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Buurtzorg

Buurtzorg, a Dutch nonprofit home nursing organization founded in 2006 by Jos de Blok, Gonnie Kronenberg, and Ard Leferink, had developed a unique model. Its client satisfaction ratings were 30% higher than the average ratings of comparable organizations, while its levels of absenteeism, overhead, required hours of care per client, and turnover were one-third to two-thirds lower.[1,2] Buurtzorg (which means "neighborhood nursing" in Dutch) used local teams of no more than 12 nurses, with minimal centralized back-office support and a flat organizational structure.

By 2022, Buurtzorg had over 10,000 nurses in about 900 teams across the Netherlands, an administrative team of 50 people in Almelo, and two directors, Jos and Gonnie. Buurtzorg also had a growing international presence, with nurse teams in Australia, Sweden, Brazil, and elsewhere.

Buurtzorg attributed much of its success to empowering its nurse teams to build relationships with patients and make independent decisions, not only about patient care, but also about team management. Thijs de Blok, leader of Buurtzorg's international branch (and son of Jos), said, "It works because there is zero hierarchical dynamic. It is completely flat." There was no middle management, only a group of coaches whom nurses could call for advice at their discretion.

Many Buurtzorg nurses shared knowledge and best practices with one another through informal, unstructured mechanisms, from texting and calling to using BuurtzorgWeb, an internal IT system with an enterprise social network. During the COVID-19 pandemic, however, as guidance shifted rapidly, Buurtzorg created a crisis team to share knowledge and best practices in a more structured way, so that nursing teams could adapt as quickly as possible. Nurses also entered data on patients' conditions, treatments, and outcomes into a structured system (the Omaha System) on BuurtzorgWeb. Buurtzorg's IT partner, Ecare, had started to analyze these data to provide nurses with recommendations on improving treatments and outcomes. Joost de Blok, another son of Jos and a likely successor to lead Buurtzorg in the Netherlands, wondered if Buurtzorg should do more—even post-pandemic—to identify best practices (e.g., via brainstorming sessions or data mining), test them (e.g., through A/B testing or data analytics), and present them to the nurse teams (e.g., using structured categories of best practices in BuurtzorgWeb). Thijs worried that investing in a more structured organizational learning

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model could undermine their decentralized management model. Buurtzorg's philosophy had been to leave research to researchers and universities and to focus on supporting well-trained nurses who were in the best position to decide how to care for patients. Both Joost and Thijs intended to keep Buurtzorg flat, but they also wondered whether or not they should adjust aspects of the learning model.

Adding urgency to these questions was an increasingly dire nursing shortage in the Netherlands as much of its population aged. Buurtzorg's headcount had grown quickly over 15 years, but many of the nurses who had joined it to flee more hierarchical organizations were near retirement. There simply weren't enough new nurses to hire. Buurtzorg needed to encourage its nurses to work as efficiently as possible, while also attracting a newer generation. Could the learning model better leverage knowledge within the nursing teams, without undermining the flat organization and culture?

Home Health Care Services

Buurtzorg nurses provided home health care beyond what family, friends, and neighbors could provide.[3] Such services could be long-term—for elderly patients or those with chronic illness or disability—or short-term—for patients recently released from the hospital, preparing for or recovering from childbirth, recovering from an accident or illness, or facing the end of life. Home care could range from performing medical tasks (e.g., taking blood pressure or giving medication) to providing medical supplies (e.g., wheelchairs, crutches, bed pans, or special beds) to offering education (e.g., prenatal or post-partum courses or nutritional advice) to helping with daily tasks (e.g., dressing, eating, or showering).[4, 5, 6] Home care nurses often coordinated with informal caregivers (family, friends, and neighbors) and with other care providers.

Globally, the home care market was estimated at $320.6 billion in 2021 (85% services, 15% equipment) and was projected to grow 7.9% annually from 2022 to 2030 as the elderly population segment grew, along with the incidence of diseases like dementia and the prevalence of portable medical devices.[7] Global interest in home health care was due not only to how it provided comfort and convenience for patients, but also to the fact that "hospital-at-home" programs were estimated to cost 30% less than the same care delivered in hospitals.[8]

The Dutch home care market was estimated at $7.3 billion in 2021 and projected to grow to $11.6 billion by 2027 (see **Exhibit 1**). More than 500,000 people annually used home or maternity care or lived in nursing homes.[9, 10] Dutch home care providers spent an average of 168 hours per patient per year[11] and demand for nurses routinely outstripped supply. The Dutch home care market was highly fragmented, with many regional and local providers;[12] Buurtzorg was the only national player.

Insurance Coverage for Home Care

In 2006, Dutch public and private insurance markets merged under the Health Insurance Act to create one universal social health insurance program. Coverage was now mandatory for all Dutch residents and had to be purchased from private insurers.[13] Almost all health insurance companies were nonprofit cooperatives that earmarked any profits to cover required reserves or to return them to buyers in the form of lower premiums.[14] All health insurance plans had to provide certain basic types of care, including essential medical care (such as home health care when prescribed by a general practitioner).[15] (See **Exhibit 2**.) At the end of 2016, only about 23,000 people (about 0.2% of the population) were uninsured.[16]

In 2016, the Netherlands spent 10.5% of its GDP on healthcare. Of that, about 37% came from payroll taxes paid by employers, 18% from general taxation, 17% from insurance premiums paid by

individuals, 9% from copayments (for certain types of care, such as hearing aids and orthopedic shoes), and the remaining 19% from other sources. People with lower incomes received an allowance from the Dutch tax authorities that allowed them to cover some part of their premiums and/or the policy excess fee. The government used public funds to pay for insurance for those under 18.

Buurtzorg's Story

In 2006, Jos, Gonnie, and Ard founded Buurtzorg, a nonprofit, after much reflection on their prior work in home health care. "Being a community nurse in the 1980s gave me all I wanted," explained Jos. "I had the freedom to decide how to take care of my patients. I had great colleagues. We just did what we needed. There was no management structure, strategic plans, or planning tools." In many later roles, however, the founders experienced great frustration with the Dutch healthcare bureaucracy and with poor management. In the 1990s, the Dutch government established the Care Needs Assessment Centre (CNAC) to analyze (and scrutinize) the needs of each patient. Delivery of home care became more managed—with layers of managers to coordinate tasks—and more product- and activity-driven. "You noticed an enormous change in how people talked about care," Jos said. "It was fully dictated in tasks and how much time you could spend on them."[17] He added, "No one could really do what they thought necessary."[18]

After 10 years of managing two large home-care organizations, Jos concluded, "[W]hat we did [as managers] did not at all contribute to better care or nicer work for professionals, but quite the opposite. I thought, 'It's a pattern I see everywhere, so let's completely change things.'"[19]

Founding Buurtzorg

Buurtzorg represented an alternative approach. Just before founding Buurtzorg, Jos had worked on a self-managed project in Ukraine to attain consensus among Ukrainian doctors, nurses, and other healthcare professionals in the primary-care system about the direction general healthcare should take. "I thought, 'If I can do this over there, why can't I do this in the Netherlands?'"[20]

Together with Gonnie and Ard, Jos began to develop a business plan and a framework (see **Exhibit 3**). They put together a plan for an organization of nurses with the independence to work with patients in the ways they felt delivered the best care. Jos ran a small consultancy that earned him enough money to set up the Buurtzorg nonprofit organization and to fund the first nurse team, which he himself joined, both to save money and to see how well his idea worked in action.[21]

Jos realized his new organization would have many touchpoints with regulatory bodies, from the national health inspection service to workers' unions. "All sorts of parties who have authority in health care and who think it must be done a certain way, we have to be able to respond to," he said.[22] He undertook the role of managing Buurtzorg's relations both internally with nurse teams and externally with regulators, insurance companies, the media, and other relevant parties. "I was the back office, in the beginning," Gonnie said. Meanwhile, Ard developed Buurtzorg's IT system, called BuurtzorgWeb. As Buurtzorg grew to about 12 teams and as it added BuurtzorgWeb, Gonnie hired a few others to work with her on back-office tasks and Ard spun off Buurtzorg's IT systems into Ecare, an independent, for-profit organization led by Ard and Geert Quint. Ard and Geert continued to run Buurtzorg's IT and kept Buurtzorg as Ecare's main client, but also sold Ecare software as a service to other self-managing nursing organizations.

The idea embodied by Buurtzorg began to take off more broadly after several newspapers and television news programs covered it in 2007. Jos began to speak to groups of medical professionals,

including nurses clamoring to join Buurtzorg. Recruitment picked up sharply and he described the company environment as almost euphoric, with teams taking great pride in the way that Buurtzorg allowed them to work (see **Exhibit 4**.)

Buurtzorg in the Netherlands

Buurtzorg defined its purpose as "to help people live more healthy and autonomous lives."[23] Jos considered nursing a vocation and assumed that other nurses also experienced satisfaction from helping people.[24,25] This resulted in three guiding principles for Buurtzorg—humanity above bureaucracy, simplicity above complexity, and the practical above the hypothetical.[26] (See **Exhibit 5**.)

Nurse Teams Self-managed, self-steering, neighborhood-based teams of no more than 12 nurses drove Buurtzorg and made up about 99.5% of its workforce.

Team Composition New self-managed nurse teams emerged organically. If a group of four or more nurses (whether Buurtzorg employees or not) wished to form a Buurtzorg team in a new location, they made a proposal to the back office, describing how their team would improve the quality of local patient care and what resources they might need. If the proposal was accepted, a two-day onboarding process began and then the nurses could get to work.[27] Nurse teams needed to recruit their own clients. Teams stayed small to limit the need for coordination, allowing them to take ownership over their relationship with the neighborhood. If a team grew past 12 nurses, it split into two teams. Conversely, teams that dropped below six or seven nurses often merged with another team.

Teams recruited locally and decided whom to hire, how to develop them, and whom to fire.[28] The teams only hired nurses at certification levels 3 and above (see **Exhibit 6**). Buurtzorg nurses self-identified as hard-working team players. Jennifer Bergkamp, a nurse in Aalsmeer, acknowledged that, when starting a Buurtzorg team, she needed to learn many new skills about self-management. The back-office team was always available for consultation, "but I loved figuring it all out [myself]."

Nurses recruited locally. Sophie van Veenen, a nurse in Almelo, joined Buurtzorg just after finishing school. "I didn't choose Buurtzorg on purpose. I first wanted to work at the hospital—working in home care felt a bit old-fashioned—but I didn't have enough experience. I thought I would work here for a year and leave, but I loved it so much, just being your own boss. Now I am visiting my old school to teach the new nurses that it is cool to work here; everyone young who goes into nursing wants to work in a hospital."

Not everyone fit at Buurtzorg. "The person who doesn't want to self-organize; the person who just wants to go to work and come home; the person who never speaks in meetings . . . can't work well here," said Saskia de Wilde, a nurse in Baarn. "Sometimes colleagues try to be managers," added Carolien Dijkstra, also on the Baarn team. "That doesn't work."

Role Design Each nurse engaged in both *nursing work* as well as *self-management activities*.[29] Finding themselves in high demand, teams could decide for themselves both how to recruit clients—often through relationships with neighborhood doctors—and which to accept. A diverse client mix was encouraged, such that, for example, a team with both ordinary-care clients and extensive-care clients would not become vulnerable if it suddenly lost a few of the latter.

Typically, three to four nurses collaborated to care for each patient, providing consistent care and persistent relationships. Nurses were very flexible in their day-to-day work. They built their local networks and leveraged local knowledge to optimize patient care[30] and were authorized to prepare, implement, and adjust a patient's care plan as his or her needs changed. Nurses also decided where to

buy medical supplies and often ordered them while on home visits. "It is important that these nurses feel the autonomy to do what they think is needed at the moment that problems occur," explained Jos, "and that they also have the autonomy to share it with their colleagues. . . . They can build on things they find out themselves, they are not using solutions created by somebody else."[31]

That autonomy is what brought Jennifer to Buurtzorg from another home health organization. "Jos gave nurses the opportunity to say what our standard for quality was and how to take care of people. Other employers thought for you and decided what quality was and it was all money-driven. It was all about what the cheapest option was." Jennifer took pride in her many close relationships with patients and their families. An artist, she drew portraits of many of her patients, which she showed at a local gallery, together with short vignettes of their life stories (see **Exhibit 7**).

Nurses relied on what Buurtzorg called the "onion model" to enhance the patients' health and autonomy.[32] Layers of the onion included the patient at the center, an informal network of friends and family surrounding that patient, the Buurtzorg team (nurses) serving that patient and his or her network, and—as the outer layer—a formal network including doctors and specialists.[33]

In addition to nursing activities, each nurse engaged in self-management activities.[34] Teams found and set up their own offices.[35] Each team member held an administrative role—housekeeper, reporter, developer, planner, team player, mentor, or vitality manager (see **Exhibit 8**).[36] Team members typically rotated through these roles on a regular basis, but some long-standing teams kept people indefinitely in the roles that fit. "I like to do the planning and scheduling," said Heleen Munneke, a nurse in Amersfoort, "taking into account the clients, the times they want care. It's a puzzle, and I like that. "

Most decisions did not require back-office approval. Nurses might call the back office for a solution to a problem, but most often the issue was referred back to the team. "There is no central decision-making process," Jos said. "Collective intelligence grows fast. If teams feel ownership over their decisions, they happen faster." Nurses and other Buurtzorg personnel were encouraged to see themselves as part of a greater collective. "Others will understand and welcome your role as long as you are not taking a hierarchical position in your interactions with them," Jos said.[37]

Performance Management To preserve team autonomy, the back office avoided monitoring nursing teams, applied only a few constraints, and tracked only a few performance measures. Teams had a productivity threshold of 62%, meaning that no fewer than 62% of the team's hours should be spent on patient care (the minimum percentage of billable hours necessary to run a profitable team). The back office also gave teams monthly budgets based on local prices, which did constrain their finances.

Nurse teams even managed performance issues that pushed the limits of self-management. One team had to deal with a colleague who claimed that the COVID-19 virus was fictitious and would not wear personal protective equipment. She also claimed burnout for months and stopped working. "We aren't educated to solve problems like that," said another nurse from that team. Nonetheless, "it stayed on the team," another nurse said. The problematic nurse later left, but it took over a year. In rare cases, teams might invite back-office support on serious issues; for example, with a major ethics violation (such as stealing from a patient). But even in such cases, most teams addressed the issue themselves.

Sources of Motivation Buurtzorg paid nurses more than the minimum recommended by the Dutch government. Each earned a salary recommended for one level above their actual certification (see **Exhibit 9**.) At the same time, nurses always operated as equals. "We are all the same, regardless of our nursing level," said Saskia. "Every voice counts the same."

Nurses might also receive an annual bonus based on Buurtzorg's overall performance. Every year, Buurtzorg reserved 2% of revenues (built into the 62% productivity threshold) for unforeseen costs. If any of that money ended up unused, Buurtzorg—which could not make a profit due to its nonprofit status—would allocate half the surplus to innovation projects and the other half to a bonus pool shared across all employees. In most years (with the exception, for example, of the pandemic years when there was a spike in unforeseen costs), the bonus—typically about half-a-month's salary—was paid.

Despite above-market salaries, Buurtzorg's nurses cited intrinsic motivation as their main motivation. Positive experiences with clients inspired them. Deborah Warta, a nurse in Amersfoort, recalled: "We had a young client, he was paralyzed, but because we came every morning, his wife said she could have a role as his partner, instead of being his nurse in the morning. She was so thankful that we took care of him, so that they could have their normal life together." Many nurses valued being empowered to make full use of their abilities. Mirjam de Leede, a nurse practitioner, said:

> I learned that working in an organization that trusts you and cares for you makes things possible that you had not thought about before. I see an enormous benefit in that I can develop myself and grow in my profession. I can use my skills to the maximum. Because I had this enormous freedom, especially during COVID-19, the creativity was just out of the box. It is amazing. You can get so much out of a person, they bring so much to the table, and it is so innovative to work this way. I wish lots of other people had that, too.

Back Office Support Buurtzorg's directors, Gonnie and Jos, as well as the 50 back-office employees, saw their role as providing service to the nurse teams, rather than managing them. "I like to make procedures as easy as possible," said Gonnie. Jos said that he saw leadership as inherent in each individual and that every time a nurse took responsibility for a patient, he or she showed leadership.[38] He saw leadership through management, however, as something that led to poor outcomes: "In organizations, for example, if you have these different management layers, then usually management is connected with leadership. And I think that's wrong . . . hierarchies have a big negative influence on the leadership of the frontline. That's how people lose touch with the client."[39][40]

Back-office employees handled time-consuming activities requiring specialized expertise, including billing, financial reporting, lease contracting, car rentals, and IT. Jos and Gonnie wanted administrative processes to work efficiently and simply. "Keep it simple," she said. "Communicate and be open—no hidden agenda. Keep it informal and be accessible."

Despite the unusual level of flexibility, certain things were standardized. "All the teams work the same way, so it is not so complex," Gonnie explained. "They have to use BuurtzorgWeb and the Omaha System. But they can make their own planning choices with patients, so it feels different." "Buurtzorg behind us is our wall," said Heleen. "We can work the way we do because they exist."

BuurtzorgWeb and the Omaha System BuurtzorgWeb was an integral part of infrastructure. "We don't need middle management," said Gonnie. "A good IT system is very important there." Ard and Geert built BuurtzorgWeb based on what Buurtzorg's nurses said they needed. "We developed the system with the teams," Geert said. He found it easy to get the nurses to use it. "There was always somebody on each team who knew the system; they helped and taught each other." The earliest version allowed nurses to enter notes from patient visits and pass them along to the next nurse. Building on the need to track patient data, BuurtzorgWeb later incorporated the Omaha System, a US-based open-source system, for patient assessments, care plans and services, and outcome evaluation.[41] The Omaha System helped standardize the data nurses entered about patients and their outcomes. Some of this information passed through to insurance companies. It had 42 possible problem areas and, if a nurse

selected one, the system would suggest potentially related outcomes and treatments. "It made it easy to build a good care plan without necessarily a lot of practice," said Joost.

Nurses made other suggestions for additions to the platform that could improve their work. The IT team added text communication features, such as message boards with filters, after several nurses asked if there was a way to chat across teams.[42] This became a primary source of value for the platform and quickly built community among the nurses. In 2014, IT also added a scheduling module based on nurses' requests. "Over time, we added bits and pieces," said Ard.[43]

BuurtzorgWeb also allowed the nurse teams to track a few performance measures, including patient satisfaction (see **Exhibit 10**). "But we need to look at quality of care in other ways, too," explained Joost. "We are always in discussion on the [data] project team—we are wondering if patient satisfaction ratings say that much." He added that by tracking other outcomes, such as how much care a patient received or whether they had complications or went to a hospital, Buurtzorg might be able draw more insightful conclusions.

Coaching for Nursing Teams Buurtzorg employed 22 coaches responsible for advising and assisting about 40 to 50 teams each. They had to provide support while being careful not to step in and directly solve the teams' problems. Instead, they steered teams to make decisions by building consensus. "A good coach has to help the nurse teams, not correct or control them," Gonnie said.

Coaches typically had a community nursing background. They helped with matters from informal brainstorming and problem solving to team expansion and division and coping with absences and extended sick leaves. At times, coaches connected teams if they were having similar problems or needed to explore a merger. Coaches could also see team productivity data on BuurtzorgWeb, both by team and by individual, to assist with each team's financial viability.

Margreet van den Heuvel, a coach (and former nurse) supporting 43 teams, said, "As a coach, I'm a bit of a safeguard of the framework. It is not anarchy. We help teams work within the Buurtzorg framework and when we see them [go] outside the framework, we guide them back." She described the four principles for self-managed teams as (1) solution-focused communication, (2) solution-focused meetings, (3) team decisions made in consensus, and (4) dividing and rotating roles and tasks. Coaches met with all the teams they coached once or twice per year but spent most of their time helping teams facing challenges. Each coach met with Jos and Gonnie about three times a year. The coaches themselves divided into teams of about six, which met every six weeks or so, mostly to discuss difficult cases.

Within reason, nurses were free to decline coaches' help. "You can just say, 'No, go away,'" said one nurse. "I've even asked Jos if we could fire a coach."

Buurtzorg Gatherings The company used annual regional conferences and larger events to enhance team building. Buurtzorg Festival, a companywide festival held each May, had a carnival-like atmosphere, with live music, food and drinks, and workshops ranging from yoga to cocktail making. Every Buurtzorg nurse could attend and was encouraged to do so to meet others. (See **Exhibit 11**.)

Activism At times, Buurtzorg's actions ran counter to those prescribed by the government and national regulations. "If there is a rule [that doesn't make common sense], it stops at Buurtzorg," said Carolien, a nurse in Baarn. For example, during the early stages of COVID-19, the Dutch government discouraged the use of face masks. Jos and others on the crisis team cynically thought that the government had taken this position to cover up for a lack of supply, so they used Buurtzorg's website to advocate for masks. They posted a video showing how to sew your own mask at home. "We felt

taken care of," said Irma Uhlenhop, a nurse in Amersfoort. "We saw people were dying due to lack of protection—it was so simple to protect ourselves. Most competitors were working without masks and were even part of the problem."

Nurses also felt comfortable following the spirit but not necessarily the letter of the law. For example, insurance companies would not pay for services after the date of the patient's death. If a Buurtzorg nurse considered that a family meeting to review patient care could not occur on the date of death because family members were grieving, it was acceptable within Buurtzorg to hold the meeting later and backdate it for insurance purposes. Also, certain patients were supposed to have a nurse with the highest possible educational certification available to Dutch nurses write their care plan to submit for insurance. Yet the nurse who knew a patient best was not always one who held a top certification. In that case, if the nurse who had attended the patient knew how to write a care plan, she or he would write it and have a nurse with the top certification sign it. "I learned at school to write these plans. Why would I learn to write them if I then cannot use these skills?" said Petra Huizinga, a nurse in Baarn who did not have the top-level certification. "I know much more about my patients than other colleagues who may not visit them very often," said Saskia, adding "Jos said, 'At Buurtzorg, even if you do not have the right certification, you can do this.'" Thijs said that the rule simply did not work in practice. "The rule is theoretically good—it makes sense to have a highly qualified person signing off on care. But there aren't even enough highly qualified nurses to routinely do this, and if all of the top-level nurses did this, then they probably would not do anything else. It shouldn't come at the cost of delivery of care," said Thijs. "It's a good idea, but it doesn't make it workable or practical."

Such positions often caused tension between Buurtzorg and the government, but Buurtzorg had also shown itself to be a trusted and influential player, in part through Jos testify8ing in front of Parliament or speaking out through the public media. In 2010—2011, Buurtzorg ran a pilot to demonstrate to the Dutch government that the Care Needs Assessment Centre—part of what prompted Jos to found Buurtzorg in the first place—was undermining effective care rather than enabling it. The pilot was very successful, resulting first in the exemption of Buurtzorg from CNAC practices and oversight and, ultimately, in the government's decision to wind down CNAC altogether.

Expanding Buurtzorg Domestically

As Buurtzorg's nursing model continued to grow and mature in the 2010s, a frequent question emerged: where else might the model apply? Buurtzorg began investing in other areas within the larger market for client care, including domestic help, mental health care, maternity care, child care, assisted living care, hospice, and holiday care (see **Exhibit 12**). The first investment, in 2009, was Buurtdiensten—a company of small neighborhood teams providing domestic help (of which elderly people in the Netherlands were entitled to 1.5 hours per week without copayment), including shopping, cleaning, and cooking. By 2022, Buurtdiensten had almost 4,000 employees, in part because Buurtzorg had formed an agreement with the government in 2015 to take over part of a failing Dutch company, TSN, which Buurtzorg renamed Familiehulp. Buurtzorg then transformed Familiehulp into a self-managed organization before formally integrating it into Buurtdiensten in 2020. Despite such a significant change from Familienhulp's hierarchical operating model, the acquisition was a success.[44]

Expanding Buurtzorg Internationally

Buurtzorg had also extended its model outside the Netherlands (see **Exhibit 13**), partnering with other organizations with varying success. Buurtzorg teams had launched in more than two dozen countries, including Sweden, Germany, China, Brazil, and Australia. However, replicating the organization's culture of autonomy and independence sometimes proved very difficult. For Buurtzorg

Brazil, for example, "the main challenge was how to train people and change their minds," said Martha Oliveira, executive director. "This type of responsibility isn't something everyone wants to have. Still, after a year, we saw so much change in our teams. We said, 'It's possible.'" Iohanna Salla, the first nurse to use the Buurtzorg model in Brazil, agreed. "The hardest part is the change in mental model. [Nurses here] are used to a hierarchical model with the doctor as boss. This is very different." There were concerns about brand reputation when launching a Buurtzorg team in a new country. "We can't expand into a new country unless we are working with a partner that we completely trust," said Thijs. It could take longer to find out if an international team was having a problem and the means of addressing it often were not the same as in the Netherlands.

Learning and Evolution at Buurtzorg

Even as Buurtzorg explored domestic and international options for applying its operating model, it wanted to keep improving that model in Dutch neighborhood nursing. Good ideas could emerge from any nurse or nurse team, the back office, or Ecare. Different organizational learning mechanisms had emerged as teams sought opportunities and/or solutions to problems and as they shared their knowledge. Jos said, "How can we make a nursing team's growth bubble out to others?"[45]

Social Learning

For nurse teams, learning was social, bottom-up, and on-the-job. Nurses on a team were in frequent contact. "In my first month, I worked with other nurses, went with them to all the houses they visited, first just watching, then doing a few things," recalled Sophie. "Now people are going along with me. We call and text each other with questions a lot. We have one meeting every two weeks to say all of the big things, but for the quick, small stuff, we just call each other."

Buurtzorg had also begun to host regional conferences. Gonnie said, "All the teams in a certain region come together and talk about what they are facing, so they have to work together a bit more." For similar reasons, in some neighborhoods where there were multiple nursing teams, the nursing teams chose to share a single office space.

Online Learning

BuurtzorgWeb contained a wealth of useful information, including message boards and a list of nurses who could share specific expertise. The message boards were part of an enterprise social network. Posts were neither edited nor curated. Ard explained that some users only wanted to read posts and others wanted to post their opinions and engage in discussions.

There was a themes section, curated by the back office. It included policies and best practices from various projects (see **Exhibit 14**). Themes included Buurtzorg's vision, Buurtzorg's documents, recruitment of new colleagues, and best practices within nurse teams. Categories were deliberately broad, allowing a great deal of information to live under each theme. "Everybody can check the webinars they find interesting," explained Joost. "We often see that one person from each team views them and that is good enough. The furthest we go is to strongly advise people to watch certain webinars, but we never demand it."

The COVID-19 Crisis Team and the Care Paths Project

In early 2020, a COVID-19 crisis team of 12 people, including Mirjam, Jos, and Gonnie, was assembled with Jos' approval. At first, they set up a crisis hotline for nurses. "People kept asking the

same questions," said Mirjam. "How do I care for a Covid patient? What do I wear when I go there? How do I wash it?" After two days, she created and posted a Q&A with common queries. Soon after, the team launched a crisis website with common questions, information about making masks, guidelines on personal protective equipment, and other topics.

While on that team, Mirjam created a care path (a detailed document that identifies patient needs and a timeline for interventions based on those needs) for COVID-19 patients that she posted on BuurtzorgWeb and LinkedIn (see **Exhibit 15**). Each page allowed a reader to send feedback. As the COVID-19 care path attracted attention, she spoke to Jos about creating care paths for other ailments and diagnoses that nurses could access as references or guides. Mirjam hosted a Zoom meeting, attended by 40 nurses—not all from Buurtzorg—during which she recruited others to write care paths. "At first, I asked other nurse practitioners within Buurtzorg," she said. "Later, I posted on the Internet—who is interested in writing a care path about treating delirium, for example?" By May 2022, teams led by Mirjam had created care paths for falls, dementia, heart failure, and more. The teams could track the popularity of specific paths (see **Exhibit 16**). Care paths were posted on other sites in addition to BuurtzorgWeb and could be used by non-Buurtzorg nurses.

Mirjam said that the care paths differed from traditional nursing protocols. "Those can be huge, maybe 80 pages on how to deal with a type of condition," she said. "No nurse has the time to read those. It doesn't help a nurse trying to work in an evidence-based way. I wondered—can I do this in a Buurtzorg way? If we have a few experts in a particular problem, they can easily collect the information for a care path, make it sensible, a summary. If you are really focused, you can go to others quickly for feedback—doctors, therapists. Then you can incorporate their feedback and publish it."

Project-Based Learning

The COVID-19 crisis team and the care paths project encouraged Jos, Joost, and others to explore additional projects that could help identify and disseminate best practices. Jos encouraged and inspired nurses and back-office employees to identify such projects and then assembled small multidisciplinary project teams to explore the most promising. He focused his own attention on supporting the execution of these projects and measuring performance outcomes.

Some projects followed nurses' initiatives. For instance, Els Schopman, a nurse in Almelo, experimented with building a "vitality club" in her area; that is, a social group that allowed people to walk and exercise together, chat, and share meals. She had seen doctors from the Leyden Academy for Vitality and Wellness promote the concept. "I have 42 people in our group and they meet once a week," she said. "The youngest is 49 and the oldest is 89. They just move and have fun." While some other nursing teams adopted this idea for themselves per Els's suggestion, others were not receptive, which frustrated her. "Some people said, 'It's all very wonderful what you do, but I am not interested, I just want to do my own work,'" she said. "I put it on BuurtzorgWeb, but didn't get too many responses. Most people just focus on their core work."

Other project teams followed leads from the back office. For example, three groups of Buurtzorg district nurses went to Havana to study prevention. The Cuban nurses taught people to work through health problems themselves, in part to manage incredibly strained resources. "I've heard that they do tai chi, they have neighborhood houses where people meet and get their meals if they can't cook for themselves, their whole system is geared toward independence for as long as possible," said Els. "This is a system that Buurtzorg very much likes. If I notice my neighbor isn't walking well or my other neighbor isn't eating anymore, I should tell the district nurse, so she learns it at an early stage."

Buurtzorg explored ideas to gain efficiencies in view of the nursing shortage and high demand for nursing services. In 2021, the back office hosted a webinar calling for ideas as well as "mirror conversations" between unproductive teams (spending many hours) and highly productive teams (spending very few hours) delivering care for the same problem or patient type. "In many cases, they did the same interventions, but had different attitudes, or their education level was higher, or they were better at team negotiations," Joost said. In other cases, the conversations uncovered ideas and practices that explained why some teams were more productive than others, above and beyond the conditions in which they operated. One project team developed an initiative named "Buurtzorg Future Proof" (see **Exhibit 14b**), which suggested that promoting patient autonomy could improve both patient outcomes and nurse productivity. Another project team developed a rotating system to allow teams to share responsibility for nighttime calls from patients. Gonnie said that they had outsourced some of the nighttime work; they had also tried bundling Buurtzorg teams in groups of 10, with one team covering nights for one week, then rotating to another the following week. The cost savings from this arrangement helped Buurtzorg boost salaries one level higher for all nurses, but some teams wanted to cover their own availability. "You need the power of all the teams, or most of them, to make a joint decision [about how to cover night availability]," said Joost. "Maybe not all of them agree, but most of them do."

Machine Learning

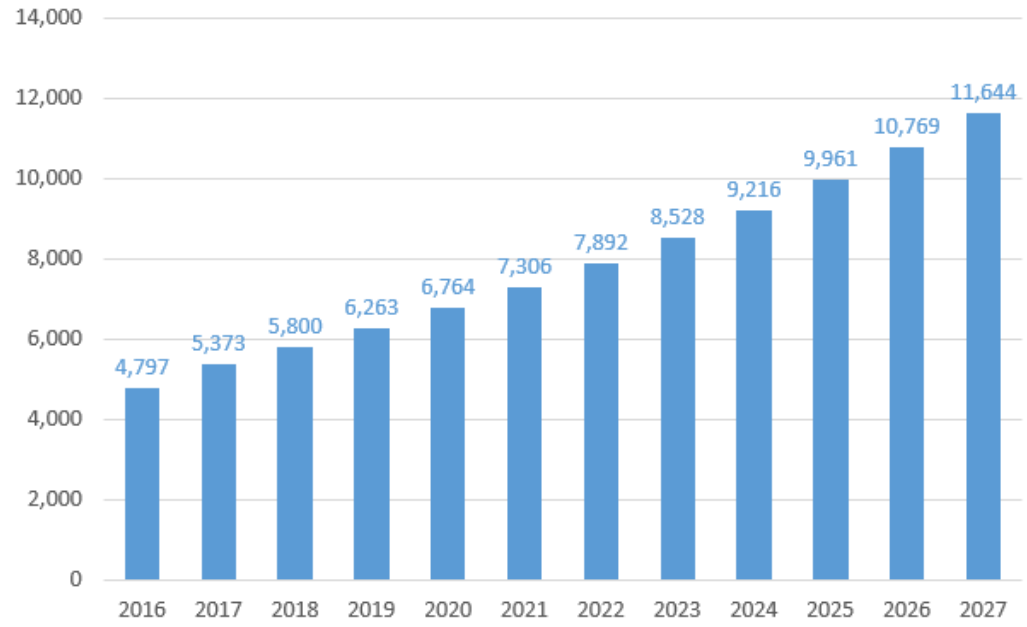
Buurtzorg also began to mine its data. "We are using more and more data to see the kind of patients we have, the kinds of illnesses they have, the average amount of care they get per week, productivity per team, number of employees sick at a given time, and patient satisfaction," said Joost. Exploring—through statistical analysis—how different nurse team activities could affect patient outcomes could help Buurtzorg uncover best practices. Ecare took the lead on mining the data collected through the Omaha System on BuurtzorgWeb. The software company hired several data scientists and connected them with nurses to generate testable predictions on the type of care that different types of patients should receive for better outcomes. So far, the results from the data mining exercises had been rather underwhelming, resulting in unsurprising insights such as that a patient who had fallen in the past was more likely to fall in the future. Still, the insights emerging both from data analysis and from discussions with nurses were integrated into the system. Where nurses tracked each patient's care in BuurtzorgWeb, the system presented evidence-based pop-up suggestions. For example, if a nurse noted that a patient was socially isolated, the system produced a "pop-up notification" suggesting that the patient might be emotionally unstable and recommending that the nurse incorporate emotional support in the care plan.

The Future of Nursing at Buurtzorg

Buurtzorg had come a long way and its nurses were incredibly resourceful and knowledgeable. They were accumulating more data about best practices and how their teams worked. At the same time, an aging population and an impending nursing shortage meant that Buurtzorg's nurses would have to become even more efficient. Small shifts upward from the 62% benchmark could have a significant impact on the shortage.

They struggled, however, with prioritizing that knowledge and applying it more widely, precisely because of the easygoing culture that had allowed some of that learning to occur in the first place. They shied away from any solution that felt controlling and wondered how they should structure knowledge to be credible and accessible to the nurses. Joost and Thijs wondered how to bridge this gap, given that a core part of the organizational philosophy was simply not to interfere.

Exhibit 1 Netherlands Home Healthcare Market, 2016-2027 (USD million)



Source: "Home Healthcare: Market Estimates and Trend Analysis From 2016 to 2027," Grand View Research, 2021, p. 123.

Exhibit 2 Healthcare Covered by Dutch Basic Health Insurance Policies, 2016

Examples of Insurance-covered Healthcare
• Medical care by general practitioners and specialists • District nursing (nursing at home or within a community) • Hospitalization • Mental health care, including hospital stays of up to three years • Medications • Physical therapy, speech therapy, and occupational therapy • Nutritional and dietary services • Ambulance and sedentary medical transport • Physiotherapy for chronic illnesses

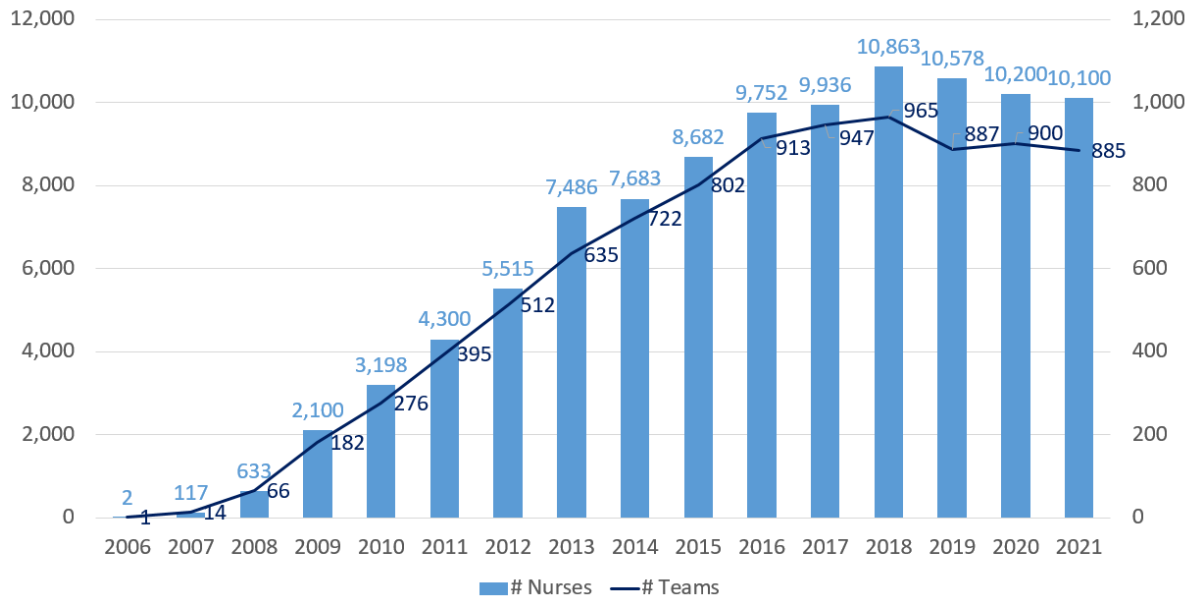
Source: Adapted from "Healthcare in the Netherlands," Ministry of Health, Welfare, and Sport, January 2016, p. 8.

Exhibit 3 Buurtzorg's Framework

Key Aspects of the Framework
1. The Best Care at Home: Neighborhood Care Teams are Generalist and Knowledgeable
2. Self-Management: Do What You Find Necessary for the Clients with a Solution-Orientation
3. Financial Fitness: A Productivity Standard of 62% Keeps Us Healthy
4. Regional Coaches Support Teams Proactively, On-Demand, and with Guidance
5. Project Teams and HR Coaches Support Regional Coaches on Situations Requiring Extra Expertise
6. The Back Office is Not a Headquarters—It Supports Teams and is Constantly Evaluated to Avoid Unnecessary Bureaucracy
7. We Will Always Invest in Training and Knowledge as Teams See Fit
8. Buurtzorg Will Strive to Always be an Attractive Employer
9. Buurtzorg Will Take Action When 'The Outside World' Gets in the Way of Teams Being Able to Deliver the Best Care at Home

Source: Adapted from company documents.

Exhibit 4 Number of Nurses and Teams, Buurtzorg, 2007-2018



Source: Adapted from company documents.

Exhibit 5 Buurtzorg's Mission Statement

Source: Corporate Rebels Academy.

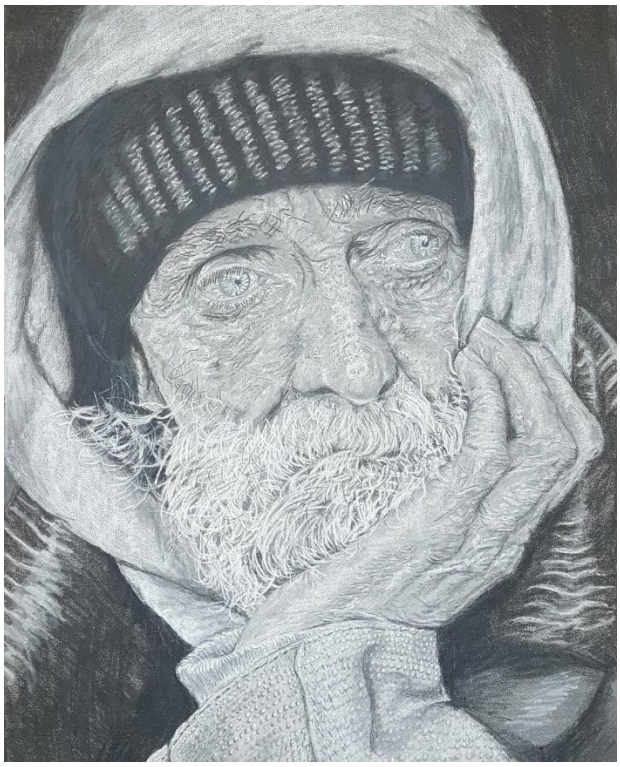
Exhibit 6 Dutch Nursing Certification Levels

Name	Possible Education Requirements	Work Includes
MBO Level 1	No previous education	'Care Assistant'. Works in home care, elderly care, or disability care. Supports people in need of care in household tasks; performs light caring tasks; assists people in need of care to learn how to do as much independently as possible.
MBO Level 2	VMBO vocational track, or MBO Level 1 diploma	'Care Helper'. Works in home care, elderly care, disability care, child care, or hospital. Helps people in need of care (i.e. wash or dress themselves); organizes physical activities for people in need of care; carries out the care plan.
MBO Level 3	VMBO Kb/G/T pathway; VbO with 2 subjects at C level, rest at B; Mavo; transition certificate from HAVO from year 3 to 4; MBO Level 2 diploma	'Caregiver'. Works with diversity of target groups and can be specialized in home care, maternity care, disability care, or mental health care. Provides basic care; performs nursing activities (i.e. administering medication; inserting catheters); helps drawing up care plans, and carries them out.
MBO Level 4	VMBO Kb/G/T pathway; Lbo with 4 subjects at D level and one at C level; Mavo with 4-6 subjects at D level; transition certificate 3-4 HAVO; MBO Level 3 diploma	'Nurse'. Works in all kinds of directions in nursing and care, and can be specialized within certain industry. Provides complex care to patients; guides patients in their daily life; independently draws us care plans, and caries them out; coordinates care; takes on leadership roles
HBO Bachelor (Level 5)	HAVO/WVO; MBO Level 4 diploma	'Nurse'. Works in all kinds of directions in nursing and care, and can be specialized within general healthcare, social healthcare, mental healthcare, or nursing gerontology geriatrics. Provides complex care; guides patients in their daily life; independently draws up care plans, signs them off, and carries them out; coordinates care, takes on leadership roles, contribute organizationally to improve the quality of care.
WO Master (Level 6)	VWO or HBO	Research; theory; public health

Note: Level 4 and Level 5 nurses are considered "registered nurses" (RNs) in the international context.

Source: Adapted from "Care and Welfare Courses: Levels," https://bit.ly/3AicxHk, and from "The different levels of nurses," https://bit.ly/3zW4jDs, accessed June 2022.

Exhibit 7a Drawing by Jennifer Bergkamp of Patient "Thomas"



Source: Photographs taken by the artist.

Exhibit 7b Drawing by Jennifer Bergkamp of Patient "Theo"

Source: Photograph taken by the artist.

Exhibit 8 Nurse Team Roles at Buurtzorg

Name	Description
Nurse	Provides nursing and caring
Housekeeper	Organizes facilities, such as the office, and takes care of maintenance
Reporter	Monitors the hours spent by the team on contracts and arrangements with Buurtzorg; monitors the team with regard to hours spent, productivity levels, and communication
Developer	Collaborates with Buurtzorg team members and external stakeholders to share knowledge and participate in relevant external working groups
Planner	Schedules the care commitment according to the arrangement between clients and team members
Team player	Encourages enjoyable working relationships within the team
Mentor	Coaches new colleagues and provides instruction, advice, and feedback. Serves as contact for content-related organizational needs within the team.
Vitality manager	Explores, on behalf of the team, the various vitality-related knowledge and activities within Buurtzorg, taking the initiative to put these topics on the team's agenda. Puts in place activities and measures which can improve personal or team vitality.

Source: "Team Roles," Module Three, *How Buurtzorg Works*, Corporate Rebels Academy, https://bit.ly/3QHb6ry, accessed May 2022.

Exhibit 9 Nursing Salary Scales, March 2022

Nursing Level	Starting Monthly Salary (Minimum)	Starting Monthly Salary (Buurtzorg)
MBO Level 3	€2200.70	€2863.68
MBO Level 4	€2422.65	€2937.68
HBO Bachelor (Level 5)	€2937.68	€3084.18
WO Master (Level 6)	€2937.68	€3783.39

Source: Adapted from the Collective Labor Agreement for Nursing, Care Homes, and Youth Health Care 2022-2023 "The client at the center, THE EMPLOYEE ON ONE!", https://bit.ly/3dqLdOe, and from "CAO VVT salary scales 2022," https://bit.ly/3SKjsjP, accessed June 2022.

Exhibit 10 Performance Scorecard, BuurtzorgWeb

Each nurse team could click through any of the above to access multiple metrics tracking the performance of their teams, including:

1. Average productivity (overtime and relative to the national average)
2. Efficiency (hours per client)
3. History of client hours per week or month
4. Number of clients
5. Average # employees/client
6. Client satisfaction level
7. Employee satisfaction level
8. Average score on team climate
9. MIC (Melding Incidenten Client) report, capturing client incidents

Source: Company documents.

Exhibit 11 Nurses at Buurtzorg Day, 2022

Source: Photographs taken by casewriter.

Exhibit 12 Buurtzorg Initiatives Beyond Nursing Teams

Name	Description	# Employees	# Teams	Separate Entity from Buurtzorg?	Year Started
Buurtdiensten	Domestic help: Small teams providing help with shopping, cleaning, meal preparation, and other domestic activities	3826	446	Y	2009
Buurtzorghuis	Care holiday: Facility offering care for client and family while vacationing during illness recovery or rehabilitation	93	5	N	2009
Buurtzorg Jong	Youth care: One single point of contact coordinating the care of youths (1 week – 23 years), such as risk evaluations, crisis care, parent advising, and care plans as needed	83	12	N	2012
Stichting Maja	Charity: Foundation that supports small, sustainable projects in second/third-world countries financially and with knowledge and experience	4 (Board)	0	Y	2012
BuurtzorgT	Mental health care: Home visits to psychiatric patients involving sessions with no time limits and joint e-learning modules for patients and psychiatric professionals	480	65	Y	2014
Buurtzorg Hospice	Hospice care: Facility offering end-of-life care	89	4	N	2014
Buurtzorg Kraam	Maternity care: Maternity nurses offering support during delivery and up to 10 days after birth	25	4	N	2014
Buurtzorg Pension	Care hotel: Facility offering temporary nursing and care for those who cannot live independently at home for a while, such as due to illness	240	8	N	2015
Buurtwonen	Neighborhood living: Small housing complexes where residents receive care	1	0	N	TBD

Source: Company documents.

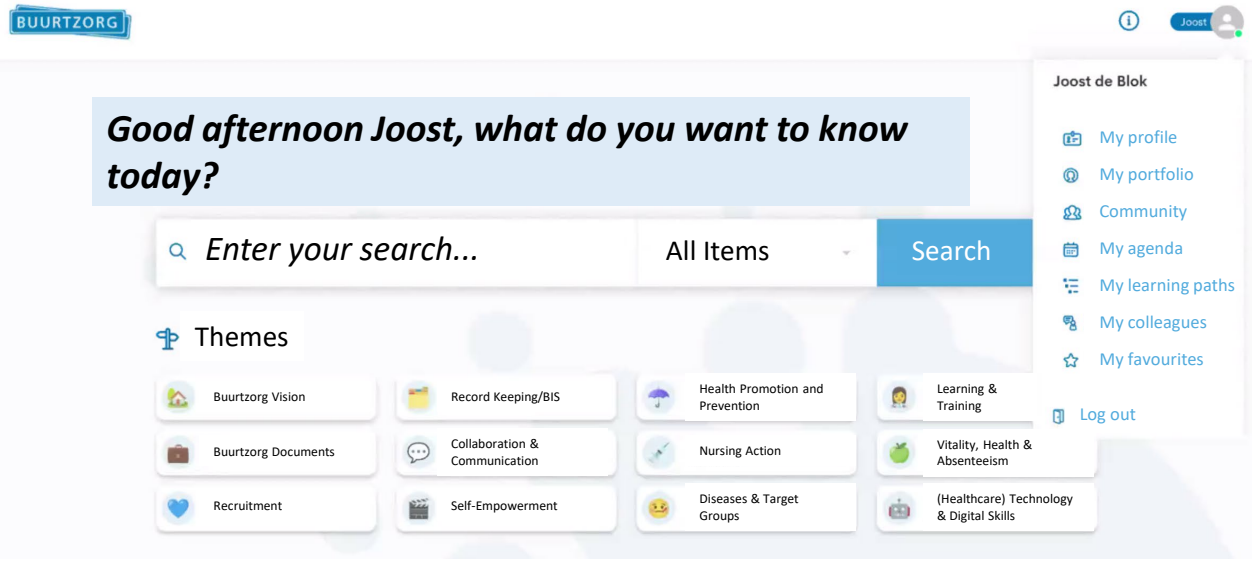
Exhibit 13 List of Buurtzorg's International Partners, 2022

Country	Name
Aruba / Curacao / Saint Martin	Visser Group
Asia	Buurtzorg Asia
Australia & New Zealand	Future Proof
Australia & New Zealand	Viva
Austria	CuCo Communitas GmbH
Brazil	Laços Saude
China	Buurtzorg China
Denmark	Haderslev Municipality
Denmark	Syddjurs Municipality
Denmark	Mannaz Consulting & Education
Finland	Jyväskylän Hoivapalvelut (HOIVA)
France	Soignon Humains
France	3BGA
Germany	Buurtzorg Deutchland
Hong Kong	BOCKH
India	Buurtzorg India
India	Edugreen
Japan	Buurtzorg Services Japan
Solvenia	IZAVA d.o.o.
Sweden	Sonder AB
Switzerland	Seneca Project
Taiwan	THN (Taiwan Home Nursing)
United Kingdom & Ireland	Public World
United States	SwiftShift

Source: Company documents.

Exhibit 14a Themes (main page), BuurtzorgWeb

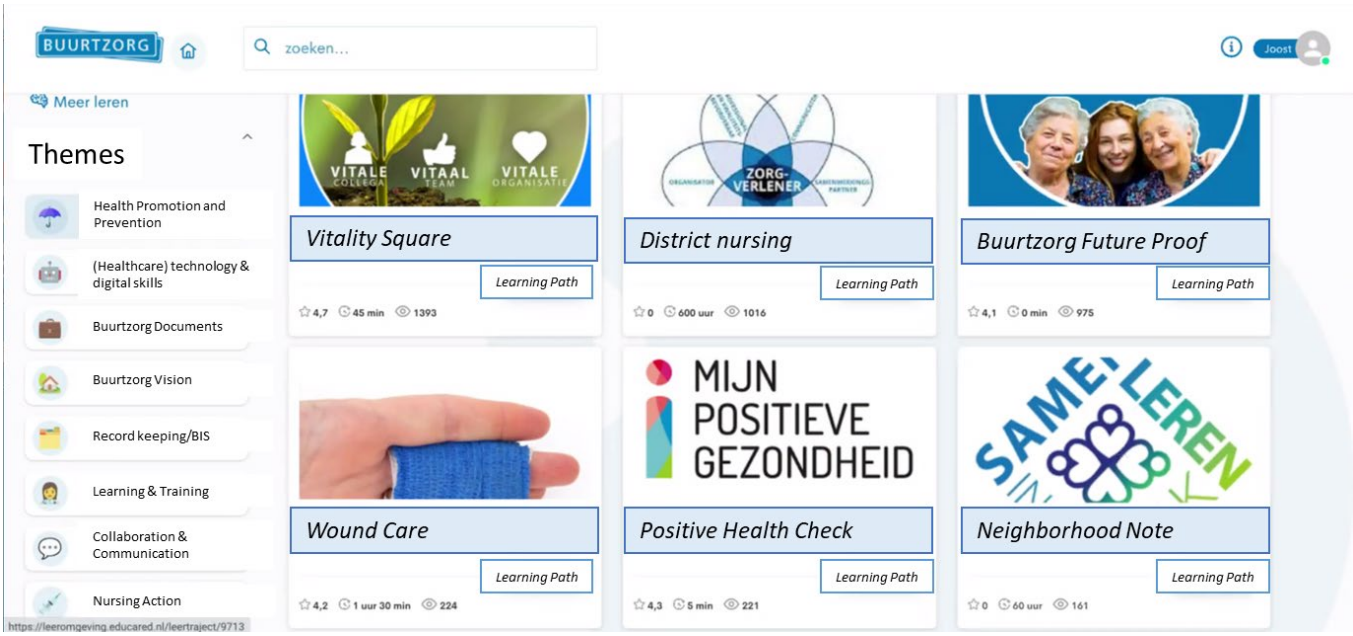
All themes appear in the main "communications" page. Clicking on the "Health Promotion and Prevention" tab will take you to the next screen featured in Exhibit 14b.



Source: Company documents.

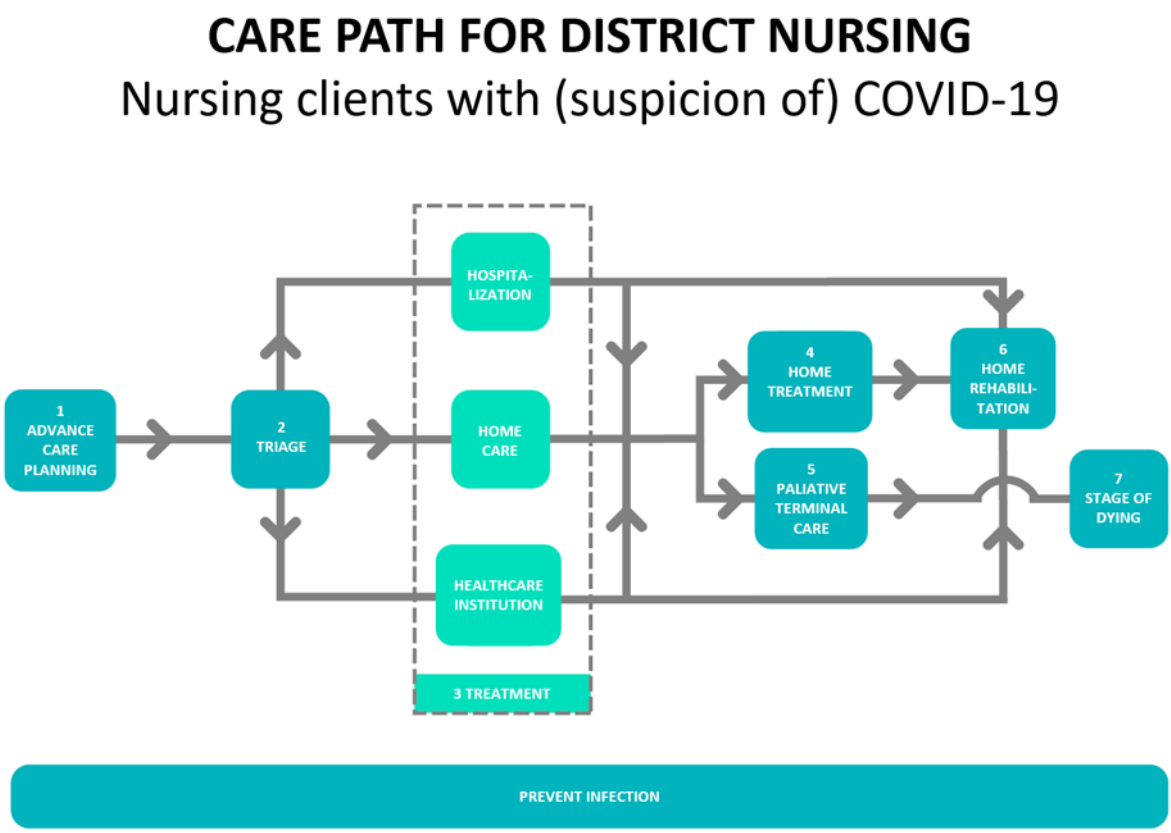
Exhibit 14b Themes (next page), BuurtzorgWeb

All the themes appear in the left column. The boxes in the main screen on the right provide a link to various projects and/or best practices.



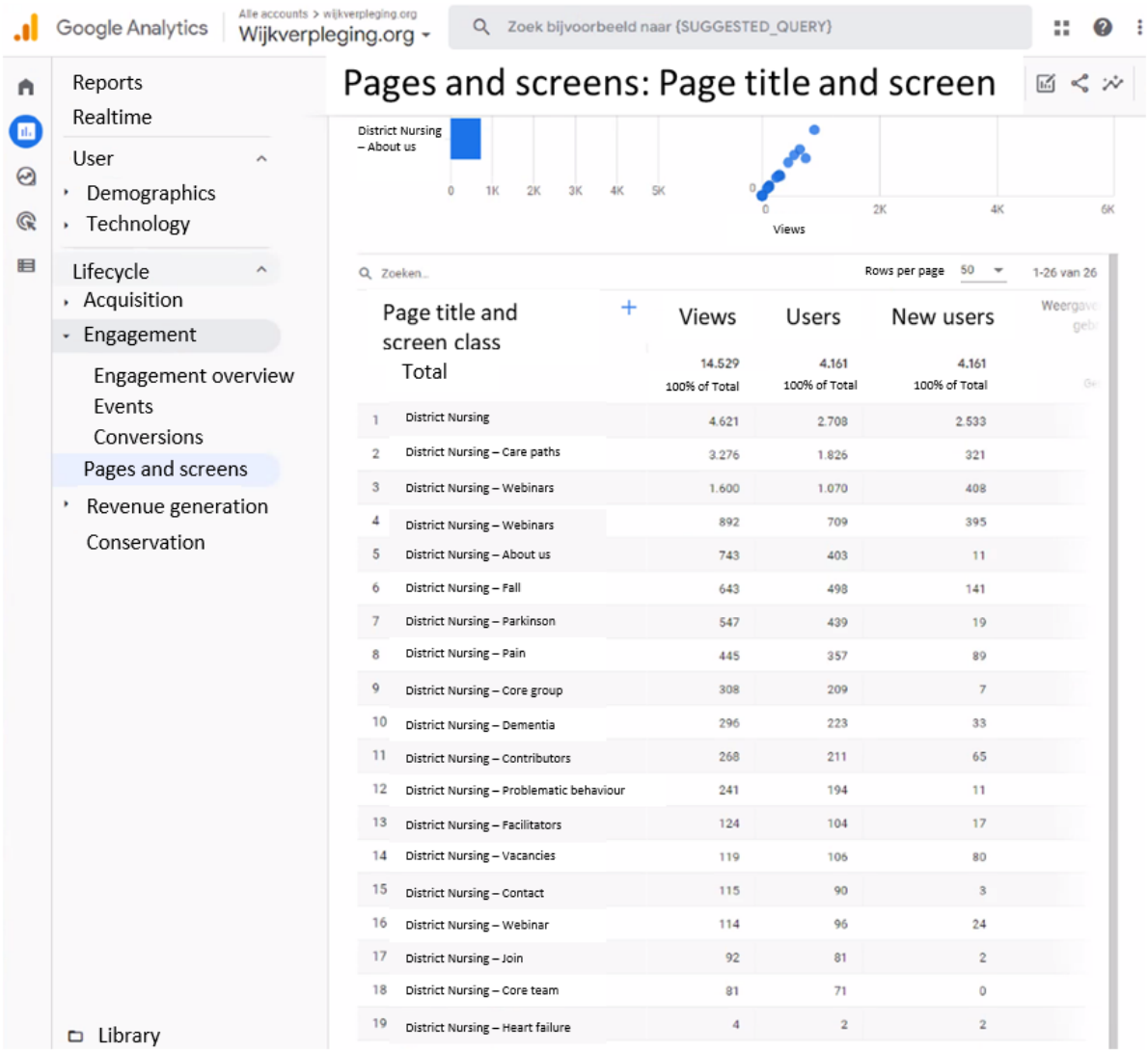
Source: Company documents.

Exhibit 15 Covid-19 Care Path



Source: Company documents.

Exhibit 16 Care Path Usage Metrics, June 2022



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