw that Zorgdomein is used by almost all GPs and I do not even have to try to get them to use another system. We are not going to do that.

LK: No, no.

EK: Make sure that Zorgdomein can also refer people to welfare and that welfare is able to process that referral and that there is a connection with Zorgdomein. I think that is possible in principle, but that does raise the question of who is going to pay for it?

LK: Yes.

EK: But I am also curious, I do not know if that is part of your research or, uhm, what GPs think about it.

LK: Yes, it is. That is also included. Because in addition to looking at the other parties, we also look specifically at what are the, uhm, wants and needs of both clients and GPs and welfare coaches. Because what we have noticed, especially now, is that there are many, at least among welfare coaches, who use a lot of different ways of documenting what is not GDPR-proof, shall we say. One does it in a notebook, another in an excel file and that way the GP does not actually get correct feedback.

EK: Exactly, exactly.

LK: And on the other hand, it is very often the case that the patients who need the welfare services, for example, are helped with a medication or another kind of referral to a specialist when they might need the welfare coach. So that has a lot to do with the feedback between the GP and, for example, the hospitals or the welfare coaches. That is also a large part of the research.

EK: Exactly. No, yesterday I had a meeting in the region around Zwolle, where I am active, among other things, about a project plan to introduce Welzijn op Recept in eight municipalities. Uhm, and the GPs' organisation is also involved in this, and they said, yes, they indicated two things from the GPs' position; 1. He just has to know what he has to do and he has to be able to do it as simply as possible. The referral must be very easy, and he must not have to spend a lot of time sending the patient to a welfare coach. And 2. The feedback. That is just important for those GPs. And if you continue to justify this, then Zorgdomein is almost a necessary functionality for GPs to be able to work with.

LK: Yes because it is already there. If it could be supplemented, that would perhaps solve a lot of things, of course. And uhm, yes, if I can ask it like that. We were wondering, from your perspective, Welzijn op Recept...

EK: You can just say You, remember?

LK: Yes, from your perspective. What the Landelijk Kennisnetwerk or, in fact, Welzijn op Recept could do as a methodology to strengthen their positions within the insurers or, in fact, the municipalities.

EK: Well, then you should know that recently I have also been quite closely involved in a development within the Landelijk Kennisnetwerk about precisely this question, I believe. Jan Joost has also taken the initiative to organise a meeting with several insurers and municipalities, and with the help of Movisie, to draw up a kind of model or agreement for better agreements between insurers and municipalities and GPs and welfare for the implementation of Welzijn op Recept. I am already involved in that and, uhm, from Zilveren Kruis, and I think that is a very good step that has been taken. Because I think it is still a bit of a long way to go. Because in my experience, it still depends too much on the goodwill of a GP and a welfare organisation. You would like to have more mass, so that, uhm, a large number of practices take part and that it is easier for them to expand the number of participants. So that is what we are working on. And after what has already been made is a nice purchasing framework as well. This is also the result of discussions with the Landelijk Kennisnetwerk about what would be helpful. And yes, what will ultimately be very helpful is hard and factual conclusions about the impact of Welzijn op Recept. What does it mean in terms of less workload for the GP, in terms of health gains for the patient, and less care? Yes, so that is what Jan Joost is doing, I am aware of that. But these are ultimately questions that we are also interested in, of course: is it worth investing in? I am convinced that it is, but it would be nice if it could be proven somewhat harder.

LK: Yes. You want to be able to reflect on it in the end. Yes. Ok, in any case it is good to hear that a lot is already being done and I think it is also very important for the situation in the Netherlands. But uhm, in addition to that, we were wondering if there are any other digital referral options besides Zorgdomein that you or you might encounter?

EK: No, no...

LK: No, not really?

EK: No. I do not know anything other than Zorgdomein.

LK: Yes, because prior to this interview I also spoke to another health insurer who had a whole list of other referral systems that he also sometimes had to deal with and he found it indeed quite unclear because there are many different options and therefore, he also noticed that different GPs were working with different systems and therefore no clear overview. It would therefore be very handy if Zorgdomein had everything in one place. No, okay, but then it is clear that there are no other options that you can come into contact with.

EK: No, I mean that is, uhm, also my lack of specific knowledge on that part. But as far as I know, Zorgdomein has a market share of I think 92%, so of course there are not that many other options.

LK: No. The next question was whether you had heard of the Vecozo initiative because that would be something in which some other insurers cooperate.

EK: No. I do know Vecozo. I know more or less what they do, but in terms of initiative in this area, you mean especially those referrals. No.

LK: Yes, yes.

EK: I am not aware of that.

LK: They are cooperating to be able to offer a referral option. But we are also planning an interview with them, and if that is the case, we will get more information from it. Uhm, no ok, my last question would then be whether there is anything else you would like to say from your position about the course of contact and how referrals could be made better. We have already talked about that, but if there is anything else you would like to say....

EK: Yes. No, not on that aspect. As I said, I am not very deep into that aspect of the referrals, I am mainly involved in making Welzijn op Recept possible in the municipalities and in the region. And there are some great products from the Landelijk Kennisnetwerk and Tim is also working hard to emphasise that. And I really believe in it because it makes an important contribution to the wellbeing of residents, but also to relieving GPs of the burden of all sorts of issues that do not belong there. For me, I am a fan. And based on that role, I am also committed to seeing opportunities in the region to make use of that.

LK: Yes. I think it is very good to hear that you are in favour of it, of the methodology and the initiative, and I think that Jan Joost would be very happy with this information.

EK: No, but it is true that not every insurer is equally enthusiastic about it, I think, and I do not know how it fits into the policy of every insurer. We have room for it in the policy, we have already made room for it. But other insurers, I think, are less well equipped. So that is not... maybe Jan Joost will be pleased with the way I have expressed my views, but that is not yet the view of all the insurers.

LK: No, I think that is true. I must say that this was also a very interesting conversation in which other perspectives emerged. I think I was able to get what I wanted to hear. So I want to thank you very much for this conversation and for the time that has been freed up. We also have close contact with Jan Joost, and I have received you as one of his contacts, and I think that all the contacts who have come from Jan Joost will also hear something about what the research has ultimately revealed. Something about that will certainly appear.

EK: I am definitely interested in outcomes and what he can do with them. It was a pleasure to do it. No problem at all. Did you receive my email?

LK: Yes, I received it! I will certainly have a look at it.

EK: Very good.

LK: I wish you a very nice day and thanks again.

EK: You too! Good luck with the research.

LK: Thank you very much.

[Interview with Ayse Caliskan](#)

**File:** Interview Zorgdomein-20211210\_140523-Opname van vergadering.mp4

**Duration:** 70:46 Minutes

Date: 10/12/2021

*\*Recording starts at the beginning of a presentation given by Ayse Caliskan\**

Ayşe Caliskan: It automatically goes to the secondary line of care. The secondary line of care is hospital, GGZ, VVNT. Those are the more expensive care institutions. What we have done, on our platform we have given the GP the option. We do the digital referral as we are the digital referral application. The GP can next to the secondary care also the social district teams into their scope. I have talked with Jan Joost Meijns and discussed to also include wellbeing care institutions onto the platform, and we accomplished that, we got a couple. Around 20% of the referrals is being transferred to the zero line of care. We did this with the goal of lower care costs and optimising communication towards GP's. This process what you can see here, what also is interesting for you guys, we tried to digitalise that. Our struggle we've encountered, because I just heard about digital patient files etc; I did research to this as well and that I kind of a challenge to get everything digital as there are many small organisations, who don't have patient files and registration software. Yet, this is important for the cooperation what your challenge is about. Your challenge is linking the social domain with the medical domain in a digital environment. WoR is the social domain and to link that digitally I reckon you should have a registration system in place in both parties and that is not always present. What more is interesting? That is about it, I can share some documents with you guys. However, that is what we have researched. I need to look for it, I'm going to stop sharing my screen. So, you have an overview of what we do. We do nothing else than facilitating the referral from the GP to the wellbeing sector with a digital platform. If they don't have a link or digital system in place, it goes as a PDF file towards an encrypted email address. So, the GP can at any point make a referral to wellbeing organisations. If they have a link it will go into the registration system and if they don't they get an encrypted PDF file. They can then see what data the GP sends.

Hidde van Poppel: Indeed, one of the biggest challenges we face is that many wellbeing organisations are very small and have their own way of working. Sometimes digital, sometimes not and making that link is a large bottleneck currently. You mentioned, that for every GP it is possible to make a referral through Zorgdomein, towards local wellbeing care?

AC: Yes, regardless of the fact they have information system. As long as they have a secured email environment, they can receive this referral. All GP's on our platform can see the supply available of care products. On that basis uhh, shall I just show you a demo? We have got an hour or how long? Or one and a half hours?

HvP: We have as long as you have time for us.

Gijs Latten: Yes, exactly.

AC: I've got 1,5 hours for you guys. I have to look. I am going to login and then I can show it. Otherwise, it will be too much information and then maybe you won't understand. Look here. Oh no I had to do the demo. I will share my screen now and you will understand the entire story of what we are doing. Can you see my demo environment?

HvP: Yes.

GL: Yes.

AC: Im going to play the demo GP. What is going to happen is, at the moment you go to your GP, he logs into the GP information system.

GL: So, this is actually how it looks?

AC: Yes, so this is how it really looks. I am now the GP, and this is what they see. First, he logs into the HIS. Per GP, there are different kinds of HIS available. We are connected to all of the different HIS. He takes the patient data. At the point when he wants to refer, there is a button Zorgdomein and he clicks that and the patient data automatically gets transferred to that page. He may have a care question. The GP can do everything digitally, that is what we offer. For you guys, it's the button 'Welzijn/Hulpmiddelen'. The social domain is also here. I'm not going to explain everything as it will become too complicated. This is the social domain. I am going for now to the wellbeing section. So, his patient has a wellbeing question. We'll take this, lifestyle in general is also an option. If he does this, he goes to the environment in which all care suppliers related to wellbeing care are presented. These are all clients and they showcase their offer so the GP can see what options are available. Therefore, a wellbeing organisation can state here, we organise walks, provide meal service, dept restructuring. I am just mentioning some examples. You can input the specific process for a patient. Look here, this is a municipality and they have WoR. They have stated WMO here. Look, inhabitant supported profile. You can filter by availability and times and other criteria you can select. So, the GP can see if it fits the criteria and may send his patient towards that institution. You can see the supply page where you end up as GP and he can digitally refer his patient. I going to select lifestyle consult. Weekly psychical activities for elders, that is a WoR offer. He does the referral and the patient gets notified through email if he has his email connected or on paper. Most elderly don't have an email address so they get a printed document of the referral and that looks like this. Patient message with the expectation from the patient. You have been referred to a wellbeing organisation. So, what should you do and what should you bring. So, the wellbeing service can put information on that document that is important for the referred patient to know. Well, and the GP sends this patient and on request of the patient I have referred. Medical information usually doesn't go to wellbeing organisations. Medication doesn't as well. He can add something, like notes and some context. Then he is done, the GP. And he sends a patient to that wellbeing organisation. That wellbeing organisation gets this as PDF and can report back towards the GP. This is going to be really difficult if I explain the entire system. So, that is actually what we do. We ensure that demand from the patient gets met and matched to the supply in the region. What do you need and what can you find. A sort booking.com. You look for a room and you see how much the costs are when it will be available and what is the process. That is what Zorgdomein does. It matches demand and supply. Well, if it is a hospital or a wellbeing organisation, that doesn't matter. The difference shows in how the information is processed by the wellbeing organisation to receive the referral. If they receive it as PDF, they have to manually retype everything and the process is way slower. If you have a link to your registration system, it will automatically go into the system and a patient file is created. You don't have to retype everything. So, that is mainly the difference if you have a registration system in place and when not. The problem with wellbeing organisations is that they are often sole proprietorships. Like for every activity a separate business. There are also larger organisations, the LEF group is one in the south of the country, BNA is another. What more. Go for Youth is another one. So, we have larger organisations on it as well. Those do have a registration system in place. Then it isn't a bottleneck. Only bottleneck for

the smaller organisation is the financial aspect. To showcase yourself costs money and usually this is paid for by the municipality.

HvP: Yes, that is indeed a lot of information. It brings up a couple of new questions as well. You answered already, that is costs for every organisation who applies whether it be a medical specialist or a LEF group. It costs money to showcase themselves on Zorgdomein?

AC: Yes.

HvP: Now, we are also interested in knowing what these costs look like. You mentioned, these are financed by municipalities, insurers etc. How are these costs build up? Is it like €50 a week to showcase or?

AC: The costs are determined, based on how large the organisation is. If you are a large cooperation, a hospital pays a lot more than a wellbeing organisation. A wellbeing organisation minimally pays on our platform €100 per month as structural costs and you can send infinite referrals. Sometimes we can lower this to €75 if you are really small. That are the subscription fees. The implementation costs are €1100. You pay that once to get the system installed including licensing costs. So, if you are really small you can be done for €1500. Then you are fully installed and you pay monthly those €75/100 which means you can showcase your supply.

HvP: Organisations who chose not to do this, what would be their option? Would that be another system or?

AC: Well, there are none. We have no competitors. Almost none. So, we are the only referral application what is being used by 92% of the GP's. All hospitals are connected with us expect one, in Maastricht. You are from Maastricht, right?

HvP: Yes.

GL: Correct.

AC: UMC Maastricht has let us know they will join Zorgdomein as well.

HvP: I was going to say, maybe we can have a word with them. Then, going back to the way of giving and receiving feedback that we quickly discussed. You told us that wellbeing organisations can give feedback to the GP through Zorgdomein but how does this work if they don't have a registration system themselves? Do that go through email?

AC: It is possible through email. I going to show you. Can you see my screen?

HvP: Yes.

GL: Yes.

AC: I'm going to play the district nurse. They can log into the web domain of zorgdomein. They have their 'Regie' section there. There the referrals are stored. You can see what they have received and what they can do there is digitally send encrypted documents or report. It goes as follows, you chose GP X,Y or B. I'll take a GP where they want to send feedback to. They select him and they get asked what kind of report do you want

to make, I'm going to choose an end report. The reason of the report I'll make the dismissal of a patient. They can fill in this form for the GP and they can send pictures or an attached file. You can preview and it looks like this, with everything organised. Who has send it, what is the reason, about which patient is it about etc. It automatically takes the patient info as well.

HvP: The GP receives this in his Zorgdomein?

AC: Yes. The GP, wait a minute if a go to the GP, he will see it like this. Here you see. He can than report back to the wellbeing organisation, I won't do it now. You can open the PDF file and he can read it. That is how it looks. In the web environment you can communicate back and forth. That is the digital link between the medical and social domain. That is what you are investigating.

HvP: Yes, we are focused on the wellbeing domain. As we know, you have a monopoly position regarding the medical side. In the link between GP's and hospitals, there is no real other option than Zorgdomein.

AC: No.

HvP: But there other ways between GP to wellbeing.

AC: Not is the way we offer. There is Zorgmail, that is an encrypted mailing service. GP's have this and they can have secure email contact. We would have is taking information from your information system and transferring it as a digital courier.

HvP: You are really integrated in the system of the GP and if the wellbeing organisation is linked to Zorgdomein also with them.

AC: Yes, correct. And outside our system they can send secure emails with each other. The GP can with Zorgmail, which is not by us, send to those wellbeing organisations as well and they will just simply receive and email. GP's have to then fill in everything manually and they tend to dislike this due to time constrains.

GL: Yes, that has become clear for us.

HvP: Right, so to conclude, Zorgmail is something every GP, wellbeing organisation, everybody can use for free.

AC: It's a paid mailing service. Comparable to Zipher, which is also a secured mailing service with two factor security. That is an alternative to communicate and useable outside of Zorgdomein. If that is the goal, then it is a good alternative but there is always more than just that.

HvP: Okay. Looking at the wellbeing organisations that you offer, how does that process work. Do you guys step towards them or the other way around?

AC: Jan Joost Meijs is the chairman of the Landelijk Kennisnetwerk. He is GP himself...

HvP: He is the person who negotiates with you?

AC: He is GP himself and he knows our old director and with him I have researched this link. Through him, WoR has become more widely known and through the social domain have the wellbeing organisation come to us. We don't actively approach organisations, they come to us.

GL: How many wellbeing organisations are there in a certain municipality?

AC: Per municipality I don't know. I know what we have in our numbers, let me see. I'll look it up.

GL: Those wellbeing organisations individually pay those monthly costs?

AC: Yes, we have around 10, let me see. In total we have... I can't find it right now. I will share this presentation with you as well.

GL: That would be really useful!

HvP: Yes, definitely some interesting information.

AC: I don't know how much, I think I know but not exactly in my head how many wellbeing organisations there are.

AC: Okay, I have sent one presentation to you guys now.

HvP: That's really nice, thank you.

AC: Then you'll have that already. And the number... Recently we have done a large research about the social domain...

HvP: I have received the email.

AC: Oh, I have found it. I was a bit of a search. The numbers... I hope they are here guys. Currently, we have 41 clients in the social domain.

GL: In total?

AC: Yes, in total. .... What I can do, if I can get that on my screen. To give an idea, I hope it works. No, it doesn't work. I'll just send it through mail. You will have an overview of the.... This may be interesting as well, I have send that as well.

HvP: Thank you. I think we can use every bit information really well.

GL: Definitely!

AC: I had researched, how many wellbeing organisations there are. I don't know it by heart. No. I think you can find that out yourself as well. How many wellbeing organisations there are in total. There are many in total.

GL: Yes, I think so as well.

HvP: I fear there are many as well. That is logical.

AC: Currently, we have 1600 to the social domain. So, per year, the medical specialists refer 1600 patients to wellbeing care through our system.

HvP: That is really interesting. I have another question about the referring. You earn your money by showcasing organisations on your platform, do you also make money by referring?

AC: No. Well for the hospitals we do it per transaction. One reference is €1.20. With the wellbeing organisations we don't do it like that.

HvP: Okay. Eventually, the costs for such organisation come down to an amount per reference. I know that wellbeing organisations count up to €700 to the municipality per wellbeing reference.

AC: €700?

HvP: Yes, Gijs is that right?

GL: Yew, it's true. €700 per wellbeing reference.

AC: So, a wellbeing organisation receives €700 per patient?

HvP: Yes, from the municipality. Those are the costs. The municipality are accountable for the costs of wellbeing. So, an average that is €700.

GL: Exactly.

AC: Well, I think with the €100 we ask is doable for them. With one patient they can cover the costs. How many patients do they treat in a year?

HvP: This includes the whole treatment from start to end.

GL: The whole treatment indeed.

AC: Yeah okay, I see. I am wondering how many patients they can treat in a year.

HvP: That varies greatly. Beginning GP's you see that being 20 a year and with more experienced that is around 120 a year.

AC: If a wellbeing organisation on our platform gets 2 referrals. that is €1200, they have gotten €1400 of the municipality.

GL: Yet, those costs are to cover the whole treatment.

AC: In those costs, the treatment is already included.

HvP: Well, another problem. Not the one we are researching. Yet, another problem is that when municipalities see referring go up, the costs go up and they are wondering why they would want this to happen. So, they don't really have an incentive for increasing referrals.

GL: The level of wellbeing is something that is difficult to measure as well.

AC: Hidde, I have sent you the numbers as well.

HvP: Ahh yes, I have them, thank you!

AC: Well, the benefits for the municipality is that they don't have to go to the second line of care, which is always more expensive. Also, it is also prevention. If someone comes with a headache and he says that he has depts. The GP can prevent the psychological problem from becoming larger by sending him to wellbeing care.

HvP: No, definitely. We agree, and the theory that is true it should lead to less costs. However, to convince the one budgeting the money in the municipality to allocate money to a prevention is difficult because there is not much metrics to observe. Only when it has become a big problem. That is something we are encountering at the moment.

AC: Agreed! Here, I have the care expenses. I can mail this or send in chat, what you want. You can see the costs of 500 wellbeing organisation that are linked to social work Netherlands, 84 projects.

HvP: Let me see!

AC: I can mail it as well, if you want.

HvP: No, it's okay like this. Only a little hard to read. So, the blue ones are totals..

GL: All financial agreements.

HvP: These are all social...?

AC: Look, total finance agreements is blue. Orange is government. The WOZ, I have deleted. And you can see what the expenses are. This is from RIVM, from the CBS. Also, sociaalwerknederland is where you can find many data about wellbeing care.

HvP: I have last question about the costs, because we have talked about that for a long time now. Are the costs of WoR, also for the municipalities?

AC: Yes. Look, the insurer doesn't pay for the mental care up to 18 years. The municipality pays for that. That's why the social domain was created, because the municipality enforces the youth care. WMO, wet maatschappelijke ondersteuning of which WoR is part. The government is legally obliged to socially support. In this category falls when someone is unemployed and they have no money to buy a suit. Or they don't know how to solicitate. The government has a law and they have to support them. When you are depressed because you are lonely, then the government helps you with a buddy which does activities with you to reboot you for society. That is the WMO and WoR falls under that financial budget. WoR has to be financed, patients can't afford it. Insurer doesn't pay it as well. So, who benefits from the increased wellbeing, that is the municipality/government. That is why this is always paid for by the government/municipality.

HvP: Yes, that's clear. As it is preventive, it counts as cost saving for the medical care and the insurers that pay for it as they profit from that as well.

AC: Exactly! So, you can wonder whether and some municipalities do that. I have that in my summary as well. I have written that... uhm I am just going to send it as well. This is all I did. I want to see your report and that you refer correctly to us.

HvP: Are these internal documentations? And can we use this in our report?

AC: You have cite us.

HvP: Okay, but it's okay to use this information.

AC: It's okay when you correctly refer to us.

HvP: Yes, of course. We have to anyway.

AC: Here I have researched the measure and risks. Risks of wellbeing organisations and what we can do about it. Additionally, one of your questions is also mentioned in this report as well. These are all the risks with WoR. There is also no integrated tariff for WoR. Cooperation of insurer and municipality is a complex refund structure. I have inventarised what our risks are and what the measures could be. I don't want you literally copy this but use this as guideline. Let me read it first before it gets published.

HvP: It is really interesting what you said. All the parties involved, we see them as separate islands so to say while in fact they are all interconnected. Wellbeing care lowers the pressure on medical care as it is a prevention. That is really interesting. We reckon that one of our findings is that that will have to change. Sorry Ayse, you are muted!

AC: What happens is, WoR is new in the care environment. I would plead for more cooperations. There are 350 municipalities and every one of them executes their own policy. Partly due to the varying problems. In Rotterdam, there is much youth crimes and in Groningen there is more elderly care. What isn't there is a nationally unified fund for WoR. It is very parted at the moment and they have to work more closely together.

HvP: Yes, when I look at how that would be arranged in my municipality, that would completely differ from how the next municipality arranged their wellbeing care.

AC: Exactly!

GL: I can vary massively from one municipality to another, that is also known and very much what is going on at the moment.

AC: Because the people are not the same in those municipalities.

HvP: They have very different goals.

GL: Yes. And priorities.

HvP: That's what I meant, thank you.

AC: As WoR still hasn't been proven what the effects are, it may not always be backed. In the UK they started with social prescribing and GP's there refer a lot to wellbeing care but here it is just getting started. You can see the shift to the second line of care. Care

is going up and the realisation is that there are more ways to refer than just the second line of care. Basically, the care at the right place by not sending patients unnecessarily to the hospital. There are too few hands and with patient coming back for problems that are not solved due to the wrong care, they cannot be used in another place. Everybody benefits from the right care at the right place for patients.

HvP: Yes, because an elderly man who is lonely doesn't need to go to hospital but will come back to the GP because he may experience physical complaints from being lonely and will keep coming back to the GP with those complaints while the cause is psychosocial related.

AC: Yes, if he has stomachache and he is sent to the hospital. They do scans and they don't find anything. But this can also happen with young people.

HvP: Yes, we have notices in our area during the pandemic especially. Every age group suffers from this.

GL: I think now more than ever that these problems arise.

AC: Lifestyle care is something that is also being created in hospitals as a department.

GL: For wellbeing care?

AC: If you need a knee surgery, and you weigh 180kg's. He sends you to the specialist and he says I can't perform surgery, you will need to lose weight first. So, before he goes to the hospital, it is known that he can't be operated on. So, time isn't lost by sending him to the hospital first to hear the same they can hear from the GP. That is really important that they know beforehand what to expect and not unnecessarily go to the specialist. Knowing where they need to go beforehand, that process is increasingly becoming more important now.

GL: To win time for everybody in the process and provide the right care to the right person.

AC: Exactly! The at appointment that you have to be weighted, just costs time and if the weight is not good it is wasted time, while the patient himself can see if the weight is correct at home.

GL: So they say, come when you have reached your weight.

AC: Yes, because only then we can perform surgery.

GL: Okay, clear.

AC: It is just an example. Formerly, they just let everybody come in and now they assess this much more through the benefit of the process. What can we do and what not. You don't have all the time in the world so you have to decide on what things you send your time.

HvP: Okay, very good. We have done much about the wellbeing environment. Gijs, looking at you as well, but we want to ask some specific questions about Zorgdomein as well. To begin with, what have been for you KPI's in the last years? Referral numbers?

GL: Ease of use?

HvP: Do you do surveys. With GP's?

AC: Very good questions. We have KPI's only I don't know them by heart but our mission is to become the best care matcher in the world. That means to bring the right care to the right place. Basically, matching supply and demand. To maximalise the algorithm in such a way that when a GP has a question, who needs to join. We have many functionalities. Our most important KPI is that you can find the best care fitting for you with Zorgdomein. I can ask Felicia to...

GL: Do you talk to GP's about their satisfaction and do they mention what they think about the system?

AC: Every year we have NPS scores, which include these things. We keep track of what they think of us and what could be improved, that is the survey side. We are the account managers divided by region. I have 14 hospitals. We have discussion with these hospitals, nationally, regionally and we also do surveys for them. We do a lot. I don't know I can share that. Maybe that is a good question for Felicia.

HvP: If it is confidential, we understand it too. We just want to get an image. You are the largest player in the market, almost monopolist and how do you stay on top of the game.

AC: The most important thing for us is to know what is going on in the market. For example, we have to subsidy agreement, which is an important one. The government has ruled that the care environment should become digitalised. We try to bring a transfer module to our customers in which a patient is fired from hospital but cannot return home and you don't want that person to stay in hospital so they have to go to a care institution. With the transfer module you can find and arrange this transition. It sounds easy, but in the backend this is very complicated.

HvP: Yes, I believe that!

GL: Yes, I believe that!

AC: That optimisation we do with our product managers. We look what struggles arise in the process. The transfer nurse you need to work with, the hospital systems. There are different hospital systems that need to be worked with, that is the hospital side. You also have the receiving side who also have different systems. That is what we try to optimise. We want to connect as many systems as possible, but they need to be willing to work with as well. So, what is our biggest challenge, is to become the largest care matcher and everything that comes with that.

HvP:

GL: What are reasons for institutions not to join Zorgdomein? Maybe they find it too expensive? Or are there other things?

AC: Price is often the reason. Some say it is unnecessary. However, you have to imagine that if I have complaints, I will not go to my municipal counter. If my GP's says I can

best go to that specialist I will do so. If the GP sends me to the municipal counter, I will go but not by myself in the first place. Some municipalities have own rules and say everyone can come in so why do we need a system. What it's about is actually the relation towards the municipality and that you don't go to them with complaints.

GL: Okay, so it's important to have that GP as middleman.

AC: Yes, that connection with the medical domain.

HvP: Maybe this is a difficult question, how does a GP obtain information from Zorgdomein? Is information kept about the total figures? And who else retains information from it? Hospitals? You as well?

AC: Yes, true. All those can obtain that information. All the referrals the GP makes, he can check on daily, weekly level. He can see what he does with the patients and where they go. He can see that he refers x number of times to that and x number of times to that. The hospital can see how referrals they get from certain GP's. Not on a patient level as that is classified. So, on a transactional level. Hospitals can see, for example, how many patients they got on their sleep department. So, they can consider changing this. Important information for hospitals.

HvP: Really important management information and information in general.

GL: Very valuable information indeed for hospitals to make important decision to effectively divide departments.

AC: Yes, I'm going to share a presentation. The general presentation in have shared already. See, this is the dashboard in which hospitals can obtain information and how many transactions they have gotten compared to last year. Where to get most of the referrals. Very detailed information.

HvP: A lot of information and very important I can imagine. Because a hospital is a company as well.

AC: What we support is advise question before you go to the hospital. If the GP has doubts, he can ask a medical specialist of the hospital which saves a lot of care costs. They can draw blood, request diagnostics, refer and transfer. With everything you can exchange information.

HvP: I am almost inclined to see you have everything. Are there other things you hear users are missing?

AC: Well, those are strategical question. However, for the care landscape, many things are covered. Yet, not everything is possible such as the inability to report to anybody. Some things we are still working on. If those things are done, then new things arise. The basis is very broad, yes.

GL: You have the function to refer to wellbeing care. Does that link exist for a long time?

AC: Well, we have just added it and not much else. We edited the non-medical template a bit. Yet, next year, we don't have the capacity to launch it on the roadmap. For social

domain, altering the entire system, we haven't done. Around 2023 that will be on the planning.

HvP: That is your vision right, the social domain?

AC: We are testing right now in what we have right now. There is nothing special set up.

GL: So, it is still in the early stages so to say?

AC: We don't have many clients in social domain, so we don't feel the need yet. We have 5...

GL: Do you notice that GP's are unaware about the link in Zorgdomein?

AC: Yes, that is with every care institution on Zorgdomein. They are the odd one out. So, the GP must now. The institution must actively create awareness to increase numbers, but that is with everybody.

GL: With talks different GP's, the image arose that they are unaware about this link and how to deal with this.

AC: Therefore, it is important to make this widely known. I have four minutes.

HvP: That is all good, we are happy you could make some extra time for us.

GL: Yes, really nice, thank you.

AC: If you have questions, ask them now.

HvP: Those final two here Gijs, are important as well.

GL: Yes, we should definitely ask those.

HvP: You mentioned that there are no competitors, yet we are aware of some and talked to them. VIPLife is one, do you know them.

AC: Yes, I know.

HvP: We also offer this service, yet on a much smaller scale. What is your view on this competitor and is this maybe the reason you are switching to the social domain in 2023?

AC: Good question. Indirect, you always have competitors. Do you mean on the social domain?

HvP: Yes, focused on the social domain.

AC: VIPLife is much more advanced in that?

HvP: Well, no no no no. Yet, they offer the link to the social domain. So, there is Zorgmail, which is encrypted...

AC: If I look at it from the GP perspective, they don't want to continuously switch systems. Yet, if reckon if they can offer everything including the social domain they are a competitor. Yet, it will take much time before they catch up with us as we offer a large package.

HvP: Yes, VIPLife is still in baby shoes. Yet, progression is made and do you keep track of that progression?

AC: We always keep track of them to keep sharp and see when to take action. We know there are player in the market. Yet, we focus on ourselves and our proposition. So, we don't feel the threat of VIPLife for the social domain. I am not aware of it.

HvP: Yes, your competitive advantage is so large as you are connected to 92% of the GP's.

GL: Not something you can easily duplicate.

AC: And if Maastricht joins as well, we will almost have all.

GL: I will hit them up after this meeting.

HvP: We will quickly swing by hahah.

HvP: I think we will wrap up. I want to thank you massively. For this extremely interesting interview.

AC: If you have more questions, you can mail me. Let me read if you use anything please. I shared quite a lot as I did those researches myself

HvP: We will do if we use it. We will send you the report at the end. Expect around end of January. Before we can also a contact. Thank you very much and if we have any question we know where to find you and have a good weekend!

GL: Thank you very much and have a good weekend as well.

AC: Have a good weekend and good luck with the report, bye.

HvP: Bye.

GL: Bye.

## Interview with Esther Ockeloen

**File:** Interview\_project Welzijn op Recept-20211216\_103211-Opname van vergadering.mp4  
**Duration:** 40:35 minutes  
**Date:** 16/12/2021  
**Organisation:** AdSysCo – Regicare

Lucka Koelman: If it is all right, we are recording now.

Nicky Meziane: Before we start, let's have a short introduction. Uhm, well well. My name is Nicky. I am 24 years old. I'm currently in my graduation year, International Business at Hogeschool Zuyd, in Maastricht. And well, with regard to our research, we're doing a project on Welzijn op Recept and we're actually focusing on the link between primary care and wellbeing care, especially for GPs and wellbeing coaches. And we are also looking at the extent to which a good IT system or data management system could add to this and actually promote the process. And then I'm actually talking about a referral from a patient to a welfare coach. That's actually where we put our focus in the research. Yes.

Esther Ockeloën: Nice.

LK: And we also look at other factors that also play a role, but the focus is indeed on, uhm, how an appropriate referral system could run better. Uhm, well Nicky has already said it. We are students at Zuyd University in Maastricht, International Business. And I am 22 years old. We are doing this project together with 3 others, but since we have several interviews going on these days, it was not possible to do the interview with the whole group. But that is why I am here. Nicky will mainly ask the questions and I, uhm, pay more attention and make some notes and where I think more explanation is needed I will ask for it.

EO: Yes, all right!

LK: Then we can start.

NM: Maybe we could...

EO: Shall I describe my role, uhm, yes. I am Esther Ockeloën. I've been working for AdSysCo for 3 years now. AdSysCo is an automator in the social domain. In addition, I have my own company, I am a coach in the field of vitality, so that's where well-being comes in. So well-being is very much in my heart. Uhm, at AdSysCo I'm responsible for innovation and development, and you have to remember that AdSysCo has about 3.5 million citizens in its systems. Systems that we have put in place at about 200 welfare organisations in the countries. So we have quite a few people who are, yes, in the systems of our customers. And what we notice there is that a lot of things still happen, sometimes on the old-fashioned beer mat or excel sheet, and that technology, um, can be a solution. A solution to make people self-reliant or self-reliant together more quickly. From my role, innovation and development, I am involved in blended services. Uhm, that's a group that calls itself the BEP leaders: Blended, effect measurement and benchmark, so we want to see that it has an effect, but also to see if it might work differently in rural and urban areas. Small cores or urban cores. Uhm, we have developed customer journeys that we support with a registration system and additional tools. You also have to think of a Welzijn op recept, Positieve Gezondheid (Positive Health), monitoring the effects, using data from Statistics Netherlands and such like. In addition, I am, uhm, the initiator of a project called Buurtcommunities. What we're actually doing there comes not from the welfare and WMO angle, but from the WLZ: Long-term Care Act. So how can we prevent acute care demands, how can we postpone care and actually pick up on the latent care demands that residents may have in their neighbourhood, and strengthen them, make them self-reliant in terms of loneliness, vitality, mobility and so on. Ensuring that they can continue to live in the neighbourhood. This actually has everything to do with well-being and wellbeing.

NM: Yes, exactly. NM: Yes.

EO: And as an automation company, we're involved a lot in those projects and I'm, well, Piet is one of the two owners. Uhm, is from the, yes, Sales. Annoying word. He just has his tentacles in the field and I'm the one who tries to make it happen together with him.

NM: Okay.

LK: Yes. Sounds very interesting in terms of what you do and what it entails.

NM: Definitely, definitely.

EO: I think I have the best role in the organisation.

LK: I think so.

EO: Yes.

NM: Then, uhm, all right. You mentioned that you are familiar with Welzijn op Recept and, uhm, I'm actually curious, what is the collaboration with Welzijn op Recept? Or, is there some kind of collaboration, uhm, with Welzijn op Recept?

EO: Well, we've had a number of meetings, this year and at the end of last year, with Jan Joost and, um, I've forgotten the name of the lady, uhm...

NM: Miriam.

EO: Miriam Heijnders, indeed. Uhm, been in touch. We very much believe in Welzijn op Recept, that people come into the doctor's office with a question that requires attention, a loneliness question, instead of a pain in the big toe or wherever. Uhm, what we have noticed is that GPs or, in fact, doctors in the health care sector are very attached to a system called 'zorgmail' (healthcare mail), which means that each message costs 1 euro, which is actually public money, and that GPs also want their money back. So there are quite a few euros going back and forth. Uhm, doesn't fit with our footprint as AdSysCo, being the automator of the social domain. So we want to do that in a different way, but not many first-line, um, service providers are open to it. Because we have a tool, a registration system, and that's just the back end, that's a cloud solution to which also a portal can be attached for inhabitants, and those inhabitants can also say who can enter their framework. So they can invite a GP to put something in his file so that the welfare coach can get back to work. Yes, that really is what I sometimes call a curse. Yes, they work with care mail and it's really struggling a bit with funding right now. So we do know it. Many of our clients use it and a type of work has been created in our systems, or a methodology, so that if someone comes in from a contact called Welzijn op Recept, we know that they've been referred by their doctor. So we know that they have been referred by a GP or physiotherapist or some other person, and then the services start. Whether or not in a blended way.

NM: A very interesting way of working. I think that could indeed solve a lot of problems. But then it would have to be that, uhm, the GPs are also prepared to adapt their way of working.

EO: Yes.

NM: But, uhm, as you say, the financial picture plays a very big role in it, of course.

EO: Yes. There are two parties: you have zorgmail and you have another one, and, uhm, well, we think it's a bit of a scandal for us as computer experts in the social domain that so many euros are spent on

message traffic back and forth, which cannot be spent on the resident who needs that welfare so badly.

NM: Exactly.

EO: So, um, we don't refuse to work with that. That's not the right word, but we do hope that we can get a movement going, and through the neighbourhood communities, among other things, we see that it's already working. Look, the GP support worker might as well type something into our system, rather than into that healthcare email.

NM: Exactly.

EO: So there really is a long breath. You have to keep talking and then you can solve it and you can speed it up, I think. What we do now, by the way, is advise our clients to put one of your welfare coaches in the health centre. So, if the GP, and it really happens in a couple of places, so if the GP says: gosh, according to me I hear that, I know a lot, you are lonely or have needs to meet people. Walk with me. I'll introduce you to the welfare coach. Welzijn Bloemendaal is one of them, I know it happens like that. Yes, he just sits there a couple of mornings and the woman is put there by the GP or the GP support worker, starts talking to her, yes, and gets to hear what her latent question is.

NM: Yes, yes. I think that's a good start, yes. Uhm, good. We've done a bit of research, of course, and if we look at the Regicare package. Could you explain a little bit, um, what the package itself entails and what possibilities it offers?

EO: Yes. I have a few sheets that I can show you, also to explain.

NM: Yes, certainly.

EO: Yes, I will share the screen. I think I have those rights. Let's see. I think you can see my screen now.

LK: Yes.

NM: Yes, definitely.

EO: Uhm, no, I'm just taking it from the point that we... from the Buurtcommunity idea. Then it doesn't matter how we work. What we also say is that there are two ways of doing Welzijn op Recept. On the one hand, it's physical, so the GP walks with Mrs Janssen to the welfare coach, or on the other hand, it's physical that something is exchanged. And we really... we really believe that if you link care and welfare, you'll solve something. After all, we've already mentioned a few. Loneliness, etc. How does that work? The digital solution that we have, um, and yes, we've cobbled this together really quickly. Our designer still has to work on it. Then it starts with talking to a resident. He or she can just walk in to welfare or to the family doctor. So below at registration, there's a person behind a desk, it could also be the GP who says: wop. I will report Mrs Janssen. Mrs Janssen can also do it herself if she is digitally literate enough. Uhm, we have various tools for that. It can also be a volunteer who says: hey, I'll help that lady, or someone will do it themselves. Then you come either into our system, or a resident himself on that green top application, the client portal, or a volunteer can also do something through the volunteer portal. From that trigger, so actually that someone comes to welfare, referred or not, you start a conversation. Of course, you ask sincere and good questions about what the question behind the question is. Uhm, we record that. We can also link certain apps or tools to it. Uhm, the resident can also indicate: I need a buddy, or my garden needs to be done, or whatever question he or she has. Then, at supply and demand, there is a system whereby, you see the person behind the desk at supply and demand again, we think it is important that the right match is made between, for

example, a buddy and, um, and a resident with a request for help. So someone can say: hey, I need someone. A volunteer thinks: I want that. But if there is someone in between, a sort of professional judgement to see if this is the right person, if there is a certificate of good conduct or if this resident perhaps has a question, I'll just mention a few in relation to relationship issues. Then you will start working professionally or with a professional or perhaps with a fellow sufferer group. The implementation is then, so to speak, really the work of welfare, whether or not supported by volunteers. Because we believe that with the ageing of the population, care and welfare will no longer suffice. With the resources that are available for that purpose, but that you actually have to prepare the people, where pension insight is, for: hey, don't fall into a hole, what does it mean for your loved ones. Yes, and you could then invoice that as well. So we notice that the system behind this, you don't see it now, but it is actually very accessible. As a professional, you can enter things there, or as someone from the framework who we give access to this data. And we can restrict or open that up completely by means of roles and rights. Of course, you have to deal with the privacy, GDPR legislation.

NM: Yes, yes.

EO: The resident can do it himself if he thinks, hey, you don't need to help me, I'll do it myself, there are volunteers, and so you can actually use digital technology to find out what I want to change, what can be found in my area, and how I am going to organise it.

LK: Yes, but would it also be possible for a general practitioner, for example, to register the patient?

EO: Definitely. Yes.

LK: And is it then... and this registration is then actually the same as a referral button if I can put it that way.

EO: Yes.

LK: Okay.

EO: What we have noticed is that, for example, the Buurtcommunitie Group was started by a VVT organisation, the elderly organisations. So it's actually the last place you go if you've been given a really heavy indication of the extent of your care.

NM: Okay.

EO: there are people from care mediation or a GP, so GP employees also speak to people and they can go on a... yes, that's still a terrible word we use: care employee page. We'll think of something more fun for that. So they can quickly say: hey, Mrs Janssen, Reigerstraat 2, needs a buddy and some services. That comes to a welfare coordinator within that organisation and he or she goes and sees: hey, oh I have a volunteer and I can make a match right away.

NM: Yes, yes.

EO: Or he will make contact. Especially if loneliness is an issue, the extra contact is really a good thing, that visit with a cup of coffee and, uhm, asking further questions. Then she goes further into the process. Yes, so a GP, just like a GP assistant or someone from the care mediation service can very easily create a first trigger that starts the process. And we can already see in this project in Kokkenge that the support person is in that care institution, which is quite a big one, and she indeed sends a message to the coordinator saying: hey, hey, let's get in touch with this lady. Sometimes with some

coordination: is there something else I should know? Uhm, but you can't do everything there from a privacy point of view. So the GP has to ask: are you OK with us passing on your details? This is all regulated in the process and also in the system, so that the right checkboxes can be ticked there.

NM: Okay. So basically...

LK: And that system, sorry, that system is actually called Regicare?

EO: Yes, Regicare is our system.

LK: Okay.

EO: Yes, but there are more systems like that, like AdSysCo. We think we have the best, haha.

NM: No, no. Understandable. So it is actually very easy for smaller parties to join, isn't it?

EO: Definitely.

NM: Because the larger institutions are very, very expensive, they don't have the financial resources for it. So this would actually be an ideal solution.

EO: Yes, and the nice thing is that very often you notice that the organisations and the processes are based on the organisations. Our starting point is very much the resident. So whatever the GP enters, the resident can always see it, because it's his or her file and you always have the right to see your file. Uhm, a resident can also ask: hey, involve my GP in this because I might also be on medication for depression, so you might also want to put a link in there. So you can, yes I think, whether you're a small organisation or a large one, as it happens I just had a terrible audit for a very large organisation. They all ask questions like: how do they do this? How do they do that? What do you record?

NM: Yes, yes.

EO: And rightfully too. Fortunately, we have the necessary certifications and they have just given us the green light: hey, we are going to do it! And perhaps even more broadly within the organisation. Because they already work together with other institutions, but also with the general practitioner and also with welfare. So you see the market is moving towards each other, but, uhm, you shouldn't start from the organisation's perspective but continuously from the resident's perspective. I think that technology will enable you to make rapid progress.

NM: Okay. And if we look at... of course there are a lot of bottlenecks, but if we look at what do you think that besides the financial factors, what do you think are more bottlenecks that should be taken into account, that should be solved actually.

EO: Uhm, I'm a personal fan and I notice that Positive Health is also being discussed more and more within health care and welfare. I worked for a health insurance company myself, so I come from a bit of a medical background. It's all very medicalised. So someone goes to the doctor, gets a pill, and so on.

NM: Yes.

EO: There's a lot of money behind this at the pharmaceutical companies, of course, so I can understand it. But I hope and wish that there would be a lot more honest conversation. So that people actually start to de-medicalise, look at lifestyle instead of treating the disease, really tackling the cause. So on

the one hand that's really... your fibres believe in Positive Health or another model. Uhm, I think that funding, apart from care mail, for example, is also part of the compartmentalisation and compartmentalisation of the WLZ, WMO and Health Insurance Act. Uhm, I'm also noticing this now with the cooperation from the communities. Like, hey, that belongs there. No, it's all about the resident. Yes, whether you are looking for help from one fund or another, you need to be helped so that you are less likely to need long-term or acute care. So I think that the care system, faith, starting from the sincere conversation and thinking about what someone needs, what do you want to change instead of the disease, that that is really a solution throughout the Netherlands. Whether you're at school, a coach, a GP, to get that movement going.

NM: That is indeed something that we often discussed with Jan Joost. Because the fact is that the medication now actually does away with the symptoms and the patients just keep coming back. Because as soon as the treatment is finished, they come back and say: yes, the symptoms are back. And then it's a cycle. It keeps coming back.

EO: Yes. You know, I've noticed that myself. My father died eighteen months ago and my mother was given medication for depression. While I think; no she is not depressed, she is grieving. What she needs is not just the people who are just pampering and petting and being sweet and saying; oh do you miss him, yes of course you miss him. So she just needs something that is going to fill that gap. And I have fortunately been able to give her a kick in the pants that she has indeed now become a volunteer. That she... yes, she is used to cooking a lot. She now lives in a flat. The neighbour is an expert and they also cook for others. So look for the connection.

NM: Nice, yes.

EO: But the doctor who started taking medication for depression, I was like, Mum, I'm going to flush it down the toilet, you know this is not right.

NM: No.

EO: And that's where it starts. Really with doctors who I think really look at it from a holistic perspective and not the sadness. Someone can be sad, but you don't have to mask that with medication.

NM: No, no.

EO: I think if we do that and apply fewer, uhm, yes, just plasters, it will create so much happiness and people will be so much happier and healthier.

NM: But wouldn't that also... it actually start with the GP, right?

EO: Yes.

NM: In a way, he or she should perhaps be trained to work with this, and then you could say that perhaps you should start with the training of GPs themselves.

EO: Yes.

NM: they learn how to deal better with patients like that.

EO: I think in any case, lifestyle can be a more important element in a medical study. I believe it is 1 module in the 6 years of what you are doing. Yes, it's scandalous. You have 3 years of real medication.

NM: Yes.

EO: Then I think: well, I guess it's a bit of a stretch. Because I think that a lot of it is self-inflicted. That's more of a personal conviction. So I think if you start there and then also, welfare has only a tiny bit of the money and care has a lot. So if you suddenly start referring all those people to welfare, that won't work either. Then you actually need more volunteers who can do that with you, or more money needs to go to welfare and more staff need to be employed there. So it's going to be something and we're going to come up against some obstacles, which is that from a technical point of view, we see what's possible and from the point of view of AdSysCo and another partner, we're very busy creating something to deal with the double aging of the population, where you're actually going to have all these pains and cares, from that point of view, how can we actually use the Welzijn op Recept for the old people out there, early seniors and old seniors, how can we solve that? And that does start with the GP.

NM: Yes.

EO: And we have to be able to absorb that. So you'll also have to do something with your entire pool of volunteers. And then it's not like: those volunteers are mine and those volunteers are mine. No, the volunteer wants to do something for the community, so we should have much less of; mine, yours. But; it's from all of us. So that's how social cohesion really works. So you do develop it in stages. And that's why I think this concept of Welzijn op Recept is going to be successful.

NM: Okay. Uhm, let's see. Then maybe some questions about the costs actually. Because how... maybe a very direct question. What is Regicare's revenue model? Because if we look at a healthcare domain, for example, such a large institution, we know how it's structured and we know that it's simply unaffordable for many parties. So what is Regicare doing, or AdSysco doing, to make that possible?

EO: Yes. Regicare was really born from the social footprint. The two directors did a management buy-out in 2013 and really started making this bigger. They have a SAAS solution: Software As A Service. So where a lot of parties also have running costs, so you've already lost a ton before your project starts, we have a subscription where you pay per head, employees so to speak. So if you have 50 employees, you pay 50 times the monthly fee. Irrespective of how many residents or how many volunteers are involved. So we really link it to the organisation. But we say: hey, your organisation is so big that for us it's pay times q price times the number of employees. Uhm, and we don't say whether you use 1 or 10 modules, eh, then we'll differentiate, no you have 1 package we also want to see, we learn that they can do an entire business operation in it. They had 87 different packages from various mergers and takeovers, and now they are down to 4 packages for HR, accounting, our package and office around it. And if you see what a difference that makes in terms of costs. So we don't force you, but we do advise you: you can put everything in this. So you need an office, HR, finances and a good system with which you, as a care or welfare organisation, can carry out your processes very well and also make the link to your residents, volunteers and residents with a package, so with an extra feature. We believe that we have a very social model in this respect. We are still looking at how we can optimise this by linking new tools to it, so they now get Positive Health as a gift from us instead of everyone having to buy it separately. We have linked it to our software so that they can also learn from the data and can therefore have better conversations with the financiers. So we really see SAAS: Software As A Service, which is really what we believe in.

NM: Okay.

LK: No. Is it true that this is a onetime payment? Because I can imagine that a company can also have new employees, right?

EO: Yes, we set the number per year. So actually based on the numbers at the end of 31-12. Uhm, we calculate the subscription for the whole following year.

LK: Okay, clear.

EO: Yes.

NM: And just to come back to the GPs. If we look at the system. Can you sketch a bit of a picture of how often a GP is involved and that people say; I would like my GP to be part of it... and that he can also look into the system. Can you tell us more about that?

EO: Yes. We know that, say, 20 of our clients, welfare organisations, actually work with Welzijn op Recept. It's top of mind for a lot of clients: are we going to do it or not? Uhm, GPs don't go into the system yet because they still refuse to work with another system. From our point of view that you can help the resident digitally but also physically, that's what we actually suggested. So we are actually a business partner, a sounding board for our organisations or our customers. And we said: hey, whether you're working at the town hall in Bloemendaal or at the family doctor's, if there's a spot, just sit down and pick up the question. Then you don't have to send an email, you're immediately connected, accessible too, instead of someone thinking: yes, I'll do it, and then thinking: no, no, don't do it. So we are creative in our solutions. In terms of admitting people, that doesn't happen. It does happen between care institutions and welfare. We do see it there. Or school social work, for example, which is a theme, in which a teacher is asked to work within the theme. But we haven't got GPs in yet.

NM: Okay.

LK: But would it be realistic to think that that could happen, that GPs would do that?

EO: Yes, we think so. We work with ICC, I think it's called, one of the systems. Uhm, yes, then you type it into Regicare. We are certified, so it also meets all the criteria. We can even work on an EPI and an exchange in which only the relevant details are passed on: name, address, telephone number, and not whether she uses depressants, etc. You can put all that into an EPI. You could even set that up in an EPI, in a link. But, uhm, they're not really working on it yet.

LK: No, because we know from our research that a large proportion, or more than 90%, of general practitioners work with Zorgdomein who actually refer to specialist treatments in the hospital. We also know that they already have the option of referring patients to welfare, but this option is not being used yet because no one wants to pay for it at this point in time. This should actually come from the municipal costs, they think. But, um, so far no solution has really been found. But are you afraid, or is that perhaps a strange word, but is it realistic to think that, say, Zorgdomein has 90% of the market already in it and they have that option, and GPs don't want to switch because they already have the system but they have to find the funding to make that option possible? Is it then realistic to think that they would switch to Regicare just for those referrals?

EO: Uhm, look you don't have to, I don't think you even have to, in Regicare, if there's an EPI or if there's a link built so a bridge from like that option Welfare, just like sending something to the pharmacy. Actually, that's the same thing. It skips the important things. Uhm, we've made some contacts there and the tons of money fly by before that can be workable. Whereby there is also a euro per message, so to speak. If we had to invest a million euros, I don't know if I'm allowed to say that, but we would. Because that is hours, that is building, that is fine-tuning, that is doing all your checks and balances to ensure that if the GP says; wellbeing, that at the pharmacy the label is rolled out, with us it arrives on the doorstep of the coordinator of wellbeing. But if welfare also has to pay a euro per referral, we are never going to do it.

NM: No.

LK: No.

EO: Then we would be draining welfare and that money should be spent on the citizen and not on the system. So we won't be participating in that. We would very much like to build a link. We have already tried to contact them a number of times, but it really depends on the costs per referral.

LK: Yes.

EO: I just finished my last one. I think my colleague was still working on it at the beginning of this year. I don't remember his last status, but if things change, we will be the first to knock on his door to build this bridge, this EPI.

LK: Yes.

NM: Okay. Is there anything else you can do internally to talk to the GPs, because if you can persuade them, then yes.

EO: No, we as AdSysCo do not. We are really a system supplier. And we are also a partner in the social domain and are often asked by Sociaalwerk Nederland and others. We are now in conversation with care offices again about the financing of Buurtcommunities. Uhm, fortunately we're getting good funding for it because we really dare to say that we're going to postpone or delay care if more attention is paid to it. Uhm, but not with the GPs, no. It could be one, but I think it should be on another table. I rather think that perhaps the municipality, GP and welfare should come up with something there.

NM: Okay.

EO: Or from care because you prevent care. After all, you know, at the beginning of January, I'm back with the care administration office and, of course, it's the Health Insurance Act and not the VLZ. I do see possibilities, but we as automation experts in the domain have not yet taken up the gauntlet. But the question is: can you make sure that the information gets from A to B? And then welfare says: yes, but how about this, if 100 or 10000 people come, then I will lose 10,000 and I can no longer deploy my coordinator.

NM: Yes.

EO: Yes. So no, I'd love to, but something will have to happen and I think that's mainly on the side of the GPs and the care domain.

LK: Yes.

NM: Okay, uhm...

EO: Or a financier, or let the health insurance company finance it, who then says: hey, if this happens, then yes... or maximise it in the catchment area, there are so many inhabitants and that's the maximum we'll pay. So you don't do a P times Q per message that is forwarded but you make an appointment with the GP per head of population in a municipality or based on the client database. All sorts of things are possible, but something will have to be done at that level. I don't think that can be AdSysCo's role. We are happy to talk about it because we have an opinion, but we are not a determining party in that story.

NM: OK. Good. Uhm, I actually have two questions. First question is could you give some examples of competitors or are there any parties at all that we can see as competitors? They put us in danger, so to speak.

EO: Yes, you know, there are a number of players on the market who also have a registration system. One is more focused on care and the other more on a very specific welfare activity. There's MyNeva, uhm, Regas, uhm, what's the name of the other one, SV-office, V-office, there are a few tools. We have noticed that a few have made a very conscious decision to do only social work, and if you, as a broader welfare organisation, want more, they come in droves. You also notice that a few larger parties from the care sector now think they have a welfare tool. But we do have a very steady base, so we are... no, of course we continue to look at the environment, but I think that MyNiva, Regas, SV-office are the parties we also talk to when we are at Sociaalwerk Nederland. Then we see them all in the room.

NM: Okay. Well, that was it. Then perhaps the last question, are there any important aspects that we should perhaps take into account in our research? Are there any advices of which you think you should really pay attention?

EO: Uhm, yes, you know, I'm very curious as to whether GPs... yes, I'm very much on behalf of my company in a foundation here in the middle of the country, I live in Utrecht, a healthy neighbourhood alliance. And there's a GP in it who works from Positive Health, she's co-written a book, she firmly believes in it. Uhm, if you see... you need years of data anyway, but she also says: Es I think that there are 80 to 100 people per week in my consulting room of which I only refer 2 to 4 to welfare. Wow. If you realise that and still medicalise and make people come back to your consultation every time. I am originally a controller. Uhm, then I think: oh it's also a real piece of faith and belief of the people that welfare can solve something. So I think it really starts with the GP. They also say we don't have time to make that referral or that message or whatever, so yes, technology must make it easier. But I get really disgusted when I hear that only a fraction of 4/5% is actually referred to welfare and I really think: guys, what are we doing? So, um, fortunately I have Caroline van Den Brekel, who I know from Positive Health, who is really an advocate. Uhm, but that can be told everywhere, just like what Jan Joost and Miriam do, of course. Yes, Welzijn op Recept people, that's what you need. A cuddle, attention, whatever, meeting people, and not that medicine. The start is really in that doctor's office. Yes, it is.

NM: Yes.

EO: I also think that money is going to the wrong movements, but that is a logical consequence. That is how it is organised now. You can't turn that around just like that.

LK: Yes, and of course we also see this in our research, but unfortunately we don't have that much time or that many possibilities to investigate this in its entirety, but these are indeed factors that play a very important role and if there is a point to it, then of course a lot changes at once.

EO: Yes. Look, and if a GP feels that instead of sending a prescription to the pharmacy, he can easily send it to the welfare department, they face the challenge of being able to deal with it, but technology can do a lot in that respect, such as online on-boarding and welcoming people, all of which you can meet. And if money is not a factor in this, then I think we can make a very good step forward.

NM: I think so too.

EO: Yes. So I hope that your advice, your research, is really very big and gets to the right tables. Also in The Hague.

NM: Yes, I hope so.

EO: And that they also, um, look, we are also trying, from these Buurtcommunities, to eventually change the funding streams within 5 to 10 years. That you no longer have to deal with the WMO, WLZ, Zorgverzekeringswet, boys, it's all about the resident, the resident must be helped properly. And if you only have such a budget for welfare, it's possible that we'll reach for WMO funds. So there... and I have a feeling that if this becomes very big, they'll have to look at what you're looking at.

NM: Yes, I think so.

LK: Yes, and I also think, um, what I wanted to say... yes, because most of our contacts that we have spoken to and interviewed come from Jan Joost, because it is difficult for us to get into the network.

EO: Yes.

LK: But that is why I think that each of the people we have spoken to, including you, will get an extract or update on what the investigation has led to, so to speak.

EO: Nice.

LK: So I think that in a few weeks you will also hear something about it I think.

EO: Nice, very much. Do you still need general practitioners for interviews? Because I think that Caroline van den Breken might be open to it.

LK: Uhm, we have had a number of them. But we now have a bit of a problem with the time we have. We actually have until about 20 December to map out the current situation. I think we have spoken to about three or four general practitioners. Maybe she's one of them, I don't think so. But, uhm, yes, I don't know if it would be possible to make time for her in a few days, I don't think so. But, uhm, I can discuss it in the team and we can always come back to it.

EO: Yes, or perhaps as a kind of professional judgement. Who can review when you have written it. I'm sure she would love that. Precisely because she wants to make the step from her general practitioner's point of view to: how can this be done differently? Talk to people instead of prescribing.

NM: Yes, we could discuss it.

LK: We will certainly discuss it.

EO: Yes.

NM: Given the time we have... the GPs are so busy, yes.

EO: Yes... but she also has time to do these things. Also in the healthy neighbourhood alliance, so if you think: we need it, I can try to connect you to see if she can talk to you within the possibilities.

LK: Very nice in any case.

NM: Definitely.

LK: If that is the case, we will let you know.

EO: Fine.

LK: No good. I think we have been able to collect a lot of answers. A lot of interesting perspectives too. I thought it was a fun and interesting conversation. I think Nicky did too.

NM: Definitely.

EO: Yes, definitely.

LK: Yes. So thank you very much in any case.

EO: You're welcome and good luck with the research and the graduation.

LK: Yes, thank you.

NM: Good.

EO: You're welcome. Have a nice day!

LK: Good day!

EO: Bye!

NM: Goodbye.

## Interview with Michiel Boerkamp

**File: interview Michiel Boerkamp Vecozo**

**Date: 17-12-2021**

**Duration: 30:37 minutes**

**Company: Vecozo**

Nicky Meziane: first of all, a short introduction, well my name is Nicky and I am 24 years old and currently in my graduation year at hogeschool zuyd in Maastricht. We are currently doing research with my project group for Welzijn op Recept. In this research we focus on primary care and Wellbeing care. And specifically on the link between general practitioners and wellbeing coaches. We also look at other factors that come into play such as the importance of IT systems and what they could provide in the referral process between these parties. That's a bit of a summary of what our research entails.

Michiel Boerkamp: Are there people involved from the healthcare field, such as your client?

NM: Our assignment is actually from Welzijn op Recept, but we do have contact with all the parties involved such as wellbeing coaches, general practitioners and with these parties we have also had interviews. So hence we thought it might be interesting to engage with Vecozo.

MB: How did you guys find out about us?

NM: Our supervisor at Welzijn op Recept had told us that Vecozo was currently developing a referral system. That's actually how we found out about VECOZO.

MB: In Maastricht I mainly know the group of general practitioners (zio?), so I assume that it was just a rumor from that side of the sector?

NM: I am not sure where our supervisor got acquainted with your services. But he is well known throughout the profession so he surely heard about it somewhere.

MB: When you guys have completed the investigation can I receive it?

NM: I think so yes, we are also in the process of writing a publication. So I'll write it down.

MB: yes please, I find the subject very interesting. If something comes out of your research I would love to receive it.

NM: yes good to hear. I must point out that the publication and the research are both in English.

NM: Well first of all, could you explain your position within VECOZO and briefly tell us what it is that VECOZO does?

MB: Yes definitely, VECOZO stands for secure communication in healthcare. It was founded about 15 years ago to digitize and bundle a number of services that insurers had to offer to healthcare providers. In the past, care providers had to forward every invoice, depending on where a client was insured. And the healthcare providers didn't like that very much; they wondered if they couldn't do that all in one place. That's how VECOZO came into existence, in other words, from declarations. And then a number of services were added, such as checking on insurance law. For example, a patient must be registered is this person insured or not? If so, where. These are all digital services that have been added. All in all,

VECOZO offers about 30 services and employs about 200 people. These services are actually carried out for various target groups. One that is still a very important group is insurers, but there are also assignments that are performed for third parties. Take, for example, the registration by name, or in other words, which general practitioner is registered with which patient. That is a large register of all Dutch citizens. But there are also services for hospitals, for example, which they need to get their financial services in order. So that's what VECOZO is and our location is in Tilburg. The shareholders are the insurers. My position is actually, I'm an independent consultant, I do different things around digitalization in healthcare. Including this, and my role in this is that I'm a program manager. The initiative started 3 years ago I did the first analyses then and looked at how the market is and what developments were happening. Now one and a half years ago we went from a research question to a realization trajectory, so all together we now have 20 to 25 people who are now setting up a new service, namely a referral system. That consists of ICT development, and a whole section that has to do with customers and users. So, we have several tracks, one track is the ICT development, and the second track has actually to do with healthcare providers and with regions and the third track has everything to do with what we call the "governance". So, a foundation is currently being set up in which the umbrella organizations for healthcare, the hospital sector, the GGZ laboratories sector and therefore also the paramedics and physiotherapy will in any case assign tasks to VECOZO. So that's what we're doing at the moment, so to speak, on our third track. So that's a brief summary of VECOZO, the outline of the process and my role in it.

NM: Okay, and then with regard to the new referral system, how long do you think it will take before the system comes on the market and what kind of realistic time frame can we think of?

MB: We start with referral support, or "the GP refers to" that's the example case we're talking about. Which we start with two things refer to medical specialist care so the hospital or the independent clinic and requesting diagnostics. Diagnostics can really be the function tests or the blood tests that's kind of the two big groups that are in there. that's what we start with. In the world of referral, that's about 90% of the volume. pilots will be done for that next year summer 2022. And the ambition is to go live with these two products in the fall. And the ambition is to further broaden that in the year after, which would mean from the perspective of the GP, the referral to the GGZ, paramedics and physiotherapy is the largest and also to the Nursing and Care Homes and Thuiszorg (vvt) and that is then planned for 2023.

NM: okay and then with regard to the system, is it also ultimately possible to gather data from the system? Think for example of patient data and such data

MB: yes, it will be an automated and integrated chain. So that means that I as a GP, make a referral, I'm in the patient file and press the refer button and then in the background the relevant part of the file goes along and is also delivered automatically to the receiving system of the healthcare provider. And we have agreements with all the relevant suppliers about that as well which was quite a job already (laughs).

NM: Okay okay (laughs), we are of course curious as to whether it will eventually also be possible to refer to welfare? You just indicated that in the beginning the focus is probably not there yet? And then I mean particularly that for example a general practitioner could refer to a wellbeing coach.

MB: That's not in uh, that's in the ambitions now but this is not in the planning yet. The difference of course is the fact that firstly, time, money and people have been reserved and secondly: we think we want to do that, but we still have to do further research to see what it should look like and what the investments are and what the foundation is for the parties involved to actually use it in the end. so, it is on our list to do the future, there is just no time or planning attached to it yet. Uh the timeframe will largely depend on the impact; it's actually determined whether this type of referral is going to

fundamentally differ from the type of referral to specialist medical care. And I think that the difference is not that big and that it will be possible to realize it in that sense quite rapidly. But I don't know that yet because we haven't investigated it. So, if you would be able to get an insight into the need and what it should look like, and you would be willing to share that with us, then we could find out.

NM: Yes, I know, I think it's extremely important for a wellbeing coach, for example, to be able to give feedback to a GP. For example, a GP wants to know what is going on with his patient when referred to a wellbeing coach. The wellbeing coach has to be able to give feedback to the GP, like this is what is going on at the moment and we have started this process with the patient. So, I think this will be a very important function in the wellbeing care.

MB: Yes exactly and this function is also generic because it is the same at a medical specialist or at physical therapy. This need does not differ.

NM: no indeed hence that is going to be a very important function. Could you maybe clarify again which other organizations would be able to participate directly from the beginning and use VECOZO's new service?

MB: So that's the 76 hospitals in the Netherlands and that's about 40 laboratories and the general practitioners of course. So those are also all parties that are now connected to the initiative both the umbrella organizations hospitals, general practitioners and laboratories. So these are, so to speak, our clients in this.

MB: Does that answer your question?

NM: yes, actually it does!

MB: so that's the first step, second step is then to expand to mental health and nursing and home care and the third step is actually nurses and nursing homes and paramedi and of those the most important group is physiotherapy and that's for 2023.

MB: But it could just be that an expansion into wellbeing care could possibly be a very simple one and we might not have to do anything at all for that. But we haven't explored that at the moment.

NM: I still have some questions regarding the cost of the system. So what would it cost for parties to join the new system. Because of course we all know that ZorgDomein has a huge market share and they are not affordable for smaller wellbeing organizations. What would this cost in the new referral system of VECOZO?

MB: half of zorgdomein or less.

NM: okay half of Zorgdomein or less okay!

MB: Yes, that's the whole principle because it started because ZorgDomein has a monopoly. And to they use this to increase its profits significantly, the hospitals ran into this problem. Just to give you an idea, there are hospitals that used to pay two hundred thousand a year and then this became four hundred thousand and they thought this was a bit too much. Because they had no alternative, because 95% of the general practitioners in the Netherlands use zorgdomein, so if you're not on it (audio disappeared) and you have less turnover, you have less turnover to cover your costs. There is no alternative. So that's why the hospitals and diagnostic centers said (audio disappeared). So that ZorgDomein can no longer be a monopolist, that's how this initiative came about.

So we also made calculations and we see that now in the realization. We are in the process of building and we have also noticed that the ICT required for this is not so bad. The most important thing is to make sure that you get into all the GP information systems that is quite a hassle. (audio dropped), that is network knowledge and experience. So we made a business case that for the hospital care and diagnostic centers we can offer this for half of the care domain rate and then basically we looked at the independent clinics and physiotherapy checked and we think we can even go below those prices.

MB: So we have no profit motive, as VECOZO being. The foundation is from and for healthcare. So the idea is precisely that those costs are lower and so that those smaller parties can also participate. Because they are not going to pay 500 euros a month for ZorgDomein. This is precisely the reason, because we are fully aware of the needs of the other sectors.

NM: Exactly, I do think that the financial aspect is a bottleneck for many wellbeing organizations, so I think that the prospect of you being prepared to include wellbeing care is a very good initiative.

MB: And do you have an overview of what that sector looks like? Because how is it organized? What parties are there? Is that something you guys have included in your research?

Jordy Gilbert: You drop out sometimes, your connection drops out from time to time.

Gijs Latten: of the wellbeing sector you mean?

MB: yes.

Gijs Latten: look the wellbeing care is for the most part really fragmented and that's also largely because of the size of wellbeing organizations. There are also quite a few organizations that keep administrative records literally with a pen and paper. That's also kind of where it lags behind. So as soon as a system is involved, these things have to be converted manually as well. Many wellbeing organizations use many different methods, and if they use systems at all, they are often just smaller systems that also differ a lot from each other and are not connected to central information systems.

MB: but that means on the other hand that any solution, no matter how small would already be profitable.

GL: yes it is.

MB: a hospital gets 100,000 referrals a year, so they rightly also have demands regarding digitalization.

MB: but that means on the other hand that any solution, no matter how small would already be profit.

GL: yes it is.

MB: the hospital that gets 100,000 referrals a year, so they rightly also have requirements regarding automation.

But if you don't have any digitalization outside of a notebook or a word document, then if you can receive it, that's already worth more.

GL: For wellbeing organizations, the problem is in the financial corner, because they simply can't justify spending so much money for a small number of referral. That's why ZorgDomein is a problem for them.

MB: If we divide up the healthcare providers, we see that on the one hand the very big guys are the hospitals and the top 10 mental healthcare institutions, which are large organizations with large budgets and ICT departments. There, digitalization is key, which is logical. (audio disappears).

The characteristic of this sector we have a different type of subscription for that we do not want to ask a registration fee, we simply say you pay per each individual receipt or referral (audio disappeared). The rate that we are on now for the paramedi would then now be euro 1.20 per referral. And so over time that would start to decrease. So you don't pay 50 or 100 Of 200 euros but you just pay per referral, and you get it delivered digitally. You can publish your product range as a care provider, so you can say these are my branches, and this is my care range, and this is my waiting time that's then the publication and the product and services as we are. And then from that point on, all GPs can refer to you so there's no start-up or affiliation costs involved.

JG: yes so that's how VECOZO tries to differentiate itself?

MB: yes we think the features should look like that. We see it as infrastructure and so we want to finance it in a way that fits an infrastructure. So if there are more cars driving over the infrastructure then the price will just go down even further.

GL: Guys, unfortunately I have to go, I have another appointment, so good luck with that, it all sounded very interesting, Michiel. I'm curious what else the interview will bring. Have a nice day.

MB: yes bye!

NM: okay my next question was actually how are you going to distinguish yourself from Zorgdomein because now 91% of the GPs have zorgdomein. It's obviously the financial aspect but the GPs also have to eventually get used to the new system if they were to work with VECOZO.

MB: yes, that's right.

NM: what have you guys come up with on that? Is that something you've already thought about?

MB: yes, of course we have thought about that. The approach indeed becomes a regional approach because you can only do that if (audio disappeared)

NM: sorry your connection was gone for a moment, we couldn't hear that last part at all.

JG: yes occasionally the connection is poor.

MB: yes I'll switch to my phone and I'll be back in a minute.

NM: fine.

MB: there is a regional approach so every time a coalition is made between the relevant healthcare providers. in any case the biggest healthcare provider are the hospitals and diagnostic centers that are 90% of the referrals from the GP. And the general practitioner care group. That's the unit we want to connect where we say, well if you take this decision together then you can stop using ZorgDomein. So that's step one and after that we're going to look in the region to see what other care providers would like to connect. Look, it adds nothing at all if we have well-being work in a region of Groningen or Maastricht and the general practitioners in the neighborhood don't use this service. Then there's no point in signing up for our service because then you're just not going to receive referrals. This only makes sense if your region has decided to.

NM: okay

MB: your region as (audio disappeared) a pilot region just take middle Limburg and south Limburg so Maastricht academic hospital and the hospital in Heerlen I thought, there are talks with those, we definitely have on the list there are also talks with them on the GP side as well as the hospitals. I expect that somewhere around 2023 the first steps will be taken there (audio disappeared).

JG: yes so to make that switch?

MB: yes exactly

JG: okay clearly.

NM: Jordy do you have a separate question? Because I think we have answered most of the questions now?

JG: yes, I did have a question about the future plans for VECOZO, but that has already been answered.

MB: Yes we have actually discussed everything and we actually want to keep expanding the services in that sense. Journals and trends that we want to start giving a place is to give digital care a place also in this referral. And we also want to start adding a referral advice component that's one of the things we're already doing with ZIO (audio disappeared). They ran a pilot last year with appropriate referral (gepast verwijzen), which is very interesting, it's also public information and we're now looking to integrate that into our services as well. We also want to add appointment scheduling as an option, so we really want to add much more convenience to the environment. So ultimately from a logistics system also a system that's going to help make the right care choices in that general practice.

NM: I think that can be a very important motivation for a GP to have those functionalities. That's what they're struggling with now because everything is now very easy to do via Zorgdomein. But if another party is now available that is also capable of providing all these functions, they will be more willing to switch. I think it will be crucial for VECOZO to find out how you are going to persuade the GPs to switch.

MB: Yes, but that is indeed the most difficult thing. That willingness of the GPs is the biggest challenge. I have a final question, I would very much like to discuss how a product might or might not fit in with what we can do in terms of wellbeing care?

NM: Maybe we can put you in touch with our supervisor of Welzijn op Recept. I think he would certainly be willing to discuss with you he was already very enthusiastic about the interview.

NM: Thank you and we will keep in touch

MB: Yes, and good luck with your research.